

# **Case study on the impact of Private Public Partnerships through Publicly-funded insurance schemes on women in India, with special reference to Chhattisgarh State**

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## CHAPTER 6

### CASE STUDY ON THE IMPACT OF PRIVATE-PUBLIC PARTNERSHIPS THROUGH PUBLICLY-FUNDED HEALTH INSURANCE SCHEMES ON WOMEN IN INDIA, WITH SPECIAL REFERENCE TO CHHATTISGARH STATE

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#### **ABSTRACT**

*Publicly-Funded Health Insurance (PFHI) schemes were introduced in India more than a decade ago with the aim of providing financial protection and of improving access to quality hospital services for the poorest and most vulnerable. The National Health Insurance Scheme, or RSBY, was launched by the Indian government in 2007. In 2018, it was expanded (in terms of population and annual amount coverage) in the form of the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY). PMJAY is considered to be the largest Public Private Partnership (PPP) initiated by the Indian Government. It is promoted as a strategy to achieve Universal Health Coverage (UHC) and the Sustainable Development Goals (SDG) of the UN. This report assesses the impact of PFHI schemes, especially the PMJAY, as a form of PPP, for women in India, with special reference to Chhattisgarh state.*

*PFHI schemes were introduced within a context of a largely unregulated, and powerful “for-profit” private health sector. The RSBY was the first government scheme to rely on and contract private providers on a large scale. The PMJAY extended it further. Under the PMJAY, the institutional and governance arrangements were modified, which*

*enabled the formation of the National Health Authority (NHA), thereby bypassing the Health Ministry, and the inclusion of the “for-profit” private sector.*

*The PFHI schemes have had serious implications for women’s health and their access to health care, especially for women belonging to socio-economically vulnerable sections of society. The requirement for enrolment poses several challenges. Moreover, enrolment does not translate into real access for all women due to geographical inequity in the availability of hospitals, or denials by the private sector. While the hospitalisation rates of women may be higher in some states, many claims packages (such as those for high-end surgery) have a clear male and geographical bias. A large number of women have also been subjected to unnecessary hysterectomies and Caesarian sections under these schemes. Women are forced to incur additional out-of-pocket payments (illegal payments) when utilising the PFHI schemes, especially in the “for-profit” private sector. Many have to face harassment and abuse due to their inability to pay. Women bear the burden of financial hardship as the risk is often transferred to their families due to government’s failure to build effective regulatory mechanisms. Even during the Covid-19 pandemic, the PMJAY has failed to provide financial protection.*

*Studies show that public hospitals cater for the more vulnerable groups, including women, even regardless of PFHI coverage. However, the private sector has been receiving a larger proportion of the PFHI scheme claims in most states, a trend that has continued under the PMJAY. Funds that could have been used to improve the public sector, which provides more equitable health services and caters more for women, are being diverted to the private sector, which is concentrated in urban centres, and engages in unethical practices. While women are most affected by these schemes, they have no formal role in their functioning.*

*People’s health movements and women’s collectives have put up resistance against such PPPs. India needs to strengthen its public-health system, instead of promoting the private health sector. Clearly, public funding for private provisioning has proven to be a disaster for women. The commodification of health care must be abandoned, and health care re-instated as a right.*

## **1. INTRODUCTION**

In India, profound inequities exist with regard to health-service utilisation and access to health care, and these are determined by socio-economic and political status, geography, and gender differences, amongst others (Balarajan, Selvaraj and Subramanian, 2011). This is

reflected in higher mortality rates, and a larger burden of disease(s), along with high levels of malnutrition among socio-economically vulnerable groups, such as the Scheduled Tribes (STs), the Scheduled Castes (SCs),<sup>1</sup> the rural populations, and the urban poor. Historically, these groups have been subjected to a process of impoverishment and marginalisation, through exploitation by the dominant social and economic groups, and through a lack of appropriate and responsive development processes (Drèze and Sen, 2013). Within this context of inequity, it is different groups of women who face the brunt of the multiple disadvantages and vulnerabilities that intersect with each other, and this affects every stage of their lives. While India “progresses” on its development paradigm in a liberalised economy, it is women who have been the ones most affected by the increasing violence, dispossession and resource capture, environmental degradation, migration, informalisation of labour,<sup>2</sup> and the dominance of the conservative right-wing. Age-old discriminatory practices such as sex-selective abortions, child marriage, the dowry system, witch-hunting, and honour killings all continue to this day. All this, combined with an inadequate increase in social welfare, decreases in the public provision of public services, and increasing privatisation has made the women who belong to the lower socio-economic categories, castes, and tribal groups, more vulnerable. Women’s organisations and feminist organisations have been resisting and campaigning against the processes that undermine the status and agency of women. Women belonging to the ST and SC communities have led the struggles against the capture of resources, displacement, and corporatisation, and also against the privatisation of the health sector. Recent mobilisations have been led by young women and campaigns on specific issues have built solidarity with broader social movements.

Chhattisgarh is the tenth largest state in India, with an area of 135,191 km<sup>2</sup>, and the seventeenth most populous state in India, with a population of just over 25.5 million (RGI & Census Commissioner, 2011). It is located in the south-eastern part of central India, and became a separate state in the year 2000, when it split from Madhya Pradesh (Figure 1). It is divided into 27 districts.



**Figure 1: Location of Chhattisgarh State in India**

Source: <http://mapsopensource.com/chhattisgarh-location-map.html>.

Around 41 per cent of Chhattisgarh's geographical area comes under forests (Forest Survey of India, 2017). The population is mostly rural with only 22 per cent of the households living in urban areas (RGI & Census Commissioner, 2011). Nearly 86 per cent of the households in the state have been defined as being poor. Out of the total population, 31 per cent are STs and 13 per cent are SCs (RGI & Census Commissioner, 2011).

In India and in Chhattisgarh, the gender-based differences are clear with regard to health and nutrition indicators. The overall health-care scenario for tribal communities has been that of poor access to public health programmes and health services, which has serious implications for the women of these communities, which is reflected in their health and nutrition indicators, including in Chhattisgarh. Although Chhattisgarh has seen a significant

improvement in health indicators since the year 2000, it is still one of the low performing states in India, with mortality rates higher than the national averages.

While the previous disease patterns (malaria, TB, and leprosy) remain, newer conditions, such as non-communicable diseases and mental health issues, are now being identified. There has been some improvement in the access of women to health care in India after the initiation of the National Rural Health Mission (NRHM) in 2005 (NHSRC, 2012), although gaps remain with regard to the quality of care and the coverage of all kinds of health services, and not just those relating to maternal health, the health of women during pregnancy, childbirth, and the post-natal period. Recent interventions in the form of Health and Wellness Centres, aimed at providing a comprehensive set of services at primary level, could improve the access of women to a range of services. However, this programme remains under-resourced and its implementation is inadequate. The largest “flagship” programme of the national government in recent years has been the publicly-funded health insurance (PFHI) scheme, *Pradhan Mantri Jan Arogya Yojana* (PMJAY), an expanded version of previous PFHI schemes. The PMJAY is considered to be the largest Public-Private Partnership (PPP) initiated by the Indian government (Mukhopadhyay and Sinha, 2018).

## **2. HOW PMJAY BECAME THE LARGEST PRIVATE PUBLIC PARTNERSHIP (PPP) IN INDIA**

The Structural Adjustment programs (SAPs) of the 1990s led to the withdrawal of government from the social sector, and this damaged India’s public-health system (Rao, 2009). When a new coalition government, the United Progressive Alliance (UPA) that included left-wing parties, came to power in 2004, they were compelled to act in order to reverse this situation. The following years saw the passing and implementation of important legislation and public programmes relating to universal health care, rural employment guarantees (in the light of the National Rural Employment Guarantee Act), the right to education, public accountability through right to information, and so on. The National Rural Health Mission (NRHM) was launched in 2005, and provided both much needed finances and an impetus to strengthen the government health system (NHSRC, 2012). The National Urban Health Mission (NUHM) was introduced in 2013, and subsequently both the rural and the urban programmes were integrated under a common National Health Mission (NHM). Though the NRHM kept the door open for PPPs, there was significant focus on improving the public-health system. This resulted in expansion of the public-health infrastructure, the provision of primary level health-care services and hospital care, especially for maternal

health, an increase in human resources for health, the initiation of community processes, and community participation for health governance and accountability (NHSRC, 2012). Although there were implementation gaps and quality issues, improvements in health and health-service indicators were nonetheless visible (Mukhopadhyay and Sinha, 2018). In 2014, the right-wing led National Democratic Alliance (NDA) came to power at national level, and dealt a blow to these efforts. Funding for health and other social programmes was reduced, so much so, that, in 2015-16, the health spending as a proportion of GDP was lower than what it had been in the early 1990s, at the time of the SAPs (Mukhopadhyay and Sinha, 2018). Since then, the National Health Mission has faced a steady decline in budgetary allocations in real terms.

