Universal health scare

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The country’s planners are debating how to provide healthcare to all. In a drastic shift from the 65-year-old public health system, the Planning Commission in the 12th Five Year Plan considers introducing an insurance scheme, which will allow a major role to private players. Will it work?

Vibha Varshney in Delhi, Alok Gupta in Bihar and Aparna Pallavi in Andhra Pradesh examine how the existing health insurance schemes are faring. They find there is a lot to learn from their shortcomings and successes before a new model of healthcare delivery is prescribed.
Free and easy access to healthcare for all. India has been striving to achieve this since Independence. But the country's poor health indices remain a cause for concern. This is the reason expectations soared when the Planning Commission dubbed the 12th Five Year Plan the Health Plan. When the draft of the chapter on health was leaked recently, it raised alarm—the Commission had taken radical decisions to turn around the country’s public healthcare delivery system by giving a greater role to private players.

The July draft, as it is called, suggested that India should embrace insurance to achieve universal health coverage. As of now general tax is used to meet the essential health requirements of all people. The Commission also pegged the government spending on health over five years at 1.58 per cent of GDP, ignoring the key recommendation of its own High Level Expert Group (HLEG) to increase public spending to 2.5 per cent during the Plan period. No one but the Planning Commission was happy with the draft.
treatment were free. According to Planning Commission’s high level expert group (HLEG), the percentage reduced to 8.99 in 2004

- People spent as much as 67 per cent of the treatment cost out of their pocket in 2011. Around 74 per cent of this was on medicines, HLEG says

- Planning Commission’s July draft shows the country’s total expenditure on healthcare is about 3.3 per cent of GDP. About 32 per cent of this is public funded

- Public health sector faces a shortage of human resources. Almost 88 per cent of posts of specialist doctors, 76 per cent of doctors, 80 per cent of lab technicians, 53 per cent of nurses and 52 per cent posts of ANMs (who offer maternal and child healthcare) lie vacant, the draft notes

The Ministry of Health and Family Welfare made its discontent clear by sending a critique of the draft to the Commission. The letter criticises the proposal to restrict the ministry’s role, saying it nullifies the success of the National Rural Health Mission. It also notes that the budget is too little.

Members of HLEG are not happy either. When the group was established in October 2010, it was assigned the responsibility of preparing a health delivery model unique to India that could help achieve the much desired universal health coverage. The group had suggested strengthening the public health system. Since India has a presence of a strong private healthcare sector, HLEG suggested that the government could contract private players to fill the gap in public healthcare delivery. Despite ambitious insurance schemes being piloted in several states as well as by the Ministry of Labour and Employment, HLEG had steered clear of insurance, saying it fragments healthcare and cannot cover all the citizens. HLEG has sent its critique of the draft to the Planning Commission.

Members of the Jan Swasthya Abhiyan, the Indian arm of People’s Health Movement, an international network of public health experts, are also against the draft. They say it is an abdication of the government’s duty and an effort to fill the coffers of the corporates.

Photo: Samrat Mukharjee
The Planning Commission is now rewriting the health chapter. A two-member committee has been set up under the National Advisory Council of the ruling UPA government to ensure that the objections raised are addressed in the final document. The Plan document is expected to be finalised by the National Development Council in October. This makes the next few weeks crucial for negotiations.

The changes being made are still under wraps. But sources say that the Commission is merely changing the language of the draft and not revising its content substantially. The latest information suggests that funds for healthcare delivery in the 12th Plan Period are likely to remain at 1.58 per cent of GDP. Insurance is likely to be the mechanism for providing universal health coverage.

The promise of free healthcare through insurance is seen as a populist move before the elections. It is said in 2007, when the ruling Congress Party launched the Rajiv Aarogyasri scheme in Andhra Pradesh, its popularity soared and the party returned to power.

