Cooperative Health Care Model In India-Current Trends

Sanjay Kumar Verma*

Background
In the recent years the cooperative movement has emerged as an effective people’s movement for achieving socio-economic transformation of the rural areas with focus on poverty alleviation. The movement has already completed more than 100 years of its eventful existence and covers 100% of the villages and 71% of the rural households. This movement has developed more than 5 lakh cooperative societies in various sectors of Indian economy with a membership of 230 million.

The cooperatives have established themselves in various segments of economy like credit and banking, fertilisers, dairy, sugar, marketing, housing, fisheries, fertilisers, handlooms, handicrafts, etc. It is well known that dairy cooperatives in India have ushered in milk revolution in the country. IFFCO and KIRIBCO are the two global fertiliser cooperatives which have churned out profits year after year. Due to their extensive reach, wide network and strong rural base, cooperatives are now considered as important organizations for forging collaborations by the public and profit-driven private enterprises. The democratic, participatory, value-oriented character of cooperative organizations along with their ability to cater to poor and under-privileged sections of the society are considered important strategic parameters for collaborations based on business considerations.

Introduction
In order to tackle the health problems, the Government has launched different schemes for providing better health for the people. However, the benefits of various health programmes have not reached the grass-root levels as desired by the government. The rural health care in most of the states is marked by absenteeism of doctors/health, low levels of skills, shortage of medicines, inadequate supervision, etc. The Government during 11th Five Year Plan introduced a Seven Year National Rural Health Mission with an objective to address the problems of rural primary health care. The objective of this scheme is to empower panchayati raj institutions, cooperatives, etc to manage, administer and be accountable for the health services at the community level. In the wake of this the purpose of this paper is to-
- explore the potentialities of the cooperative sector in the field of health.
- examine the ways in which cooperatives can play an effective role to promote health in the country.

The paper will argue that cooperatives present a strong alternative for playing an important role in the health-set up of the country. The paper will argue that the effectiveness of cooperative model of development in the health sector can not be viewed from the angle of mere profit only. This is because cooperatives being rooted in

* Jr Editor, National Cooperative Union of India [the apex organisation of the Indian cooperative movement] and Indian Representative, New Harmony Press, UK
the communities in which they reside have their social obligation in the form of poverty alleviation as a major component of their functioning which distinguishes them from other organizations. The rural poor’s accessibility through cooperatives for enjoying their democratic rights of health is a fact which can not be brushed aside. In the wake of the current emphasis on public-private partnerships as a policy measure in the health sector the paper will argue that while cooperatives have inherent strengths which are important for forging collaborations they must endeavour to align with the other bodies so that they succeed.

Definition Of Public-Private Partnership

Though there are many definitions of public-private partnership in the health sector here two definitions are provided—

“---- means to bring together a set of actors for the common goal of improving the health of the population based on mutually agreed roles and principles” [WHO 1992]

“------ a partnership means that both the parties have agreed to implement a programme, and that each party has a clear role and say in how the implementation happens’’[Bleagesou and Young 2005]

These two definitions indicate there is a relative sense of equality between the partners and there is mutual commitment to agreed objectives. The private sector here includes all non-state actors, some seeking profits and others operating as non-profit. It is generally agreed that private sector is easily accessible, better managed and more efficient than public sector. There is also near unanimity that public/private partnership would improve equity, accountability, quality and accessibility of the entire health system.

Despite the significant presence of cooperative sector in our economy the cooperatives face the problems of lack of professionalism, resource crunch, poor technology, poor efficiency, weak HRD policy, etc. In a comparative perspective the cooperatives primarily lack efficiency and financial soundness as compared to private commercial entities and public bodies. However, the cooperatives have extensive reach and accessibility than other organizations which are hamstrung by these vital factors which make a business succeed. The public-private partnership within a cooperative paradigm may include:

- Cooperatives partnering with public sector and private bodies in the operational or functional areas which can enhance the efficiency of cooperatives.
- Government partnering with cooperatives in an attempt to reach the poor sections of the society who are deprived of basic health rights.
- The private health bodies partnering with cooperatives so as to utilise their network for selling their health products.