More or less in parallel to the inception of NRHM, many states began introducing publicly-funded health insurance (PFHI) schemes, with the aim of protecting the poor from catastrophic health expenditure (PHFI, 2011).<sup>3</sup> In 1999, the Indian government had opened up health insurance to the private sector, as part of the liberalisation process, which also saw the influx and subsequent growth of the private insurance industry (PHFI, 2011). The *Rashtriya Swasthya Bima Yojana* (RSBY) or National Health Insurance Scheme was launched by the Ministry of Labour in 2007 as the first national-level scheme for the unorganised sector, targeting insurance cover for “Below Poverty Line” (BPL) households requiring hospital care. It was also the first time that the government had relied on and contracted the private healthsector providers on a large scale. Subsequently, many states expanded the coverage and scope of the RSBY. Chhattisgarh was one of the first states to implement the RSBY (meant for the Below-Poverty Line families) in 2009, and it expanded the scheme to all families (including the non-poor) living in the state through the *Mukhyamantri Swasthya Bima Yojana* (MSBY) or Chief Minister’s Health Insurance Scheme in 2012.

The national NDA government expanded the RSBY in 2018 in the form of *Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana* (AB-PMJAY), increasing population coverage and insurance coverage per household, from the previous Rs. 30,000 (440 USD) to Rs. 500,000 (7,296 USD) annually (Chatterjee, 2018). As with previous PFHI schemes, families do not have to pay for enrolment, and the government pays the annual premium for the scheme.

PFHI schemes such as PMJAY are governed by contractual agreements between the public and the private sector, located within a regulatory framework, involving commercial



interests, and are therefore considered to be PPPs (Khetrapal, Acharya and Mills, 2019). Private and public hospitals are empanelled through a contract, to provide services under the scheme as per fixed rates. PMJAY has listed over 1,300 procedures, services and forms of treatment for which rates have been fixed. The government makes payment based upon these rates, for the claims submitted by the empanelled private and public hospitals. The hospitals are not allowed to take any additional money from the patients who have used the PFHI scheme.

Earlier PFHI schemes, such as the RSBY, were considered as just one of the many government health programmes, with the NHM receiving more prominence. The PMJAY, on the other hand, has been promoted as the main and only health programme of the NDA government, and all other health initiatives have been relegated to a lesser position. The implications of this for the public-health system, government health-services, and women are discussed later in this report. The PMJAY was advertised by the government as the “world’s largest government-funded health care programme”, disregarding not only the larger universal schemes of many other countries, but also that of the NHM. The political clout behind the PMJAY is evident in the way it became closely associated with the Prime Minister, Narendra Modi, with the media referring to it as “*Modicare*”. The government modified the institutional and governance arrangements of the PMJAY from earlier PFHI schemes, in order to include the “for-profit” private sector and their organisations and to bypass the Ministry of Health. This move is located within the larger political economy context of the promotion of health care as a commodity, and not as a right, and within the right-wing neo-liberalism of the NDA government. The PMJAY has also been promoted as a strategy to “help India progressively achieve Universal Health Coverage (UHC) and Sustainable Development Goals (SDG)”.<sup>4</sup>

This report assesses the impact of PFHI schemes, especially PMJAY, as PPPs, and how they affect the women in India, with special reference to Chhattisgarh state.

### **3. METHODOLOGY**

#### **3.1. Conceptual Framework**

This report integrates DAWN’s (Development Alternatives with Women for a New Era) conceptual framework on PPPs (Enríquez, 2019), and the framework developed by the author for assessing the pathways of impact on the equity of access in publicly-funded health insurance programmes for UHC. Both are integrated in order to explore the consequences of the PFHI schemes as PPPs for women in India (Nandi and Schneider, 2020).

DAWN's framework on PPPs takes the context, the main actors, the regulatory and legal frameworks, the characteristics of the individual PPP, a gender and human rights analysis of the implementation and functioning of the PPP in question, its transparency and accountability, as well as its governance and any resistance to it into account. The framework for assessing the pathways of inequity in access under the PFHI schemes is used to analyse the impact of the individual scheme on gender and human rights. This is done by linking the design and objectives of the schemes, their implementation, and impact on service provision, utilisation, health-systems functions, the services being provided, the access dimensions (affordability, availability, and acceptability), and the health outcomes. Public and private sectors are studied separately. Equity concerns, in this case regarding gender, are explicitly explored in the elements of the framework, and the whole analysis is embedded within the larger socio-economic and political context.

### **3.2. Data Collection and Analysis**

This report draws on a range of data sources in applying the above-cited conceptual framework to an analysis of the PFHI schemes as PPPs in India, with special reference to Chhattisgarh state. The data have been collected through review of secondary data sources and participant observation by the author as an activist of the *Jan Swasthya Abhiyan* (People's Health Movement India). The report draws heavily from the author's Ph.D. thesis (Nandi, 2019). The sources of secondary data include publications on PFHI schemes in India and Chhattisgarh, including research by the author and her collaborators, programme evaluation reports, media reports, websites, and campaign and advocacy documents. The data is used to analyse the impact of the PFHI schemes, as a PPP, upon women, using the DAWN analytical framework.

## **4. CONTEXT AND EMERGENCE OF PFHI SCHEMES IN INDIA**

India's mixed health system consists of a complex network of public health-care facilities and programmes, which aims to provide universal preventive and curative health services at low or no cost for people. There is also a large formal "for-profit" private health sector which is heterogeneous, concentrated in urban centres, and provides health care upon a "fee-for-service" basis (Mackintosh *et al.*, 2016). The financial burdens related to health care are on the rise. The proportion of households reporting catastrophic expenditure on health rose from 15 per cent in 2004 to 18 per cent in 2014 (NHSRC, no date). Currently, "out-of-pocket" (OOP) payments by households constitute 60.6 per cent of total health expenditure (NHSRC, 2018).

Studies on the genesis of the RSBY reveal some of its key motivations. The RSBY was initially hosted by the Labour Ministry, rather than the Health Ministry, as the main considerations came from labour issues relating to India's economic growth in the early 2000s. The PFHI scheme was considered to be an "investment" in worker productivity, especially in the informal sector, and in India's future economic growth (Virk and Atun, 2015). This was aided by liberalisation policies, and the growth and domination of private health-care markets, changes in the regulation of private health insurance, technological advancements, and the experiences of the previous state insurance schemes (Shroff, Roberts and Reich, 2015; Virk and Atun, 2015). Other factors included a new government that wanted to be seen to be providing social protection to this large unorganised sector in a manner which was commensurate with India's high growth rate, and was aligned to the context of globalisation and the structural adjustments programmes (Shroff, Roberts and Reich, 2015; Virk and Atun, 2015). What has also emerged is that those who designed the RSBY were very critical and sceptical of the public provision of health services, and had great faith in the "effectiveness of market-based healthcare provision" through efficiency, competition, and individual choice (Virk and Atun, 2015, p. 815). These considerations were rooted in neo-liberal thinking and the dominant discourse was influenced by considerations such as human-capital development, and efficiency and productivity, rather than "needs" or "rights" (Virk and Atun, 2015). Moreover, the pitching point for the PFHI schemes was as a "business model" that was intended to be profitable for all parties involved by design, prioritising profit-making over people's health. This framing has had implications both for women's access to health care, and for their interactions with the service providers, which will be discussed in later sections.

The role of corporate entities in the evolution of the PFHI schemes was evident from the beginning. The conceptualisation and introduction of the Yeshasvini scheme in Karnataka in 2002 is attributed to the founder of a corporate hospital chain, then known for telemedicine initiatives and low-cost cardiac procedures (Venkat Raman and Björkman, 2008; Maurya and Mintrom, 2019).

