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Cooperative healthcare model: A comment on its scope in India

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Tax-financing or social health insurance are often considered ideal financing mechanisms to achieve universal healthcare (UHC). However, large informal sectors and low tax bases in low and lower-middle-income countries (LLMICs) often preclude them from being feasible pathways. While they await structural changes that would allow a shift to such mechanisms as the dominant form of financing, it is imperative to provide citizens with viable alternatives that would offer access to affordable healthcare in the interim. Hsiao and Yip (2022) provide such an alternative through a model they call "Cooperative Healthcare." The model offers a means to ensure effective prepayment and pooling of healthcare expenditures which would otherwise have been spent on an out-of-pocket basis, and to create an adequate healthcare network. We agree that the proposed cooperative healthcare model can act as the potential transition solution for LLMICs aspiring to ultimately provide UHC to their populations, albeit with some modifications. We consider this argument in the case of India and its emergent health financing challenges. We argue that cooperative healthcare can be a viable pathway towards UHC in India only when characterised by some form of managed care structure that is designed to deliver the dual objective of healthcare access and financial risk protection.

India, like other lower-middle-income countries, relies heavily on citizens' out-of-pocket expenses (OOPE) for funding healthcare services. At 53% of current health expenditure (National Health Systems Resource Centre, 2022), OOPE is a primary concern for the country. With the constraints of a low tax base and a large informal sector, alternative avenues of pooling and redistribution are required to protect people from catastrophic healthcare expenditures. India can consider offering cooperative healthcare as a practical alternative for those without formal financing cover as well as those who lack effective access to affordable healthcare even when part of a state-sponsored or private pool. A key precondition for the feasibility of cooperative healthcare, Hsiao and Yip note, is the existence of a stock of social capital in the community leading to cooperation and mutual assistance. Towards this end, the social capital of existing groups can be leveraged to create cooperative healthcare pools. India, for instance, has had a long tradition of mutual self-help amongst women (Mor, 2015). In the agricultural sector, issues such as high degree of land fragmentation and scarcity of water have given rise to cooperative farming in some parts of the country. While each collective could be small, there is also a tradition of these smaller collectives federating into a larger one, with each collective joining as an independent member. Due to the natural wisdom in doing so, there are already examples in India of such collectives starting to take on healthcare and health financing for their members as an integral part of their mandate (Mor, 2020). All of these represent welcome steps moving forward.

While cooperative healthcare offers a viable alternative, for such models to be considered a serious and sustainable pathway to reducing out-of-pocket payments and ensuring access to comprehensive care, aspects including the structure of the cooperative healthcare institutions and how they would be tied to care delivery need further attention.

There will be a need to explore the formalization of cooperative healthcare institutions without destroying their underlying culture and structure. This would require addressing key concerns that have often been raised against community-based health insurance (CBHI) schemes and are likely to be a cause for concern in the case of cooperative healthcare as well. For instance, by design, the schemes exclusively enroll community members, resulting in small pools that are vulnerable to financial instability (World Health Organisation, 2017). It is then necessary to consider mechanisms to offset these costs either by linking multiple pools of cooperative healthcare with each other or through reinsurance (Carrin et al., 2005; World Health Organisation, 2017). In its adoption of the model, the government could consider formal licensing of cooperatives as a hyper-regional player with very low entry barriers (Chatterjee et al., 2020) but with a robust framework of reinsurance and risk-based capital allocation associated with it, similar to the Sparkassens in Germany (Mor et al., 2013). Given the size of the country and its diversity, thousands of such local entities may emerge. Free or extremely low-cost technology platforms would need to be developed for the effective regulation of such entities by staff, management, boards, and regulators. Notably, in the Indian context, as observed in the case of cooperative credit institutions, there is scope for rapid politicization of such institutions. As a result, they could go from serving the needs of their members to becoming vehicles for the political aspirations of local leaders. A cooperative structure also implies that capital acquisition is closely tied to membership and often unrelated to performance. This could potentially lead to a suboptimal situation where higher-performing institutions are unable to raise the capital they need and poorer-performing ones that can infuse the required capital do not shut down. Instead, a more standardized joint-stock company model, with each investor owning a share based on the amount of stock purchased, could be better suited for cooperative healthcare.

There is also a need to consider how healthcare will be delivered and

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what role the community would play in the same. As detailed by Hsiao and Yip, the cooperative healthcare model places significant responsibility on the community leaders/representatives to create a network of providers for the delivery of "adequate and reasonable quality healthcare". The community's role in creating healthcare delivery systems can also foster a greater sense of trust in the health system and positively impact health-seeking behaviour. We argue that there needs to be an explicit recognition of the community's central role in not just the organisation of the delivery system, but also in the coordination, monitoring, and delivery of care. For example, the CBHI scheme in Rwanda has faced consistent deficits due to the fee-for-service method of provider reimbursement (Umuhoza et al., 2022). Hence, employing performance-based payment methods is crucial to incentivise provider behaviour along with strong oversight by community-led committees to ensure accountability. In essence, to achieve the objectives of access and quality, the cooperative healthcare model needs to adopt the core functions of a managed care model. By managed care, we mean a model which embodies some common features despite different forms of organisation (Ashraf, 2021). In this structure, the management would directly oversee care pathways, coordinate care across levels (primary to tertiary) and introduce incentive structures to shape providers' behaviour and align them to the community members' needs and welfare. Such a model would truly deliver an integrated product designed to ensure both financial protection and healthcare. It is also likely to foster greater trust in the health system since it guarantees access to health care and manages the entire continuum of care for the consumers. Moreover, such integrated models would act as the foundational unit of a larger scaled-up system in the future which delivers both financial protection and healthcare.

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