The UN Secretary-General's Independent Accountability Panel (IAP) for Every Woman, Every Child, Every Adolescent

Private Sector Roles & Accountabilities in Health System Strengthening, Universal Health Coverage and Privatization of Health Care, with a focus on women's, children's and adolescents' health

Contribution towards its 2018 Report on the theme of private sector accountability for women's, children's and adolescents' health

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January 2018

The CEHAT study "Government funded health insurance scheme in Maharashtra: Rajiv Gandhi Jeevandayee Aarogya Yojana" (RGJAY)"[2] (2017), critically reviewed the private sector participation under the scheme. The study sought to build evidence on the functionality of the publicly funded health insurance scheme in Maharashtra. It looked at equity concerns in access, the nature of private sector participation in the scheme, service availability and access to medical specialties across Maharashtra under the scheme, the process of enrolment & registration and identify access barriers, understand the profile of the beneficiary population as well as utilization under the scheme. Under the National Health Policy 2017 government funded health insurance schemes are expected to play a very large role. Services are to be strategically purchased from private sector to fill gaps in the public sector, improve health outcomes, reduce out of pocket payments and minimize moral hazards for scaling up the schemes and made more effective. In this context and in the light of the findings of our study, we organised a national level conference in collaboration with the Tata Institute of Social Sciences in October 2017. The purpose of this CEHAT – TISS conference invited presentations from across the country to have a focussed discussion on the collective experiences under other such PPPs from across the country. There was a need to ask critical questions such as: What have been the various bottlenecks, successes and failures of the existing national and state level insurance schemes? What are the lessons learnt so far? What are the pros and cons for adopting the insurance approach to realise the goal of Universal Health Care? What are the crucial gaps that need to be addressed for health systems strengthening for UHC and how?

We present the findings for the present submission using the four fundamental concepts for Universal Health Care - Provisioning, regulation and governance, financing and social determinants.[3] For health systems strengthening, to address the health needs of the marginalized, of women, children and adolescents; comprehensive universal health care is the way to go. We present the findings of our study and the key collective findings of the conference across this systems framework to highlight not just the gaps, but also to bring home the point that underlines the fact that aligning the unregulated private health sector in India to public health goals is a mammoth task. Importantly, this health systems framework seeks to enable achieving Universal Health care including the principles of universality and equity that impact access for women and children.

We present the findings of the study across each of these concepts followed by some of the key evidence presented at the conference, followed by recommendations.

Provisioning

- At the time of the CEHAT study, about 473 hospitals had been empanelled through the scheme of which 84% (396) belonged to the private sector. Nearly 70% of the pre-authorizations were also raised in the private sector.

- Private sector is largely urban and thus their availability through empanelment is also largely urban. Under RGJAY, merely 12 per cent of the total empanelled hospitals were available in the 12 least urbanized districts of Maharashtra put together.
- Further, about 44 per cent of the total empanelled hospitals were concentrated in six urban centres, including Mumbai, Thane, Pune, Nagpur, Nashik, and Aurangabad. Availability of empanelled hospitals was worse in those districts with a significant tribal population. This was also found to be in line with the findings of the study on the RSBY in Chhattisgarh where 3 cities together contain 63% of total private facilities.
- Total enrolment under the scheme of eligible population was less than 3% with most of these belonging to the above poverty line population. The empanelled private hospitals were also found to invest heavily to promote the hospital (rather than the scheme, which defeats the public health purpose). There were also instances where the claims ratio is purportedly very high. The third-party administrator (TPA) is entrusted with the enrolment program as well. In such cases, enrolment is deliberately cut down or slowed by the TPAs.[4]
- In the private hospital under the CEHAT study, though 17 of the RGJAY recognized specialties were available, they offered only 3 to 4 of them under the scheme as these were the ones that they wanted to promote with a profit-making perspective. Thus, 60 per cent of the patients under the scheme were admitted under cardiology with the rest being distributed over oncology (20 per cent) and the rest over the remaining specialties.
- They used the business model of profit in numbers by selectively choosing to promote specialties and procedures that were "quick exits" (those that did not require long term management and care may prove to be as lucrative leading to a faster freeing up of beds for the next patient. Quick exits mean more turnover of patients and more revenue. This way they could possibly also reflect high preauthorization's as this was one way of monitoring implementation of the scheme by the government). This leads to offering specialties selectively, restricting access.
- In general, specialties such as medical oncology are unavailable through the private sector under the scheme in 12 districts. Intervention oncology is unavailable through the private sector in 17 districts and radiation oncology in 16 districts. While the reasons for their unavailability through the RGJAY scheme in the private sector is not known, it needs to be pointed out that these oncology procedures need long term management and care.
- The limitation of the RGJAY is its narrow focus on tertiary care and on hospitalizations. it Women's, children and adolescent needs can be more effectively addressed through preventive, promotive and secondary care services. For instance, the National Family Health Survey IV (2015 – 16)[5] revealed that more than one-quarter (26%) of the abortions were reportedly performed by the woman herself at home, 18 percent of children with diarrhoea did not receive any treatment, Fifty-eight percent of children age 6-59 months have anaemia, fifty-three percent of women age 15-49 have anaemia, 51 percent of women had four or more ANC visits and only 30 per cent pregnant women were likely to take iron and folic acid (IFA) tablets for at least 100 days. Thus, focussing on such a large tertiary care scheme results in diverting precious funds away from key health needs of women and children.
- Such schemes in fact lead to creating barriers in access. The procedures are cumbersome, tedious and time consuming.
- Under the RGJAY it was found nearly 60 per cent of the preauthorization's raised were by males. The RGJAY scheme is available on a floater basis may lead to de-prioritising women's health care needs due to prevalent patriarchal norms wherein men's health care needs are prioritized as he is the breadwinner and head of the family.
- In a study of RSBY in Uttar Pradesh found that there was very limited usage of family planning and reproductive health services under the scheme due to a general lack of awareness.[6] In fact in case of the Megha Health Insurance Scheme(MHIS) in Meghalaya that covered ante natal care, post-natal care as well as services for medical termination of pregnancies it was found that the