As the global discourse on Universal Health Coverage started growing, it further influenced the push for PFHI schemes in India (Shroff, Roberts and Reich, 2015; Virk and Atun, 2015). The industry associations also started articulating their demands and recommendations through this discourse, which is evident especially in the context of the PMJAY (CII & PwC, 2018; KPMG & Assocham, 2019). The stated benefits of PMJAY for

the health system include its role to act “as a steward, align the growth of private sector with public health goals”. The website also states that “with greater demand, the private sector is likely to expand in the unserved areas of Tier-2 and Tier-3 cities”.<sup>56</sup> As we shall subsequently see, this has opened up other avenues for PPPs for government. The PMJAY is also supposed to help India’s progress towards UHC and the SDGs.

## **5. THE MAIN ACTORS PROMOTING AND IMPLEMENTING PFHI SCHEMES**

The NITI Aayog, a government think tank, is a significant actor in the PMJAY and in PPPs in India. It drives the policy-making on PPPs and is involved in developing contractual agreements, reviewing PPP projects, suggesting required institutional, regulatory, and procedural reforms, and developing PPP initiatives for the government. It has been instrumental in conceptualising the PMJAY and has also been responsible for developing the new organisational and governance structure for its implementation (NITI Aayog, 2020).

The last two years have seen a plethora of PPP initiatives and policy decisions emerging from the NITI Aayog think tank, which are seen as being “complementary” to the PMJAY. This includes a plan to provide land and viability-gap funding for the private sector to set up and operate hospitals in Tier 2 and Tier 3 cities, and a proposal for the privatisation of District Hospitals. The NITI Aayog uses PMJAY for recommending the PPP for the Tier 2 and 3 cities. It uses PMJAY as a rationale to propose that it will ease the usual regulatory and statutory compliances building private hospitals that would be required due to PMJAY coverage (NITI Aayog, 2020). The second one proposes converting public hospitals into profit-making enterprises, which would be disastrous for women, STs, SCs and rural populations if carried out.<sup>7</sup>

There has been visible participation from the private health sector (hospital owners, and doctors’ associations), international agencies (the World Bank, and the GIZ), UN agencies (the WHO, and the ILO), and philanthropic foundations (the Bill & Melinda Gates Foundation or BMGF) and think tanks funded by them in promoting, implementing, and developing PFHI schemes in India. Their participation has been in various aspects of the design, implementation, and financing, and in the provision of the various kinds of services, from direct health-care provisioning (private health sector) to involvement in information technology (IT) support and research (international research agencies). Organisations and companies working on digital health and software companies are another group that has an interest in this.<sup>8</sup> The engagement of national and state governments with the “for-profit”

private health sector through the PFHI schemes is on a scale that is unprecedented. The insurance companies and Third Party Administrators (TPAs) also have a vested interest in the continuation of the PFHI scheme.

The involvement of the “for-profit” private sector in its numerous forms and roles seems to have increased manifold under the PMJAY. The National Health Authority (NHA), which is the implementing agency for the PMJAY, lists, in its annual report, the partners for the PMJAY. They include international and multilateral organisations that were also involved in the RSBY, such as the *Deutsche Gesellschaft für Internationale Zusammenarbeit* (GIZ) and the World Bank, and new ones, such as the Asian Development Bank (ADB) and the BMGF (NHA, 2019). The CEO of the NHA has also previously worked in the ADB and in the World Bank.

Private hospitals, especially corporate ones, and doctors’ associations, such as the Indian Medical Association (IMA), have always acted as pressure groups, demanding that the government should increase the rates for the procedures under the PFHI schemes, provide more subsidies, and reduce regulation. They have threatened to go on strike and have suspended health services under the PFHI schemes in order to exert pressure on the government (Mamidi and Pulla, 2013; Nundy *et al.*, 2013). Under the PMJAY, the involvement of the corporate health sector in the functioning of the scheme has been institutionalised with their organisations, such as NATHEALTH, being recognised as formal partners of the National Health Authority and the doctors from the corporate sector being part of their governing board. Consultancy agencies, such as PwC,<sup>9</sup> also add to the demand to make the PFHI schemes more profitable for the private sector.

There is no formal role for the community, women’s organisations, or any other civil society to participate in the functioning of the PFHI scheme, nor are they part of any formal regulatory framework.

## **6. THE REGULATORY AND LEGAL FRAMEWORK OF PFHI SCHEMES**

India’s “for-profit” private health sector is largely unregulated and is known for unethical practices and for extorting money from patients (Gadre and Shukla, 2016; Mackintosh *et al.*, 2016; Sengupta *et al.*, 2017). This is even more true of corporate hospitals. The national Clinical Establishments Act (CEA) was passed in 2010 through intense negotiations with the private sector, but failed to include the critical aspects of patients’ rights, regulation, or even

the displaying of treatment rates.<sup>10</sup> Many consider the CEA to reflect a strategy promoted by corporate hospitals to close down smaller hospitals and nursing homes through the mandating of higher and more stringent standards. Chhattisgarh's own act does incorporate patients' rights, but they are not being adequately implemented (Nandi, Joshi and Dubey, 2016). The RSBY and subsequently the PMJAY were introduced into this context of a largely unregulated and powerful "for-profit" private health sector, and this affected the regulation of the schemes. A distinction needs to be made between the "for-profit" and "not-for-profit" private sectors, as the truly "not-for-profit" private hospitals have been seen to operate with public interest in mind, even under the PFHI schemes.

The government has in different periods de-empanelled hospitals due to various lapses or wrongdoings under the PFHI schemes. However, as discussed later regarding the cases of hysterectomy, often the doctors' lobby (from both the public and private sectors) unites against any such action by the government. There have been instances wherein the governing body (trust) set up to implement and monitor the PFHI scheme consists of corporate hospital owners who are themselves the recipients of a large proportion of the claims.

At national level, an autonomous body, the National Health Authority (NHA), has been formed to implement the PMJAY, thereby bypassing the role of the Health Ministry in this PPP, and thus modifying the implementation and regulation procedures. In fact, in August 2018, just prior to the launch of the PMJAY, the government attempted to outsource the functions of the NHA to a consultancy management agency and issued an advertisement to this effect.<sup>11</sup> However, this move seems to have been quashed for the time being. In a context in which the "for-profit" private sector already dominates and colludes with public-sector administrators and health personnel, setting up an autonomous body to bypass the Health Ministry does not bode well for regulation and oversight. The implication of this, especially for women, is visible.

At state level, in Chhattisgarh, since the time of the RSBY implementation, a State Nodal Agency has been created under the Department of Health and Family Welfare (DoHFW) for the implementation and monitoring of the PFHI schemes. The governance and decision-making functions regarding the PFHI schemes lie with various officials of the department. However, many of the officials who are responsible for fixing the treatment rates and monitoring the hospitals are themselves involved in private practice and own private

hospitals. This has created a clear possibility for conflict of interest, especially in situations in which the private doctors themselves form a pressure group for negotiating the details of the PFHI schemes (Garg, 2019).

## **7. THE DESIGN OF THE PFHI SCHEMES IN INDIA AND CHHATTISGARH AND THE IMPLEMENTATION STRUCTURES**

The objectives of the RSBY were to improve access to quality health care, to provide financial protection from hospitalisation expenses, to provide the beneficiaries with the power to choose from a national network of providers, and to provide a scheme which the non-literate could easily use (Jain, 2014). While, under the PMJAY, the stated objectives remain the same, there is mention of a “priority to girl child, women and senior citizens”. Most PFHI schemes cover a limited number of procedures and forms of treatment, consisting mostly of hospitalisation and a few out-patient services. While the coverage of hospitalisation services under the PFHI schemes and exclusion of out-patient services have been criticised by some, the greater potential risk of fraud in out-patient care has also been highlighted (Nandi and Schneider, 2020).

There are two models of implementation of the PFHI schemes in India. One kind is a trust, an autonomous organisation set up by the state government to empanel hospitals and pay the claims. The second model involves hiring an insurance company and paying them premiums to handle the payments. The rates upon the basis of which payment is made, is a mix of per case, per procedure and per day rates. The guidelines and conditions underlying the scheme are laid down through legal contracts between the state, the insurance company, and the participating hospitals. The hospitals are required to provide “cashless” treatment, that is, treat patients without taking any money from them, and claim the payment from the government or insurance company upon the basis of the pre-determined rates.

