A Study of Women Empowerment & Community Participation in Health Insurance Awareness in India

S T Krishnekumaar[1]

Deputy Vice President

IndusInd Bank Ltd.

PhD Research Scholar

Sri Chandrasekarendra Saraswathi ViswaMaha Vidyalaya University,

Enathur

Dr k s Meenakshisundaram[2]

Professor& Director

Lakes Institute of Management,

Manamai, Chennai

Abstract:

Women are the backbone of the family as a Home maker as well as an employee workforce. Since they are often busily engaged taking care of home and their work places, most of them ignore their routine Health Checkup unless otherwise it is warranted**.** The present paper will discuss and try to high light women towards health insurance and in particular their Awareness, Attitude & Adoption of the Health Insurance by Women. Further the Study will be focusing on the implications of the Women due to underinsurance & noninsurance. There has been Community participation in the reach of Health Insurance Inolvement of Communities in various aspects of health system when Sydney Kark introduced concept of Community Oriented Primary Care based on experience in South Africa. Similarly in Large experiments of provision for health care were conducted in locations like Jamkhed and Mandwa in India. The effectiveness of structured teaching programme on perception care was also formed a part of the study in Erode in Tamilnadu and Bangalore in Karnataka in India.This study will be with the conclusion suggesting the avenues of overcoming the burden.

KEY WORDS: NGO's – Non-Governmental Organisations, CBO's – Commnity Based Organisations, CHW – Community Health Workers, CHI- Community Health Insurance, CMHR - Community Monitoring Health Rights.

Introduction:

There is an urgent need to investigate and to know about the Women Empowerment & Community Participation in Health Insurance Awareness in India and this idea for this paper emanated on women's day by mu Research Guide throwing light onthis topic on Women's Day 8.3.2015 which has resulted in dissemination of the Researcher on this topic since majority of Women in India

especially in Rural were engaged as agricultural labourers and they need to be empowered by protection of health to carry out the tasks involved.

Objectives of the study:-

1. To assess the pretest of knowledge on pre-conception care among experimental and control group.
2. To assess the effectiveness of structured teaching programme on pre-conception care by comparing the pre-test and post-test level of knowledge among experimental and control group.
3. To compare the post-test level of knowledge on pre-conception care between experimental and control group.
4. To find the association between post-test knowledge on pre-conception care of experimental and control group and their selected demographic variables.

Dual roles of women as caring mother and an Ideal Business Manager:

According to Templeton (1980), the study revealed that many women are not in opposition to take care of their occupational pension rights during breaks in employment because of caring responsibilities. The use made by separate actuarial tables often leads to unequal treatment of women and men in pension plans.

Some important views on Women by authors from Centuries :

- Hate (1978) in her book stated that there is a positive change in the political, economic and social status of middle class working and non-working women living in four cities in Maharashtra with the advent of independence.
- Armstrong (1979) revealed that higher level employees care more for self actualization values like Career Advancement, Recognition and Independence whereas lower level employees care more for salary, fringe benefits and happiness.
- Henley(1979) stated that Women are subject to more observation because of the figure and clothing and are more conscious about their visibility.
- Kapur (1979) has shown that twin roles of women cause tension and conflict due to her social structure which is still more dominant working women in Delhi shown that traditional authoritarian set up of Hindu social structure.
- Locke (1979) pointed out that cause-effect relationship could work in both directions in work attitudes and family attitudes & vice versa.
- M R Wood (1979) showed that middle class urban women whose marriages are arranged and there is give and take relationship with their spouses especially in Gujarat.
- Rosen and Jerdee (1979) stated that women are seen less favourably in terms of knowledge, aptitudes, skills, motivation, interests, temperament and work habits demanded in most managerial roles.
- Sharpe (1979) pointed out in his book "Double identity" that optimistic for casting women's majority of talks associated with house work and child care. Men are increasingly career oriented and discussions with spouses and sharing household works. As women are contributing more for house work and child care who are serious contenders in contribution for their promotion in their career.
- Drucker (1980) in his book stated that labour force participation of married women under the age of 50 years is now just high as women. Further he states that most of the married women stay in labourforce after the first child.
- Kate Young stated that the Sexual division of labour also applicable to the organization of household. The dynamics of bargaining decision making the gender relationships within household made important contribution between productivity and consumption.
- Amarty'sSen calls it a sector of co-operative conflict where there are different interest expectation, contribution, needs and degrees of control.
- Robinson and Skarie (1980)state that stress of working women reveals that internally oriented individuals show less perception of role overload and role ambiguity.
- Templeton (1980) mentioned that many women are not in opposition to take care of their occupational pension rights during breaks in employment because of caring responsibilities. The use made by separate actuarial tables often leads to unequal treatment of women and men in pension. This research scholar also observed that life insurance cover for a home maker is only 50% of the coverage given to the spouse employed as a bread winner.
- Asha (1981) in her study states that significant difference between satisfied and dissatisfied groups of woman in cohesion. The satisfied group is found to perceive their families more cohesive than the moderately satisfied group and the dissatisfied group.
- Swete Mishra (2003) studied land reforms and women empowerment in most parts of the country. The women agricultural labourers belong to SC, ST and BC. Though the Hindu Code Act and Hindu Succession Act provide equal rights and share to children birth male and female in parental, property. But how many female children fit their share without legal legislations are yet to be reviewed by policy planners.

