

Barriers to accessing benefits in a community-based insurance scheme: lessons learnt from SEWA Insurance, Gujarat

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This paper seeks to examine barriers faced by members of a community-based insurance (CBI) scheme, which is targeted at poor women and their families, in accessing scheme benefits. CBI schemes have been developed and promoted as mechanisms to offer protection to poor families from the risks of ill-health, death and loss of assets. However, having voluntarily enrolled in a CBI scheme, poor households may find it difficult or impossible to access scheme benefits.

The paper describes the results of qualitative research carried out to assess the barriers faced in accessing scheme benefits by members of the CBI scheme run by the Self-Employed Women's Association (SEWA) in Gujarat, India. The study finds that the members face a variety of different barriers, particularly in seeking hospitalization and in submitting insurance claims. Some of the barriers are rooted in factors outside the scheme's control, such as illiteracy and financial poverty amongst members, and inadequacies of the transportation and health care infrastructure. But other barriers relate to the scheme's design and management, for example, lack of clarity among scheme staff regarding the scheme's rules and processes, and requirements that claimants submit documents to prove the validity of their claims. The paper makes recommendations as to how SEWA Insurance can address some of the identified barriers and discusses the relevance of these findings to other CBI schemes in India and elsewhere.

Key words: access, community-based insurance, equity, India, inpatient care

Introduction

Any major shock – be it a death, an illness requiring hospitalization or the loss of home or working assets – can upset the precarious financial situation of poor households. Community-based insurance (CBI) schemes have emerged as a mechanism for providing poor households with protection against such risks. Ample evidence exists to show that poor households face barriers to participating in such schemes, most notably premiums that they may find unaffordable (Bennett et al. 1998; Goudge et al. 2003; Jutting 2004). And having enrolled in a CBI scheme, poor households may find it difficult or impossible to access scheme benefits, although this issue has not been researched and documented. This study aims to assess the barriers that members of the CBI scheme run by the Self-Employed Women's Association (SEWA) in Gujarat, India, face in accessing scheme benefits.

Background

While providing poor households with risk protection is recognized as a means of helping households to emerge

from, and stay out of, poverty (Holzmann and Jorgensen 1999; World Bank 2001), mechanisms for risk protection are limited. Traditional mechanisms for managing risks include borrowing, maintaining savings accounts, investing in assets, and participating in revolving savings and credit groups. However, with increasing urbanization and migration, and consequent weakening of traditional social networks, there has been an erosion of these informal mechanisms (Ahmad 1991). Formal social security systems, usually run by government or large-scale employers, tend to cover only those who work in the formal economy, a small percentage of the total population in most developing countries. For wealthier households in developing countries, voluntary, private insurance is a commonly used risk management mechanism. Poor households have limited access to private insurance, both because premiums tend to be relatively expensive and because insurance companies focus their efforts on better-off urban populations as they offer higher-value business (Dror and Jacquier 1999).

CBI has arisen with the broad goal of providing risk protection to poor households. The main initiatives to

provide CBI have been taken by: (1) microfinance institutions (MFIs), guided by their need to protect their loan portfolios (The Microfinance Gateway, undated; MicroSave, undated); and (2) member-based organizations or health care providers who focus on providing health insurance (Bennett et al. 1998; Criel 2000). The latter are often referred to as community-based health insurance (CBHI) schemes.

CBIs initiated by microfinance institutions typically offer a compulsory policy where the member's loan is insured, which serves in lieu of collateral. In the event of the member's death, the loan insurance covers the unpaid loan amount. This insurance also protects the member's family from the liability of an unpaid loan (CARE and Microfinance Best Practices 2000).

Under CBHI schemes, a group of people, a 'community', comes together and voluntarily contributes small amounts to a common fund. When any of the members contributing to this fund falls sick and needs money for treatment, they can use the money in this fund. CBHI thus incorporates the principles of risk-pooling and resource-sharing. In most cases, CBHI schemes have institutional links with one or more health care provider, and in some cases, with formal insurance companies.

Very limited data are available regarding the equality in CBI scheme utilization. What data do exist relate to schemes focusing on health. CBHI schemes in various countries have been shown to have *unequal* patterns of utilization with respect to distance lived from health facilities. Several studies have found that utilization of health care, with the implementation of a CBHI scheme, increases more among insured households located close to the health care facility (Bennett et al. 1998). Criel et al., for example, find that while rates of hospitalization among all members are similar for critical illnesses, members living further away from the hospital facility have lower hospitalization rates for non-critical illnesses than those living nearer the facility (Criel et al. 1999). Since under most schemes, people pay the same premium wherever they live, those distant from the facility (who might in any case belong to poorer, more remote, rural communities) in effect cross-subsidize those who live close to the health facility.

The authors of this paper are not aware of any other studies that have examined the issue of differential utilization of CBI in India, and none which have made an in-depth evaluation of the reasons underlying differential utilization.