Chhattisgarh has been implementing the PFHI schemes through the insurance company system all these years and it is only from the beginning of this year (2020) that it has started a system of direct payment of claims, without the insurance company involvement.

## **8. TRANSPARENCY AND ACCOUNTABILITY MEASURES**

The oversight of the scheme at state level is with the State Nodal Agency (SNA), under the Department of Health and Family Welfare, while, at national level, it is with the National Health Authority.

The use of biometric smart cards under the RSBY was seen as a tool for monitoring transactions and identifying fraud. It was to facilitate ease of access and transparency, and detect fraud. However, experience shows that it failed to protect the patients from OOP payments. Hospitals kept the smart card as a bond, until their claim was settled by the insurance company. This means that if the family needed to use it again during that period, they could not do so (Nandi and Schneider, 2020a). The use of biometric smart cards has been discontinued in Chhattisgarh.

One of the methods of reporting grievances is through a helpline, which offers telephonic assistance. An analysis of the complaints of private sector hospitals recorded by the helpline in Chhattisgarh shows that a very miniscule number of complaints are made on the helpline. One reason for this is fear of retribution. The families of patients fear that, if they complain, the hospital and doctors will not treat the patient properly or will intentionally do them harm (Nandi and Schneider, 2020a). They are also afraid that, in future, they will not be able to come to the hospital for treatment again.

Despite the emphasis on and showcasing of IT systems, data (even anonymised) is not available for public scrutiny. In Chhattisgarh, the author has asked for PFHI-scheme data and has received it. But it is not available in the public domain. The problem of transparency has been even worse under the PMJAY. In the name of transparency, the main data available to the public is through tweets (twitter) containing updates on the number of cases under the PMJAY. Although state fact sheets are uploaded onto the NHA website, they are not updated monthly, and provide data for only a few overall indicators. On the other hand, scheme data is made available to select researchers (for instance, the World Bank and the GIZ), and sometimes to certain journalists. There are publications and studies using PMJAY data only by this very select group that has been involved in developing the scheme. Thus, they have dominance over the nature of the evidence that is being created. A similar situation was seen during the initial years of the RSBY (2011-2013) when a large number of studies or reports were undertaken by agencies that had been involved in introducing the PFHI schemes in India, or by people associated with them, of which the World Bank and the GIZ were predominant. The research on the PMJAY published by the NHA is often authored by people employed by these organisations, especially the World Bank. However, in most cases, the authors' affiliation to the World Bank is not stated. Moreover, most of these reports have a disclaimer that "The PM-JAY data used in the analysis should not be utilised/quoted without prior permission of NHA",<sup>12</sup> which further restricts their use in public discourse.



The patients and their families also face the problem of not having easy access to their own data, which is available only with the “computer person” at a far off health centre that has a computer. Furthermore, the government has proposed the creation of a digital health registry, a digital health id and also the ability to sell medical data to commercial entities. The IT-dependent PMJAY thus makes patients vulnerable to problems of data privacy and ownership.

An overwhelming concern in the PFHI schemes has been the increasing collusion between the “for-profit” private hospitals and public administrators that undermines any attempts at accountability. Dual practice by government doctors has always existed, although it has been exacerbated with PFHI schemes, as now there is a monetary incentive (the ability to file insurance claims, or to take illegal payments) to refer the patients to their own private hospitals or those of their acquaintances.

Under the PFHI schemes, no role has been awarded to civil society groups, including women’s organisations or patients’ rights groups. However, health activists and health organisations, including women’s groups, have been monitoring the scheme and raising critical issues about the scheme. *Jan Swasthya Abhiyan* (JSA) continues to bring to the fore the problems with the PFHI schemes, especially in the context of health care for vulnerable groups. Community Health Workers (CHWs) in Chhattisgarh are involved in documenting cases of denial of health care, or violations of health rights, and illegal OOP payments, and take action against them as part of their work on the accountability of the health services.

## **9. THE IMPLICATIONS OF THIS PPP FOR WOMEN’S ACCESS TO HEALTH SERVICES AND FINANCIAL PROTECTION**

The following section presents and discusses the implications of the PFHI schemes for women’s access to health services and financial protection. It discusses the evidence on the PFHI schemes over the last decade and half, both at national level and at state level.

### **9.1. Exclusions in Enrolment**

Studies on the PFHI schemes from state and national-level studies have reported lower enrolment figures in remote rural areas, and poorer districts, among socio-economically vulnerable and indigenous (or tribal) communities, female-headed households and in the poor economic quintiles (Rao *et al.*, 2014; Ranjan *et al.*, 2018). Caste, including tribal group, has emerged as a significant determinant of inequity in enrolment and utilisation, highlighting the interplay of the multiple disadvantages faced by these groups (Health Inc, 2014; Rao *et al.*, 2014; Thakur, 2015). This evidence points to the increased vulnerability of women belonging

to these communities and areas. Moreover, with women already facing extreme hardships and barriers (both within and outside their families) in accessing healthcare, having to enrol in the PFHI scheme in order to obtain or access the requisite benefit has become an additional barrier to accessing health services (RamPrakash and Lingam, 2018).

Most of the PFHI schemes are targeted for the poor, who are identified using government survey data. However, multiple problems and exclusion errors have emerged in such surveys. This is posed a problem for many poor people in proving their eligibility for the PFHI schemes (Sen and Gupta, 2017). Chhattisgarh has had a universal PFHI scheme since 2013, and thus has always had one of the highest enrolment rates in the country. Currently, around 90 per cent of families and close to 75 per cent of individuals are covered by the two PFHI schemes (MSBY and PMJAY). Studies that have analysed aggregate population data show equitable enrolment across districts and socio-economic categories (Nandi *et al.*, 2017; Nandi *et al.*, 2018). However, smaller primary studies among the most vulnerable groups, such as Particularly Vulnerable Tribal Group (PVTGs) and the urban poor have found much lower enrolment rates (PHRN, 2017; SHRC CG, WHO India and Government of Chhattisgarh, 2020). For instance, a woman who belonged to a family of waste-collectors in Raipur city did not have any identity card and therefore was not enrolled in the PMJAY. When she fell ill, her family admitted her to a private hospital using her aunt's name, in order to avail of her aunt's PMJAY entitlement. They still incurred OOP expenditure, and, once they had finished their money, she was shifted to the government hospital where she passed away (SHRC CG, WHO India and Government of Chhattisgarh 2020).

The RSBY entitled five members of a family, selected by the "head of the family", to be enrolled on one card, and in a highly unequal society such as India, which has huge intra-household disparities, this meant that the same disparities may be reflected in selecting the family members who are to be enrolled (RamPrakash and Lingam, 2018). While studies and programme data have shown an increasing and higher proportion of women enrolled (GIZ, 2015; Nandi *et al.*, 2016), age disaggregated analysis has revealed age-specific differences in enrolment based upon gender, specifically among adolescents and people over 45 years of age (Palacios, Das and Sun, 2011; Nandi *et al.*, 2016).

Although the PMJAY removed the five-person limit, gender differences in enrolment are still visible in Chhattisgarh. A 2019 study in the state shows that the proportion of women enrolled in the PFHI schemes is marginally less (66%) than the proportion of men enrolled (69%) (SHRC CG, 2020). More significantly, it showed that women had 9 per cent less

chance of enrolling in the PFHI scheme than men. Moreover, members of women-headed households had a 13 per cent less chance of being enrolled, compared to those in men-headed households (SHRC CG, 2020). Similar findings regarding lower enrolment in women-headed households have been found in other states (Rao *et al.*, 2014).