- Washer (2004) has assessed that 57.3% of working women in Delhi are working due to economic reasons and others due to non-economic reasons. According to Mehta, rising cost of living resulting in ever widening necessities of life are compelling more and more women to seek employment outside home.
- Vinita (2004) according to her that in factory employment women have been declined due to technological changes and this is accompanied by an increase in service sector employment such as public service, medical, health and education.
- Dwaraki and B Kumaresan (2005) emphasized that Rural development empowering women for the grace being associated with scavenger women is ignoramus. This research scholar states that national development and health are also in the hands of the municipal workers who contribute directly to the society.
- Further this researcher has seen a television interview of the WarrangalMuncipal Commissioner and found that all Municipal Dept meetings will be held in the Dump yard and none of the participants will be permitted to close their nose which has resulted in the Muncipal commissioner a clean town of Warrangal.
- Lalitha Devi (2006) points out that need for extra income for family coupled with demand for labour from industry is the greatest incentive for female workers. The availability of gadgets make house hold work light and less time consuming enable women to work.
- Kaur and Punia (2008) state that working women of HissarDist of Haryana, it is observed that most of working women opt for job out of gross economic necessity (50%), followed by the urge to raise economic status (23%) to make use of education (11%) to have independent income (9%) and the remaining due to miscellaneous motives.
- Franca Akarippadathu (2009) states women work has remained much debated area. The underlying assumption arguments for women's employment is that economic independence is the first pre-requisite to moving towards gender equality.

But in the observation of this research scholar that in the recent two decades it has been proved wrong by women legends like MsKalpanaMorparia – Former MD of ICICI and presently CEO of Morgan Stanley (Asia Pacific), MsChandaKochar,MD of ICICI, MsArundhati Bhattarjee of SBI etc who are chairpersons in leading banks and financial institutions.

Community Participation in Global Health:

Involvement of Communities in various aspects of health system when Sydney Kark introduced the concept of Community Oriented Primary Care based on experience in South Africa, Large experiments of provision for health care in locations like Jamkhed and Mandwa in India.

Need of the Study:

1. The Women's Movement and People's Health movement had two approaches viz., Right to participate approach and Efficiency approach. In Colonial regime the care needed in developing countries have not reached the people who needed it.
2. Successful training of minimally educated and poor women are engaged in complicated tasks as health workers and assistants in hospitals.
3. Work by number of Participatory Researchers provides insights into various problems and complexity of issues in the field of agriculture.
4. Consistent and significant body of natural pool of resources are garnered better than government and experts.

The Rights Approach is termed as a Community Participation in a crucial part of the extensive common ground shared by health and human rights. Active informed participation in the identification and development of health policy as well as in its implementation and ensuring accountability.

