Health Insurance as An Integral Component of Health Maintenance Organization (HMO) Urgent Need for Paradigm Shift

RD Lele

The World Health Organization has defined health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. India has a long tradition of health-care. “Ayurved” (literally meaning science of life), clearly stated 2500 years back that - “the aim of medicine is three-fold : Promotion of positive health, Prevention of disease and Treatment of disease when it arises”. These three aims remain as important today as in the past. One new component as a part of treatment is rehabilitation.

Ayurveda emphasizes that health is not a commodity that can be purchased - it is an asset which has to be assiduously maintained with care and husbandry; by following rules of conduct regarding diet, exercise and behavior - “The body and the mind are both considered to be the abodes of disease, likewise, of well being. The cause of well-being is their harmonious and concordant interaction. The cause of disease psychic or somatic is either erroneous, absent or excessive interaction”. “Like the lord of a city in the affairs of his city, a charioteer in the management of his chariot, so should a wise man be ever vigilant in the care of his own body and mind”, “Diseases occur in those who do not observe the rules of healthy living. Hence the healthy man should be diligent in the observance of the rules of healthy living- “Swastha Vritta” for the body and “Sad Vritta” (ethical conduct) for the mind.

Health maintenance and disease prevention need a partnership between the individual and his family and the family doctor who is a teacher and guide. The current terms such as “consumer”, “provider of health care” and “marketing of health care” are repugnant to the concept of this patient-doctor partnership based on trust (fiducial relationship).

While talking about “Health care” most people ignore the 1st and 2nd components and concentrate only on the third component. “Health care” has therefore become synonymous with “Illness care”. The so-called Health Care Industry also is concerned with illness care, pushing the importance of promotion of positive health and prevention of disease to a poorly neglected secondary position.

Health care finance in India

India spends around Rs. 1030 billion in health, which is 6 percent of the GDP of which the share of government is less than 1.3 percent (as against the WHO recommendation of at least 5 percent). Progressively government allocations in the health sector have declined from 1.3 percent of GDP in 1990 to 0.9 percent in 1999 (National Health Policy 2001). A large segment of the population is below the poverty line and has to rely entirely on the services provided by Government. Poor reach and quality of service provided by Government hospitals drive people to private facilities. Private doctors and hospitals both in urban and rural areas provide a large percentage of medical care. Bulk of medical expenses are met out of pockets of private citizens. The expenditure has grown at the rate of 12.84 percent annually, causing great concern especially for the low income groups.

Health Insurance in India

The Employee State Insurance act (1948) paved the way for introducing mandatory social insurance scheme in the formal sector. The Employees State Insurance Scheme (ESIS) introduced in 1952, benefits 33.4 million workers with income less than Rs. 6500 a month, along with their families. Care is provided through 136 hospitals, with 43 annexes (23720 beds) 1443 ESI dispensaries, 6542 medical officers and 2988 medical practitioners.

The Central Government Health Scheme (CGHS) started in 1954 for employees of central Government, members of parliament, judges, freedom fighters and their families. This contributory scheme (Rs. 15 to Rs. 150 per month per person based on salary) has 4.5 million beneficiaries.

Indemnity Health Insurance in India

Mediclaim scheme of General Insurance Corporation was introduced in 1986 for people not covered under above schemes. Only 2% of urban population (and 0.2% of total population) in India has health insurance under mediclaim which pays for in-patient treatment only. It does not cover medical termination of pregnancy (MTP) or tubectomy (necessary for population control). It does not cover costs of preventive care (e.g. immunization against Hepatitis B). Many organizations cover their employees through a group Mediclaim scheme.

*Hon. Chief Physician and Director, Nuclear Medicine Department Jaslok Hospital and Research Centre, Mumbai. Hon. Director, Nuclear Medicine and RIA Department Lilavati Hospital and Research Centre, Mumbai. Emeritus Professor of Medicine (for life) and Ex-Dean, Grant Medical College and Sir JJ Hospitals, Mumbai. Dean (Academic), All India Institute of Diabetes, Mumbai.
Indemnity Health Insurance is a financial mechanism with which people are protected against catastrophic financial burden arising from unexpected illness or injury. The level of premium is based on actively determining the likelihood of illness of the insured.

Insurance is based on the principle that what is highly unpredictable to an individual is predictable to a group of individuals. Under the existing indemnity based system the policy-holder first pays the expenses for treatment which is later reimbursed depending upon the sum assured and coverage.

In a recent survey the Insurance Regulatory Development Authority (IRDA) of India noted with concern the spiraling rise in the claims ratio of Mediclaim policy from 94 percent in 2002 to 140 percent in 2004. The problems faced by the health insurance companies worldwide clearly indicate that indemnity health insurance in its present form has no future in India and clearly point to the urgent need for a paradigm shift - viz. health insurance as an integral component of an HMO, and managed care.

