

82 *Promoting equity in a community-based health insurance scheme*

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The purpose of this study was to improve the equity impact of a large CBHI scheme (Vimo SEWA) in India. We assessed the distributional impact of the scheme at baseline and end line. Household and member surveys assessed the extent to which members represented the general population, and surveys of claimants assessed their SES relative to that of members.

Baseline research showed that, in terms of membership, the scheme was inclusive of the poorest in rural and urban areas. In terms of insurance utilization, the scheme was equitable in urban areas. In rural areas, however, poorer members submitted a much smaller proportion of claims compared to better-off members. Qualitative research revealed that barriers faced by the poor included poor understanding about the scheme's benefits, lack of ready cash for hospitalization and difficulty in negotiating formal systems.

Based on the qualitative research, we designed and implemented two interventions aimed at improving the scheme's equity. One intervention, "After sales service and supportive supervision" (AfterSS), involved house to house visits to educate members about the scheme, leaving them with a visible reminder of their membership, and with a postcard to communicate with the insurance office. The second intervention, "Prospective Reimbursement" (PR), ensured that members received their claim reimbursement while still in hospital, with a Vimo grassroots worker taking care of the required documents. The research project was carried out as a cluster randomized trial, using a two-by-two design. Equal numbers of clusters were randomly assigned to each of the two interventions, both the interventions together, or "control areas".

This trial demonstrates that, in a community-based insurance scheme in rural Gujarat, neither switching from reimbursement to up-front payment nor strengthening contacts between members and administrators was sufficient to ensure that the poorer members in each sub-district were able to enjoy the greater share of the scheme benefits. Instead, the claims rate increased significantly across the study area, and members in all sixteen sub-districts became slightly less poor relative to the background population. This was in spite of the fact that we achieved high rates of coverage with our interventions, with little leakage from one intervention area to another or from intervention to standard scheme areas. The interventions themselves were designed based on extensive qualitative research about the barriers that might prevent poor members making a successful claim (Sinha, Ranson et al. 2006).

The end-line survey found a significant increase in claims rates across the study area. Claim submission increased as a result of interventions that appear to have strengthened awareness of, and trust in, a CBHI scheme. However, the interventions did not result in a significant increase in claims from poorer members in each sub-district. This may be due to the fact that the interventions addressed barriers faced by the rural membership in general and not specifically the poorest rural members.

This research has important implications for policy and practice in various settings. Even when CBHI schemes are inclusive of the poor, they must be carefully monitored to ensure equitable utilization. Having purchased insurance, poor members in rural areas may require support in order to overcome the barriers they face in accessing health care and submitting claims.