While SEWA's insurance scheme has been running since 1992, this is the first formal study on the barriers faced by SEWA's members in using the scheme. Over the years, scheme administrators have periodically recognized difficulties faced by members in using the scheme, and have tried to address these where possible. However, until this research was carried out in 2003, there had been no systematic study to identify a comprehensive list of

barriers faced by members, with formal discussions on the topic with a cross-section of members and grassroots level workers. A specific objective of this research was to design and implement a set of interventions to reduce or eliminate these barriers to the extent possible. These interventions are currently being implemented on a pilot basis. More broadly, this research aims to deepen the, as yet, partial understanding of the multiple barriers that can limit the effectiveness of CBI schemes. If CBI schemes are to realize their potential of reducing vulnerability and increasing access to health care, we need a better understanding of the factors that may inhibit some members, particularly the poor or otherwise vulnerable, from benefiting from the scheme. This study aims to fill this gap by assessing the barriers that members of the CBI scheme run by SEWA face in accessing scheme benefits.

In the following sub-section, we describe SEWA's insurance scheme. This is followed by a description of the methodology used for the study. The third section presents the findings of the study. In the fourth and final section of the paper, we discuss the findings, propose interventions that can be instituted by SEWA Insurance to address the barriers identified, and highlight the implications of the study for other CBI schemes.

SEWA's insurance scheme

The Self-Employed Women's Association (SEWA) is a trade union of informal women workers, started by Ela Bhatt in Ahmedabad in 1972. Headquartered in Ahmedabad (Gujarat, India), and inclusive of members from 11 of the state's 25 districts, 'It is an organization of poor, self-employed women workers... who earn a living through their own labour or small businesses... (and who) do not obtain regular salaried employment with welfare benefits like workers in the organized sector' (Self-Employed Women's Association 1999, p.83). The organization has two main goals: to organize women workers to achieve full employment, i.e. work security, income security, food security and social security; and to make women individually and collectively self-reliant, economically independent and capable of making their own decisions. The union's membership in Gujarat was 469 306 in 2003.

In 1992 SEWA started an integrated insurance programme, SEWA Insurance, for its members. SEWA Insurance provides life, hospitalization and asset insurance as an integrated package. Membership is voluntary. Women are the principal members, and can also buy insurance for husbands and children. Most members pay an annual premium, and this amount is passed on to formal-sector insurance companies, which shoulder most of the financial risk. Members also have an option of making a one-time fixed deposit in SEWA Bank – the interest from this deposit is used to pay the annual premium.

In 2003, people could choose to enroll in the scheme under one of three different policies offered. Table 1 describes

Table 1. Summary of SEWA Insurance's products, 2003 (women)

	Policy I	Policy II	Policy III
Premiums:			
Female annual premium	85	200	400
Female fixed deposit	1000	2400	4800
Coverage:			
Hospital benefit	2000	5500	10 000
Natural death	3000	20 000	20 000
Accidental death	40 000	65 000	65 000
Accidental death of spouse	15 000	15 000	15 000
Asset loss	5000	10 000	20 000

the premiums paid, and the coverage provided, under each of these policies (for the sake of simplicity, data are provided for women members only). Under SEWA Insurance's most popular policy, Scheme I, for example, women paid an annual premium of Rs.85 and in return they were covered to a maximum of Rs.2000 per year in case of hospitalization, Rs.3000 in case of death due to natural causes, Rs.40 000 in case of their own death due to accidental causes, Rs.15 000 in the event that their spouse died due to accidental causes (so-called 'widowhood' insurance), and Rs.10 000 in case of the loss of house or working assets.

SEWA Insurance is run by a team of full-time staff and local women leaders called 'aagewans'. The aagewan is a grassroots level worker who is the primary contact person for the Vimo SEWA member and the critical link between the member and the scheme administrators. The full-time staff include professionals with insurance, public health, medical and information technology expertise.

When SEWA Insurance started in 1992, the primary thrust was on enrolling members in Ahmedabad City. This was because the Insurance team and SEWA Bank (a co-operative bank for SEWA members) were located in the city. As the insurance programme stabilized, it expanded to the rural members in the 11 districts. Membership grew steadily from 7000 in 1992 to over 30 000 in 2000/01. In 2001/02, membership jumped to over 90 000, an increase attributed largely to an increased appreciation for insurance following a devastating earthquake in January 2001. By calendar year 2003, SEWA Insurance had over 110 000 members: over 85 000 adult women and almost 25 000 adult men. Two-thirds of scheme members were in rural areas and one-third in urban areas (i.e. Ahmedabad City). Thirty per cent of the total membership had joined by fixed-deposit and 70% joined by paying an annual premium. The vast majority, 97% of members, were enrolled under the first and least expensive policy.

A 2003 survey, comparing the socioeconomic status of SEWA Insurance members with the general population of Gujarat, found the scheme to be inclusive of the poor (Ranson et al. 2005). Thirty-two per cent of rural members, and 40% of urban members, were drawn

Table 2. Three-year average (2002–2004) of numbers and rates of claims for SEWA Insurance

	Health		Life		Assets	
	Rural	Urban	Rural	Urban	Rural	Urban
Number of claims	1525	1244	271	159	286	1189
Rate per 1000 members per year	21.47	39.57	3.81	5.06	4.02	37.84

Table 3. Average number of days taken to process claims by SEWA Insurance members, rural and urban, in 2004

	Rural	Urban
Health claims	18	7
Asset loss claims	18	10
Natural death claims	18	6
Accidental death claims	47	25

from households below the 30th percentile of socioeconomic status (roughly equivalent to the poverty line in Gujarat).

