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The Public-Private Welfare State: constructing a data-driven health coverage in India

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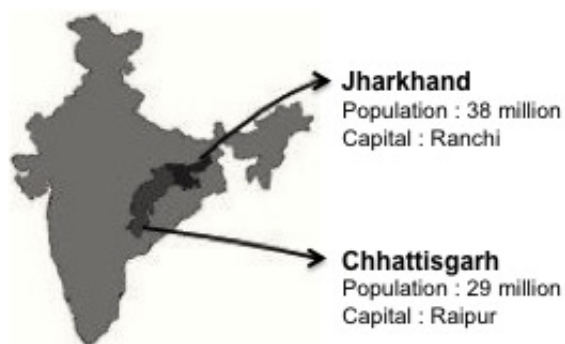


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[“Health for All?”](#) critically explores global moves towards Universal Health Coverage and its language of rights to health, equity, social justice and the public good. Highlighting emerging ethnographic and historical research by both young and established scholars, the series explores the translations and frictions surrounding aspirations for “health for all” as they move across the globe. The series is edited by Ruth Prince.

Sita arrived at a health facility near her village; she came because her delivery is covered. She showed her “smart card” to access the workroom without spending any money, — a revolution in India, where from transportation to birth certificate, women have to pay for each component of the delivery procedure. Many women in India, like Sita, do not have electricity, running water or toilets in their house but have a cellphone or a smart card that gives them access to new digitally-based health services. According to their promoters, these services will allow developing countries to ensure a good quality of care and significantly reduce health expenditures.

The national health coverage program used by Sita illustrates the construction of policies based on partnerships with digital businesses to meet the health needs of the world's poorest. How does digital technology establish new criteria for access to healthcare? What role do private digital businesses play in national health insurance policies in countries like India? This article examines the redeployment of public health policies aimed technologies designed by digital and insurance industries to meet the needs of the poorest through the construction of new digital health markets. In a context of renewed discussions around Universal Health Coverage (UHC), these new technological partnerships highlight what a public-private welfare state and a market-driven UHC would mean.



The increasing use of digital technology, both inside and outside healthcare facilities, has intensified the production and use of health data. This digitization produces new forms of quantification and surveillance that respond to commercial or political imperatives often unknown by users^[1]. This phenomenon also affects India, which has implemented colossal biometric projects – such as Aadhaar^[2] – positioning it as a “Big Data Giant” in the Global South. In India, reflections on the intensive use of biometrics and “smart technologies” materialized in 2007 with the eleventh five-year plan of the government that proposed to use “multi-application smart cards” to strengthen and deliver various social services, including health. In the wake of this plan, the Rashtriya Swasthya Bima Yojana (RSBY, literally “National Health Insurance Programme” in Hindi) scheme was launched in 2008, before Aadhaar, as a pioneering system based on the use of biometric smart cards and involving private digital players in the health sector.

This paper relies on two periods of fieldwork conducted in 2017 in the Northern States of Jharkhand and Chhattisgarh, with my colleague Rajiv K.Mishra from the Centre for Studies in Science Policy (CSSP) at Jawaharlal Nehru University. We collected qualitative data from two districts of Jharkhand and Chhattisgarh, and state data from Ranchi and Raipur. We conducted 160 interviews with doctors and administrative staff from empanelled public and private hospitals; government officials at state and district level; insurance companies; technology service providers

(TPA); community health workers (ASHA/AWW); and families targeted and enrolled in the scheme[3].

Initially called *Rashtriya Swasthya Bima Yojana* (RSBY), then *Pradhan Mantri Jan Arogya Yojana* (PMJAY), this national health insurance scheme is now commonly dubbed as "Modicare" from the name of the current Prime Minister of India. Launched in 2008, this national policy provides coverage of hospitalization up to 30,000 rupees (400 euros) per year for five members of a family living below the poverty line[4]. While 70% of health expenditure is borne by households[5], this scheme offered the first free health coverage to many Indian families. Eventually, the program aims to cover the entire population and both inpatient and outpatient health expenses. In August 2018, the Indian government announced its substantial increase to 6,000 euros a year for five members of a family, without any associated financing plan.

This national health insurance offers an interesting illustration of how health coverage can be managed by biometric databases. This "paperless & cashless" program has so far enrolled 120 million Indians. The scheme is made visible by a chip-enabled plastic card containing personal data of individuals and their family, counting and conditioning the granting of health services to them; thus, no smart card means no health coverage. The scheme relies on a digital database, a large repository of personal information of people, their photographs, fingerprint scans and address details aggregated for five members of a family who enrolled. With the help of softwares connected to this database, empanelled hospitals fetch beneficiaries' information and proof of financial solvency when they come for medical treatment, they will block specific medical packages covered by the scheme and will treat them for free or make them pay depending on the amount still available on their card. The biometric database decides access and treatment of the beneficiaries of the Indian Welfare State.

