Universal Basic Healthcare

Of late, the Government of India (GOI) has woken up to face the challenge of providing viable healthcare to its people. Earlier, the Universal Health Insurance Scheme (UHIS) was launched in the year 2004 but it failed to be popular among the masses. Now, the GOI has floated yet another health insurance scheme on national level with several improvements and named it as *Rashtriya Swasthya Bima Yojna* (RSBY). The RSBY was made operational w.e.f. 1st April, 2008, targeting Below Poverty Line (*BPL*) families, with the scope to extend it, gradually, to other vulnerable segments of the society. In this endeavour, the RSBY has now been extended to include families of workers who are engaged with building and construction work, also, even if they belong to the Above Poverty Line (*APL*) segment. The RSBY scheme envisages providing cashless health insurance cover up to Rs.30,000/- per annum per family, on a floater basis, whereby Rs.30,000/- can be availed of individually or collectively by up to five enrolled members of the family. Each state of the country is expected to cover 20% of the districts per year for the next five years, so that all the 596 districts of the country are covered within five years. The premium of this health insurance scheme is to be shared by the central and the state governments in the ratio of 75:25, and 90:10 in case of states of north eastern region and the Jammu & Kashmir, while the insured family is required to pay a token Rs.30/- per smart-card per annum, as a registration/renewal fee.

The RSBY has many plus points, like, (i) it covers pre-existing diseases; maternity related expenses with some

stipulations as well as transportation cost for undertaking medical treatment, (ii) it has very few exclusion clauses, and (iii) it operates on purely cashless basis. In order to manage the RSBY smoothly, bio-metric enabled smart-cards have been employed. Accordingly, the enrolment of the targeted people in the RSBY is considered valid only when the concerned family has been issued a bio-metric smart-card after due procedure and it keeps renewing the same annually.

The above mentioned features of the RSBY look quite attractive but still there are serious lacunae, as listed below:

1. The RSBY was primarily launched to help out about 65 million *BPL* households of the country, though irony is that more than 35% *BPL* cards issued in the country are unauthorized, as per the admission of the Government itself, as mentioned earlier in this book. On the top of it, this is also estimated that about 11 million genuinely poor families, i.e., a little less than 20 percent of the total poor, including poorest among the poor, do not possess the *BPL* card. Now, the Government has planned to cover building and construction workers belonging to the *APL* segment, too, in the ambit of the RSBY. Therefore, the identification of eligible beneficiary will itself bring further complications, corruption as well as other operational mistakes and disputes. I think this alone places a big question mark on the credibility of the successful implementation of the RSBY scheme.
2. The Government intends to bring some 20% districts of each state under the ambit of the RSBY, per year, thus a big chunk of people of the *BPL* segment will remain outside the purview of the RSBY for a long duration which will extend up to four more years for

many. I suppose this puts a big cross-section of the people at considerable loss in comparison to others who will be covered earlier, for no fault of theirs. Moreover, what would happen if a person of a family who could not be included in the list of beneficiary of a smart-card - as it has a ceiling whereby medical treatment of only five persons can be covered - falls sick? Naturally, such a family would suffer, may be it will give rise to acrimony among family members, too.

3. The RSBY appears to be quite a complex scheme in operation with several weak links, which can be exploited by the vested interests for their advantage. When a much simpler scheme like the National Rural Employment Guarantee Scheme (NREGS) is being misused rampantly, as will be discussed later under the section *"NREGS and Its Pitfalls"*, there is even slimmer hope that the RSBY can sail through smoothly. It cannot be assumed that there will not be any lacunae in the implementation of the RSBY only because the Government is paying premium to the insurance service providers and thus these service providers will meticulously and willingly take care of the problems of the targeted people. On the contrary, these service providers would like to save as much as they can on health insurance claims on one pretext or the other. **Still, there are many exclusion clauses in the RSBY scheme, like the one which excludes diseases/ accidents due to and/or use, misuse or abuse of drugs/alcohol or use of intoxicating substances or such abuse or addiction, etc. Particularly, the aforesaid exclusion will bring a lot of disputes because many people of the *BPL* segment and the *APL* segment workers engaged with building and construction**

work can be linked, rightly or wrongly, to alcohol/ drugs and thus can be denied insurance benefits. More so, when the existing insurance service providers of healthcare policies, do not reimburse cost of treatment to even educated policy holders on technical grounds then how can it be assumed that the vulnerable people covered under the RSBY will not be taken for a ride by the insurance service providers?

