Private health insurance and access to healthcare

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Abstract

The health insurance business in India has seen a growth of over 25% per annum in the last few years with the expansion of the private health insurance sector. The premium incomes of health insurance have crossed the Rs 8,000 crore mark with the share of private companies increasing to over 41%. This is despite the fact that from the perspective of patients, health insurance is not a good deal, especially when they need it most. This raises a number of ethical issues regarding how the health insurance business runs and how medical practice adjusts to it for profiteering. This article uses the personal experience of the author to argue that health insurance in an unregulated environment can only lead to unethical practices, further victimising the patient. Further, publicly financed healthcare which operates in an environment regulating both public and private healthcare provisioning is the only way to assure access to ethical and equitable healthcare to people.

Health insurance has become a dirty word. The recent spat amongst insurance companies, Third Party Administrators (TPAs) and hospitals was all about their respective shares in the booty that is collected from patients. This booty is growing at the rate of 25-30% annually and is worth Rs Rs 8,304 crore in premiums (table) with 95 lakh policies covering 5.7 crore individuals, as much as 5% of the population. This is certainly a significant number today and growing rapidly amongst the middle class in tandem with the collapse of the public health system.

Health insurance premiums: Rs (in crores) by type of company

Company	2009-10	2008-9	2007-8
Public	4,883	3,824	3,136
Private	3,421	2,801	1,988
Total	8,304	6,625	5,124

Source: Figures for 2009-10 are from IRDA Journal (1). Figures for 2008-9 and 2009-10 are from IRDA's annual report (2).

For a number of years, public sector insurance companies dominated this business with a do-good approach, as this was a very small component of their overall general insurance business. In the last few years insurance has shifted to the private sector and there has also been a shift in business ethics. As the private sector increasingly dominates this business, the rules of the game are changing and profiteering takes centre stage. Premiums are rapidly going up, more and more conditionalities and exclusion clauses are being added, and claim reimbursements are being delayed and/or short-paid. On the other hand, private healthcare provision remains unregulated as well as unethical in practice. In such an environment the current quarrel was bound to happen; the people who suffer as a result are patients who, despite paying heavy premiums for years, end up being short-changed when they seek the benefits of their policy. The hospital gets its money even if it has overcharged. The TPA makes deals with both hospitals and insurance companies and facilitates reduced cashless payments, transferring the burden to patients. And the insurance company gains by reimbursing a lower claim.

Cashless insurance indeed

I would like to highlight issues emerging from the current trends through my personal experience. For over two decades, I have had a Mediclaim policy from a public sector company, covering myself, my wife and my daughter. Except for once around 1994 when my wife was hospitalised overnight for a procedure, we had not made a claim. In March 2010 I was advised minor surgery and chose to get it done at a well known private hospital where one of my surgeon friends was attached.

Once we decided on the date of the surgery and the booking was made, the process for a "cashless" procedure began. I submitted the documents required by the hospital and the TPA on my insurance cover, and opted for a Class A room. The hospital sent the TPA the startling estimate of Rs 1 lakh. The TPA responded that, as per the fine print of the policy document (which I must have read 20 years ago when I first made the policy and since forgotten) I was entitled to 1% per day for room charges. So, in this hospital I was entitled to a Class C room, which was a triple bedroom. Otherwise, I would have to pay the difference. The Class A room cost 2.5 times as much as the Class C room, so I opted for Class C and the hospital revised the estimate to Rs 70,000.

On my admission, the hospital asked me to pay a deposit of Rs 10,000 (cashless indeed), after which I was admitted and preparation for my surgery began. After the surgery the hospital informed me that the TPA had made an initial approval of only Rs 40,000. Two days after the surgery I was given a preliminary bill of Rs 48,000. I was told that the charges had exceeded the approval by Rs 8,000 so I should deposit another Rs 8,000. I told them to adjust this amount against my deposit. On the day of my discharge I was handed a final bill of Rs 59,722 and forced to pay Rs 19,722 before I could leave the hospital - a total of Rs 29,722 for a supposed cashless hospitalisation.