As per the World Health Report, the Primary Health Care is Now more than ever and Further the report emphasizes the following :-

1. Public Health Care values to put people at the Centre of Health Care.
2. Expectations about Health and Health care.
3. Ensuring that voice and choice decisively influence the way in which the health care services are designed and operate.
4. Right to highest attainable level of health.
5. Maximising Equity and Solidarity.
6. Responsiveness to people's needs.

Communities need to get involved at all levels of activities which are classified into 6 broad categories:

a. **Community Health workers**: Getting short term trainings in the range of services including intervention which are preventive, curative and promotive.
b. NGO Delivery of Information and Services : Government contracts out to provide range of services and civil society initiatives.
c. **Community Financing:**Financial Incentives through prepayment mechanisms to the Community.
d. **Community Monitoring, Health Rights and Accountability: Communities** getting involved in monitoring of availability of services, accessibility, quality and equity of services.
e. **Participatory Planning:** Communities are involved in actual articulation and evolution of village level health plans.

f. **Internalsectoralgovernance :** Crucial aspect of comprehensive Public Health Care approach and essential for successful Health Care system like water, sanitation and literacy, income generation.

Community Health Workers (CHW) have been active in multifarious activities such as prevention and awareness campaigns on communicable and non-communicable diseases, maternal and child health such as Safe deliveries, breast feeding promotions, Nutrition etc. Intervention with Community Health Workers has resulted in decrease of maternal and child mortality and also crucial in reducing the burden of disease like Tuberculosis and malaria.

Hermann Key issues in CHW initiatives:

1. Selection and motivation
2. Initial training
3. Simple guidelines and Standardised Protocols.
4. Supervision, Support and relationship with formal health services.
5. Adequate remuneration and career structure.
6. Political support and a regulatory frame work.
7. Alignment with Border health system strengthening.
8. Flexibility and Dynamism.

Haines formulated CHW initiatives to Inter-connected factors :

a. National socio-economic and political factors.
b. Community factors
c. Health system factors
d. International factors.

Educated Community Health Workers (CHW) to have better ability and enhanced skills to perform their tasks. Attrition rate in CHW is 3.2% to 77% resulting higher overall cost and repeated process in the system. This will result in time intensive and slow to show their results.

Community Financing:

a. Reform in low and middle income groups.
b. Urgent need in developing countries for alternative financing mechanism and make more accessible in rural and remote regions to poor destitute.

Community Health Insurance (CHI) :

1. Community Control
2. Voluntary membership
3. Prepayment for Health care
4. Non-profit health financing schemes
5. Negotiations in rates with Service Providers
6. Subsidised premiums
7. Structural quality indicators in a set of hospitals used SEWA members.

Outcomes and Impact of Community Health Insurance (CHI):

a. CHI reduced out of pocket expenditure and catastrophic expenditure.
b. Negotiations for Preferred Provider System (PPS) contracts with providers.

c. WHO report mentions importance of Strategic purchasing.
d. In Self Employed Women's Association's (SEWAs) the Preferred Payment Provider System is practiced for accessing payments to members.
e. Wrong selection of participants is a key issue relating to pooling problems.

CHI in Cambodia monitors Patient Satisfaction. SKY a voluntary organisation in Cambodia negotiated range of initiatives to upgrade quality of Care Theory health centres and first referral hospitals and third payer system at Provincial and National hospitals. Viz.,

- 50% reduction for treatment in St Jean Hospital.
- 55 health centres, 10 referral hospitals and 5 provincial /National hospitals established by SKY.

Community Monitoring Health Rights (CMHR) a public oversight ideally driven by local information needs and community values. It also increased accountability and quality of social services.

Outcomes and Impact of CMHR:

Community based monitoring programmes have led to open dialogue to local service providers and provide an evidence base to lobby the local Govt authorities. Such initiatives improve public awareness and demonstrate significant improvement in user satisfaction with services.

- Based on People's perceptions and monitoring, there was a rise in immunization rates, fall in child mortality rates by 33% and reduction in absenteeism among care providers.
- A study in Africa showed regularity in a salary payments, improved interaction between users health staff and administrators and led to 20% increase in allocation for local budgeting and monitoring.