**Wrong pill**

*Insurance may not be right strategy for healthcare*

Rani Devi of Samastipur is among 2,700 insurance beneficiaries who cross checked their treatment at a health camp. Devi was wrongly treated for ovarian cyst (Photographs: Prashant Ravi)

Let’s first analyse the model that the Planning Commission is likely to recommend. Launched by the Ministry of Labour and Employment in 2008, Rashtriya Swasthya Bima Yojna (RSBY) aims to protect people below the poverty line (BPL) from staggering
expenditures incurred on account of sickness. The scheme was later extended to cover people working in some unorganised sectors. Under the scheme, the Centre pays 75 per cent of the insurance premium and the state contributes 25 per cent of it to a private insurer. The beneficiary avails an annual health coverage of Rs 30,000 for his family by paying just a registration fee of Rs 30. He is given a smart card, which makes it easier for migrant labourers to access treatment. They can approach either a public or private healthcare provider on RSBY’s panel.

While it all seems good on paper, the scheme has run into controversy.

Consider this. Early this year, Rekha Devi from Samastipur district of Bihar was diagnosed with kidney stones. “Doctors at Krishna Hospital put a machine over my stomach for five minutes and said the surgery was done,” says the 24-year-old. Six months on, Rekha still writhes in pain. But the fake surgery has made the private hospital on the RSBY panel richer by Rs 15,000. Doctors had taken her thumb impression on the consent form for surgery under RSBY and pocketed the money.
To cross-check the claims, the administration organised a two-day health camp in August. Around 2,700 beneficiaries of RSBY turned up for second opinion. Surgeries performed on nearly 1,200 of them were found to be suspicious. In some cases doctors seemed to have claimed insurance money without any surgery, while in other cases they performed surgeries even if the patient did not require it. Some patients were charged for the treatment.

So far, no one has been held responsible for this blatant fraud. The administration told Down To Earth that it was keeping the report confidential as the investigation was not over. Officials believe the scam could have been masterminded by insurance agents, doctors and to an extent ANMs (auxiliary nurse midwives who offer maternal and child healthcare). But ICICI Lombard that provides insurance cover under RSBY in Samastipur claims it brought the matter to light. Others point out that the district magistrate is at fault as it is his responsibility to monitor the working of RSBY.

When asked about the scam, P N Jha, executive director of Bihar’s Labour Welfare Society, said he was waiting for the district administration to submit the report. “We have to look into the number of cases that need action. If the number of cases that require action is, say, just 10, then we cannot say that the scheme is not working.”

A senior doctor who owns a nursing home in Samastipur explains on condition of anonymity why it will be difficult to frame charges against the erring doctors. In case of hysterectomy of underage girls, doctors can prove that the uterus was cancerous or infected, requiring removal. If a doctor is accused of charging patients instead of offering them cashless treatment, as is the norm in RSBY, the doctor can show a battery of pathological or other tests to prove that the cost of treatment exceeded the Rs 30,000 cap. However, those who conducted several fake surgeries may find it difficult to escape the noose of the district administration, he says.

The action initiated by the district administration has turned doctors hostile. Last year, Rani Devi, 29, of Rupnairainpur village was operated for ovarian cyst at Mala Nursing Home, a private nursing home on the RSBY panel. But at the health camp she found that the doctor seemed to have removed her healthy ovary. Furious, she went to her doctor. “My doctor nearly threw me out of his chamber. He was angry that I went to the health camp,” Rani says.

Public health experts say the magnitude of the scam is big in Samastipur because only private hospitals are empanelled under RSBY in the district. But the trend is visible across the state, where 814 private nursing homes and only 50 public hospitals are listed in the panel. An investigation in Begusarai shows hysterectomy has been performed on 5,000 women under RSBY. Nearly 2,500 of them are between 18 to 35 years.

The State Human Rights Commission has recently constituted a panel to probe the scam under RSBY.

Such investigations have, however, not gone down well with the Indian Medical Association (IMA). On August 25, its Bihar Chapter convened an emergency meeting of gynaecologists in Patna. Arun Kumar, president of IMA-Bihar, concluded that doctors are being unduly defamed.
The issue of malpractice in the scheme caused an uproar in the Bihar Assembly on August 6. Manjit Singh, a ruling Janata Dal (United) legislator from Gopalganj district, demanded an independent inquiry into the scam. Opposition Rashtriya Janata Dal demanded a CBI inquiry, which was rejected.