scheme had low awareness in general including of these women centric services, staff was not supportive and expensive medicines needed to be bought from outside.

- A study of the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) in Tamil Nadu revealed that highly marginalized populations such as migrants, newly married, separated or widowed women are unable to enrol in such schemes due to lack of identification proof.[7] There was a stark difference in the claims by men and women (63.7 percent for males and 36.3 for females). This was also in line with the findings of the study of the RSBY in Chhattisgarh[8] and our own findings from the study on the RGJAY noted above. Thus clearly, the enrolment of women under the scheme is significantly lesser than of men across various schemes in the country.
- The study on the RSBY in Chhattisgarh revealed, for instance, a preference for hysterectomies as it was more profitable than say for instance a C section.[9]

Regulation and governance

- The CEHAT study found that the components of monitoring have not been detailed under the PPP.
- The RGJAY being a publicly funded scheme, the responsibility of the regulation and monitoring should be of the government and the first step is to clearly lay down the procedures for the same and ensure punitive action. This is a significant gap in ensuring accountability.
- NABH (National Accreditation Board for Hospitals) Guidelines are used for auditing the hospitals for setting of package rates under the scheme. The TPA has a key role to play in the infrastructure audit, grading and scoring (which determine the package rate). It was found that in Phase I, there were discrepancies in the infrastructure audit by the TPAs and functional operation theatres, intensive care units and ventilators, for instance, were noted as available as per their reports, when on investigation, they were not.
- Maintaining case records of patients is not only a requirement for empanelment but also a component of monitoring and accountability. However, obtaining this data from private hospitals has been found challenging under the scheme.
- We nevertheless found some systems in place on the ground through in-depth interviews in our study. The RGJAY society monitors the scheme by keeping track of the pre-authorizations raised against specialties offered. Where they find that there is not enough number of pre-authorizations, then the hospital is deemed inactive and a notice is sent accordingly, and it is de-emplaned. However, there is no punitive action against the hospital per se for violating or not implementing the contract under the public private partnership. It continues to function as is even after it has been de-empanelled.
- Monitoring and accountability mechanisms in place are very weak leading to wide spread irregularities, unethical and irrational practices using public funds. Supply side moral hazard has led to increase in procedures such as hysterectomies[10] much to the detriment of women's actual health needs. The lack of accountability mechanisms as well as the lack of will and limited involvement of the government to ensure accountability is serious and it seems unfathomable how the government under the circumstances could possible promote the strategy of using public money to purchase services from the private sector and how it could possibly be promoting UHC.

