On August 16 this year, the reputed medical journal Lancet published a report on the 10-year experience of Mexico’s journey towards universal health coverage (UHC). This year, Mexico achieved UHC for all of its 100 million citizens, with Seguro Popular, a national health insurance programme introduced in 2001, extending protection to 52 million previously uninsured citizens. This month, the Planning Commission of India has proposed to extend and expand the Rashtriya Swasthya Bima Yojana (RSBY) in the 12th Plan. What are the similarities and differences between these two programmes?

UHC in Mexico is synonymous with social protection of health. In the words of an accompanying Lancet editorial, “health insurance is no longer seen as an employment benefit but as a right of citizenship”. The report describes the three stages of UHC: (1) universal enrolment, with benefits extending from a publicly organised insurance; (2) regular access to a comprehensive package of services with financial protection for all; and (3) universal effective coverage guarantees for specialised high-cost services to prevent financial shocks.

A Fund for Community Health Services covers health promotion, immunisation campaigns, primary prevention, early detection, epidemiological surveillance and risk protection. Personal clinical services which are not highly specialised are funded through Seguro Popular, which draws on pre-paid contributions (according to the capacity to pay) and public funding from general taxation (which pays for most services). There is a special fund for children and new-borns (Medical Insurance For A New Generation) and a Fund For Protection Against Catastrophic Health Expenditures (FPCHE) which provides for high cost, specialised interventions. As of 2008, states are required to invest 20% of all Seguro Popular funds on prevention, in addition to the federally-run community health fund. In contrast, only 8% of the resources allocated to Seguro Popular flow into the high-cost FPCHE, though this can be supplemented by earmarked contributions. Mexico is now moving towards a single insurance fund, mostly tax-financed, to provide universal access to a common package of essential and high-speciality interventions.

Since its introduction in 2007, the RSBY has grown rapidly to cover about 150 million persons through 32.2 million family cards in 26 states. The central government pays 75% of the cost and the states pay 25%, with the maximum premium per family set by the government at R750. The beneficiary pays R30 for the card and obtains annual family coverage of health expenses up to R30,000. The programme originally targeted BPL families, though other vulnerable groups are also now being included. The BPL lists are often incomplete and the coverage of even those listed is less than 50% as yet.

RSBY has several strengths. It offers financial protection for hospitalised secondary level care. It has built up an effective IT platform, enabling ‘cashless’ delivery of services through a ‘smart’ card. It has empanelled both public and private providers for service delivery, expanding access and providing some ‘choice’. The coverage is ‘portable’, enabling the beneficiary to access services anywhere in the country.

The weaknesses of RSBY have also become apparent over the past four years. It covers only in-hospital care, to the exclusion of outpatient care and long-term supply of medicines though they are the major sources of out-of-pocket expenditure in India. Even hospitalised care may not be fully covered by R30,000 per family,
and add-on costs imposed during and after hospitalisation care may actually increase the out-of-pocket expenditure.

Since primary health care services are not included, there is fragmentation of care which disconnects primary from the higher levels of care. Good health outcomes, at the population level, are best achieved when there is a continuum of care that enables a strong primary health care system to prevent disease, act as a ‘gate keeper’ to restrict referral to higher levels of care to persons who really need it and also provide follow-up services to them on their return from secondary or tertiary care.

Of the 12 insurance companies managing RSBY, some are claiming financial loss due to high utilisation while others appear to reap dividends from under-utilisation of the insurance. High claim ratios, such as reported from Kerala, raise questions on the financial sustainability of the programme. Fraud has been reported, in the form of false enrolment and billing for unprovided services. Even more troublesome is the problem of induced demand for unnecessary hospitalisation and procedures. This is high in the health sector because of a huge asymmetry of information and decision-making power (the patient cannot argue with the doctor!). An appalling malpractice has been the high level of unnecessary hysterectomies (uterus removal) reported from Chhattisgarh and Bihar, some performed even in young girls. Fraud was evident too, with hysterectomies reported on men!

Both the Mexican programme and RSBY are mainly tax-funded. The difference lies in the continuum of care provided to every citizen by a wide ranging spectrum of services in Mexico, with emphasis on primary health care. In contrast, RSBY provides a useful but incomplete contribution to health care and cannot substitute for UHC. It has also not served to direct fund flows for strengthening public hospitals.

Mexico has maintained its commitment towards UHC even through periods of economic downturn and crises. It has been rewarded with remarkable improvements in population health outcomes, reduction in ‘out-of-pocket’ expenditure and a rise in GDP growth. To its credit, RSBY has dimly lit up the dark space of our health care by providing some services to the poor. To move to a brighter future, however, India has to embrace a predominantly tax-funded UHC model of integrated health care for all citizens, taking advantage of the technical platform built by RSBY for achieving a swift transition.

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