Objectives

The objectives of this paper are to—

- analyse the trends related to the presence of cooperatives in the field of health.
- analyse in depth some of the prominent cooperative health interventions so as to trace the elements of public-private partnership while throwing some light on accessibility, rights of patients, etc.
- to formulate action-points or strategies so that cooperatives can emerge strongly as active players in the health sector

**Yeshasvini Rural Cooperative Health Scheme**

The cooperative farming community is the strength of our economy. The poor farmers’ allegiance to cooperative societies in the rural areas has been the strength of the cooperative sector an area where the limitations of the public or private sector are quite apparent. The health care of the cooperative farmers is very important because these farmers can not afford costly medicines. The right of the farmers to get cheap and best treatment is very important for the success of agricultural operations. Devising a health care scheme for the cooperative farmers in which the cooperative institutions are the active players while forging partnerships with the public and private bodies can be a novel way to respect the rights of the patients through accessibility to cooperatives. Based on this thinking the Government of Karnataka introduced a health care scheme called Yeshasvini Cooperative Farmers’ Health Care Scheme on 14th November, 2002.

At present any member who is a member of cooperative society in Karnataka can get the necessary treatment and have access to expensive medical procedures by paying Rs. 120 per annum. The public-private partnership model can be seen from the fact that the plan administration relies on various actors, the Government of Karnataka for partial subsidy benefit, the Karnataka State Cooperative Department for communication of the plan, cooperative societies enrolling members, cooperative banks to assist in premium collection, Family Health Plan Ltd for the administration of claims and a network of hospitals to deliver the benefits. The Government provides a quarter of monthly premium paid by members of the cooperative societies, which is Rs 10 per month. The network of hospitals under the scheme covers private hospitals too where the facilities are of high quality. This is itself an attraction for enhancing the membership of the scheme. The incentive of getting treatment in a private hospital with the government paying half of the premium attracts more members to the scheme. The Government has given key access to cooperatives as the Department of Cooperatives has been entrusted with the duty to popularise the scheme through its network of cooperatives. The Secretary of the primary cooperative society is the main person who motivates the farmers to become members of the scheme.

A review of the functioning of the scheme indicates that there is no discrimination with the patients under this scheme in the hospitals. This itself indicates that the rights of the patients who are the farmers are not neglected which is quite heartening. The services provided by the hospitals are generally satisfactory though there is still need for lot of improvement in this area. The farmers considered the hospitals as ‘temples’ in which they had complete faith. This fact clearly indicates the triumph of the cooperative spirit when it is nurtured well with the collaboration of other agencies which have faith in the cooperative principles and values.
The scheme though targeted to the poor has not been without deficiencies. The poor farmers are not covered for all health-related issues but only for out-patient care and expenses connected with surgery. This shows that the principle of ‘right to health’ of the poor farmers has not been given due prominence as this right can be guaranteed only if all health-related issues are governed by this scheme. Some of the members of cooperatives are rich and they are also availing the same facilities as the poor farmers. A policy decision to render services to the poor members of cooperatives rather than services to all the members will not only enhance the reach of the scheme but will also remove partiality and introduce equitable standards of governance. In the recent years the cooperative officials have not been given ample professional opportunities of training. This is mainly because cooperatives have not been able to effectively collaborate with other non-cooperative bodies in those functional areas of training which have wider relevance. The secretaries of the primary level cooperative societies must be well trained so that they take more initiatives to popularise the scheme. This scheme has been limited to only members of agricultural cooperative societies. Widening the ambit of the scheme to cover the members of all types of cooperatives in the rural areas will be very important in this regard. In this respect the other types of cooperatives must contribute some premium amount so that the financial viability of the scheme is not affected.