Table 2 shows the rates of claims submission for rural and urban areas for a 3-year period starting from January 2002. Health insurance claims are the type of claim most frequently submitted to SEWA Insurance. It has been a pattern for many years that rates of claims submission for all types of claims are higher in urban versus rural areas. On average, 10–14% of the claims for sickness and death in both rural and urban areas are rejected.

Table 3 shows the average number of days taken from the time the member registered her claim to the time she received her payment in the year 2004.

The health insurance component of the scheme is of particular interest and concern at SEWA Insurance because: (1) it is the component under which claims are most frequently submitted (see Table 2); (2) communications with members and aagewans indicate that members find it more difficult to access benefits under this component; and (3) the process of claims verification – ensuring that the loss for which a member has submitted a claim actually occurred – is more difficult for health claims, compared with life and assets claims. For the same reasons, the health insurance component is predominant in the findings in this paper. As background, we provide additional detail about the health insurance component below.

Under the health insurance component, the choice of health care provider is left to the discretion of the SEWA Insurance member. Members are eligible for reimbursement whether they use private-for-profit, private-non-profit or public facilities. After discharge from hospital, the SEWA Insurance member is required

to submit the following documents within a 90-day period: a doctor's certificate stating the reason for hospitalization and the dates of admission and discharge; doctors' prescriptions and bills for medicines purchased; and reports of laboratory tests done during the hospital stay. After submission of these documents, the member is usually visited by a SEWA employee who verifies the authenticity of the claim. All documentation is reviewed by a consultant physician, and a final decision on the claim is then made by a claims committee made up of SEWA members and staff. Finally, the claimant is notified of the committee's decision and, when applicable, is paid by cheque.

Exempted from coverage under SEWA Insurance are certain pre-existing diseases (for example, chronic tuberculosis, certain cancers, diabetes, hypertension, haemorrhoids), normal deliveries and disease caused by addiction.

Studies have shown that the health insurance component: (1) provides significant financial protection; (2) appears not to have impacted on rates of hospital utilization; and (3) suffers from inequitable patterns of utilization, by socioeconomic status (in rural areas) and by place of residence (urban versus rural). An analysis of all claims submitted in the 6 years from 1 July 1994 to 30 June 2000 (Ranson 2002) revealed that claims were rejected in 11% of cases. The mean rate of reimbursement for all reimbursed claims was 76.5% (median 92.6%). Reimbursement more than halved the percentage of catastrophic hospitalizations (expenditures >10% of annual household income); for 35.6% of claims, the total spent on hospitalization would have been catastrophic for the claimant, while expenditures by patients after reimbursement were catastrophic for 15.1%. A study, conducted in 2000, compared rates of claims among Vimo SEWA members, ages 18 to 58 years, in 242 Vimo SEWA households (in Anand and Kheda Districts) with age-matched women in 381 non-insured households in the same villages (Ranson 2004). This study found no significant association between membership in Vimo SEWA and frequency of hospitalization. Recent research has found that submission of claims for inpatient care is equitable in Ahmedabad City, but inequitable in rural areas. The financially better-off in rural areas are significantly more likely to submit claims than are the poorest. Members living in areas that have better access to health care submit more claims than those living in remote areas (Ranson et al. 2005).

Methodology

This study aimed to build on past research by exploring the barriers faced by members – particularly poor in rural and remote areas – in benefiting from a CBI scheme. Further, we wanted to understand these barriers in the context of the specific steps that a person has to take in order to benefit from the scheme.

To learn about the nature of barriers faced by the poor, we used a qualitative research methodology. We selected this methodology because the issue being explored was poorly understood. We wanted to have open-ended and wide-ranging discussions to capture the maximum number of possible barriers. Our initial focus group discussions (FGDs) confirmed the complexity of the issue being explored and thus our choice of methodology.

We held four village-level FGDs with members of Vimo SEWA and two district-level FGDs with grassroots level workers (aagewans).

The geographic areas for carrying out the FGDs were purposively selected to include both less developed and more developed regions of the state, and to ensure urban and rural representation. Further, we purposively selected those villages that had at least four to five recent claims, as we wanted to discuss issues around claim submission and reimbursement.

We included only those members who had suffered some loss covered by the scheme. Members who had not suffered any losses were excluded since they would have no experience of seeking reimbursement for losses covered by the scheme.

An effort was made to include relatively poor members, as it was anticipated that they would face more barriers (particularly those related to lack of material wealth) relative to the less poor. In order to include poorer members, we conducted the FGDs in (and thus included respondents from) poorer areas – urban slum areas and villages that are relatively small and remote.

All six of the FGDs were conducted in the Gujarati language and were video-recorded. They were later translated into English and transcribed (simultaneously) by the interviewer(s). The transcribed FGDs were then coded using N-Vivo software. Prior to the FGDs, we had expected to find barriers to seeking hospitalization and barriers to claim submission. On examining the FGD data, we found that members encountered barriers at two more stages: barriers after claim submission and barriers after successful settlement of claim. We therefore coded the FGD transcripts in terms of the stages at which barriers were encountered, and have presented the findings using this same framework.

The transcriptions were read at least twice by the three primary researchers involved in the qualitative research. This was to ensure that we captured all the issues which came up in the discussions and as a way to cross-check our interpretations of the data.