Unhappy Current State of Affairs

There is wide-spread and growing discontent with the prevailing health care system world-wide. The richest country in the world, USA, which spends 18% of its GDP on health-related expenses is not happy with the current state of affairs.

The Institute of Medicine (IOM) in USA has stated in 2001: “The American Health Care Delivery System is in need of fundamental change. The current care system cannot do the job. Trying harder will not work. Changing systems of care will”.

“Between the health care we have and the care we could have lies not just a gap but a chasm” ( “Crossing the Quality Chasm : A new Health System for the 21st Century 2001)1. The current system fails to fulfill six aims of quality health care: safety, effectiveness, efficiency, timeliness, patient-centredness and equity. As regards safety the IOM document-“To Err is Human” in 1999 noted that almost 100,000 deaths occur yearly in that country alone due to medical errors, most of which are preventable. “Healthcare today harms too frequently, and routinely fails to deliver its potential benefits” -(IOM).

IOM calls for a “high quality, safer and more integrated 21st century health care delivery system, one in which the clinicians and health care institutions collaborate and communicate with the population to ensure an appropriate exchange of information and coordination of care”.

Paradigm shift

The paradigm shift can encompass:

1. Change from disease management to health management.
2. Shift of focus from curative to promotive and preventive aspects of healthcare and create the infrastructure especially for health education.
4. Spread awareness among the general public including organized corporate sector as well as individuals regarding the need to become members of HMOs to get managed care as well as insurance cover.
5. Constant peer-reviews in the medical profession to lay down standard of care and cost effectiveness of care.

The city of Mumbai is a good place to start implementing the concept of HMO and managed care. A family physician will be responsible for the health of 1000 families (5000 individuals). The recommended periodic health examinations to be carried out by him are listed in Table 1. I have ascertained the willingness of 2500 family physicians in Mumbai who are willing to be part of HMO and managed care.

The 13 million population of Mumbai can be divided into three economic strata-rich, middle class and poor. The subscription for HMO will roughly be 5% of their income. Even the poor are spending a lot of money for their illness beyond their means - they can be persuaded to give a regular

<table>
<thead>
<tr>
<th>Table 1: Recommended periodic health examination and patient education</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pregnancy</strong></td>
</tr>
<tr>
<td>Weight, Hb, BP, Urine examination for albumin and sugar</td>
</tr>
<tr>
<td>Prenatal care</td>
</tr>
<tr>
<td>Supplement of iron, folic acid, calcium.</td>
</tr>
<tr>
<td><strong>Newborn</strong></td>
</tr>
<tr>
<td>Neonatal hypothyroidism screen (TSH)</td>
</tr>
<tr>
<td>Neonatal jaundice (Rh, viral hepatitis, HIV)</td>
</tr>
<tr>
<td>Immunization.</td>
</tr>
<tr>
<td><strong>Childhood</strong></td>
</tr>
<tr>
<td>Height-weight charts to monitor growth.</td>
</tr>
<tr>
<td>Dental care : caries, orthodontic conditions.</td>
</tr>
<tr>
<td>Check for refractive errors: squint</td>
</tr>
<tr>
<td>Check for hearing defects.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
monthly or annual subscription which will assure them both preventive care as well as curative care for minor illness and health insurance cover for major illness.

The corporate sector in Mumbai is relatively easy to be covered by the HMO concept.

The unorganized sector in the middle class is also manageable with some effort under the HMO concept. A survey of 100,000 middle class families revealed that on an average each family spends Rs. 10,000 per year for medical expenses. If these families give the same Rs. 10,000 per year as subscription to the HMO, a corpus of Rs. 100 crores per year becomes available, through which (a) each member of each family gets a free annual medical check up and the data is put on a 31/2” floppy disk, to be carried each time a doctor is visited (b) the healthy eligible members get a health insurance cover through the HMO it self (c) those who are not eligible for health insurance still get a cover of their health problems including periodic consultations, necessary investigations, hospital admissions if required, and drugs, all at a 50% discounted price which makes the HMO membership worth while for them. Unlike health insurance (where there are lot of exclusions and disclaimers), there are no exclusions in HMO coverage. Today there are 200000 HIV positive persons in the city of Mumbai. They will need emotional support as well as protection against opportunistic infections including tuberculosis for the next 10-15 years HMO will be able to do that through its 3000 FPs. Patients with chronic disease like arthritis, chronic bronchitis and asthma, diabetes, high blood pressure, coronary artery disease will get managed care. The FP will have access to the relevant specialists on the same day. Home care and rehabilitation are also part of managed care.

The real challenge is how to provide managed care to the 3 million poor citizens who are forced to spend a lot of money for their medical care. They will pay 5% of their earnings as their subscription and Government and philanthropy have to subsidize for their managed care.