## **9.2. Are Women Able to Utilise PFHI Schemes for Hospitalisation?**

Women have a higher proportion and greater likelihood of hospitalisation than men in some states (RamPrakash and Lingam, 2018; Ranjan *et al.*, 2018). While the hospitalisation rates of women may be higher, the utility of the PFHI scheme for women who are hospitalised needs to be questioned. A study in Chhattisgarh shows that, even with a universal PFHI scheme, more than one-third of the women who were hospitalised, were not enrolled (SHRC CG, 2020). Even when enrolled, women are often unable to utilise the scheme for treatment due to the non-availability of health facilities or refusal under some pretext on the part of the hospital to use the scheme (Nandi *et al.*, 2016; Nandi, Schneider and Garg, 2018). Consider, for example, the case study below:

Case study developed from a complaint submitted by Ramabai's father-in-law to the Health Minister:

“When Ramabai, belonging to a SC community in the Sarguja district, had labour pains, she went to the Primary Health Centre. She was told that she might have miscarried and was referred to the district hospital. The family took her to a private hospital which did not accept their PFHI scheme card. Not having any choice, the family agreed to pay OOP and she was admitted in the Intensive Care Unit (ICU) after they deposited Rs. 20,000. The family had to pay up Rs. 20,000 daily plus pay for all the medicines. The family tried desperately to arrange for more money. Five days had passed and they were also not being allowed to see her. An acquaintance who works at the hospital told them that he had seen her body wrapped up and kept on the floor somewhere. The family was shocked and forced themselves into the ICU where they saw her body. She had died some time during the period in the hospital. The hospital forced them to deposit a further Rs. 100,000 before releasing her body. The family had incurred costs of around Rs. 350,000 by then. They arranged for the money by mortgaging the land that the whole family (consisting of four brothers and their families) owned.”

### **9.3. Availability of Hospital Care for Women**

Studies show that, under the PFHI schemes, public hospitals cater to the more vulnerable groups, including women (Prinja *et al.*, 2013; Ranjan *et al.*, 2018). In Chhattisgarh, the public sector caters more to women, tribal communities, and the poor than the private sector, regardless of PFHI scheme enrolment (Nandi *et al.*, 2016; Nandi, Schneider and Dixit, 2017). Obstetric and childbirth-related conditions are significantly more likely to be treated in the public sector than other conditions (Nandi, Schneider and Dixit, 2017). In West Bengal, women have talked about placing trust in the public hospital and being unsure of what they might be subjected to or how much they would be made to pay at a private hospital (Sen and Gupta, 2017). They felt that the public hospitals were more transparent and would respond to any queries, whereas the private hospital would not tell them till the end how much they would be charged (Sen and Gupta, 2017).

Even in terms of the geographical distribution of hospitals, public-sector hospitals are distributed relatively equally, whereas the distribution of the private hospitals is highly unequal and concentrated in only a few cities (non-tribal areas) (Nandi, Schneider and Garg, 2018). The inequitable distribution of private-health facilities and utilisation under the PFHI schemes is visible across states (CEHAT, 2017; Garg, 2018). Study of high value claims under the PMJAY found that that the claims are inequitably distributed across the country, with a clear male-bias (Dong *et al.*, 2019).

### **9.4. What are Women Being Treated for under the PFHI Scheme?**

The data show that the utilisation of the PFHI schemes is concentrated on a small set of services. The for-profit private sector provides narrow and selective services, engaging in “cherry picking” of the more profitable packages and often convert out-patient care to inpatient (Dasgupta *et al.*, 2013; Maurya and Ramesh, 2019). There is a pattern of unnecessary operations such as hysterectomies, under PFHI schemes that will be discussed in the next section.

A PMJAY report analysing high and very-high value claims (claims > Rs. 30,000 or 400 USD) covering specialities such as cardiology, radiation oncology, cardio surgery, orthopaedics, and neurosurgery, finds that they are skewed against women. While, of the total claims, 48 per cent are of women, when it comes to the high value claims, the women’s proportion reduces to 38 per cent (Dong *et al.*, 2019). However, under oncology packages, women had a higher proportion of utilisation (Kaur, Jain and Bhatnagar, 2019).

In Chhattisgarh the overall PMJAY claims proportions are similar for men and women and the most common claims are for dental and ophthalmology services (SNA, 2019). For women, childbirth deliveries (Caesarean (C-section) and normal) and conventional tubectomy (tubal ligation) are the other highly utilised packages. However, similar to the national data, men have higher utilisation of packages related to non-communicable diseases (such as haemodialysis) and high-end operations (SNA, 2019).

### **9.5. Experience of Women in Utilising the PFHI Scheme**

The PFHI schemes were supposed to ease access to quality healthcare, increase “choice” and provide financial protection. However, we find that women who are finally able to utilise the PFHI schemes for hospitalisation face a lot of problems in all these dimensions.

There is overwhelming evidence that, when utilising the PFHI schemes, (1) most women have had to make OOP payments; (2) many have had to face harassment and abuse due to their inability to pay the amount demanded, especially in “for-profit” private hospitals; and (3) a large number of women have been subjected to unnecessary procedures and forms of treatment.

#### **(1) High OOP Expenditure Despite Insurance Coverage**

Financial risk protection from catastrophic health expenditure is seen as the main objective of the PFHI schemes. Although studies show that the PFHI schemes have not enabled free hospital health care, and that patients, including women, continue to incur very high OOP costs and catastrophic health expenditure, mainly in the private sector (Dhanaraj, 2016; Gupta *et al.*, 2017; Karan, Yip and Mahal, 2017; Prinja *et al.*, 2017; Ranjan *et al.*, 2018). The incidence and quantum of OOP expenditure is many times higher in the private sector, and this is mainly due to the illegal payments demanded by private hospitals (Rent and Ghosh, 2015; Ranjan *et al.*, 2018; Garg, 2019).

In Chhattisgarh, too, high OOP expenditure has been reported, especially in the “for-profit” private sector, from the very beginning of the PFHI schemes (Nandi *et al.*, 2016; Nandi, Schneider and Dixit, 2017). After controlling for other factors, women are significantly more likely to incur OOP costs than men, and the median OOP costs for women who were insured (Rs. 3,080) was also higher than that of insured men (Rs. 2,500) (Nandi, Schneider and Dixit, 2017).

Under the PMJAY, the same pattern of OOP health costs for patients, especially in the private sector, continues, despite the increase in the insurance coverage amount (Garg,

Bebarta and Tripathi, 2020). Women still incur very high OOP payments in the private sector, regardless of whether they are insured or not. For enrolled women, the OOP expenditure was Rs. 10,000 (133 USD) in the private sector, compared to Rs. 400 (5 USD) in the public sector (SHRC CG, 2020). The National Health Authority also reports that, nationally in 2018-19, 93 per cent of the complaints under the PMJAY were for money being demanded from patients by the hospitals (NHA, 2019).

In making the OOP payments families have to face huge financial hardships, paying out of savings, taking loans from their families or friends, selling or mortgaging jewellery, land or other assets, with women having to bear a lot of the burden (Nandi *et al.*, 2016; Nandi and Schneider, 2020a). As primary caregivers, women also have to bear the brunt of health-rights violations. The following instances were narrated at conventions on the “Right to Health” organised by the JSA Chhattisgarh:

“A participant from Pandariya, hailing from Gond tribe, broke down while sharing how a private hospital in Raipur refused to treat her husband under RSBY and made her pay Rs. 2.4 lakh. When her husband was declared dead after 10 days of hospitalisation, the hospital asked for an additional Rs. 23,000 to release his body. She could manage to give only Rs. 10,000. It is then that the hospital took her RSBY card and deducted the rest of Rs. 13,000 and released his body! She had taken the money on loan that she was now responsible for returning on her own. She was facing a lot of financial difficulties as neither did she have any land (it still belonged to her parents-in-law) and nor were any family members helping her.” (JSA Chhattisgarh, 2014)

“One participant spoke of how a private hospital demanded extra money from the wife of a patient admitted under RSBY. She could not arrange so much money and under that pressure died by jumping from the hospital roof.” (JSA Chhattisgarh, 2018)

Case study (from complaint submitted by the patient to the Health Minister):

45 year-old man from the Pahari Korwa community (PVTG) from Jashpur was injured in September 2018. He travelled 350 kilometres to Raipur city (state capital) for treatment. The family thought they would use their insurance card, but the Raipur hospital refused to use it even after depositing it. The hospital kept asking for money, making the total bill an amount of Rs. 200,000. The family mortgaged land for Rs. 30,000, and took loans. The patient’s daughter-in-law was taking care of him at the private hospital. The hospital kept the patient

and daughter-in-law hostage in the hospital. While he was given food, she had to buy her own meals. She ate only once a day as that cost her Rs. 40, and remained hungry the rest of the time.