Reports on the findings of the FGDs were prepared and presented to six different groups of aagewans and two groups of scheme administrators and managers. Some of the participants in these groups had earlier participated in the FGDs. The primary objective here was to share the findings with the teams implementing

the programme and to validate the findings. This qualitative research was carried out between March and June 2003.

Results

In this section we present the barriers that emerged from the FGDs.

Stage 1: Barriers to hospitalization

During our FGDs, respondents spoke of three main hurdles that they, and their family members, faced in seeking hospitalization when they were ill. These were:

- (1) Lack of funds;
- (2) Inconvenience caused in the family;
- (3) Distance from hospital.

Lack of funds

The cost of hospitalization was one of the deterrents for seeking hospitalization:

Many (members of Vimo SEWA) just stay at home because they don't have money to go to the doctor... Instead of borrowing it is better not to go to the hospital at all.

(Member in a more-developed rural district)

Inconvenience caused in the family

This barrier was mentioned to us by both members and aagewans. One rural aagewan narrated to us how members, particularly women, were reluctant to seek hospitalization because of household responsibilities:

Sometimes if the woman has to cook, prepare a tiffin (lunchbox), send her children to school, then she avoids getting admitted (to a hospital). She takes some pills and continues with her work...

(Aagewan in a more-developed rural district)

Distance between home and the hospital

Some of SEWA Insurance's members lived in remote villages, which were far from hospital facilities. Transportation was expensive and sometimes difficult to arrange in an emergency:

They have to go to the city from the village to get admitted and transportation is very expensive. So they feel that, "whatever money we will get after claiming from the insurance will be as much as the transportation expenses and nothing will be left with us".

(Aagewan in a less-developed rural district)

Stage 2: Barriers to claims submission

Most of the barriers that members encountered at this stage related to the difficulty of getting the required documents for claim submission. The seven

barriers, somewhat inter-related, that emerged at this stage were:

- (1) Member unclear about documents required;
- (2) Lack of cooperation from doctors in getting the required documents;
- (3) Cost involved in getting documents;
- (4) Delay in claim submission;
- (5) Fear of claim being rejected;
- (6) Aagewan unclear about terms and conditions;
- (7) Member's weak linkages with aagewan.

Member unclear about documents required

The submission of a claim required a specific set of documents. Documents required for accidental death claims or medical claims were relatively more complex, such as a postmortem certificate or complete hospitalization bills and certificates. The information in the documents, such as name, age, date of hospitalization and discharge etc., needed to be correct and consistent in all the papers submitted. Even if members were told about the required documents at the time of insurance purchase, they may not have fully understood the requirements, or recalled these requirements when it came time to submit a claim:

The women are illiterate and women don't understand (when they are told about the documents that are required).

(Aagewan in a less-developed rural district)

Moderator: *Did you know whether the reports of the blood and urine tests have to be given to SEWA Insurance?*

Respondent 1: *No, I didn't know that.*

Respondent 2: *We just don't get any free time from our work. What can we do? We forget everything.*

(Members in a more-developed rural district)

Lack of cooperation from doctor in getting the required documents

Sometimes the doctors did not cooperate with the patients in providing the required documents. This happened particularly if the patient forgot to get the documents at the time of discharge, and returned at a later date to get them:

First I forgot (to take the documents), being in a hurry. I did not remember. Then, after 5 or 6 days, my brother went to get the papers, but he (the doctor) did not give them.

(Member in a less-developed rural district)

When it is a government hospital and the lady has had a surgery there, the doctor will not give the certificates... They (the government doctors) have taken the payment but they don't produce the certificate...

(Aagewan in a more-developed rural district)

Cost involved in getting documents

Getting the required documents could involve more than one trip to a government office (particularly in the case of a death) or to the doctor. This could become expensive, especially if the member lived in a remote village:

Respondent 1: *If she goes to get the documents from the doctor, she loses her wages.*

Respondent 2: *She also has to spend on the fare (for visiting the doctor for the papers).*
(Aagewans in a more-developed rural district)

Sometimes the doctors expected to be paid extra for preparing the bills and certificates:

She (a member) told the doctor that I have insurance, so if you make the bills for me I will get reimbursed. The doctor felt that this woman was going to get money, so he thought, "Let me ask her for some money for myself." So he said, "Give me two-thousand or twenty-five hundred rupees, and I will produce all the documents for you, and you will get money quickly."
(Aagewan in a less-developed rural district)

Delay in claim submission

Generally, SEWA Insurance accepts claims if they are submitted within 3 months of the date of loss. Sometimes members were unable to meet this deadline, either because they were not aware of it or because they were unable to get together all the required documents in time:

The thing is that they are reluctant to come here (to the district office) because they cannot pay the fare. So they do not come here. Here we don't know (about their illness), so we don't go to their village, and 15 to 20 days pass... Another thing is that they are illiterate and women don't understand, so they ask their husbands to file the claim. In all of that time is lost. After the time limit is over they come to us but by then it is too late.
(Aagewan in a less-developed rural district)

Fear of claim being rejected

Sometimes members were pessimistic about their expenses being reimbursed, and so they did not file a claim. This happened particularly if they knew of a previously rejected claim, their own or someone else's:

We just didn't have any wish to file, but all these people said, "Why don't you file." It was not our wish; as we thought that obviously we won't get the money. We didn't get the money last year, how can we get it this time?