As my research with Rajiv Mishra demonstrates, this scheme defines new state-citizen relationships in India and a new scope for health coverage with deleterious impacts in terms of access to health structures and medical services[6]. Indeed, while these digital infrastructures promise integration into the social protection system, they complicate the mechanisms of inclusion of individuals, blocking access to health facilities or medical acts based on technical criteria. This national policy is based on a "public-private partnership" between the government and companies from the insurance and digital sectors. For eligible citizens, the State finances an annual health insurance contract with companies who won this "market." In most Indian states, these private insurers have delegated their work to a "technology provider", a neophyte of health, whose core business is digital technology. The digital providers assume the recruitment of the beneficiaries, their registration and the use of each

contract; they must also recruit the hospitals, ensure that they deliver the “good” medical acts to the “good” insured patient and repay health facilities accordingly. This national health coverage relies thus on two central pillars: biometrics and delegation of service to private companies that are able to implement this biometric governance.

A digitally-driven access to healthcare

The manufacture of the smart card and the registration process to the scheme are based on the selection of families below the poverty line (BPL) or belonging to twelve other identified categories. Representatives of insurance companies, technology providers and government officials told us that this list had many redundancy issues as well as missing or incorrect data. For example in Jharkhand, one of the pilot states of the scheme, data were based on a census conducted in 2003-2004 and had not been updated in 2017. Thus, after seven years of existence of the program there, more than 50% of the target population was still not registered. According to several testimonies, many households were absent from the initial list used for registration, which automatically excluded them from the whole insurance scheme. This shows that from the very start, data acquisition and beneficiary registration was skewed by the need for computerized data, which made the scheme partial and lead to the exclusion of many eligible people.

Among those who registered, very few actually benefited from the program. Indeed, in 2015 in Jharkhand, less than 1.8% of the targeted families actually used the smart card, according to State officials. The first explanation for this low usage provided by its implementers was the “lack of awareness” among beneficiaries. This explanation glossed over the fact that for the majority of enrollees, knowing how and where to use their smart cards was a real challenge compounded by the low rate of public and private hospitals covered by the scheme and the limited validity period of smart cards (one year only in many states). Several patients and health workers told us that even when people knew the list of hospitals accepting the smart card, they could not use it because the card had already expired when they went there. Some hospitals estimated that this was the case for 90% of patients who showed up on their doorstep with the smart card.

If for seven years, the majority of RSBY smart cards remained “unused” in Jharkhand, the usage of the card itself revealed major challenges to the digitization of health coverage that should be considered. The procedures for registering, blocking medical packages on the card and discharging patients are carried out by several technologies, such as smart card readers, biometric scanners and software in which specific medical packages are referenced and selected for the scheme. When the smart card is accepted at the registration desk, it is entered into a reader with a

biometric verification of the recipient using fingerprint scanners. At this point, our investigation among others has revealed that there are frequent problems with fingerprint recognition in almost one in ten people. If registration and biometric recognition function, the selection of medical packages covered by the scheme must be done within the first 24 hours of registration. Patients, most of the time, are not informed of the selected medical packages and the amount taken on their card. This absence of communication facilitates manipulation and fraud with the card. Indeed, several hospitals blocked “unrequired” packages or clocked in several days of hospitalization after the patient had already been discharged. We met several cataract patients who spent less than 24 hours in private hospitals, where a three-day hospitalisation package of 20,000 rupees (240 euros) was taken from their card. Some hospitals seek to block the maximum amount on the card, even when the patient did not need as much care, or did not even use the service. The many cases of manipulation mentioned by state officials, doctors and patients of the scheme also reveal the lack of monitoring of the use of smart cards.

The rise of private health markets

According to several published articles, the real beneficiaries of this scheme are the insurance companies, digital firms and private hospitals^[7]. Indeed, while the number of users of the coverage remained low, registrations of smart cards led to the payment by the State of Commissions to the mandated companies, who thus collected the premiums associated with many families who never benefited from the scheme. According to technology providers and district officers, the yearly registration process often took longer than six months. So, in most cases, after receiving their smart card, patients only had a few months to use it before it expired. The same companies were also responsible for enlisting hospitals under the scheme, but it was not in their interest to enroll many hospitals because the more hospitals in the scheme, the more medical acts they would have to refund. This explains the low geographical coverage of the program in some states and also its orientation towards private hospitals. In Jharkhand, even if the majority of public hospitals were enrolled, 95% of the reimbursements of medical packages under RSBY were in favour of private hospitals. One of the digital technology providers overseeing registrations and hospital claims told us that public hospitals never obtained any money from insurers even though they used the smart cards and submitted claims, a statement confirmed by several public hospitals accountants. In our study, small private hospitals with less than 10 beds were identified as central care providers for RSBY beneficiaries, particularly in rural districts. Indeed, the scheme brought them a lot more customers from among the poorest who, before they joined the scheme, rarely visited private hospitals for fear of the incurred costs.

