Letter from North America

HEALTH INSURANCE REFORM

Over the past few months, healthcare reform has been the hot topic of media and political debates in the USA. As a candidate in the 2008 Presidential elections, Barack Obama emphasized the importance of reforming American healthcare, and now as President, he is campaigning to secure major reform legislation by the end of 2009.

The need and the debate for health insurance reform are fuelled by the rising healthcare costs and the current economic downturn. US national health spending is expected to reach US$ 2.5 trillion in 2009, accounting for 17.6% of the gross domestic product (GDP). By 2018, national healthcare expenditures are expected to reach US$ 4.4 trillion. The expected increase in national health expenditures are faster than the growth in GDP: 6.2% per year compared to a GDP increase of only 4.1% per year. Economists and public health experts agree that this alarming increase in healthcare expenditure is no longer sustainable. The government insurance providers, Medicare and Medicaid, are expected to account for 50% of all national health spending by 2012. In the private sector, health insurance costs are the fastest growing expense for employers. The average employer-sponsored premium for a family of 4 costs nearly US$ 13 000 a year, and the employee bears about 30% of this cost. Over the past decade, employer-sponsored health insurance premiums have increased 119%. Employer health insurance costs overtook profits in 2008, and the gap grows steadily. A recent study found that 62% of all bankruptcies filed in 2007 were linked to medical expenses. About 1.5 million families lose their homes to foreclosure every year due in part to unaffordable medical costs.

The Obama administration has decided to push for bold health reforms, capitalizing on Barack Obama's popularity and an economic crisis that has given support for federal intervention. The President is using his oratory skills to rally support for reform. In a series of speeches and town hall meetings, President Obama has directed his attention to covering the uninsured and those whose insurance is in imminent jeopardy—every day 14 000 people lose their health benefits according to US government estimates.

About 15 years ago, the USA appeared to be on the verge of enacting similar comprehensive health reform. President Clinton, a democrat, came to the White House with sizeable majorities in the House and Senate. With increasing costs and growing numbers of uninsured, the Clinton administration believed it had a public mandate for reform. There was consensus on the need for change from a variety of interest groups, including businesses threatened by rising health insurance bills. Clinton's plan proposed both to achieve universal coverage and to control costs by requiring employers to pay for their workers' health insurance, establishing a system of regulated competition between private insurers, and setting limits on increases in health insurance premiums. The Clinton administration's campaign for health reform ended in defeat. The Health Security Act never came close to passing in Congress and following the 1994 elections the opposition party secured majorities in both the House and Senate.

In 2009, the Obama administration will attempt to proceed using the lessons learned from President Clinton's failures. The Clinton administration ignored congressional leaders and excluded health industry groups from the planning process, which bred resentment. President Obama left primary responsibility for drafting the health reform plan to the Congress and the democrat leaders. Though the President has articulated broad principles he would like to be followed—including adopting some kind of public insurance option and reducing overall costs—he has indicated that he is flexible about how Congress translates those principles into legislation. The Clinton approach to reform took too little account of the political reality that many people who have insurance now are satisfied with it, and are wary of changes. Keenly aware of how the Clinton plan frightened middle-class insured Americans, the Obama administration has emphasized that Americans who are satisfied with their present coverage and doctors can keep them. Powerful industry groups fought intensely against the Health Security Act in 1993–94. Obama and Senate leaders have sought to avoid a multifront war with the healthcare industry and business community by including both in discussions about reform and negotiating pledges by industry groups to back reform provisions.

The Obama administration's strategy of moving quickly within a year of being in the White house has worked at initial stages. He has negotiated deals with the opposition, and deferred the details of legislation to the Congressional leadership. In general, the democratic congressional plan attempts to include provisions for increasing the role of Medicaid, provide tax credits to middle-class Americans, and establish a health insurance 'marketplace'. The marketplace will in theory allow for lower premiums and more benefits for policy-holders. The mainstays of the democrats' goals are to regulate private insurers and require individuals to obtain health insurance or pay a penalty.

The question of a public option plan has emerged as the most contentious issue in health insurance reform. The goals of a government-run health plan and its existence has divided the democratic majority. Many citizens and pundits view it as government takeover of American medicine and warn of the dangers of a government-run system in which care is denied, delayed and rationed. The White House and congressional Democrats argue that a set of fiscally sound policies can enable the reform process: paying hospitals and doctors on the basis of the quality of care provided (pay for performance), enhancing preventive medicine, promoting electronic medical records, investing in comparative effectiveness research, and improving the coordination of care for chronic diseases.

The outcome of this public debate is anxiously awaited as President Obama has accelerated the pace of discussion and is planing to take it to more town hall meetings. Wary of the potential political drawbacks in a prolonged debate, the administration is pushing to pass the health insurance reform bill by the end of 2009.