(Member in a more-developed rural district)

Aagewan's lack of clarity about SEWA Insurance's terms and conditions

Often members depended upon the aagewan to help them submit their claims, and if the aagewan was unable

to guide them properly, they were not able to submit a claim. In the following case, a member was provided with inaccurate information, based on which she was hospitalized. Later, she learned that she was not eligible for reimbursement:

Afterwards, from the nearby doctor, I got the medicine. Then she (the aagewan) said, "You should get admitted to hospital, then you will get the money." So I got admitted in the hospital for 3 days. I was given intravenous drips for 3 days and the doctor also gave his signature on the hospital certificate. After that she (the aagewan) said that you have an old illness and you cannot get the money for this hospitalization.

(Member in a less-developed rural district)

Member's weak linkages with aagewan

As mentioned above, members often depended upon the aagewan to help them submit their insurance claims. However, if they did not have regular contact or good relations with the aagewan, they could encounter problems in submitting their claims:

Respondent 1: *Those who have a good relationship with the aagewan, get the money.*

Respondent 2: *It has nothing to do with wealth. Those who are close to the aagewan know everything about Vimo so they can easily get the money.*

(Members in an urban area)

Stage 3: Problems in claims processing

Sometimes problems occurred even after claims had been filed, particularly when incorrect or incomplete documents had been issued by the doctor or government official:

My husband went four or five times to get the papers. He submitted the papers and they said that the dates were not right and that there were three or four diseases written by the doctor, so the claim was rejected. Then they (the claims committee) gave the paper back to us.

(Member in a more-developed rural district)

Stage 4: Problems after decision

Even after their claims had been approved, some members faced problems in getting the reimbursement in cash. This occurred when the claim payment was made by cheque. The poor in rural areas rarely have bank accounts. Further, many live miles away from a bank. A claim payment by cheque resulted in additional costs and delays in getting the money. As a member whose thatch and mud hut was destroyed by fire told us:

Actually my expenses (due to the fire) amounted to more than 7000 rupees...and I have received only 2400 rupees... And out of that also, we spent around 100

rupees for opening the bank account along with some money for the transportation, so finally we were left with only 2200 rupees.

(Member in a less-developed rural district)

Discussion and conclusions

Summary of findings

The focus group discussions yielded a total of 12 barriers faced by members in utilizing the insurance scheme. These barriers occurred at any of four different stages of the scheme utilization process: (1) hospitalization; (2) claim submission; (3) claim processing; or (4) getting reimbursed after successful claim submission. The research yielded valuable insights into the nature of the barriers faced at each of the stages.

While we did not try to rank the barriers in any formal way, it was clear that the largest number of barriers related to the process of claim submission (7 of 12), followed by accessing hospital services (3 of 12). This illustrated the complexity of successfully negotiating these two stages. As expected, given that SEWA Insurance targets poorer women and their families, some of the barriers related directly to lack of material wealth; for example, lack of money to pay for hospitalization, and the costs associated with compiling documents for an insurance claim. Other barriers were less clearly related to wealth, such as ‘inconvenience caused in the family’ as a barrier to seeking hospitalization, and the member’s lack of clarity about the necessary documents as a reason for failing to submit a claim.

Strengths and limitations of study

The strength of this methodology was that we were able to talk with SEWA Insurance members and staff in relatively un-structured group discussion settings, and across a wide geographic area. The fact that, toward the end, relatively few new barriers were emerging in the FGDs and interview, suggests that our findings about the range of possible barriers are fairly comprehensive for this particular insurance programme.

A second strength of the study was that it explored barriers from the perspectives of both members and aagewans, and in rural and urban areas. This diverse group of respondents helped us to explore barriers at different stages in the claims process, and across the different geographic areas where SEWA Insurance operates.

A limitation of this study was that we were not able to rank barriers in order of importance. The reason for not ranking the barriers was the small and diverse nature of the respondent pool. Most of the respondents (and members in particular) could speak from personal experience about, at most, a few of the barriers. Although we experimented with a ranking exercise in two of the FGDs, respondents found the exercise too abstract given

that they did not have first-hand experience relating to most of the barriers.

Secondly, the sampled respondents may not have been ‘representative’, strictly speaking, of SEWA Insurance’s members and claimants. The members were selected largely from a list of members who had actually submitted claims to SEWA Insurance. Additional barriers may have emerged had we included more respondents who were members of SEWA Insurance, and who had incurred a loss eligible for reimbursement under the scheme, but who had not actually submitted a claim. Including such respondents was difficult as there was no ‘ready’ list of such members with SEWA Insurance; they would have to have been identified either by a fairly large-scale survey (large given that the events insured against are relatively rare), or through the social networks of members and aagewans (a time-consuming task given that friends and neighbours were often unclear about the nature and/or timing a loss). Furthermore, as described in the methodology, we did attempt to include poorer members in the FGDs; thus, respondents may have been poor, relative to the membership overall. Findings may have been different had we instead tried to include less-poor members of the scheme. The lack of a truly representative sample also meant that we may have given too much attention to barriers that were relevant to only a small minority of members. We tried to avoid this bias by removing from our results those barriers that arose in our discussions a single time only.