## **(2) Women Facing Harassment and Abuse due to the Inability to Pay the Amount Demanded, Especially in “for-Profit” Private Hospitals**

What has emerged from women’s narratives of their experiences of using the PFHI scheme in the “for-profit” private sector is that, despite attempts to exercise their agency during hospitalisation, they and their families are rendered powerless when dealing with private hospitals demanding illegal payments (Nandi and Schneider, 2020a). They face abuse and humiliation from the staff and doctors of the private hospital when they are unable to pay the illegal amounts demanded of them. The hospitals do not allow the patients to dismiss themselves of their own free will, and instead create circumstances under which the patients’ families have no choice but to pay by keeping the patients at the hospital (Nandi and Schneider, 2020a). The following quotation from the author’s Ph.D. illustrates how the private sector is prepared to go to any lengths to extract payment, and irrespective of all public interest even when the PFHI scheme is used:

“Meena narrates: ‘We told the doctor that we could not continue as we had run out of money and asked for the child to be discharged.’ The senior doctor said: ‘if your [economic] condition was not ok then why did you bring the child here? You should have taken him to Mekahara [government tertiary hospital] ... You shouldn’t have come here. You should have let him die.’”

## **(3) Women Subjected to Unnecessary Procedures and Forms of Treatment**

Since the introduction of the first state PFHI schemes, women have been extremely vulnerable to unnecessary procedures and treatment (Prasad and Raghavendra, 2012; Nundy *et al.*, 2013; RamPrakash and Lingam, 2018; Chatterjee, 2019). Unnecessary hysterectomies and a rise in Caesarean section (C-section) rates under these schemes have been documented in private hospitals in many states, including Chhattisgarh. While “for-profit” private hospitals had always been performing unnecessary procedures/forms of treatment, the introduction of the PFHI schemes, in which the government was now paying for these procedures/forms of treatments, seem to have incentivised them towards doing more such unnecessary procedures or forms of treatment.<sup>13</sup>

*(3a) Unnecessary Hysterectomies*

The issue of unnecessary hysterectomies relating to usage of publicly-funded health-insurance schemes in private hospitals has emerged in many states of India and remains a concern under the PMJAY. National data also show that women with no or low education and those from households which have insurance coverage were more likely to undergo a hysterectomy (Prusty, Choithani and Dutt Gupta, 2018).

Under the Aarogyasri PFHI scheme in Andhra Pradesh,<sup>14</sup> a large number of women (below 30 years of age) of the Lambada tribal community, who had sought treatment for conditions such as stomach pain, white discharge, *etc.*, were subject to hysterectomies in private hospitals (Mamidi and Pulla, 2013). In Bihar, around 16,000<sup>15</sup> hysterectomies were reported under the RSBY in private hospitals during 2011, many of which were performed on younger women.<sup>16</sup> The National Human Rights Commission ordered the government to pay compensation of Rs. 250,000 (3,300 USD) to 702 women, but the Bihar government reduced it to Rs. 50,000 (700 USD).<sup>17</sup> In Chhattisgarh, cases of the unnecessary hysterectomies emerged under the RSBY in 2012. Over a period of 30 months, nearly 7,000 cases were booked under the insurance scheme, mostly by “for-profit” private hospitals. Women aged between 30-35 years, and belonging to lower socio-economic strata, were operated on without being made aware of any other forms of medical treatment or of post-hysterectomy issues. Most of the women were (illegally) charged additional money for the operations. The private doctors in Bihar<sup>18</sup> and Chhattisgarh did not face any long-term punitive action. The women were never paid any compensation, were neither given any medical support nor any other form of support. Two of the women narrated their experiences:

“Two women from Abhanpur Block, Sharda and Ramkali (names changed), spoke about the hysterectomy operations they were made to undergo. They narrated how the doctors in one of the private hospitals in Raipur prescribed that their uterus be removed in order to relieve stomach pain. Sharda was made to pay an extra Rs. 20,000 despite using the Rashtriya Swasthya Bima Yojna (RSBY) card, which offers cashless hospitalisation for up to Rs. 30,000. ‘We had to sell land to arrange for the money,’ she said. More than 20 women in her village had undergone hysterectomies.”<sup>19</sup>

In Chhattisgarh, the government placed restrictions on hysterectomies under the RSBY in the private sector after these incidents had emerged. However, these guidelines



were abandoned when the PMJAY was implemented in September 2018. This once again led to a surge of hysterectomies in the state. An analysis of the claims for hysterectomy under PMJAY for the period from September 2018 to April 2019 shows that more than 75 per cent of those claims came from only six states, with Chhattisgarh having the most cases (Kaur, Jain and Desai, 2019). Age-wise data show that 23 per cent of the hysterectomies were done on women aged below 39 years. Nationally, 68.6 per cent of all the hysterectomy cases were done in the private sector. In Chhattisgarh the proportion of hysterectomy claims in the private sector was 94.5 per cent (Kaur, Jain and Desai, 2019).

*(3b) Caesarean Sections*

High Caesarean section (C-section) rates in the private sector under the PFHI scheme have been another issue of concern, particularly in Chhattisgarh. Claims data for one year (September 2018 to 2019) show that, under the PMJAY, 78 per cent of normal childbirth deliveries are performed by the public sector, while 93 per cent of the C-section deliveries are performed by the private sector (SNA, 2019). The proportion of C-section deliveries of the total deliveries performed under the PMJAY is 29 per cent, which is very high, according to the WHO 2015 guidelines. In the private sector, the proportion of C-section deliveries is much higher, at 63 per cent. These figures point to serious problems in advising C-section to patients coming for childbirth under the PMJAY. The financial incentives of the PFHI schemes have clearly led to the higher proportion of C-section deliveries in the private sector. It is important to note that, while the proportion of Caesarean deliveries is extremely high under the PMJAY, its spread is highly inequitable. In Chhattisgarh, the women of the four districts where the main urban centres are located, account for 31 per cent of the C-sections, while the women residing in the seven districts of the Bastar division, which are “remote” districts with a high tribal population, account for only seven per cent of the C-section deliveries in the state (SNA, 2019).

**9.6. Neglect of the Public Health System and Primary Health Care and its Implications for Women**

Since the time the PFHI schemes were introduced, a larger proportion of the claims’ amount has been going to the private sector in most states. This is related to the issues of “cherry-picking” and the provision of selective services, and illustrates provider capture. This trend continues under the PMJAY, too. In 2018-19, 62 per cent of the total claims’ amount went to the private sector (NHA, 2019). This means that public funds which could have been used to improve the public sector which provides more equitable health services and caters more for

women, has instead gone to the private sector, which is concentrated in urban centres, and engages in unethical practices.

While the private sector has managed to capture the market under the PMJAY, the PMJAY itself has seen huge increases in its budget. The PMJAY was introduced as part of the “*Ayushman Bharat*” initiative, which also includes a primary health-care programme called the Health and Wellness Centres (HWCs). The HWCs model is a re-orientation of the existing sub-centres and primary health centres to respond to community’s health needs through the addition of human resources and the expansion of their scope to cover non-communicable diseases (NCDs), mental health, *etc.*, in addition to their previous work on maternal and child health, and communicable diseases. A study in Chhattisgarh shows that functional HWCs have greatly increased the utilisation of public-health services by both women and the aged, and has enabled the access to free medicines for NCDs, such as hypertension and diabetes (SHRC CG, WHO India and Government of Chhattisgarh 2020). Despite the obvious advantages of such a programme, the national government continues to neglect it, refusing to fund it adequately. The national government has prioritised the PMJAY over the HWCs and all other government health programmes including the NHM, as is evidenced by the manifold increases in the PMJAY budget and the simultaneous underfunding of other programmes. This is clearly evident in the union budgets.

In the 2019-20 the central government’s budget, nearly Rs. 40 billion (530 million USD) was allocated for the PMJAY, which was an enormous 167 per cent increase from the previous year’s budget (JSA, 2019). The HWCs were allocated only Rs. 16 billion (213 million USD) and that, too, was to come from the National Health Mission’s allocation, which had not seen any real increase. This meant that, if that amount had to be made available for HWCs, some other programmes would need to be cut under the NHM (JSA, 2019). In the same budget, the allocations for Reproductive and Child Health (RCH) component under the NHM were also drastically reduced. In fact, the NHM’s share in the union budget allocation on health showed a reduction from 61 per cent in 2014-15 to 49 per cent in 2019-20.

