Role of Government in Funded Health Insurance Schemes

TEJAL BARAI-JAITLY, SOUMITRA GHOSH

State-funded health insurance schemes do not target the truly needy or completely miss them, while the government is unable to regulate the private sector. These aspects were not taken into account when the government announced the National Health Protection Scheme. The scheme will turn out to be just another means for the growth of the private sector in the secondary and tertiary care segments.

All the existing national- and state-level publicly funded insurance schemes in India have identified target populations that are eligible for the particular schemes. However, several schemes have in fact resulted in mis-targeting or missing the target altogether (Ghosh and Datta Gupta 2017; Rent and Ghosh 2015; Wagle and Shah 2017). There is a fundamental problem with using the below poverty line (BPL) lists, as the criteria for inclusion and exclusion are faulty. For instance, widows or women-headed households tend to get excluded. There is also no realistic understanding of urban poverty for the purpose of the lists. These lists are also not updated regularly, excluding those who have been recently impoverished.

Thus, these schemes do not take into account the fact that there are existing social exclusionary processes that exacerbate the situation for the vulnerable and marginalised, and therefore they are unable to gain any benefit from these. Migrants, tribals, and deserted or widowed women were found less likely to be covered by insurance schemes. The inability of the schemes to provide coverage to the eligible population is highlighted by the fact that enrolment rates are as low as 2.45% as in the case of the Rajiv Gandhi Jeevandayee Aarogya Yojana (RGJAY) (Wagle and Shah 2017) and less than 5% in several states under the Rashtriya Swasthya Bima Yojana (RSBY) (Ghosh and Datta Gupta 2017).

Role of the Private Sector

The private sector being largely urban and profit-driven, has led to inequitable empanelment of private hospitals and promotes more profitable and quick-exit procedures under the scheme. Thus, the schemes fail to make available several specialties despite including the private sector. The Centre for Enquiry into Health and Allied Themes (CEHAT) published its report titled, "Government Funded Health Insurance Scheme in Maharashtra: Rajiv Gandhi Jeevandayee Aarogya Yojana" (Wagle and Shah 2017). Though a private hospital under study in this report had 17 of the RGJAY-recognised specialties available, it actually largely promoted only three to four of them. In general, under the RGJAY, specialties such as medical oncology are unavailable through the private sector in 12 districts. Intervention oncology is unavailable through the private sector in 17 districts and radiation oncology in 16 districts. Even specialties such as nephrology, and cardiothoracic surgery were unavailable through the private sector in almost one-third of the districts of Maharashtra.

The urban-centric nature of the private sector means that gaps in the public health sector have not been filled through partnerships with the private sector. Thus, Nandurbar, with more than 65% of its population belonging to Scheduled Tribes (STs), has only one empanelled hospital, which is a public hospital, and no private empanelled hospital (Wagle and Shah 2017). This leads to significant inter-district travel, adding to costs. In the case of Nandurbar and Beed, about 90% pre-authorisations were raised in a different district (Wagle and Shah 2017).

High Out-of-pocket Expenditure

At the National Conference on Health Insurance and Universal Health Care in India, organised by CEHAT and Tata Institute of Social Sciences in Mumbai in October 2017, evidence across the multiple studies presented also clearly shows that there has been no significant impact on the out-of-pocket expenditures (OOPE) incurred by the poor and none of the schemes were cashless as envisaged (Ghosh and Datta Gupta 2017; Nandi et al 2017). The reasons were several. Patients and their families continued having to pay for diagnostics and medicines, and the practice of reimbursement of costs is common. The situation for the poor can get aggravated if the claims are rejected or there are delays in settling claims or reimbursements. The continued inter-district travel mentioned earlier also adds to cost of healthcare. The Megha Health Insurance Scheme, based on the RSBY, in

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Tejal Barai-Jaitly (*tejal@cehat.org*) is a researcher at the Centre for Enquiry into Health and Allied Themes. Soumitra Ghosh (*soumitra@tiss.edu*) teaches at the School of Health Systems Studies, Tata Institute of Social Sciences, Mumbai.

fact follows a reimbursement model. Here too, the OOPE was high, reimbursements were delayed, no credit was available to registered patients, and expensive medicines needed to be bought from outside the hospitals, adding to the tedious nature of the scheme, besides the cost (Wundavalli et al 2017).

High OOPE is also a consequence of the absence of the continuum of care approach, as the maximum expenditure is incurred by the patient prior to reaching tertiary care services and at the level of the outpatient department (OPD). It is also bizarre to think that the government is willing to pay much more for the same services that would be cheaper were they made available through the public sector. It is also argued that strengthening the public healthcare facilities will lead to an increase in their utilisation. This will lead to a decrease in OOPE and reduce the dependence on the private sector (Muraleedharan 2017).

State schemes wherein there was incentive to recruit patients under the scheme led to the public and private sectors competing for the incentives, at the cost of the health of the patient. Patient care was found to be delayed until the required procedure could be covered under such schemes (Rajalakshmi and Lingam 2017). This creates serious barriers in access to healthcare. Awaiting health issues to be escalated to tertiary levels in order to have them covered under the scheme for the purpose of increased incentives is unethical.

The government has been a key facilitator in the growth of the private sector in the country. And yet, the government has limited control over it. The private for-profit health sector in the country is powerful, unregulated, unmonitored and unaccountable. This is clearly evident when we see the might of the private sector lobby in their resistance towards the Clinical Establishments (Registration and Regulation) Act, 2010. There is also evidence that charitable hospitals are not honouring their commitments in return for the benefits they have received from the government (Kurian 2013). Even within a public–private partnership, there is no attempt by the government to ensure accountability. Evidence from studies of various public health insurance schemes also highlights the issue of the supply-side moral hazard. There has been evidence of a rise in hysterectomies in Andhra Pradesh and Chhattisgarh under these schemes (Nandi 2017; Nandi et al 2017). This is a clear indicator of the lack of standard treatment guidelines and a failure of the state to regulate and monitor these schemes.

Conclusions

Ensuring universal healthcare requires a publicly managed health system giving free, comprehensive, and quality healthcare to all. Its foundation is in the rights-based accountability framework that also addresses the social determinants of health. It requires strengthening of the public sector and promotion of the continuum of care approach. Even within the public healthcare system, focus should be on removal of barriers towards ensuring free access to quality healthcare across all levels of health services to all people. The private sector needs to be regulated and monitored and the public health sector strengthened. Thus, instead of a National Health Protection Scheme (NHPS), we need to continue to aim for a comprehensive "national healthcare service" as was recommended by the Bhore Commitee in 1946.

Clearly, the burgeoning evidence against state-funded health insurance schemes and the inability of the government to regulate the private sector seems to be ignored when the government announced the NHPS recently. The private sector through the NHPS will have access to the money of billions of taxpayers. Seen this way, the NHPS seems to be just another way in which the growth of the private sector will be facilitated in the secondary and tertiary care segments. This move would also be contrary to the National Health Policy 2017, which suggested using the private sector only to fill the gaps. The government has to play a pivotal role in ensuring universal healthcare and equity.

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