4. There is considerable scope that the people will be baptized with corruption and misuse the RSBY scheme towards the end of the year when their limit of Rs.30,000/- will be about to lapse in the same way as sometimes even high salaried employees of reputed firms check in for a few days to stay in corporate hospitals, with five-star comfort, for no good reasons.

I suppose we should have had the following points in mind while providing healthcare assistance to the people of the country.

First, the healthcare should be provided to all the people of the country, irrespective of their ability to pay the premium for healthcare insurance cover, only then schemes, like the RSBY, can be run efficiently and successfully. As far as financial implication due to expanded coverage of all the people is concerned, it will not be so much that it cannot be handled by the Government. Presently, also, the Government intends to cover about 65 million families who belong to the *BPL* category and other families who are engaged with building & construction jobs even if they belong to the *APL* category, thus at least 30% of the total people may get coverage under the RSBY scheme. The annual premium under the RSBY per beneficiary family per smart-card is about Rs.600/-,

whereas another healthcare scheme run by Andhra Pradesh state government, viz., *Rajiv Aarogyasri Community Health Insurance Scheme* (RACHIS) which has already covered about 65 million people belonging to the *BPL* category, in a short span of 15 months after it was run as a pilot project in three districts, runs on an annual premium of Rs.330/- per *BPL* family. The RACHIS appears to be a much better scheme as it provides a floater family cover of Rs.150,000/-, extendable up to Rs.200,000/- in case of major surgeries, with a further cover up to Rs.650,000/- in case of cochlear implants and related surgeries. The RACHIS does not require any contribution from the insured family unlike the RSBY which stipulates Rs.30/- per annum for renewal of registration under the RSBY scheme. There are other popular health insurance plans in our country, also, like, (i) *The Yashaswini Health Insurance Scheme* operating in Karnataka since 2003 and (ii) *Health Insurance Scheme for Handloom Weavers* launched in 2005 on national basis.

It is a basic principle that the larger is the base of the insured population, the lower is the premium for the insurance plan. Even a premium of less than Rs.100/- per person per annum (Rs.500/- per household per annum) with elaborate coverage of medical care would have been acceptable to the insurance service providers, if we would have covered all the 1.1 billion people of the whole nation. Accordingly, a premium of Rs.100/- per person per annum for 1.1 billion people, would have entailed an expenditure of Rs.110 billion per annum, only, on a healthcare plan similar to that of the RSBY. When the Government is ready to foot the bill for the 30% population then it can surely foot the additional bill for the remaining 70% population, too, resources for which can be generated easily, as will be discussed later in the Part II of this book. I would go one step further and plead that, if needed, even a premium of Rs.200/- per person per annum or more can be considered

by the Government for universal healthcare plan, if an elaborate insurance healthcare plan including coverage for treatment up to some pre-fixed limit, for common sicknesses, like, fever, diarrhoea and others, which do not require hospitalization and can be treated on day care basis, could be negotiated with the health insurance providers. Even a premium of Rs.200/- per person per annum, will burden the Government by Rs.220 billion per annum, only. Accordingly, I shall continue my arguments further with a projected expenditure of Rs.220 billion per annum, for the Government, for providing reasonable healthcare to all the people in the country.

Secondly, the guidelines for healthcare insurance should be straight-forward leaving no scope for confusion. It has been observed that cashless services under health insurance plan need pre-authorization before undertaking a treatment, which sometimes eats up crucial time besides burdening clients with costs of waiting. **To eliminate all such problems, I propose that some treatments should be administered without waiting for pre-authorization; however, for other diseases separate guidelines can be issued. For example, medical treatment up to some pre-approved limit, should be allowed for all kinds of accidents, without any exclusion whatsoever, for all the people, without waiting for pre-authorization. One can safely assume that no sane person would ever like to get hurt in an accident, whether intoxicated or not, just to avail of the benefit under health insurance plan. Even the transport should be arranged for the victim of the accident as part of the insurance plan.**