The scheme is not working too well in other states either. An analysis by non-profit Public Health Resource Network into the working of RSBY in Chhattisgarh shows high expenditure in this cashless scheme is of serious concern. The highest average cost of hospitalisation in Raipur is Rs 6,678. Despite the fact that public health facilities in the district are relatively better, 72 per cent of hospitals empanelled under RSBY are private. In Durg, which was the first district in the state to launch RSBY, most people are unaware of the scheme and continue to pay out of pocket.

“In RSBY, insurance companies are interested in the premium, which they get upon enrolling people,” says David Dror, chairperson of Micro Insurance Academy, Delhi. But enrollment does not ensure services and satisfaction. The government has repeatedly projected the first-time enrollment figures to flag success. The real focus should be on delivery of more, better and faster access to healthcare, and one indicator for this is the renewal rate. So far, data on renewal rates are not published, he adds.

Other schemes no better

Other than RSBY, there are some more government-sponsored health insurance schemes in the country (see infographic on).

In Andhra Pradesh, a state-run scheme, Rajiv Aarogyasri, assures tertiary care (or the highest level of healthcare) to all and offers annual health coverage of up to Rs 2 lakh per family. Though an impressive 1.5 million procedures have been performed on the poor since the inception of the scheme in 2007, the scheme still does not protect people from large out-of-pocket expenditure.
The scheme has a list of procedures for which a patient is insured. This includes 783 packages of surgical procedures and 159 packages of medical procedures. And herein lies the problem.

M Sanjeevalu, a 50-year-old marginal farmer from Malkapur village in Medak district, told Down To Earth that he was hospitalised in Krishna Institute of Medical Sciences in Secunderabad in March last year for bypass surgery. But he developed fever just before he could be operated on. To the family’s bewilderment, the hospital asked them to admit Sanjeevalu elsewhere for the treatment of fever because it was not part of the package. Fifteen days of intensive care for fever at another clinic cost him Rs 90,000, which his family borrowed from a moneylender at 36 per cent a year interest. The bypass surgery was for free.

In Kondapur village of Medak, landless agricultural labourer D Bhagyamma developed a breast lump in 2010. She was referred to the Nizam Institute of Medical Sciences, Hyderabad, where she was tested for cancer. The results showed the lump was benign. Bhagyamma was relieved but shocked when the doctors told her she was not eligible for Aarogyasri benefits. She had to shell out Rs 25,000 for the biopsy. “I was given no reason for being denied benefits when I had the card,” says Bhagyamma who is now working to pay off the debt.
D Bhagyamma (right) had to undergo biopsy to diagnose if her breast lump was cancerous. She was denied Aarogyasri benefits after it was found benign (Photo: Aparna Pallavi)

While people agree that the scheme gives one a sense of financial security at the onset of illness, they feel that the diseases covered under the scheme are very few and rare. “There are families in my village who cannot even spend Rs 50 on treatment,” says K Veerappa, a marginal farmer from Kondapur. “The scheme offers them no relief unless they suffer from a serious disease that requires hospitalisation.” According to the National Sample Survey Office (NSSO), the cost of hospitalisation in the country is between Rs 3,500 and Rs 5,000.

Rajan Shukla, associate professor of healthcare quality at the Indian Institute of Public Health, Hyderabad, points out the problems with insurance schemes like Aarogyasri. The scheme has not evolved out of any mapping or assessment of healthcare needs of the population. Rather, it is based on the identification of procedures that are easy to administer, with an inherent market element. Hence, the emphasis on surgical procedures rather than comprehensive healthcare, he adds.

Aarogyasri does not even cover the cost of drugs which can be prohibitive, particularly for poor families, earning between Rs 10,000 and Rs 30,000 annually. Around 30 per cent of the country’s population is below the poverty line.

N Srikanth, chief executive officer of Aarogyasri, says a tertiary care-centric scheme is not a disadvantage because government hospitals do exist to cater to minor healthcare needs.