This pattern has continued in the subsequent year. In the 2020-21 union budget, PMJAY received a 100 per cent increase in allocations, from Rs. 32 billion (426 million USD) to Rs. 64 billion (851 million USD) (JSA, 2020). On the other hand, budget outlays for the NHM, which includes the component on HWCs, Reproductive and Child Health (RCH), disease control programmes, immunisation and so on, have been reduced in real terms. In

fact, the budget allocations for women-specific schemes across sectors (nutrition, health, *etc.*) have all been reduced. Moreover, there is a sharp reduction in capital outlays of 58 per cent, compared to the actual expenditure for 2018-19 in capital outlays (meant for building hospitals, providing services, and procuring equipment) which could further debilitate the public health system (JSA, 2020).

In Chhattisgarh, the cost for the PFHI scheme has been increasing. Its budgetary outlay in the state budget increased by 40 times in eight years from Rs. 200 million (2.7 million USD) in 2010-11 to Rs. 8 billion (106 million USD) in 2018-19 (Garg, 2019). Even in Chhattisgarh, this progressive increase for the PFHI scheme has been accompanied by simultaneous reductions or stagnation in the allocations to other health programmes. For instance, though the National Health Mission budget has been increasing in real terms, it has a much lower rate of increase than the PFHI scheme budget (Nandi, 2019). Currently, the PFHI scheme (PMJAY and MSBY) ranks second to the NHM in terms of being the largest item on the state's health budget (Garg, 2019). Moreover, in Chhattisgarh, the tribal sub-plan (funds meant to benefit tribal communities) accounts for 39 per cent of the PFHI scheme budget (Garg, 2019). However, these funds are mainly utilised in non-tribal areas and urban centres, as private hospitals have captured the market under the PMJAY in these areas, thus resulting in resource transfer from more vulnerable communities/areas to less vulnerable areas. A similar pattern has been seen under the PFHI schemes in other states, such as Kerala, Odisha, Maharashtra, Gujrat, and Andhra Pradesh (Garg, 2019).

### **9.7. The PMJAY and the Covid-19 Pandemic**

India reported its first case of the Covid-19 infection on 29 January 2020. Since then, the figures have multiplied, and, as of 1 July, India has reported more than 560,000 infections and 17,000 plus deaths. As the number of cases increased, so did the requirement for hospitalisation. Considering the prominence and resources given to the PMJAY and the “for-profit” private health sector by the government, it was expected that they would prove useful during the Covid-19 pandemic. However, both the PMJAY and the “for-profit” private sector failed to provide the critical support to hospitalisation for Covid-19. Private sector hospitals either closed down operations or are refusing to admit patients who are Covid-19 positive. Wherever the private sector is treating such patients, they have been price gouging and making people pay huge hospital bills out of pocket.<sup>20</sup> Even though the government has widely publicised that testing and treatment would be free for people under the PMJAY,

private hospitals are not using these packages. According to news reports as of 20 May 2020, only 2,132 claims had been made under the PMJAY for Covid-19 treatment.<sup>21</sup>

In fact, overall claims under the PMJAY have decreased drastically since the pandemic started. This means that private hospitals are not providing health services even to non-Covid patients. There was more than a 51 per cent decline in the average weekly claim numbers during 10 weeks of the lockdown, compared to 12 weeks before the lockdown, and a 76 per cent reduction in the claimed amount in the early period of the lockdown (Smith *et al.*, 2020). There was also a 3 per cent shift in claims for women both before and after the lockdown. For conditions (such as pneumonia, respiratory failure, fever, *etc.*) that may be related to Covid-19, there was a 68 per cent decline in number of claims in the first week of the lockdown (Smith *et al.*, 2020). While part of the reason for this may have been due to the inability of patients to travel for treatment due to the lockdown, the major reason was that the private hospitals suspended their services or refused to admit patients under the PMJAY. Throughout the pandemic, government hospitals and laboratories have been providing most of the Covid-19 testing and treatment. Despite this, the NITI Aayog is reported<sup>22</sup> to have written to the state governments, in the midst of the pandemic, in order to accelerate the implementation of the PPP, which involves handing over of the district hospitals to the private sector.

#### **10. THE RESISTANCE OF PEOPLE'S MOVEMENTS TO THE PMJAY AND ALL OTHER PPPs**

The *Jan Swasthya Abhiyan* (People's Health Movement), of which the author is also part, has been involved in the documentation and research into the implications of the PFHI schemes for people, especially for the poor, women, and the STs and SCs communities. The JSA is the Indian regional circle of the global People's Health Movement (PHM). It is constituted by 21 national networks and organisations and the state-level JSA units. The network partners of the JSA include a range of organisations, including NGOs working in the area of health, feminist organisations, people's science organisations, service delivery networks, and trade unions.<sup>23</sup>

The JSA has put up strong resistance<sup>24</sup> to all PPPs in health care that are seen to have negative implications for both the people and the government health system, through evidence-based advocacy, direct street action, and collaboration with other social movements. The JSA regularly analyses national and state health budgets in order to understand the

patterns and shifts in funding among the various programmes, and issues statements with the analysis and related demands,<sup>25</sup> such as for universal and equitable healthcare, and investment in and strengthening of the public health system and so on. The JSA national and state units, along with associated organisations have been involved in highlighting cases of violation of health rights and the denial of health care under government schemes, including the PFHI schemes. JSA activists have published research and opinion pieces both in academia and the media (both national and vernacular). The JSA has also organised public consultations, including public hearings in which women have come and presented their testimonials regarding their experience in accessing health care, including that offered under the PFHI schemes.

The Chhattisgarh JSA unit has been involved in a number of campaigns against the privatisation of the health services, the PPPs and the PFHI schemes (Nandi, 2018). Civil society organisations, such as legal-aid organisations, community based organisations, and patients' rights groups, research institutions and workers' unions under the JSA Chhattisgarh have been actively monitoring the PMJAY and the previous schemes, and have provided documentary evidence and testimonials of violations (JSA Chhattisgarh, 2014, 2018). In addition, in Chhattisgarh, the government CHW programme called the *Mitanin* programme, which includes the CHWs (*Mitanins*, or female health volunteers) and their support structure, has been involved in monitoring and highlighting the issues that women face in accessing the health services, including those under the PFHI schemes. The CHWs have helped patients to access the grievance-redressal helpline, and have shared some instances in which the hospital has been forced to pay back the illegal OOP payments that it had extorted from the patients. The following extract describes this role played by CHWs:

“Action on health system accountability started with raising ‘local’ issues, for example, absence of nurses for immunization. Then Mitanins started raising issues of absence of staff and medicines in primary health centres. They used the learning from such action to raise issues of maternal deaths due to gaps in the in-patient services of public hospitals. This experience in turn was used by Mitanins to question corruption in private hospitals around state-funded health insurance. As their engagement with these issues increased, Mitanins were also able to point out some systemic gaps.”  
(Garg and Pande, 2018)

State elections were held in Chhattisgarh in the months of November and December 2018, prior to which the JSA and other groups had advocated for strengthening of the public

health system through recruiting staff, improving working conditions, improving availability of medicines, *etc.* The opposition had included these points in their manifesto. They won, bringing a change in ruling party for the first time in 15 years. Due to years of advocacy by civil society groups and the evidence of the negative impact of the currently functioning PFHI scheme, the government has now developed new guidelines for the scheme, one which has a focus on public hospitals.<sup>26</sup> Under the revised universal health care scheme inaugurated in January 2020, a number of procedures related to primary and secondary care and those that were susceptible to provider-induced demand have been reserved for public hospitals. There is already a reversal of the previous trend, with public sector receiving a higher share in the overall claims amount. While some ground has been reclaimed by the public sector in Chhattisgarh, the “for-profit” private sector continues to behave as before.

## **11. CONCLUSION**

With the introduction of the PFHI schemes, India saw a shift in the way health services were organised and financed. As the largest PPP that the Indian government has ever promoted in health care, the PMJAY prioritises the private sector over the public health system. Health care is being promoted as business, rather than a right.

