COMMENTS

Identifying beneficiaries for user fee waivers: ethical challenges in public health

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Shortages in the public budget for government health services led to the adoption of a system of user fees for healthcare in many developing countries. The Government of India introduced user charges in public health services on a pilot basis as a part of its health sector reforms in the late 1990s and early 2000 (1). A major criticism of user charges relates to 'equity'. Full waiver of the fees has been recommended for the poor to ensure equitable access to services. Waiver is a right conferred on an individual that entitles him/her to obtain health services in certain health facilities at no direct charge or at a reduced price (2).

One of the key challenges is to identify those who truly need the waiver. In India, we depend on documents and certificates which indicate whether patients fulfil the criteria entitling them to receive benefits under various schemes. The potential beneficiaries have to submit proof that they fulfil the criteria. In spite of the well-intentioned decision to grant waivers, many errors take place in the field. Here I describe a couple of instances (case studies 1 and 2) which indicate how a good policy decision can go haywire. In a lighter vein, these stories tell us how a bit of friendly help can lead to big trouble. On a serious note, these two instances reveal the limitations of the existing procedures for identifying the poor and needy for the provision of healthcare services. Similar problems may also crop up in other sectors in which subsidies, exemptions or waivers are given to people possessing specific documents. Such situations bring out not only the existing administrative problems, but also ethical issues which need to be addressed.

CASE STUDY 1: This incident occurred when I was working in the anti-rabies outpatient department (OPD) in a medical college during an earlier posting. Among other management modalities, we used to give an intramuscular injection of Rabipur to patients with class II and class III animal bites. All patients with the below poverty line (BPL) card or the yellow ration card were given the vaccine free of cost, while others had to pay a nominal amount. Patients with the yellow ration card/ BPL card were sent to the Resident Medical Officer, who would stamp the OPD paper, declaring that the patient could be given the vaccine free of cost.

One day, a six-year-old boy, accompanied by his father, presented to the OPD with a history of dog bite. As they had the BPL card, they sought waivers, which were granted. After the boy's name was noted in the register, he and his father were requested to wait in the queue. After some time, the child's name was called out but no one responded. When he did not respond despite his name being called out repeatedly, I walked into the area where the patients were sitting and called out his name. Yet no one came forward. The boy was sitting alone right in front of me. I went to him and requested him to accompany me to the OPD room. I was taken aback when he told me that the name I was calling out was not his! I was trying to sort out the confusion when the boy's father, who had gone out for a cup of tea, rushed back. He tried to avoid my questions, but as I persisted, he gave me the actual picture. He had brought his son to the OPD a few days earlier to have him treated for the dog bite. During that visit, he had learnt that patients with BPL cards are given free treatment. He had gone back without getting his son treated. He had approached a friend who had a BPL card, as well as a son of the same age as his son. He was planning to use this BPL card for the treatment of his son and had hence got his son registered under the name of his friend's son. The innocent boy was not aware of his father's plans and had inadvertently let the cat out of the bag. The next time I opened my records, stored scrupulously in registers, I kept wondering how many of those names and addresses were genuine.

CASE STUDY 2: This incident was narrated to me by a friend in the public health services. It is the story of an old woman who was admitted to hospital with malaria. As it was late by the time she had sought help and she had already developed complications, she died while under treatment. The public health authorities were notified about her death. They noted down her name, age, address, etc and a team visited her house to verify her residence. The team had planned to conduct a survey to identify cases of fever, provide the patients with treatment and spray insecticide in the neighbourhood. When the officers reached the patient's house and tried to verify her residence by making enquiries about her, they were flabbergasted to see the woman in question walking out of the house. A short period of confusion followed. The mystery was cleared when the woman's

son came home. He took the officers aside and told them that his friend's mother had been ill and his friend had asked for his BPL card so that the mother could get free treatment. As a result, the friend's mother was admitted to hospital under the name printed on the BPL card. Thus, this woman received the free treatment and died under another name in the record books.

Designing waivers is a complex task as it entails the adoption of different rules for different individuals and poses ethical challenges in public health. Kass has set out a framework for public health ethics that is designed to serve as an analytical tool to help public health professionals consider the ethical implications of proposed interventions (3). On the basis of this framework, this article attempts to analyse the intervention of waivers of user fees.

It is important to understand that the goals of the waiver system are to reduce the out-of-pocket cost of care for the beneficiaries, and to ensure both equity in access and equity in the financing of health services (2). The first step towards achieving this goal is obviously to identify the beneficiaries of the waiver of user charges. The method adopted in India is to identify individuals who possess the necessary documents. For example, the documents that the poor need to possess are the BPL card or the yellow ration card. These documents are provided by the revenue department once a household applies for them, supplying the necessary proof of identity. The public health services have no role in issuing these documents.

When waivers are provided in a health system, it implies that the system will differentiate between those eligible for waivers and the rest of the population during the course of treatment. This should not lead to any discrimination between the two groups, be it in the area of treatment or interaction with the doctors, paramedical professionals and administrative staff.