**Self-Employed Women’s Association [Sewa]**

Most of India’s work force is engaged in the informal economy and are poor, vulnerable and illiterate. It is well known that women are the poorest and most vulnerable, and their work is always at the cost of health as they are exposed to various health hazards. Can through formation of cooperatives their work and health-related problems be addressed in an effective manner? SEWA which is a union of 2,50,000 women workers of the informal economy has very successfully ventured in this area and has built up its own reputation. SEWA has today grown to include a bank with 1,30,000 depositors and more than 80 cooperatives of various kinds, all owned and managed by themselves. SEWA has been working hard to improve its members’ health or health security. SEWA has identified and trained health workers who are performing the function of doctors in their unique way in their own communities. SEWA’s midwives and health workers have formed their own cooperatives which are run democratically and are sustainable both in financial terms and activity-wise. These cooperatives make drugs available to SEWA members at low cost through outlets run by local women. The health expenditure of the women is brought down by these cooperatives as the accessibility of poor women to these cooperatives helps them in solving the health-related problems. These cooperatives’ partnership with the government can be seen from the fact that they have been entrusted to run RCH diagnostics and screening camps, especially village-based mobile RCH clinics under the programme of Ministry of Health and Family Welfare. The partnership has resulted in widening the levels of services to women and their families thus enhancing their level of accessibility.

The cooperatives are also playing an important role in developing health education amongst the rural women. Providing health education and information through cooperatives is a way of empowering them so that they can take control of their lives
without depending on others. The cooperatives being empowering institutions can best empower the rural women through health education.

An analysis of SEWA’s health and social security systems for the poor shows that SEWA has very well developed an initiative to protect poor women from burgeoning medical costs and other risks. Each member has the option to join the programme by paying Rs. 60 per annum and is provided limited cover for risks arising out of sickness, maternity needs, accidents, floods, etc. SEWA started out this scheme in partnership with a public sector company. The cooperatives are playing an important role in educating the rural community on understanding the concept of insurance.

Developing wide linkages in the case of SEWA’s health programmes is very important. Regular interactions with the professional doctors and training of the health workers in collaboration with other bodies are the measures which need to be taken in this respect. Operationalising more government programmes will provide more accessibility to the rural women. In the case of medical insurance the scope of the scheme should be enlarged and the coverage must be increased. Design of the products catering to the lower income group at a reasonable cost is the biggest challenge, and in this respect the partnerships should be forged with the government/private bodies which must catalyse the new products for poor and low middle class at low costs.

**Cooperative Hospitals In Kerala**

In Kerala medical cooperatives were set up under the government patronage. However, at present the hospitals are grappling with various problems. They are facing tough competition from the public sector health services, and the emergence of private hospitals. The hospitals face numerous problems in different areas of their operations. These areas are casualty and emergency services, outpatient services, diagnostic services, nursery, pharmacy, transport, etc. The political reasons like lack of autonomy, government interference, etc have their own significance.

The vast potentiality of the health care industry in the state of Kerala is enormous. The cooperative hospitals must visualise ways to forge partnerships with government, private sector, NGO’s, etc. The hospitals must constitute governing bodies which must include representatives of all sectors. In the operational areas the hospitals must develop partnerships with the private sector. The hospitals must develop comprehensive health care programmes. As Kerala is cooperatively more developed state as compared to other states, the successful cooperatives must pour in financial resources and pool expertise from all quarters to revitalise the hospitals. In the wake of increasing accessibility of the poor to the cooperatives the cooperative hospitals must strengthen their programmes focusing on rural poor. The cooperatives in Kerala in general have played an important role in poverty-alleviation in the recent times.

**National Cooperative Union Of India**

National Cooperative Union of India is the apex organization of the cooperative movement in the country. The prime objectives of this organization revolve around education and training. The 44 cooperative education field projects of National
Cooperative Union of India in the under-developed rural areas of the country play an important role in sensitising the rural folk to form cooperatives to improve their socio-economic condition. The men and women project staff who are the grass-root functionaries act as catalyst for promoting the cause of the cooperatives in the rural areas. The project staff also have a social role earmarked for them. They have to create awareness on health issues amongst the rural population. For this they collaborate with the primary health centres from where doctors come to educate the people on various diseases. Various programmes are regularly organised to create awareness about AIDS, pulse polio, child care, etc. Health camps organised time and again also act as good sensitisation measures in this regard.