Financing

- RGJAY was envisaged as a cashless scheme and offer financial protection from catastrophic expenses. However, out of pocket expenditures continue to be incurred despite availing care under the scheme. In fact, more than 60 per cent of the grievances in both the private and public sector were related to collection of money.
- One reason for this is because of the strategies used by the private sector of selective referral under the scheme and due to irrational procedures.

- Reimbursement of costs, particularly for diagnostics and medicines, is widespread practice under the schemes. This essentially requires the patient to first pay up the required money for diagnostics and medicines at the time of seeking these from an external source. The bills are subsequently reimbursed. Thus, the patient and the family are required to cough up significant amounts to start with. The time taken; the delays and the unpredictability of receiving the reimbursements further disadvantage the patient who have often travelled from distant places to avail the scheme having been informed that it is cashless. If these are outstation patients, then the follow ups to claim and collect these reimbursements add to their cost and inconveniences them and adds to their OOPs. Several grievances were also found to have been registered as the reimbursements have not come through.
- Expenditure due to inter-district travel, unavailability of diagnostics and medicines were also common under the scheme.
- Rejections of preauthorization's has to patients ending up paying from their pocket for procedures covered under the scheme. In this case, it is important to note that of all the pre-authorizations that were rejected, it was found that nearly 65 per cent originated in the private sector. Rejections due to "wrong amount being quoted or amount not being as per RGJAY package" were also higher in the private sector (more than 60 per cent of the cases rejected under this category came from the private sector). The TPA, a private entity, is the one that reviews these pre-authorizations and get commission for reduction of claims. These aspects need to be monitored closely.
- Strategic purchasing results in tax payer's money being utilized to fund further growth of the private sector and it is getting access to a larger client pool (of the poor) at the cost of limited public resources.
- Under the CMCHIS[11] scheme too there were significant OOP expenditures and several women related morbidities were not covered under the scheme.
- Moreover, it was found that hospitalization has increased in the presence of insurance and the likelihood has gone up over the 2 decades.[12]
- Private sector continued to be more expensive than the public sector despite insurance. This was associated with increase in incomes for the private sector associated with increase in caseloads and irrational selective procedures such as indicted due to increase in hysterectomies. Conditions treatable at primary level transferred to secondary/tertiary level leading to avoidable expenditures by incentivizing hospitalisations. Moreover, doctors in public hospitals were also practicing in the private sector which can lead to diverting of funds.[13]
- Several insurance schemes have incurred claims ratio what are very low. This is a direct indicator of inefficient spending. Moreover, the loading cost is too high, and most states have allowed the insurance companies to keep at least 20% of the total premium revenue towards their so called administrative cost. There is a large fragmentation of the insurance pool. There should be only one insurance pool per state. [14]

Addressing social determinants of health: in the context of women and children

- Government funded health insurance schemes are clearly not aligned to the key components of Universal health care and public health gaols. Preventive and promotive aspects are not covered and there is no systematic addressing of non-communicable disease prevention.
- Consequently, even social determinants of health care are not taken into consideration and principles of Universal health care of universality, equity, inclusion, non – discrimination, financial protection, patients' rights are compromised under such schemes.

To achieve the SDG goal 3.8 for UHC, the following are recommendations in the light of evidence presented above -

- To tread on the path of UHC, programmes must have blanket and universal coverage.

- Comprehensive health services available to all need to be provided through the government at all levels of health care free of cost at the point of delivery. This requires substantial increase in government funding as well as development and strengthening of the public sector. Moreover, costs of service provision in the public sector are much less than in the private sector. It also promotes the continuum of care approach and would contribute significantly towards reduction of prohibitive cost of in-patient care for the poor protecting them from impoverishment. This is the key way forward to ensure universal health care and equity and ensuring health care services for women and children.
- It is only the public sector that can be present and available in the remotest corners of the country to the neediest population, women and children. Experiences with PPPs therefore reinforces the fact that comprehensive coverage, UHC, Equity and access can be best achieved by the public sector. The public sector too should be regulated and made accountable.
- There should be strict monitoring and regulation of the private sector per se with implementation of standard treatment guidelines also focusing on quality of care and cost as well as patient's rights. should Clinical Establishments Act, 2010 should be implemented in all states. It would also regulate the costs of services in the private sector. Besides this, Charitable Hospitals should be made to honour their legal obligations for reserving beds for the poor. Accountability mechanisms need to be put in place within the regulatory framework.
- Universal health coverage necessitates universal access. Focus should be on removal of barriers that women and children face towards ensuring free access to quality health care across all levels of health services.

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