Finally, the fact that these data were collected through focus group discussions meant that individuals may not have expressed their own definitive view. ‘They are speaking in a specific context, within a specific culture, and so sometimes it may be difficult for the researcher to clearly identify an individual message’ (Gibbs 1997). Consciously or sub-consciously, respondents may have voiced opinions that they thought would be most acceptable to the interviewers, or to other respondents. Members and aagewans alike may have withheld some of their complaints about the insurance scheme, for fear that this would displease the interviewers. Members may be more likely to share experiences that they felt would amuse, or resonate with, other respondents. We have tried to avoid such biases in reporting by having claimants tell the stories of what actually happened with their insurance claims, with minimal reliance on hypothetical questions.

Recommendations: how SEWA Insurance could respond to the findings

Before discussing the ways in which SEWA Insurance can respond to the findings, we discuss the factors which underlie the barriers to using the insurance scheme, and the extent to which the underlying factors (and the corresponding barriers) are amenable to change by SEWA Insurance (Figure 1). Some of the barriers are rooted in factors largely outside the scheme’s control, such as the financial poverty of members and other

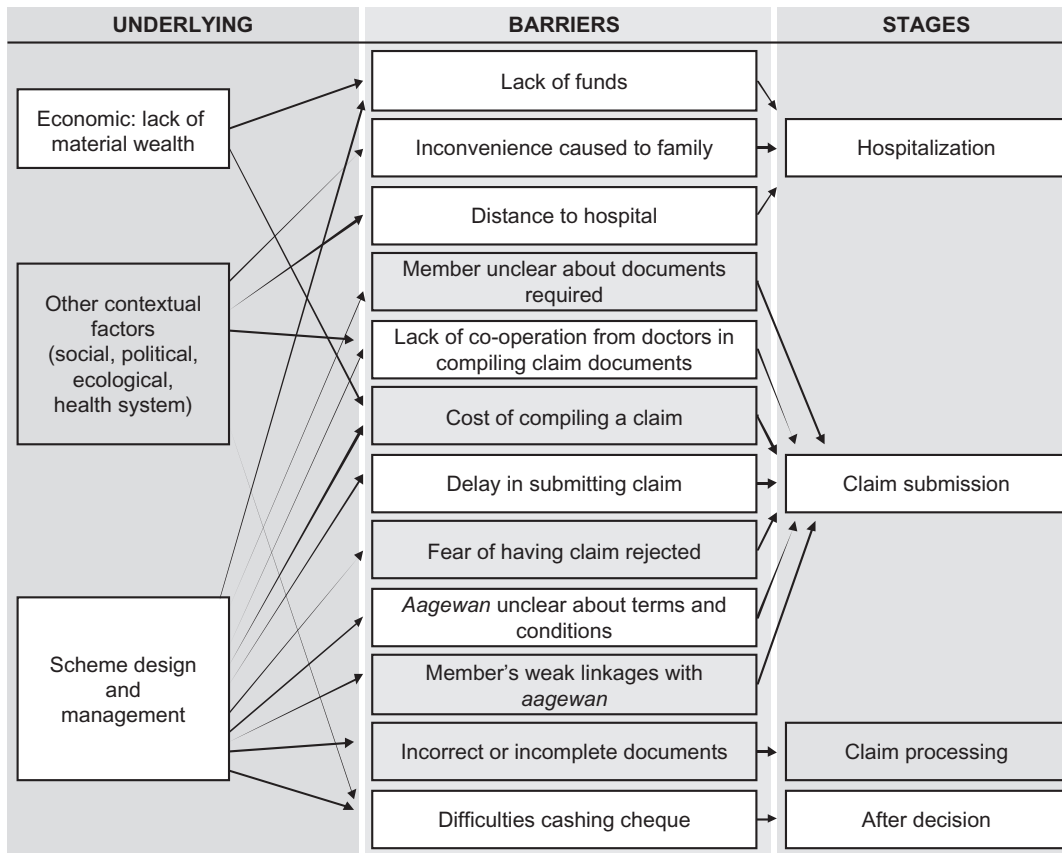


Figure 1. Relationship of identified barriers and stages to underlying factors

contextual factors. Other barriers relate largely to the design or management of the scheme.

Financial poverty directly underlies two of the barriers; lack of material wealth may prevent sick members from seeking hospitalization (as they know they will face both indirect and direct costs), and it may prevent those who have incurred a loss from submitting a claim (as there are costs associated with compiling documents and getting the claim to SEWA Insurance). Although not illustrated in Figure 1, financial poverty is correlated with other contextual factors – such as illiteracy and lack of abilities and confidence to negotiate formal systems – that make it harder for the poor to benefit from an insurance scheme.

A second group of underlying factors are contextual factors other than the material wealth of households. This category includes socio-cultural factors; for example, the fact that women bear many responsibilities within the home, such as cooking, cleaning and childcare, which may hinder their ability to go for health care or hospitalization. It includes limitations in the health care and transportation infrastructure, which may make hospitalization difficult. And this category includes socio-political factors. For example, the claims process is made harder because doctors and government officials at times charge unofficial fees, or behave in an uncooperative manner. While the contextual factors are surely important, they

lie largely outside the control of SEWA Insurance administrators.

