Healthcare Woes at Bottom of the Pyramid: Mutual Aid to the Fore!

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Abstract

This exploration is based on a recent interaction[1] with Shailabh Kumar, Director and Founder of Pune based ***Uplift Mutuals****. Uplift Mutual has ably demonstrated how a health insurance mutual can successfully address the challenges faced by this segment. What has been highlighted here is based on their experiences in the slums of Pune, Mumbai and tribal areas of Rajasthan and Gujarat. An excellent prototype for the much-desired safety network here in India.*

Introduction

A mutual is an entity which collectively pools its members' risks, as opposed to transferring the risk to an insurer. The entity collects the premiums from its members and pays out the claims itself. The funds are retained and redistributed within the group. Members will donate funds (premium or contributions) into a pool held by the Mutual. In event of a deficit, members can be asked to make either supplementary payments or reduce the entitlement to loss compensation. Mutuals have had a long history but have declined in numbers as many have demutualised. The pandemic has brought back the spotlight as 'a radical practice is suddenly getting mainstream attention.'Mutual aid is proving to be a big boon in very many creative ways for those left outside the safety network, even in the USA[2].

There was strong sense of anticipation twenty plus years ago that with the opening of the insurance business the Mutuals would be allowed to set up shop here. However, it did not happen. Covid-19 has laid bare how broken our healthcare system is particularly for the vast population at bottom of the pyramid.

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1. *"7,000 people slip into poverty every hour in India because of catastrophic health expenses": www.thediversityblog.com (May 2, 2020).*
2. *https://www.newyorker.com/magazine/2020/05/18/what-mutual-aid-can-do-during-a-pandemic (May 18, 2020).*

Symptoms: Say it all!

Primary Health Care	Rural / Tribal villages	Urban Slums
Availability	Low to negligible availability (non-working PHCs). Mostly Govt. facilities dotted with informal private providers and faith healers.	High availability, mostly private facilities. Public facilities either closed or staff unavailable. People prefer going to OPDs in public hospitals.
Accessibility	People prefer faith healers and local quacks. PHCs are far away and most of the time are turned away because of absence of medical staff. Where NGOs work, accessibility is better.	Doctors of all kinds are available within a kilometre's distance. Private facilities are open based on people's convenience whereas public facilities have fixed time often not matching with people's availability.
Affordability	Low to extremely low. People prefer giving in kind to faith healers, charge low or give on credit. PHC are almost free but many times medicines are not available hence they have to buy from outside.	Can afford up to Rs. 100 a consultation but should include three-day medicines (mostly generic). Otherwise short-term borrowing for managing cost of medicines.
Quality	Almost nonexistent, do more harm than good.	Doctors/Medical that provide immediate relief are preferred - very high use of steroids. Quality docs are available but navigation towards them is a matter of chance.
Seeking behavior	Waiting period ranges from 2-7 days before showing to anybody as distance and affordability major issue.	As availability is high, waiting time to seek care is lower but may hop from one to three doctors if no immediate relief.
Gender	Women and girls suffer the most.	Discrimination exists between girl and boy but in certain communities, overall lower than rural areas.

Diagnosis: Primary healthcare - deficiencies

7,000 people slip into poverty every hour in India because of catastrophic health expenses. 70% of all out of pocket expenses on health care are on medicines and OPD. A look at the macro level data shows that if a good primary healthcare ecosystem is available, the poor will be able to take care of his/her health much earlier and much better. Primary healthcare with quality accessibility and good referral facilities is essential if the poorest of the poor must grow out of that situation. There are some very exhaustive public programmes available on maternal and infant health. What is, however, amiss is the primary screening facilities including pediatric, gynecology and geriatric ones.

Shailabh Kumar alludes to some shocking healthcare expense induced bankruptcy triggers for poor families. Desperation drives people to health loans at 120% per annum and children get pulled out from school as one of the first casualties of health indebtedness. Uplift has seen many families indebted for life, paying interest over two generations, losing all their savings, paying 50-70% of their income to health loans. There are also enough instances of families stopping to buy care for lack of financial resources specially for the elderly, particularly their monthly medicines. And this is not just a rural but also an urban phenomenon, he says.

COVID-19 has laid bare the faulty thinking that the Government should increasingly move from building health care infrastructure to health financing. Healthcare and education are two extremely critical infrastructure that need to be publicly funded. There are already many good practices available across states that can become the foundation of a comprehensive primary healthcare ecosystem. There are strong lessons emerging from the states that have been able to contain COVID and we must not lose them be it Kerala or Karnataka.

Prescription: Moving away from 'antibiotic' to 'vitamin' approach

The existing form of health insurance, he says, takes an 'antibiotic' approach - with no interest in keeping people healthy. Its current design is vastly different from what people want. Uplift Mutuals wishes to transform it to a 'vitamin' approach which prioritises well-being.

It is time to talk about yet another'P', reminds Shailabh. What he calls the Public, Private and People Partnership. Government and Private interventions have their benefits and shortcomings but what is acutely lacking in the country is people participation in health. Likewise, the supply side is far better organised than the demand side. If demand can be organised too, we have greater chances that health infrastructure whether public or private will be better utilised. From his personal experience health infrastructure at the primary health care level can have PPP but it should have a people financing component like an OPD cover insurance.

In the current circumstances, for instance, Gurudwaras are doing commendable work locally and internationally - to fill the glaring vacuum in healthcare space. Shailabh seriously believes that the Gurudwaras and the likes can easily become a mutual health protection provider given the

quality of solidarity and responsibility they command with their patrons. They could become the provider of primary health care financed through a mutual risk sharing model in the first stage.

Any people-based infrastructure can organise or express demand better than a public or private entity. This is what a community based, or mutual insurance model does, he highlights. For example, within Uplift Mutuals when they sat with poor women to design a mutual solution this group was very clear that they would need this protection when they are old and hence the elderly should not be excluded from entering the risk pool. In another instance they covered transportation costs for normal pregnancies as women said that this would heavily encourage institutional deliveries in rural areas. These features which come from listening to the ground are the ones often missed by commercial players.

India, he rightly reminds, has had only one model of insurance when there are others available too. What is needed is a multiplicity of models given that insurance is a very perception driven offering. Mutuals build solidarity and responsibility from bottoms up. They are the building blocks that can be utilised by either public or private insurers to build better and larger covers. Without a mutual base which focuses on risk reduction and good insurance behaviour neither public nor private insurance solutions can last for long or will last with massive exclusions and control. It is this mutual platform that works as the first line of defense in any problem.

By design self-help groups (SHG) can bring about the much-desired diversity into insurance. The women driven model for instance. However, he cautions that one cannot leave all to the women (they are already doing majority of the housework). It calls for handholding, technical training, technology infusion, transparency, good governance protocols and the ability to take feedback from everyone without fear or favour. There is a gestation period of about 3-5 years where all this should happen. Their experience shows that once the system is in place, it works without supervision, has quality checks and controls - an SHG design is one of the most suitable form of institution to run insurance. At Uplift Mutuals all the technical work has been taken away from women. They participate mostly in decision making across the functions (product, process and risk reduction design, claims settlement, policy governance) aided by a technical team.

In conclusion

With two decades since its liberalisation, the Indian insurance business needs to revisit the areas that need crying attention. The crumbling primary healthcare infrastructure poses a serious challenge to those in the extreme margins of our society. Penetration into this segment calls for a differentiated approach. A mutual model in the health insurance space is one such with an emphasis on people participation. Uplift Mutuals, a successful prototype, has some valuable lessons to share. The vision of its founder to be an 'Amul' of health insurance sets the bar rather high.

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