I also noticed when I scanned the detailed bill that the charges levied were higher than what I was told on the day of my admission, which happened to be on March 31. I asked why and was told that the hospital's rates had been revised from April 1, 2010. I had not been informed of this and argued that my contract was dated March 31, so only those rates could apply. They replied that the matter was not in their hands since their computers had been programmed to calculate the figure.

I lodged a complaint of violation of contract terms but the hospital administration has not bothered to respond to my letter.

On the insurance front, things were worse. The TPA gave final approval to only Rs 31,270 of the Rs 40,000 it had agreed on, and the hospital called me, demanding Rs 8,730. They eventually adjusted it from my deposit of Rs 10,000 and refunded Rs 1,270 to me. Now, in addition to my battle with the hospital for overcharging me, I was fighting with the TPA and the insurance company for inadequate approval of my expenses. I sent several e-mails and made many calls to the TPA and insurance company but they would not budge, nor would they provide any reason for the short payment. I did learn informally, from the TPA, that the hospital where I was admitted was known to overcharge its insured patients, so the company routinely made a 20% deduction from any charges at that hospital. Of course, this was not communicated while I was negotiating admission to the hospital for cashless hospitalisation.

My next stop was the insurance company where I was asked to fill a new claim form for reimbursement of the amount over and above the approved amount. However, they did not respond to my repeated reminders for over four months. Finally I approached the company's grievance cell and lodged a complaint of short-payment. Immediately the concerned development officer called me and asked me to fill another claim form as they could not locate the one I had sent earlier. (I am sure many people are dissuaded when they are told their claim form has been lost, and just give up on pursuing the claim.) I have filled in a new claim form, and also sent a complaint to the insurance ombudsman. And now I await justice.

Need to regulate private healthcare

My experiences are illustrative of the ethical violations encountered in the insurance business. There is complete lack of transparency: by the hospital which overcharges you and/or changes rates without informing you; the TPA which cheats you by reducing the approved amount for irrational reasons, or by not giving any reasons at all, and the insurance company for washing its hands of the matter and passing the buck to the TPA. From the patient's perspective, beneficence, autonomy and justice have all failed. The patient was overcharged and cheated, was not informed about increase in charges, was not informed about the 20% "co-payment" because it was a hospital that was deemed to be overcharging. The patient was forced to make advance payments even though it was a cashless policy utilised at a hospital on the TPA's list of authorised providers. The TPA reduced the approval amount without assigning any reason, and even after a delay of six months, the balance reimbursement has not been made to the patient.

This is happening primarily because the private health sector does not have any rules and regulations for its conduct. There are no standard treatment protocols, no price and cost standardisation for procedures, no monitoring of quality, no prescription audits, no social audits. Further, providers - both individual practitioners and hospitals -have very little respect for ethics of medical practice. They do not provide information to patients pro-actively. They often resort to unnecessary diagnostics and prescriptions to inflate bills of insured patients. They cheat patients by giving them incomplete information at the outset and then announcing additional payments. So the patient is a victim of unethical medical practice.

There are also occasions when patients cheat by not declaring pre-existing problems, or by bribing doctors to hide these problems. This largely happens because of the way in which insurance operates. Many patients buy insurance only when they anticipate surgery or a medical procedure. When they are done with the procedure they opt out of the insurance system. So the insurance system sees high turnovers of insured clientele. This adversely affects the claims ratio and consequently leads to harassment of patients with legitimate claims by the insurance company. In an unregulated environment, insurance actually needs to resort to unfair means and cheating.

However, regulation and standardisation alone do not ensure that insurance companies will behave ethically. In the United States, the only country in the world where private insurance is the dominant mode for financing healthcare, insurance companies threaten the autonomy of not only patients but also of doctors. They dictate terms and conditions to doctors and hospitals of what they can do with patients and what they cannot do. Increasingly insurance companies are controlling hospitals through managed care programmes and preferred provider organisations through which they influence the clinical behaviour of healthcare providers and/or patients, often by integrating the payment and delivery of healthcare. Incentives and disincentives are used to control provider behaviour and clinical decision-making and this often leads to affecting patient -provider relationships (3, 4).