Thirdly, the way the CBI scheme is designed and managed underlies many of the barriers identified in this study. For example, while difficulty in getting the required documents from uncooperative government officials and doctors is linked to systems external to the programme, the fact that these documents are required is a design feature of the programme. These documents are required because this particular insurance programme allows members a choice of health care provider, which in turn necessitates supporting documents for medical claims to minimize fraudulent claims. Similarly, the barriers relating to lack of clarity among the aagewans about the scheme's rules, and to insufficient contact between members and aagewans, are also programme linked. Aagewans are selected from among the members' communities so that there is periodic interaction with the members and greater trust in Vimo SEWA. However, drawing aagewans from relatively poor communities means that they come with limited capacities. Building the capacities of these local aagewans so that they are able to fully comprehend and communicate fully all the features of the scheme is a challenge.

The following are three main recommendations that relate directly to SEWA Insurance scheme design and

management, and attempt to overcome one or more of the barriers identified in this study.

Institutional linkages with providers

We recommend that SEWA Insurance link up with select hospitals to provide services to insurance members, with reimbursement provided directly to the hospital. This would help to address 'lack of funds' as a barrier to hospitalization. As well, it would remove many of the barriers associated with filing a claim, as claims submission and processing would become the joint responsibility of the hospital and SEWA Insurance.

There are a number of factors which make the implementation of these linkages a challenge, and in fact prevented SEWA Insurance from implementing them at an earlier date. First, it has been difficult, from a policy perspective, to move away from a model where insured members can choose their inpatient provider, and towards a model where the choice of provider is somewhat restricted. This is because one of the underlying beliefs at SEWA Insurance is that women should be empowered to choose their own health care provider. Secondly, many of the hospitals most suitable for these linkages (based on acceptable quality and low cost) are public hospitals. Establishing direct financial ties with public hospitals in India is difficult largely because the authority for signing formal agreements or contracts lies not with hospital administrators but with municipal- and state-level authorities. Thirdly, selecting hospitals for tie-ups, communicating with hospital administrators, and monitoring the cost and quality of service provision requires some level of public health technical expertise. It will take time to establish such expertise at SEWA Insurance, and the marginal costs associated with the new processes and personnel will also need to be carefully considered.

Intensified contact with scheme members

Insurance is a new product for the poor, with relatively complex terms and conditions. Generally at SEWA Insurance, members are provided with information about the scheme and its processes by the aagewan, only at the time of the annual insurance campaign. Given the struggles in the lives of the poor, the insured may forget the terms and conditions of their insurance, and sometimes even the fact that they have bought insurance. We recommend that, at least during the first couple of years of their membership, the insured be provided with one or two face-to-face reminder visits. This can be expected not only to improve members' knowledge about the scheme, and facilitate the submission of claims (for example, by providing an opportunity to hand claims documentation directly over to the aagewan), but also to build the members' stake and trust in the system (Schneider 2004).

The main constraints to implementing these reminder visits are cost and coordination. With two-thirds of its members in rural – sometimes isolated and difficult to

reach – areas, it can take a considerable amount of time and effort to reach members' households. The costs – of transportation, aagewans' time, and supervision and coordination – will all need to be carefully monitored, and weighed against the added benefit of the visits. Secondly, the capacities for planning and supervising these visits to tens-of-thousands of households each year will have to be strengthened.

Capacity-building and supportive supervision of aagewans

The aagewans are the critical link between the members and the insurance programme. The crucial role of such a cadre in improving implementation and access to services has been widely accepted since Lipsky's work on street-level bureaucrats (Lipsky 1980; Walker and Gilson 2004). We recommend that these aagewans should receive enhanced training to ensure that they understand the scheme's rules thoroughly and can clearly communicate these to the members. As well, it is important to ensure that they are getting adequate support to perform their roles, and also to provide regular oversight and encouragement. Providing supportive supervision to the aagewans will improve motivation and performance levels (Marquez and Kean 2002).

The main constraints to this intervention are the baseline capacities of some aagewans, and lack of personnel and skills for training and supportive supervision. The fact that many of the SEWA Insurance aagewans, particularly in rural areas, cannot read and write poses a limitation to the extent to which they can learn and retain information. Providing periodic training to and intensified supervision of aagewans, of whom there are currently more than 100, will require a great many more supervisors skilled at working with and supporting the aagewans in their work than currently exists.

Conclusions: implications of the findings for other countries and schemes

The lessons learnt from SEWA Insurance's experience have policy implications for community-based financing schemes in other settings, and for governments and donors more broadly.

Firstly, the SEWA Insurance experience highlights just how tricky it is to make such schemes 'user friendly', particularly when the target group includes the socially disadvantaged, for example poor, illiterate, female. On the one hand, the underlying ethos and objectives at SEWA Insurance are client-oriented; this is reflected in changes made to the scheme over time to respond to the needs voiced by members, and by the fact that membership in the scheme has risen fairly consistently from one year to the next. Nonetheless, scheme members and staff voiced a variety of different barriers that prevent members from actually using the scheme. Thus, community-based financing schemes, governments and donors need to pay heed to, and document, how well such schemes are actually working for their members.

Secondly, this research suggests that CBI schemes must have in place mechanisms for *actively* identifying and assessing problems faced by members in using the scheme. It is unlikely that routine quantitative monitoring – for example, examination of claims rates – or even consumer complaints systems which require the consumer to take the initiative in registering a complaint (e.g. telephone hotlines or drop-boxes) would be effective in this regard. Methodologies which can be used in identifying and assessing barriers include: (1) FGDs and in-depth interviews, particularly as a first step, when the nature (i.e. type) of barriers is not known; (2) consumer satisfaction surveys of claimants to explore (and quantify) the problems faced by those who have actually submitted claims; and (3) consumer satisfaction surveys of members to explore (and quantify) factors that have prevented members from submitting a claim.