To make the health component strong the project officials must build wide-ranging partnerships. Ways must be visualised to also involve the private doctors who may be professionally more qualified. The training of the project officials in health care in the reputed public and private sector health institutions can be very useful in enhancing their competencies.

**Strategies**

The presence of cooperatives in the health sector in the country is almost negligible. Based on the example of Kerala definite measures to popularise the concept of cooperative hospitals have yet to be undertaken. The problems of cooperative hospitals in Kerala and their inability to compete with the public and private bodies may be a stark reality which has acted as a discouraging factor in this regard. However, dismissing the idea of setting up cooperative hospitals on the ground that they may not be economically feasible or profitable is not based on sound reasoning. If primary health care has to be provided in inaccessible areas and to tribal and to tribal and weaker sections, profitability cannot become the yardstick for performance. The service viability of the cooperatives becomes important here. The ability of cooperatives to work for the welfare of the communities becomes paramount here. The profit yardstick can not be applied everywhere particularly in a setting where the poor being exposed to health hazards have very few choices before them.

The cooperative sector in fact has not been able to undertake strong advocacy to popularise the cooperative model in the health sector. Lack of quality research studies has been a big hindering factor in this respect. Strong advocacy, research and lobbying must be the catch-words in this respect. Effective lobbying with the government must be undertaken so that the government policies and programmes lay emphasis on setting up cooperative hospitals, or the health schemes with focus on cooperatives like Yeshaswini Cooperative Health Scheme in Karnataka. The success of Yeshaswini Cooperative Health Scheme is an eye-opener as it has clearly indicated that the cooperative institutions in the rural areas can be the most reliable institutions which can take the lead in popularising a health scheme in partnership with public and private bodies. The accessibility of poor to the health schemes through cooperatives should be the key strategy for the success of any health scheme in the country. This is simply because the people mobilisation efforts through cooperatives is enormous as compared to other organizations.
The SEWA cooperative health care scheme also presents useful insights which can be used for strategy-formulation. Organising women rural work-force through health cooperatives can be a very good strategy which can not only improve the living standards of poor women but also empower them to take up the health issues with help of partnership agencies. The replication of SEWA health model is the need of the hour as it will widely popularise the cooperative health model all over the country.

A review of the cooperative trends indicates that the cooperative sector in India has been diversifying in new areas like insurance, tourism, etc. The areas in which diversification is taking place have primarily a rural orientation. The successful and cash-rich cooperatives like IFFCO and KRIBHCO which have many member cooperatives in the rural areas through partnership with non-cooperative private enterprises are trying to empower the rural community by improving their living standards. IFFCO’s partnership with Tokyo Marine and Air Tel in the fields of rural insurance and information communications technology is an example in this regard. Based on this precedent it appears that rural health will also be a priority area for intervention by the successful cooperatives. The cooperatives should also think of actively partnering with National AIDS Control Organisation at a time when AIDS prevention has been a prime area of policies and programmes of all types of institutions in the country.

Creating health awareness can also be a very effective strategy of the cooperative organisations. At present the potentialities of cooperatives have not come to the fore in this area. The role of cooperative promotional organizations becomes very important as a torch-bearer in this respect. Capacity-building of the cooperative officials in the health sector as shown by the evidence in the paper is also very important if a professional touch has to be given in the efforts for creating health awareness at all levels. At present the cooperative training programmes on health are almost negligible. There is no clear-cut strategy for building partnerships with the government and private bodies.

**Conclusion**

At a time when public-private partnership has emerged as a vital strategy for improving the socio-economic conditions in the country the cooperatives have all the inherent strengths and are quite capable to emerge as key players for improving the health scenario of the country. In rural health the cooperatives can effectively partner with the public sector and the other civil society organisations. It is high time that the cooperative policy-makers should work seriously for devising health policies with a clear-cut vision so that the image-building of the cooperative sector gets a huge boost. The accessibility of poor to health services through the medium of a cooperative can concretise in a big way if cooperative model of health is popularised all over the country.

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