But Shukla points to an uncomfortable reality. In the years following Aarogyasri, the state government funding for secondary healthcare has increased by only two to three per cent and that for the tertiary healthcare has remained the same. Funding for primary healthcare has fallen by 14 per cent.
Many features of the scheme also put private hospitals at an advantage as compared to government hospitals, Shukla says. “Since rural hospitals do not fit the 50-bed criterion for empanelment, the scheme gets concentrated in urban areas, which adds to the peripheral cost of treatment for the rural poor.”

The viability of such an expensive scheme is often questioned. Recently, the trust that runs the scheme terminated the contract of its insurance provider Star Health and is managing on its own. This was reportedly to save the trust Rs 100 crore in service charges.

Executive officer, planning and coordination, Ch Chandrashekar admits that for the past two-three years, the funding for the scheme was nearly static at Rs 1,200 to Rs 1,300 crore. In 2007, the scheme had Rs 600 crore for three districts. But he denied that the axing of the insurer was a cost-cutting measure and said it was hired to help set up the system and was removed once the system was in place.

There are reports suggesting that the state has requested the Centre for assistance to run the scheme. Srikanth says the request came in the context of the Centre’s insistence that the state take up RSBY. “We feel our scheme is better, and hence requested the Centre to divert RSBY funds to Aarogyasri.” Srikanth, however, says that universal healthcare can only be delivered through strengthening the public sector and not through insurance. It can at best be a temporary system to buy time to repair a failed public health system, he says.

All the healthy societies—the UK, Germany, France—have their base in systems run by a government set up.

**Insurance game**

*Is it to please the industry?*
There is little evidence that providing insurance improves access to healthcare and saves one from the high out-of-pocket expenditure. It has not worked anywhere in the world, especially in developing countries (see ‘Lessons from abroad [a]’). “In any country, hospitalisation is a rare event. Insurance schemes cover only secondary and tertiary care (that require hospitalisation). The benefit package is too shallow,” says Sakthivel Selvaraj, health economist with non-profit Public Health Foundation of India.

Instead of gathering evidence, the Planning Commission wants to get into the quagmire of the insurance system. Public health experts allege that such desperation is only to help private healthcare and insurance industries tide over the economic crisis. Planning Commission chairperson Montek Singh Ahluwalia is not averse to privatisation anyway. Health is another area where he is trying to set down policies to offer sops to the industry at the cost of the public exchequer.

In fact, it is whispered that the July draft was written in collaboration with industry bigwigs—Naresh Trehan, head of Medanta-The Medicity in Gurgaon, and chairperson of the Confederation of India Industry’s national committee on healthcare; Devi Shetty, founder of Narayana Hrudayalaya near Bengaluru; and Kiran Mazumdar Shaw, head of Biocon Ltd in Bengaluru.

Down To Earth could not confirm if there is any truth in these allegations. But what is evident is that big corporate chains are coming together to push for changes in the existing public health system and reap the benefits. On August 28, industry lobby Federation of Indian Chambers of Commerce and Industry (FICCI) organised an international conference on universal health coverage. It was attended by major private health and insurance providers, including Fortis Healthcare, Max Healthcare, Apollo Hospitals and ICICI Lombard, who emphasised on the need for the government to contract private players and provide them incentives and subsidies to achieve universal health coverage. These companies are likely to have an assured flow of patients once the insurance system is put in place.
But even the industry feels that the money being put out by the Planning Commission might not be sufficient to provide coverage to the country. A report released by market research organisation Ernst and Young at the FICCI meeting points out that several countries have managed to provide healthcare to 80 per cent of their population through insurance, but at the cost of five to 12 per cent of the GDP. Thailand and the Philippines are the only exceptions to have achieved universal health coverage through insurance by spending just 3.9 and 3.6 per cent of the GDP. The report suggests that since the cost of treatment is low in India, the country’s healthcare and insurance industries would be able to achieve this kind of coverage by 2022 using something between 3.7 and 4.5 per cent of GDP.

The Planning Commission is willing to shell out only 1.58 per cent of GDP. The funds that private players wish for are even much higher than what HLEG recommends in its report for universal health coverage—2.5 per cent of the GDP. In view of this, will contracting private players be a good idea? Will it not be better to go for HLEG’s model which is less expensive?