In India, the share of public financing in total healthcare is about 1% of GDP compared to 2.8% in other developed countries. Over 80% of total health financing is private financing, much of which is out-of-pocket payments and not prepayment schemes. In 2004, healthcare spending per capita was US$ 32 compared to US$ 5365 and by percentage of GDP is 5.3% compared with 17.2% in the USA. India's healthcare insurance market is grossly under-penetrated with only 2% of the country's billion-plus population possessing a health insurance cover. Health insurance

industry in India is witnessing a growth of about 30% per year. The industry is estimated to have reached about Rs 65 billion in revenues this year (US$ 1300 million), compared to about Rs 50 billion in 2007–08. The demand for health insurance has gone up considerably over the past few years. With incorporation of the healthcare sector, hospital treatment costs have increased, which has led to more people buying health insurance coverage.

The current health insurance debate in the USA and its outcome are of importance to Indian healthcare policy-makers as booming healthcare costs with limited public options may soon raise similar issues and debate in India.

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Letter from Chennai

PUBLIC–PRIVATE PARTNERSHIP

Andhra Pradesh launched the Rajiv Arogyasri Scheme on 1 April 2007, and expanded it to cover the entire state in July 2008. Families with an annual income below Rs 75 000 are insured for Rs 150 000 by the government against diseases needing hospitalization and surgery, including those of the heart, diseases requiring neurosurgical treatment, renal failure, cancer, burns and polytrauma not caused by motor vehicle accidents. The government pays Rs 330 per family as premium. An extensive list of 389 surgical and 144 medical conditions was drawn up after discussions between 30 groups of doctors and the management of many private hospitals, and rates of reimbursement for the different conditions were fixed. Only inpatient treatment is covered, though I found that haemodialysis is offered on an outpatient basis. Of interest to me, renal transplantation is also covered. The policy was offered by insurance companies and the premium was paid by the government—320 hospitals in the private sector and 30 government hospitals have been recognized for such treatment. They levy their charges, which are paid by the insurance companies. Different sources quote different numbers of hospitals and diseases, and the figures I mention here are from one source, which seem fairly representative.

A number of camps are held in different parts of the state to identify patients who are then referred to specialty hospitals for the necessary treatment. Figures mentioned in July 2009 indicate that 10 578 camps had been held at villages in 23 districts. A total of 1 789 075 people had been screened and of those 152 431 had been referred to hospitals for further screening. Since many patients went directly to the hospitals for care-seeking, the total number seen in the hospitals was 487 659. Till July 2009, a total of 300 015 operations had been done at a cost of Rs 9.63 billion. In light of this figure, the sum of Rs 9.25 billion allotted to the scheme in the current budget seems unrealistic.

I recently visited Hyderabad and Visakhapatnam, the largest cities in Andhra Pradesh, and spoke to doctors about the working of this scheme. It has clearly been a boon for those who have benefited so far. Many patients who would have died have indeed been saved. They are poor, and could never have availed of the facilities of the 5-star hospitals without this scheme. Surely, this is the best way to solve the health problems of the poor of the state. Or is it?

My misgivings start with arithmetic. The population of the state is 76 million, 26% are below the poverty line, or approximately 20 million. Assuming 5 persons in a family, the insurance premium of Rs 330 for 4 million families amounts to Rs 1.32 billion. This does not tally with the figure of Rs 9.63 billion spent during 2008. Clearly, no insurance company can afford to subsidize the scheme to that extent. The expenditure to the government is much more than that projected. Where does the money come from?

Having allocated Rs 9.25 billion, almost a quarter of the health budget of Rs 38.21 billion, towards this scheme for the year 2009–10, the government is feeling the pinch. The Chief Minister said on 18 July that he would ask the Prime Minister for Central funds to defray the expenses. There is also a proposal to raise taxes on cigarettes and alcohol, and to spend the extra income on the Arogyasri scheme. I am all for any measure that would reduce the intake of alcohol and the use of tobacco, but how much money can realistically be raised by these means?

For obvious reasons, much of my time was spent with nephrologists. Many of them have done renal transplants under this scheme. I gather immunosuppression is provided only for 6 months. While patients and nephrologists between them scrape together enough to cover immunosuppression longer in some patients, many patients do not succeed and have inadequate funds. They give up their medications and lose the kidney, making the whole exercise futile. There is no solution in sight. It is a crime to deprive a living donor of a kidney if it will be maintained only for 6 months. At the end of that time the patient goes back on dialysis. The scenario for long term dialysis is better. I heard various figures of the number of dialyses covered for each patient, but it seems that around 8 dialyses would be paid for per month for an indefinite period. While this frequency of dialysis would not be adequate to maintain perfect health, it should keep the patient alive. The problem arises there. If the patient stays alive, and an equal number of patients are added each year, the costs would keep mounting. My own data from the Kidney Help Trust suggest that 87 people per 1000 of a rural population develop end-stage renal disease (ESRD) each year. More people have renal failure in cities, but let us take the rural figure as the basis of our arguments. For the 20 million poor of Andhra Pradesh that means 17 400 people reaching ESRD each year. A reasonable estimate of the cost per dialysis is Rs 700.[1] Ninety-six dialyses a year would cost Rs 67 200 per patient per year, and for 17 400 poor souls that adds (or multiplies) up to Rs 1.17 billion a year. If the patient survives 5 years on dialysis, at the end of 5 years we would be spending Rs 5.85 billion a year on dialysis alone. One machine can