The impact on the government health services has been devastating. Public resources have been diverted to the PMJAY and the public health system has been neglected and under resourced. Essential government health services such as primary health care services, disease control programmes, and reproductive and child health programmes are being starved of funds while the budgets for PPPs such as the PMJAY have been increasing manifold. The role of the “for-profit” private sector in government has been legitimised, from decision-making to implementing to monitoring. Collusion between public administrators (who are otherwise supposed to act in the public interest) and the “for-profit” private sector is promoted. There has been provider and regulatory capture by the private sector.

Thus, the PMJAY has serious implications for women’s health and their access to health services, especially for women belonging to ST, SC, the poor, and other vulnerable communities. Women do not have any role in decision-making or at any stage of the PMJAY implementation or monitoring, even though they are the ones most affected by it. There is inequitable access to health care under the scheme. The under-funding of the public sector that mainly caters for women, the poor, and other vulnerable communities has further exacerbated inequity in access. Women and other vulnerable groups are pitted against the most powerful (“for-profit” private providers). The scheme enables private interests to gain

control over women's own bodies which are seen as a means of making profit, and subjected to unnecessary procedures and forms of treatment. Through the PFHI schemes, the government has prompted women and others place their trust in the "for-profit" private sector, but has failed to put in place effective regulatory or grievance-redressal mechanisms. As a result, the risk is transferred to the family-accessing health care under the PMJAY, which is often borne by women disproportionately. The basic objective of the scheme, which is that of preventing OOP expenditure, is far from being realised, and, instead, women have to face abuse and humiliation when resisting such payments. Funds that should have been spent directly on women's health have been diverted to private sector through the PMJAY. As the evidence shows, in a context of an unregulated and powerful private sector, public funding for private provisioning has clearly proven to be a disaster for women.

People's movements have been putting up resistance against such PPPs. Even the Covid-19 pandemic has shown that, despite being continually prioritised in terms of resource allocation, the PMJAY has failed to enable access to free health care even at a time of crisis when it was needed the most. The Indian government must recognise the failure of the PMJAY and abandon it. They must commit themselves to strengthening the public health system for free and making access to health care more equitable. Health care must be reinstated as a right.

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## Notes

<sup>1</sup> Recognising the discriminatory nature of the "caste system" in India, the Constitution of India classified disadvantaged social groups and communities into "Scheduled Castes" (SC) and "Scheduled Tribes" (ST) and made special provisions in order to undo socio-economic and political injustices towards them.

<sup>2</sup> See "Executive Summary: Report on the Status of Women in India", available at: [https://wcd.nic.in/sites/default/files/Executive%20Summary\\_HLC\\_0.pdf](https://wcd.nic.in/sites/default/files/Executive%20Summary_HLC_0.pdf).

<sup>3</sup> Catastrophic health expenditure is an economic shock to families or individuals due to health-care expenditure. It occurs when a family or person has to incur expenses on health-care costs that are above and beyond their capacity to pay.

<sup>4</sup> See "Benefits of PMJAY", available at: <https://pmjay.gov.in/benefits-of-pmjay>.

<sup>5</sup> About Pradhan Mantri Jan Arogya Yojana (PMJAY), see "Why PM-JAY: A Background", available at: <https://www.pmjay.gov.in/about-pmjay>.

<sup>6</sup> Tier 1 cities are the metropolitan cities, and Tier 2 and Tier 3 cities follow them in terms of lower population, levels of urban development, standards of living, and other indicators.

<sup>7</sup> See "Central Government's Move to Privatise district Hospitals Spells Disaster for India's Poor", *Gaon Connection*, available at: <https://en.gaonconnection.com/central-governments-move-to-privatise-district-hospitals-spells-disaster-for-indias-poor>.

<sup>8</sup> See "Ayushman Bharat can be a Success if Modi Govt Incentivises Digital Data for Private Players", *The Print*, available at: <https://theprint.in/opinion/ayushman-bharat-can-be-a-success-if-modi-govt-incentivises-digital-data-for-private-players/353827>.

- <sup>9</sup> See “Panels to Review Ayushman Bharat Price Caps”, *The Economic Times*, available at: <https://economictimes.indiatimes.com/news/politics-and-nation/panels-to-review-ayushman-bharat-price-caps/articleshow/69867242.cms>.
- <sup>10</sup> See “Patients fleeced as Governments Dawdle”, *The New Indian Express*, available at: <https://www.newindianexpress.com/thesundaystandard/2020/jan/26/patients-fleeced-as-governments-dawdle-2094601.html>.
- <sup>11</sup> See “Request for Qualification (RFQ) cum Request for Proposals (RFP) for Procurement of Project Management Consultant for ABNHPM”, available at: <https://pmjay.gov.in/node/169>.
- <sup>12</sup> Considering that these selective reports are the only source of PMJAY data available in the public domain, and on the principle of public ownership of data sourced from public programmes, this paper uses and quotes these reports without any such “permissions”. The reports are available here at: <https://pmjay.gov.in/resources/publication>.
- <sup>13</sup> See “The Uterus Snatchers of Andhra”, *The Times of India*, available at: <https://timesofindia.indiatimes.com/india/The-uterus-snatchers-of-Andhra/articleshow/6239344.cms>.
- <sup>14</sup> See “Greedy Doctors Con 600 Tribal Women into Surgery”, *Mumbai Mirror*, available at: <http://www.carped.org/attachments/article/30/Greedydoctors.pdf>.
- <sup>15</sup> See “16,000 ‘Illegal’ Hysterectomies Done in Bihar for Insurance Benefit”, *Indian Express Archive*, available at: <http://archive.indianexpress.com/news/16000--illegal--hysterectomies-done-in-bihar-for-insurance-benefit/993625>.
- <sup>16</sup> See “In Bihar, Hysterectomy on 14-yr-olds”, *Hindustan Times*, available at: <https://www.hindustantimes.com/patna/in-bihar-hysterectomy-on-14-yr-olds/story-QR2M49qazDcR14NE8RykDK.html>.
- <sup>17</sup> See “Bihar Government Slashes Compensation for 702 Women who have Lost their Wombs”, *Scroll.in*, available at: <https://scroll.in/pulse/823650/bihar-government-slashes-compensation-for-702-women-who-have-lost-their-wombs>.
- <sup>18</sup> See “Bihar Women who Lost their Wombs to Needless Surgeries Suffer while Doctors Thrive”, *Scroll.in*, available at: <https://scroll.in/pulse/816202/bihar-women-who-lost-their-wombs-to-needless-surgeries-suffer-while-doctors-thrive>.
- <sup>19</sup> See “Public Health, Private Tragedy”, *The Hindu*, available at: <https://www.thehindu.com/opinion/op-ed/public-health-private-tragedy/article6633520.ece>.
- <sup>20</sup> See “Statement on the Role of the Private Health Sector during the Covid-19 Pandemic”, *Jan Swasthya Abhiyan*, People’s Health Movement-India, available at: <http://phmindia.org/2020/04/28/statement-on-the-role-of-the-private-health-sector-during-the-covid-19-pandemic>.
- <sup>21</sup> See “Only 5,600 Health Insurance Claims – 3% of Total Covid Cases”, *The Indian Express*, available at: <https://indianexpress.com/article/business/only-5600-health-insurance-claims-coronavirus-6438004>.
- <sup>22</sup> See “NITI Aayog to States: Speed up Medical Colleges on PPP Model”, *The Indian Express*, available at: <https://indianexpress.com/article/india/niti-aayog-to-states-speed-up-medical-colleges-on-ppp-model-6423201/lite>.
- <sup>23</sup> See *Jan Swasthya Abhiyan*, *People’s Health Movement-India*, available at: <http://phmindia.org/about-us>.
- <sup>24</sup> See *Saúde: Em Debate*, 44 (1), available at: <http://revista.saudeemdebate.org.br/sed/issue/view/33/v.%2044%2C%20n.%20ESPECIAL%201>.
- <sup>25</sup> See *Jan Swasthya Abhiyan*, *People’s Health Movement-India*, available at: <http://phmindia.org/about-us>.
- <sup>26</sup> See “Chhattisgarh: A Single Healthcare Scheme to Raise Efficacy, Accountability”, *The Indian Express*, available at: <https://indianexpress.com/article/india/chhattisgarh-a-single-healthcare-scheme-to-raise-efficacy-accountability-6145898>.



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DRAFT for discussion

## **DAWN Discussion Paper #23**

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