Metamorphosis of TPAs

Third Party Administrations (TPAs) are neither insurance companies nor health providers (family doctors, specialists, hospitals). They are independent organizations that provide specialized services to support the administration and management of health insurance products offered by insurance companies. Most of TPAs have focussed on corporate clients.

Since indemnity insurance in its current form has no future in India, I expect a transition from the present system of indemnity insurance to managed care. I suggest a metamorphosis of existing TPAs in India into HMOs in collaboration with a network of family physicians specialists and hospitals. The expertise and experience of TPAs will be a great asset to the shift towards HMO - managed care.

The Rural Health Care

The Government of Maharashtra has negotiated a World Bank loan to improve the standard of Community Health Centers (serving populations of 100,000). NGOs and private sector agencies are encouraged to play an important role in this effort. At a cost of Rs. 2.75 crores a 30-bed hospital (including staff quarters) can be constructed and Rs. 75 lacs will give the essential equipment. I have suggested that Banks give loans of 3.5 crores at low interest rate (4%) to a group of 4-6 doctors (physician, surgeon, obstetrician / gynecologist, anesthesiologist etc.) to settle in rural areas to establish such hospitals, with a tax holiday for ten years. Insurance companies should encourage this development since it will help them to expand health insurance in rural areas. Considering that 300 million rural poor lack elementary facilities like drinking water and latrines and proper housing, and are entirely dependent on whatever prevention and curative care is provided by the Government, rural health insurance is a tough assignment indeed. China opened up insurance sector in 1992 to foreign players. China concentrates on home care which is cheaper than hospital care.

Rural Health Insurance

IRDA has made it mandatory for health insurance companies to have significant presence in rural areas. As part of fulfilling this obligation IRDA requires a detailed plan on how the insurance company will cover rural areas. Dr. N.H. Antia, Director, Foundation for Research in Community Health has proposed a model for people-based decentralized health care in the panchayat raj.

The Gram Panchayat should get a group health insurance for the entire village and can raise local taxes (for which the Panchayat has power) to pay the group insurance premium. The main problem is referral of the insured villager to the nearest community hospital. The first hurdle is approach roads. Over 70% of Indian villages have no approach roads to the main roads. A village woman in difficult labour cannot reach the nearest hospital for want of quick transportation; with the result that one woman dies during delivery every six minutes in this country. Construction of approach roads is included in the activities under the rural employment guarantee scheme and should be undertaken on a priority, to allow access to ambulances and mobile health vans.

Public Private Partnership is going to be the strategy for introducing of rural health insurance in India, considering the inability of the government to increase the required financial inputs for rural health care, both preventive and curative. Private partners may adopt primary health centre and community health centers. Groups of doctors from cities can be encouraged to migrate to rural areas to run the PHCs and CHCs.

I urge all physicians in India to read C K Pralhad’s book “Fortune at the bottom of the Pyramid” which will change their entire thinking about the urban and rural poor. Pralhad exhorts us to stop thinking of the poor as a burden on society requiring charity & subsidies to be permanently doled out by the state, and start recognizing them as resilient and creative entrepreneurs and value-conscious customers. By innovative approaches such as micro-financing and micro-health insurance we can provide them cost-effective healthcare -
not as charity but as profitable professional endeavour. We need vision, innovative thinking and sustained effort to succeed in this objective.

Insurance companies and financial institutions can come together to make progress in this field as a pre-requisite to spread health insurance to rural areas.

The importance of this HMO approach for the entire Indian community will be appreciated by the fact that by the year 2025, half the world’s population of diabetes mellitus will be in India. Mumbai will have its own share. Indians are at high risk for abdominal obesity, high blood pressure, diabetes and coronary artery disease (CAD). All of these illnesses have their origin in childhood hence prevention beings in childhood. Normal healthy children and siblings of patients with the above four conditions show abnormal metabolic changes (e.g. high fasting insulin, low HDL high LP (a) even in childhood. Fortunately their genes can be kept under control by regular exercise, diet containing 400 gm. of fruits and vegetables, avoidance of putting on weight (abdominal girth > 90 cm.), and avoidance of smoking or tobacco use. Prevention is far better and cheaper than cure.

Acknowledgement

Based on the key note address given at the Asian Health Insurance Congress on Sept., 1, 2, 2004 at The Taj Mahal Hotel in Mumbai.

REFERENCES


Announcement

International Symposium for Diabetes Educators

One Day Course For Diabetes Educators By Indian Association of Diabetes Educators, Mumbai, on 8th January, 2005

Venue : Renaissance Mumbai Hotel and Convention Centre, #2 & 3B, Near Chinmayanand Ashram, Powai, Mumbai 400 087.

For further details contact : Dr. Shashank R. Joshi, Organising Secretary.
Conference Secretariat : Dr. Joshi’s Clinic, 1st Floor, 12, Golden Palace, Turner Road, Bandra (W), Mumbai – 400 050. Email : srjoshi@vsnl.com