Disadvantages of CMHR:-

1. Participation is complex as women participation is low.
2. Difficult to disaggregate data based on gender to assess differential impact of services of men and women.
3. Lack of literacy and numeracy leading to local ownership is crucial.
4. Monitoring of NGO's political process.
5. Capacity constraints to resources, information and availability of appropriately skilled individuals.

Participatory Planning:

- Attempts to assess the impacts and issues arising due to these components.
- Women's Group for Maternal and Child Health (the WARMI project), EKJUT trail in Jharkand and Odisha, FRHS project in Hosur, Karnataka.

In a Democratic and Developing countries, the countervailing power of the State relates to "Co-governance". **Rights to create Rights** are the result of the participative form of governance. These participative forms of Governance seek to supplement the roles of citizens as voters or as watchdogs through more direct forms of involvement.

Murthy and Klugman clarified that Degree of Participation is nothing but NGO's who represents the community as Middle Degree and NGO's who represent their interests as High Degree of

Community Participation. The Mode of Community Participation classified Individuals as Lower Degree, Small collections as Middle Degree and Mass Based Organisation as Higher Degree.

NGOs (Non-Governmental Organisations) & CBO's (Community Based Organisations) and their role:

- Important players in dissemination of information.
- NGOs are recognized by Govt. They are also active in reproductive and child health services, primary care services and prevention campaign and in some non-health related areas such as micro-finance.
- NGOs are also active in Health Service Delivery, Capacity building, Training, Initiatives, Health financing and Advocacy.

Services Provided by NGOs

1. Setting up facilities in areas where there are no public facilities.
2. Contracts to NGOs by Govt to run government facilities
3. Facilitators
4. Helping in Capacity Building
5. Prevention – promotion campaigns
6. Spill over effects of other Non-health programs of NGOs.

Improvements in Health Indicators by NGO

- Maternal Mortality
- Neo Natal Mortality
- Child Mortality

Advantages of NGOs

1. Better accessibility to poor.
2. Better development of aids.
3. Capacity Building activities
4. Monitoring and Supervision
5. Simultaneous Development programs

Outcome and Impact

NGO provisioning of Health Services include Health Indicators, Access, Service Utilisation, Quality of Care, Efficiency, Cost of Delivery of Services and cost effectiveness.

Disadvantages of NGOs

i. More expensive compared to traditional public services provision.
ii. Scalability
iii. Sustainability

In Bangladesh, Nutrition programs by NGOs resulted in less efficiency and delivery of services.

Inter-Sectoral Convergence:

WHO has defined inter-sectoral convergence as "actions affecting health outcomes undertaken by sectors outside the health sector, possibly, but not necessarily in collaboration with the Health Sector?"

- Not all initiatives are targeted as health or health outcomes.
- Have indirectly resulted in health benefits

Top down Approach:

Initiatives started by Govt and flow through community to local levels.

Bottom-Up Approach:-

Initiator is at Community or Local level and flows up to the Strategisers.

- Review by Public Health Agency of Canada for Health Systems Knowledge Network for Equity in Health in East and South Africa (EQUINET). There is positive education, sanitation, income generating activities and empowerment strategies had a positive impact on health.
- SEWA in India has been used as inter-sectoral approach and expanded its activites.

The Health Insurance sector in developing countries forms like legal and self regulation and people's participation in regulation under the concept of "Institutionalized co-production".

Health Insurance care once assessed will have more utilization. The Randomised Evaluation in Cambodia will offer the opportunity test of the competing models of selection.

Major Effects of Health Insurance:

1. Health care utilization – Public Health facility utilization and substitution of public facilities, private health centres,preventive care utilization.
2. Health Outcomes – Frequency and duration of illness, subjective self-health assessments, objective health measurements.
3. Economic Outcomes – Medical spending, Sale of productive assets, Household debts and Loans.