**HLEG model vis-a-vis insurance**

“What we want is phase-wise changes in the existing public healthcare system,” says K Srinath Reddy, chairperson of HLEG. In the initial three years, the focus would be on strengthening the infrastructure of public healthcare facilities, right from the level of primary health centres. During this period, a package would be created to provide essential primary, secondary and tertiary healthcare services for free. The packages would be state-specific. For example, kala-azar, which is restricted to Bihar, could be part of the health package of the state but not of others. After three years, gaps in the health system would be identified and accordingly, private players would be contracted to fill them. The efforts should then be merged with the next five year plan.

‘We are not asking that existing health insurance schemes be stopped. These need to be incorporated in the universal healthcare system instead of being expanded as standalone schemes’

*K SRINATH REDDY, CHAIRPERSON, HIGH LEVEL EXPERT GROUP*

HLEG also recommended that to reduce the overall disease burden in the country, 70 per cent of all healthcare expenditure should go to primary healthcare, which includes awareness, screening for risk factor and treatment.

But the Planning Commission’s draft limits the responsibility of the public health system to preventive care. The draft does not even mention the amount of money that would be made available for this purpose. This suits the private sector as it will be roped in for
curative care, which is profitable. Private players will earn a profit even in the event the disease burden goes down. The Commission recommends that each insurance company would be paid according to the number of beneficiaries it enrols. If people do not fall sick, it is money in the bank for the company.

This is the reason industry is not willing to accept the HLEG recommendation of limited contracting just to fill the gap. “Look at the reality of the healthcare system in the country,” says Naresh Trehan of Medanta. Due to lack of money, the government will not be able to make good hospitals and buy technology or maintain them. There is already a shortage of doctors, nurses and paramedics in the public health system. The government should rather save money by purchasing tertiary care from private providers, Trehan says. He suggests a multi-layer insurance model, in which different treatment costs would be fixed for those below the poverty line, the middle class and the rich.

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NARESH TREHAN, CHAIRPERSON, CONFEDERATION OF INDIA INDUSTRY'S NATIONAL COMMITTEE ON HEALTHCARE

The industry also has plans to take care of the rural areas, where the presence of private healthcare providers is slim. Sangita Reddy, executive director (operations) of Apollo Hospitals and chairperson of the FICCI Health Services Committee suggests that in rural areas private hospitals can treat patients through telemedicine. “We will never turn away patients and would find a way to meet the requirement,” she says, while admitting that the method has to be financially viable. For this, she suggests, the government has to provide incentives and subsidies.

Other than tax-based funding and insurance, some industry experts suggest using microfinance for funding healthcare. Several community-based insurance models already use this funding mechanism. Bangladesh is one such country which improved its health indicators through microfinancing of health system. But neither the Planning Commission nor HLEG has recommended this. “No country has delivered health insurance to the entire population at 100 per cent subsidy when the majority of the population does not pay taxes,” says David Dror of Micro Insurance Academy. The system should expect everyone to make a dedicated contribution. We know that many people at the base of the pyramid can pay. They pay now even when they have RSBY, he adds.

With the large presence of private sector in the country, it might be difficult to completely keep them out of the health system. Jashodhra Dasgupta, member of HLEG, suggests that if the private sector has to be incorporated, it would be better to put in place
regulations before rolling out the plan. There should also be a mechanism to reduce their role once the public sector has been strengthened sufficiently, she adds.

Bhargav Dasgupta, managing director of ICICI Lombard, says that insurance companies work as checks and balances in a health system as they are good at finding frauds. Had the government been providing insurance service in Samastipur, it would have never been able to dig up the fraud, he adds.

T Sundararaman, executive director of the National Health Systems Resource Centre, Delhi, cautions against depending on insurance providers for identifying fraud. “They do not share data, say, what kind of diseases are prevalent in an area, with the district administration which makes it difficult for the authorities to take preventive steps,” he says. Sundararaman feels that the Planning Commission can do better by designing a scheme that insures against loss of livelihood due to sickness. RSBY was started with this idea but it got lost with workers seeing health insurance as a right. Those who benefit from the scheme would be averse to losing the benefits. This puts a question mark on HLEG’s insistence that insurance schemes be scrapped.