But even though these small private hospitals have been able to benefit from the scheme and bill insurers for medical packages, many have lost “the game of claims” and some have even closed shop because of this scheme. The companies in charge of the scheme gave different explanations for the non-payment of hospital claims. The late uploading of usage data on the central server is one of the first reasons. If the data was not uploaded within 24 hours of the patient’s discharge, the request was rejected. The second major reason for non-settlement of claims is related to misuse of medical packages by hospitals or even fraud charges. In these cases, the treatments claimed by the hospitals were not justified and therefore not reimbursed. The companies identified misuse through data stored on the central server or random checks in suspicious hospitals. But their staffs are not really qualified to be able to “separate the wheat from the chaff” online as well as offline, as they recognize themselves: “We are not doctors, so we do not know if the patient needs a treatment rather than another[8]”. However, the allegedly suspicious claims were not reimbursed and these involved virtually all hospitals affiliated with the program in Jharkhand, who still claimed their money after years.

For the Indian government and the state of Jharkhand, a program like this one is a triple loss. First of all, very few eligible people could actually be treated for free. In many cases, patients had to pay to be treated in costly private facilities that they would never have turned to without this scheme. Secondly, public infrastructures did not benefit at all from the program and did not improve their facilities or resources with the money that could have been injected through this scheme. Lastly, private companies have always kept their hands on digital data, in order to adjust their rates and re-evaluate their premiums each year after having carefully analysed the usage of the scheme to ensure that their involvement would generate sufficient benefits. In addition, there was no mechanism in their contract for protecting the data collected; insurers and technology providers could use them for their own commercial projects. The commercial valorisation of collected health data is a central issue for firms involved in these digital devices. Because real-time patient information in the clinic is valuable to many stakeholders, digital health data is becoming the crux of health markets, and digital platforms are the newest means to collect and market it.

Far from the UHC model advocated by WHO, this program reveals the forms that health coverage can take in the Global South. It stresses the crucial role of digital technology in establishing new criteria for exclusion or allocation of health benefits. While programs like this one promise health coverage for all, their digital infrastructures complicate access to health services and reveal new patterns of exclusion based on digitally constructed criteria. The technological as well as the partnership dimensions of such programs lead to the commodification of health. In

addition, they show that digital health PPPs can be a double win for the private sector and weaken public health infrastructures by diverting public health funds for the benefit of private companies.

Notes

[1] See Lisa Gitelman, eds., "*Raw data*" is an oxymoron, Infrastructure series (Cambridge, Mass., London, England: The MIT Press, 2013).

[2] "Aadhaar" is the name of the world's largest digital ID system. Launched in 2009, Aadhaar is a unique identity number assigned to almost all of the Indian population, combining identification data, fingerprints and iris. Initially non-mandatory, the current government has connected Aadhaar to the private sector, making it mandatory to create a bank account, open a phone line, take out insurance or a loan. The centrality of the database, its interoperability between the public and private sectors and the lack of protection of the personal data it houses are at the heart of a transnational controversy from India, in which civil society organisations have seized the supreme court of India in 2012, 2015 and 2018 which ruled against government policy and in favour of the protection of personal data.

[3] The initial round of interviews was based on purposive and convenience-based sampling using contact details of various actors and institutions mentioned in the RSBY website, like insurance agents, private and government hospitals; from there we did snow balling of our samples. The interviews were conducted in three languages (Hindi, English and local ChotaNagpuri). A longer and more detail analysis of RSBY in Jharkhand is to be published in *Science, Technology and Society*, Al Dahdah Marine and Rajiv K. Mishra "Smart cards for all: the digitization of universal health coverage in India", to be published in 2020.

[4] This amount is the maximum total coverage for 5 people of the same family during one year, meaning that if one member of the family uses this amount at the beginning of the year, the rest of the family members covered on this card won't benefit from it and will have to pay out of their pocket to access healthcare until the end of the year. Central government pays 75% of the coverage, the rest has to be endorsed by State governments. Some State governments refused to endorse the scheme because they already have another health coverage scheme in place, like the Southern State of Tamil Nadu for instance.

[5] Vikram Patel et al ". Assuring health coverage for all in India ", *The Lancet* 386, n^o 10011 (December 2015): 2422 – 35.

[6] See the detailed analysis of the survey we conducted with Rajiv Mishra

in Jharkhand on RSBY, Al Dahdah Marine and Rajiv K. Mishra ” Smart cards for all: the digitization of universal health coverage in India. In *Science, Technology and Society*, to be published in 2020. Also the study of ILO (2014). Evaluation of RSBY Key Performance Indicators: A Biennial Study | Microfinance Gateway – CGAP. and Karan, A., Yip, W., & Mahal, A. (2017). Extending health insurance to the poor in India: An impact evaluation of Rashtriya Swasthya Bima Yojana Social Science & Medicine, 181, 83-92.

[7] R. Dasgupta et al “. What the Good Doctor Said: A Critical Examination of Design Issues of the RSBY Through Provider Perspectives in Chhattisgarh, India ,” *Social Change* 43, n^o 2 (1 June 2013): 227 – 43 ; ILO, ” Evaluation of RSBY ‘s Key Performance Indicators: A Biennial Study | Microfinance Gateway – CGAP “, July 2014, <https://www.microfinancegateway.org/library/evaluation-rsby%E2%80%99s-key-performance-indicators-biennial-study> .

[8] Excerpt from an interview with one of the private insurers responsible for RSBY in Jharkhand.

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