WHO - Fact sheet reveals approximately 150 million people experience financial catastrophe i.e., spending more than 40% of available income on health care after meeting their basic needs. The spends are categorized according to Income level as under:

1. Low income level has the impact of High medical expenses, Leads to high level of debt, sale of assets, removal of children from school etc., **Short term health shock can result in long term poverty.** Comparing Insured and Uninsured households depends on characteristic of households.
2. Financially Stronger and Educated have better Insurance coverage and better health. Govt policy changes have credible impact estimates. Several studies conducted on very large Medicare and Medical aid for poor and near-poor in United States. Curies and Gruber conducted study in 1996 &1997 as to how variable timing of expansion of medical aid across states. The Outcome was 3.1 deaths per 10,000 children.

Litchenberg 2002 and DobkingMaestras (2007) studies reveals that Medicaid for below 65 years of age. All of them were covered by medicare was the outcome of the research.

The RAND Health Insurance experiment study conducted on 4000 people consisting of 2000 families in United States between 1974-1982 reveal that cost-sharing assigned plan sought less treatment than with full coverage.

Improvement in high blood pressure led to statistically significant 10% reduction in mortality risk apparently due to increased detection and treatment of high blood pressure among low income household with free care.

The Obama Care is the finding of new ways to buy health insurance products in a regulated manner, the cost assistance andd the law relating to health insurance that has impact on the Americans. TheLaw of PPACA implements unprecedented benefits, rights and protection leading to better quality and more affordable health insurance. Most of the Americans will buy insurance through their employer to update their insurance cover. But the Middle Incomegroups of American wage earning population buy insurance from regulated and subsidized insurance cover through online health insurance exchanges.

In Poor Nations the changes in outcomes for insured and uninsured which may not hold even though the match insured and household to uninsured households are identical on unobservable characteristics. The Authors also found that probability of contact with health care providers was higher, out of pocket health expenditures were lower and non-medical household consumption was higher among insured group.

Summary of the RAND Health Insurance experiment are:-

- Health insurance usually increases access to healthcare.
- Wealthy Nations like United States suggest that health induces greater utilization of health services and modest improvement of health.

In China, the institutional structure of health care favours increased utilization and substitution towards more expensive services treatments.

Adverse Selection vs Positive Selection

Rothchild and Stigiltz, (1976), Akler of, (1970) studies revealed that Insurance markets will suffer adverse selection as voluntary insurance cannot be financially sustainable since Premium levels will not be able to cover the high costs of care.

Pre-conception Care of Women

Pre-conception is recognized as a critical component of health care for women of reproductive age. It is a part of care of a larger health care model that results in healthier women, infants and families.

Pre-conception Care – A Review

- National Families Health Survey (NFHS) found 37% of all pregnant women in India received no pre-conceptions.
- Women folk constitute 48% of population. Poor Nutrition, Gender discrimination, low age at marriage, risk factors during pregnancy, unsafe, unplanned and multiple deliveries, limited access to family planning methods and unsafe abortion services.
- 16% of population lives in more than 10 kms away for medical facilities.
- NFHS Survey states that 37% pregnant women of which 13% are literate women, 18% do not receive pre-natal care and 42% receive pre-natal care are from urban areas.

There are sample surveys taken from 236 nos. in the age group of 15-45 years and the outcomes are as under:-

a. Unfavourable outcomes is 36.4%
b. Difficulties in pregnancies is 20.3%
c. Unwanted pregnancies is 29.7%
d. Suffering Domestic Violence is 30.8%

Nurses play a vital role in teaching, creating awareness. As per the 2001 census, the Maternal Mortality rate was 453 at National level and in Karnataka Maternal Mortality rate was 45 per 1,00,000 women.

- Study conducted among reproductive age group women who consume alcohol is 2.5% to 20%.
- Mother's who are heavy drinkers is 3% to 4% of babies delivered at will have a major congenital abnormality.
- 5% of the abnormalities are chromosomal
- 10% due to tetrogenes
- 20% are genetic

Major anomalies were lower among pre-conceptional care receipients is 2.1% and Non-receipients is 6.5%. Outpatient pre-conceptional probably reduces women with presentational diabetes mellitus. This is done with counseling.

Health Safety – X ray radiation resulting in neoplasms and leukemia among children.