“We are not asking that existing health insurance schemes be stopped,” says Reddy. “These need to be incorporated in the universal system instead of being expanded as standalone schemes.”

**Members of People’s Health**

Movement suggest that instead of changing the entire system, it would be better to put in more money in strengthening the existing public health system. “The public health system has never been given the chance to deliver. Now that it is not able to perform, it is easy to shoot it down,” says Amit Sengupta, member of Jan Swasthya Abhiyan, India.

> ‘The public health system has never been given the chance to deliver. Enough money has never been put in it. Now that it is not able to perform, it is easy to shoot it down’

> **AMIT SENGUPTA, MEMBER, JAN SWASTHYA ABHIYAN**

With no clarity on what the final health chapter presented to NDC would contain, public health experts have decided to use the next few weeks to tell the state ministers about the critical flaws in the Planning Commission’s reasoning. They have drafted letters to chief ministers and MPs so they can make a more aware choice at the NDC meeting. Clearly, health and its care is too important to leave unattended.
Lessons from abroad

There is no perfect model of healthcare delivery. India will have to innovate a model for itself

The World Health Organization recommends that each country should strive for universal healthcare, but it does not say how. While some countries have used the route of insurance, others deliver healthcare through public health services. Experts accept that there is no perfect model in the world.

Consider Mexico’s Seguro Popular, or popular health insurance policy, which the Planning Commission wants India to follow in its July draft. By providing insurance, Mexico achieved universal health coverage in less than 10 years. Its health indicators have steadily improved since 2003. Antenatal care increased from 14 per cent to more than 81 per cent of women, and cervical cancer screening in women covered almost half of the population. But the system has not worked effectively in providing care to people in remote areas and covers only 30 per cent of the population in such areas. Besides, only a limited range of diseases are covered under the policy. This is despite the fact that the government is spending 2.8 per cent of the GDP, or half of the total health expenditures, in the country.

Mexico’s neighbour, the US, beats any other nation when it comes to spending on healthcare system. The healthcare cost in the US is around 15 per cent of the GDP. Half of the expense is borne by the country’s government. Despite putting huge amounts of money in the scheme, the country’s public health provision has failed. Around 28 per cent of the population has no insurance coverage and another 34 per cent is partially covered. Only the rich who can buy personal insurance get the benefits in the country.

Some public health experts suggest that the Brazilian model of healthcare delivery might be better suited for India. Brazil is one of those countries which recognise right to health as a legal right. (In India, the National Health Bill, which aims to lay down legal obligations regarding right to health is still in the draft stage.) In 1988, Brazil created the Unified Health System to improve access to healthcare. A couple of years later, it enacted a law, specifying the attributions and organisation of the healthcare system. It linked healthcare to social security and allowed communities to monitor the healthcare system. The
agenda was driven by the civil society, not by the government, political parties or international organisations. To improve health infrastructure, it introduced three sub-sectors: the public sub-sector is financed and provided by the state, the private sector financed both by public and private funds; and the private health insurance sub-sector. People can use services in all three sub-sectors, depending on ease of access or their ability to pay. But this too has problems. Subsidising the private sector is undermining the health provision. The tertiary care is provided by the private sector and the government is unable to control the rising cost of tertiary care.

India would have to innovate and find its own balance. It will surely have to invest more. The 1.58 per cent of GDP suggested by the Planning Commission might not be enough. This is much lower than other countries aspiring for universal healthcare have allocated. Even countries like Sri Lanka and Thailand have a total health expenditure of 4.1 per cent of the GDP, with Sri Lanka’s public share being 1.79 per cent of GDP and Thailand’s public share being 3.04 per cent of GDP.

HLEG has suggested 2.5 per cent of the GDP. “Health is one area where governments need to invest even in times of economic crisis,” says K Srinath Reddy, chairperson of the High Level Expert Group constituted by the Planning Commission to prepare an approach paper for the health chapter. This is important as fertility rates are going down in India and the country’s demographic window of opportunity is just opening. If one does not invest in health now, one will miss reaping the demographic dividend, he adds.

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