Thirdly, all abortions/pregnancies related medical treatment, including transportation cost, should be covered under the insurance plan, say, up to a limit of Rs.5000/- in

one's life, barring major complications, without any other condition. Those undergoing tubectomy operations without exhausting the aforesaid limit of Rs.5000/-, can be given some additional incentive, by way of increased healthcare cover or otherwise. This may motivate people, to some extent, to have smaller families. I think this is much better than the clause of the RSBY which does not cover medical expenses on the third and onward pregnancies, irrespective of the risks to the lives of the mother and the child. We should look for other means and motivations for limiting the size of families than using such riders, which penalize the victim of unwanted pregnancies, the hapless woman!

Fourthly, (a) all acute common diseases, like, fever, diarrhoea and others; (b) unforeseen diseases, like, cancer and others, which occur infrequently but can bring untold physical as well as financial burden on the patient and his/her family; and (c) communicable diseases, like, Tuberculosis, etc.; should also be treated free of cost under health insurance plan with appropriate limits as deemed fit by the Government.

Fifthly, for the remaining diseases, some appropriate limit on floater basis for a family, as deemed fit, can be fixed under the healthcare plans. However, with a view to minimize misuse of insurance healthcare plans, the future cover limit of concerned persons should be increased progressively, as a token of appreciation, if they have not availed of any medical treatment in previous years. It will help in curbing misuse of insurance healthcare plans, for which it is often reported that sometimes the pseudo patient(s) play as a willing accomplice of the hospitals to fleece insurance service providers. Such incentives which reward the honest and careful people, will also fuel healthy growth of healthcare schemes in the larger interest of the people of the country.

I suppose the aforesaid steps will bring following immediate benefits with a win-win situation for one and all:

1. Universal basic healthcare plan for all the people will provide a sense of tremendous relief among all, that in case of any unforeseen accident and diseases, like, cancer, they will be looked after reasonably and will be provided basic care. It is not that only poor people dread accidents and diseases, like, cancer. Even upper middle class people when faced with such eventualities, feel utterly helpless and whatever sense of security they and their families possess, gets shattered in no time.
2. It will increase institutionalized child-birth deliveries in the country and thus reducing mortality rate of the new born and the mothers. Presently, when about 99 percent institutional deliveries take place in Kerala, only 20 percent institutional deliveries take place in states, like Bihar and Uttar Pradesh, thus gravely risking the lives of the child as well as the mother.
3. In fact, annual grants to the government-aided hospitals should also be linked to the medical services they provide to patients under country-wide insurance healthcare plans. This will improve productivity of these hospitals as well as develop and foster a patient-friendly culture in these government-aided hospitals. Besides the above, it will also stop the racket of pilferage of free-medicines which are supplied to these hospitals for the treatment of patients but are siphoned off for black-marketing. Presently, about 80 percent expenses on healthcare by the Government are spent on paying salaries to government healthcare personnel, and still patients often face indifference at the hands

of these personnel when they need to visit these government-aided hospitals. **If we link a significant portion of grants to government hospitals to the healthcare they extend to the patients, it will bring a sea-change in the proper functioning of these hospitals, which the Government can never bring about by any sort of legislation or other cosmetic inspections which its functionaries sometimes carry out at these hospitals. I feel the die-hard primary health centres of the Government will also start functioning, when grants of these centres are also linked to the services people receive at these centres, which can easily be monitored, now, using smart-cards.**

The above contention is not out of context. Even the government hospitals of Andhra Pradesh could earn about Rs.220 million out of a total claim of Rs.2030 million paid by insurance providers to the hospitals towards the cost of treatment of patients under RACHIS of Andhra Pradesh (Source: *Business Standard* dated 23rd August, 2008). **The similar strategy can be replicated in the entire country with even better results, which will help in alleviation of sufferings of the masses to a large extent. Moreover, in this manner, private hospitals, too, will be forced to be more sober towards their patients. This way the Government can also save enormous resources which can be ploughed back in augmenting infrastructure of existing government hospitals, establishing more government hospitals as well as providing even better healthcare cover to its citizens, which will ensure more humane and tender care towards millions of unfortunate patients of the country and thus kindling hope among all that there is some one to protect them in their crisis hours.**

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