Genetic Counselling – Downsyndrome for which risk is 1% for women around 40 years of age.

Structured Teaching programme

Structured Teaching Programme on pre-conception care was also conducted for women in age group of 18-45 years in rural Chennai. Out of the 80 samples of which 40 are done in experimental group and 40 are done for control group.

There was another study of 200 samples of adolescent school students on reproductive health is inadequate. The use of structured teaching programme is effective in improving knowledge and attitude of the adolescents on reproductive health.

A study was conducted at Govt Hospital in Erode with 60 no's of samples regarding Structured Teaching in the age group of 18-35 years of which 57% have significant knowledge and 36% are control groups. The study revealed that majority of mothers has inadequate knowledge of pre-conception care and structured teaching programme was effective. Use of eating healthy foods, folic acid, reading food labels, physical activity and multivitamin.

Benefits to the Health Insurance Community:

- Improved Health Outcomes
- Changes in Health Behaviour and Socio Environmental risk factors.
- Strengthened Social Capital networks
- Empowerment of Women
- Better accountability and pro-poor policies
- Efficiency Gains and Rational administration

Shortcomings of the Health Insurance Community:

- Exclusion and lack of genuine representations
- Differing levels of success of strategies
- Ambiguity in success of scaling up

- Fragmentation and Increased inequities
- Difficulty in measuring and evaluating the impact
- Lack of mechanism for participation and planning.

Major Findings

In India, the increase in cost of insurance and the need for insurance requires coverage to all strata of people and in particular to the lower and middle income group in order to manage their resources with healthy life.

The Empowerment of Women through NGO's is being focused in India only in the States of Tamilnadu, Andhra, Maharashtra and Gujarat. But, the intensity has to be focused and the community health, education and sanitation can be protected through these NGO's in all rural areas which is mainly dependent on the State Administration in the years to come

Suggestions:

1. Reporting verbally through Group meetings for participation regardless of literacy levels.
2. Phasing in intervention slowly during training, enabling volunteers to assimiliate the information.
3. Multiple strategies for individual and group.
4. Rewards can function as motivators for recognition and group identification.
5. Quarterly surveys to verify data collected by volunteers.
6. Information sharing relationship building between community and Ministry of Health.
7. Group meetings will function as venues for problem solving, peer counseling, social and educational activities.
8. Householders ensuring proper medical checkup periodically and compulsorily for their women at home.
9. Motivation to women for physical exercise and walking as a routine.
10. Adequate health and safety insurance for all women as they contribute multifold in our daily life and 50% coverage for unemployed women is required to revamp.

Conclusion:

The success of a health micro insurance program depends on its ability to improve health and economic outcomes while maintaining financial sustainability or at the last among donors that their money is being spent in most efficient way possible. Many Developing countries know a little about the risks and benefits of offering micro-insurance in developing countries and how best to design an insurance program so as to meet the needs of the poor. Randomised experiments like the SKY Evaluation will contribute to the literature by providing vigorous answers to manage these questions. The Study revealed that improvement in knowledge of pre-conception care among women. There is an association of knowledge with that of age and education of women.

REFERENCES

1. http://shodhganga.inflibnet.ac.in/bitstream/10603/1029/9/09_chapter%202.pdf
2. http://www.rguhs.ac.in/cdc/onlinecdc/uploads/05_N010_13211.doc
3. https://www.google.co.in/search?noj=1&biw=1242&bih=606&site=webhp&q=Literature+review+on+effects+of+Health+insurance+and+selection+&oq=Literature+review+on+effects+of+Health+insurance+and+selection+&gs_l=serp.12...4634.44033.0.53330.130.56.0.0.0.0.2376.6942.5-2j1j1j1j1.6.0.msedr...0...1c.1.64.serp..125.5.4562.FlSEsTaDbX0

4. Insurance India News Letter – Insunews edition 21-27 March 2014.
5. Times of India dated 28.3.2014
6. uhc-**india**.org/downloadpdf.php
7. www.iimahd.ernet.in/publications/data/2006-07-02rbhat.pd