Thirdly, the research points to ways in which governments and donors might support CBI schemes. Firstly, it remains the responsibility of government to address many of the barriers that lie outside the CBI scheme's control. For example, government can help to improve access to scheme benefits, particularly among those in isolated rural areas, by: improving the quality of roads and access to public transportation; ensuring that rural primary health centres and hospitals are fully staffed and equipped; and providing rural communities with telephone connections. Secondly, government and donors can facilitate the exchange of information between CBI schemes, such that lessons learnt by one CBI can be shared among others. Thirdly, financial and technical support may be required by schemes that have identified barriers, but require assistance in overcoming them. Fourthly, government and donors can encourage research which examines barriers to CBI scheme utilization and the relative cost-effectiveness of mechanisms to overcome them.

Finally, this research suggests that there are some barriers to CBI scheme utilization which will be very difficult to overcome – through efforts of the CBI scheme itself, government, or donors – except in the very long term. The complete absence of inpatient facilities in some remote, rural areas is one example. The fact that women bear domestic responsibilities in the home that may prevent them from seeking care is another. Both of these barriers should be addressed, but overcoming them will be a complicated and long-term process. In the interim, CBI administrators need to be aware of such barriers, to monitor the rate of claims among disadvantaged groups relative to others, and to consider charging lower premiums (or providing additional benefits) to members who have restricted access to benefits. It might make sense, for example, to charge higher premiums to those who live nearby to inpatient facilities than to those who live further away, as is the practice at a number of CBI schemes (Bennett et al. 1998).

References

- Ahmad E. 1991. Social security and the poor: choices for developing countries. *The World Bank Research Observer* 6: 105–27.
- Bennett S, Creese A, Monasch R. 1998. *Health insurance schemes for people outside formal sector employment*. Geneva: Division of Analysis, Research and Assessment, World Health Organization.
- CARE and Microfinance Best Practices. 2000. *International discussion forum on micro-insurance: report on the proceedings*. Dhaka: CARE, Bangladesh and Microfinance Best Practices Project.
- Criel B. 2000. *Local health insurance systems in developing countries: a policy research paper*. Brussels: Directorate-General International Co-operation.
- Criel B, Van der Stuyft P, Van Lerberghe W. 1999. The Bwamanda hospital insurance scheme: effective for whom? A study of its impact on hospital utilization patterns. *Social Science and Medicine* 48: 897–911.
- Dror DM, Jacquier C. 1999. Extending health insurance to the excluded. *International Social Security Review* 52: 71–97.
- Gibbs A. 1997. Focus groups. *Social Research Update* issue 19, online. Guildford: University of Surrey. Available at: [<http://www.soc.surrey.ac.uk/sru/SRU19.html>].
- Goudge J, Khumalo N, Gilson L. 2003. *Breaking barriers: which policy options can improve access to health care for the poor?* Johannesburg: Centre for Health Policy, School of Public Health, University of the Witwatersrand.
- Holzmann R, Jorgensen S. 1999. Social protection as social risk management: conceptual underpinnings for the Social Protection Sector Strategy Paper. Washington DC: Human Development Network, The World Bank.
- Jütting J. 2004. Do community-based health insurance schemes improve people's access to health care: evidence from rural Senegal. *World Development* 32: 273–83.
- Lipsky M. 1980. *Street level bureaucrats: dilemmas of the individual in public service*. New York: Russell Sage Foundation.
- Marquez L, Kean L. 2002. Making supervision supportive and sustainable: new approaches to old problems. *MAQ Papers*, no. 4. Washington DC: USAID.
- Microfinance Gateway, undated. The Microfinance Gateway, online resource for the microfinance industry. CGAP, Washington DC, USA. Website: [<http://www.microfinancegateway.org>].
- MicroSave, undated. MicroSave – market-led solutions for financial services. Nairobi, Kenya. Website: [<http://www.microsave.org>].
- Ranson MK. 2002. Reduction of catastrophic health care expenditures by a community-based health insurance scheme in Gujarat, India: current experiences and challenges. *Bulletin of the World Health Organization* 80: 613–21.
- Ranson MK. 2004. The SEWA Medical Insurance Fund in India. In: Preker A, Carrin G (eds). *Health financing for poor people: resource mobilization and risk sharing*. Washington DC: The World Bank, pp. 275–92.
- Ranson MK, Sinha T, Chatterjee M et al. 2005. Making health insurance work the poor: learning from SEWA's community-based health insurance scheme. *Social Science and Medicine*: in press. July 27; [Epub ahead of print].
- Schneider P. 2004. Why should the poor insure? Theories of decision-making in the context of health insurance. *Health Policy and Planning* 19: 349–55.
- Self-Employed Women's Association. 1999. *Self-Employed Women's Association: Annual Report 1999*. Ahmedabad: SEWA.
- Walker L, Gilson L. 2004. We are bitter but we are satisfied: Nurses as street level bureaucrats in South Africa. *Social Science and Medicine* 59: 1251–61.
- World Bank. 2001. *World Development Report 2000/2001: attacking poverty*. Oxford: Oxford University Press.

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