Table 1
Errors and accuracy in identification of beneficiaries

	Actual status		
	Groups	**Poor**	**Non-poor**
Classification	**Poor**	Good targeting	–Leakage –Incorrectly given benefits
	Non-poor	–Under coverage –Incorrectly denied benefits	Correctly denied benefits

Table 1 sets out the errors and accuracy in the identification of beneficiaries and the implications (2). Not all poor people who are eligible for waivers have the necessary documents. In government hospitals, we come across a group of patients belonging to the most marginalised sections of society, eg beggars and street dwellers, who not only have a meagre amount of money, but also do not possess any kind of documents. The doctors are faced with the ethical dilemma of whether to refuse to provide these patients with free treatment merely because they do not have the necessary documents, or to overlook the matter and provide treatment. Refusal to provide treatment not only causes the poor to delay the process of seeking treatment or even forego treatment, which results in a poor prognosis and outcome, but also raises ethical issues. Providing free treatment to patients who do not have any proof showing that they fulfil the criteria for beneficiaries is improper in the legal context. In exceptional cases in which the patient cannot pay the bills and does not have the necessary documents, the officer concerned can use his discretion and waive the fees. However, this leads to ambiguity, introduces an informal process of decision-making, and increases the chances of leakages and corruption.

In a study aimed at mapping the flow of user fees in a public hospital in Mumbai, it was found that a large number of the patients belonged to the underprivileged category, yet very few possessed BPL cards and hence, the actual proportion of patients lucky enough to access waivers was negligible (5). This study also reported a lack of systems for monitoring and supervision of waivers and exemptions.

The need to identify the beneficiaries at the point of service imposes major administrative demands on the health system. In India, as mentioned earlier, the method for targeting the beneficiaries consists of individual identification on the basis of documentary proof. Other methods which can be adopted include identification on the basis of group characteristics, self-identification, and self-selection by type of service (2). In a country such as India, where there is widespread poverty, determining who is actually poor can be a real challenge. A number of different criteria and processes have been tried for the identification of the poor as beneficiaries of programmes in developing countries (4).

Valid identification criteria, an effective process for identifying the poor, and providing them with valid proof of their status that makes them eligible for the benefits are very important. A minimum number of documents should be sought to identify beneficiaries. The Unique Identification Number (Aadhaar), which identifies individuals uniquely on the basis of their demographic information and biometrics, gives individuals the means to clearly establish their identity before public and private agencies across the country. However, the socioeconomic status of the individual cannot be determined on the basis of this card. From the point of view of the service provider who has to identify the eligible beneficiary, a single document which is valid and confirms the identity of the person will ensure that the benefits reach the people they are intended for.

There is considerable debate over the issue of charging fees at the point of service. This policy has been criticised and it has been recommended that user charges be abolished in the government system (6). A review found that most of the studies available on the introduction or removal of user fees failed a rigorous quality appraisal, and suggested that such decisions need to be backed by scientific evidence (7). It is worth noting that the World Bank Group president has recently stated that even tiny out-of-pocket charges can drastically reduce the use of services by the poor, and that this is both unjust and

unnecessary (8). It is encouraging that the Report on Universal Health Coverage for India, prepared by the High-level Expert Group instituted by the Planning Commission, recommended that no fees should be levied for the use of healthcare services under Universal Health Coverage (9). This document enumerates a number of drawbacks of user charges. Some of these relate to the errors in inclusion and exclusion associated with identifying the economically weaker sections of society; the difficulty of providing equitable services to all economic sections of society through a differential fee arrangement; and limiting corruption and administrative costs associated with receiving payments at the point of care. We should also draw lessons from the experiences of other countries that have attempted to abolish user fees in health services (10).

Apart from user fees, there are indirect costs, such as transportation and opportunity costs, which can be a burden for the ultra-poor. Waivers and exemptions alone may not be sufficient to mitigate the erosion of income that accompanies ill health. More holistic and integrated interventions are needed to improve the healthcare-seeking behaviour of the poor. A study found that a grants-based, integrated intervention that had both health and non-health components improved the use of health services among the most deprived (11). The non-health components included grants for income-generating assets together with training, subsistence allowance in the initial phase, social awareness and pro-poor advocacy. The health component included the provision of essential health services, as well as of counselling and consumer information on health services, free installation of latrines and tube wells, identity cards to facilitate access to health services and financial assistance through community-mobilised funds.

The waiver of user fees is aimed at improving the access of the poor to healthcare services. The identification of the poor, which is the crux of the intervention, is a very complicated matter and poses several ethical issues for public health. These include the potential risks of exclusion, delay in treatment-seeking, leakages, corruption and discrimination. There is a need to come up with a valid and effective system of providing waivers, with regular monitoring and evaluation being an intrinsic part of the system.

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Corruption in healthcare: a problem in Germany, too

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According to Transparency International, corruption is "the abuse of entrusted power for private gain" (1). In many parts of Latin America, Africa and Asia, corruption is associated with healthcare in the daily life of patients, as well as routines in all types of hospitals. In the developing world, this crude corruption is felt at every moment in life: patients are often (well) treated or even allowed to see a doctor only if they pay a bribe. Money is directly and openly paid to all kinds of players in the health system: to doctors, hospitals, nurses, or administrative staff.

Open forms of corruption are not often seen in developed countries such as Germany. Corruption here is more hidden and subtle. Therefore, there is a misconception that corruption in healthcare is not prevalent in the developed world.