Importance of publicly financed healthcare

At the heart of the insurance debate is the issue of access to "ethical healthcare" -- universal access to comprehensive healthcare for all, without discrimination, especially discrimination based on the capacity to pay. This is a self-evident good and should be built into the objectives of health finance, whether private or public. The stated objective of private insurance is to cover part of the expenses of those who pay for their healthcare. But this cannot ensure universal and equitable healthcare. It does not ensure universal access to healthcare. Public financing of healthcare is critical to realise ethical and equitable healthcare.

A number of developed countries and even some developing countries use a publicly mandated system combining taxes, social or national insurance, payroll deductions and other indirect revenues like "sin taxes" to finance their healthcare. However, the care may not always be provided exclusively by the public sector.

For instance Canada has the best and most equitable healthcare system in the world that is not government-controlled (5). It assures full access to everyone without the need to make any payment at the point of care. Health Canada, a public corporation,

pools all resources and is a single payer for all healthcare services. While most hospitals are run by governments in Canada, private hospitals are also given access to these resources when citizens use them. For out-patient care, most providers in Canada are private providers who are contracted in by Health Canada on pre-agreed fees for services. The National Health Service in the UK is very similar and Brazil, Venezuela and Mexico are close to emulating these models (5, 6)

On the other hand there are examples like Sweden, Sri Lanka and Cuba which are completely state-run systems which provide universal access to healthcare (5). Thailand is the most recent entrant into this club and I think we have a lot to learn from the Thai experience because the structure of the healthcare system in India and Thailand historically has been very similar (7).

Challenges to changing the healthcare system

In India the National Rural Health Mission (NRHM) affords us a great opportunity to change the way the healthcare system works. The NRHM (8) was meant to make radical changes to the system, backed up with a commitment to provide up to 3% of gross domestic product to realise universal access to healthcare. But the necessary political backing has not been forthcoming.

The challenges across the country differ due to different levels of development of the public and private health sectors in the states. For instance, I visited Mizoram for research in 2003. This small and hilly state has an excellent primary healthcare system, with one primary health centre (PHC) per 7,000 population and one community health centre per 50,000 population. Since it has virtually no private health sector, the demand side pressures are huge and the public health system delivers. Each PHC has two to three doctors on campus available round the clock with 15-20 beds which are more or less fully occupied, and 95% of deliveries happen in public institutions. So Mizoram has indeed realised the Bhore dream. The problem in Mizoram is that there are very few specialists available and it is difficult to obtain tertiary care, though the CHCs are run by MBBS doctors who have received some additional training. Still, though Mizoram does not have a medical college, it does have reservations in other state medical colleges. The state also has a budget to send people elsewhere for tertiary care. And Mizoram does this with 2.7% of its net state domestic product and has the best health outcomes in India. In this sense Mizoram is like Sri Lanka - a model of government healthcare.

But Mizoram cannot be the national model because the reality across most other states is very different -- an entrenched private health sector which is unethical and unregulated. The private health sector has to be reined in, and this can only happen with a strong political will which declares healthcare to be a public good and which takes on the private sector to get organised under a public mandate, that is private providers are reined in under a legislated public programme for provision of healthcare, similar to the NHS in the UK or Health Canada. Under the NRHM, sporadic efforts towards this end are being undertaken in the name of public-private-partnerships like Chiranjeevi in Gujarat, Yeshasvani in Karnataka, Arogya Rakshak in AP, Rajiv Gandhi Hospital in Raichur (Karnataka government and Apollo Hospitals), etc, and these have achieved limited success. But healthcare systems cannot be built through segmented programmes and one-off initiatives like public-private partnerships. There must be a comprehensive and organised healthcare system, and in India the private sector will have to be a significant partner in this process.

So the challenge is enormous, demanding restructuring of the healthcare system in the country through strong regulatory mechanisms both for the public and private sectors, education of professionals in ethics of practice, and pushing politicians to create a strong political will to make healthcare a public good and commit adequate resources to realise universal access. Given the price advantage of India and economies of scale that it offers, the restructuring of the healthcare system and its financing strategy will actually reduce nearly by half the healthcare spending in the country and substantially reduce the household burden to access healthcare because of more rational and ethical medical practice, and pooling of resources.

There is no country in the world that provides universal access and uses private health insurance to finance it. All countries which provide universal access to their citizens use a combination of taxes and social insurance to finance healthcare. There is no exception. Private health insurance cannot be an ethical model for healthcare provision.

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