UPDATE

News and Notes

Privatisation of Medicare: Help from GIC

THE General Insurance Corporation (GIC) has announced the introduction of a medical insurance scheme, named Mediclaim, with effect from November 3. The introduction of medical insurance should ordinarily have been welcomed as an important step towards extending the benefits of modern health care to the mass of the people. However, the scheme announced by GIC through a high-powered advertisement campaign should instead be expected to, and is indeed intended to, give a strong fillip to the privatisation of health care in the country—and this notwithstanding the fact that the GIC itself is a wholly government-owned corporation. In fact, we have here another instance of how the government and public sector organisations closely collaborate with private business for the advancement of the latter's interests.

The manner in which the GIC has chosen to advertise its Mediclaim scheme tells its own tale. The advertisements read very much as if what is being advertised is a sort of lottery: "Claim medical expenses upto Rs 17,600 a year by paying just Rs 250", the GIC proclaims. Also noteworthy is the prominence given in the advertisements to the fact that the premium paid on Mediclaim policies will be deductible from taxable income under section 80D of the Income Tax Act, making it clear that the GIC is aiming the scheme mainly, if not wholly, at income tax payers who constitute some three per cent of the country's population.

In any case, the terms of the Mediclaim scheme are such that there is no possibility of anyone except the very well-off benefiting from it. The GIC is offering five classes of policies. The annual premium on the least-priced two are Rs 250 and Rs 350 and entitle the insured person to claim 80 per cent of the cost of medical treatment in hospitals subject to a maximum of Rs 17,600 and Rs 25,500, respectively. Under these policies the GIC will pay nothing if the medical expenses are not incurred in a hospital but on treatment at home. Then there are three other more expensive classes of policies, costing Rs 600, Rs 840 and Rs 1,300 per annum, which entitle the insured person to reimbursement of hospitalisation expenses upto Rs 37,750, Rs 52,750 and Rs 82,500, respectively; in addition, under these policies medical expenses incurred on treatment at home too will be reimbursed upto Rs 5,250, Rs 7,400 and Rs 11,500, respectively.

At first sight, the premium rates may not appear excessive. The catch lies, however, in the fact that to be meaningful medical insurance must cover the whole family. Taking a family of five members, the two cheapest policies, which cover medical expenses only in case of hospitalisation, will cost Rs 1,125 and Rs 1,575 per annum, respectively (after allowing for the 10 per cent discount which the GIC is offering where one or more dependents are also covered). At the other end, the premium on the more expensive policies, which alone cover the cost of domiciliary hospitalisation, vary between Rs 2,700 and Rs 5,850 per annum—quite large sums even for those in the upper income brackets. No wonder that the GIC has realised that it desperately needs the crutch of tax deductibility of premium payments to be able to sell Mediclaim. Incidentally, by its very nature, private medical insurance of the type being offered by GIC tends to be expensive. As a result, it can be meant only for a small select section of the population. Even in a country like the UK, according to one estimate, whereas nearly a quarter of professionals have private health insurance cover, for semi-skilled and unskilled workers the coverage is less than two per cent.

If, on the one hand, Mediclaim is meant to cater to upper-income income-tax payers, on the other hand, it is intended to cover the cost of medical treatment in the exclusive private hospitals set up as corporate business enterprises, the rapid proliferation of which has been one of the major developments in the area of health care in the country in the last few years. This is evident from the fact that the hospital room charges that Mediclaim allows for are Rs 550 and Rs 350 per day for the two most expensive policies and Rs 250 per day for the remaining three types of policies. Of course, there is in this country a class of people who can without batting an eyelid pay for treatment at the new private hospitals at these or even higher rates. But it is naturally a small class. So if the private sector hospitals are to continue to attract the required large investments and their number is to continue to grow and their profits are to keep rising, the demand for their services needs to be enlarged beyond that provided by the above-mentioned class of the very rich. This is precisely what GIC's Mediclaim scheme aims to do with the direct help of the government in the form of tax exemption for premiums paid under the scheme, which amounts, roughly speaking, to between one-third and one-half of the private hospitals' charges being paid out of the public exchequer in the form of tax revenue forgone. It should by now be clear how

the government and the public sector GIC are aiding the privatisation of medical care in India.

The GIC's Mediclaim scheme is only one of a series of recent moves by the government to help privatisation of medical care. In December last year the Income Tax Act was amended so that reimbursement by employers of medical expenses such as operation fees, hospitalisation charges, cost of medicines and tests, etc, incurred by employees and their families is no longer treated as a perquisite. In other words, the amounts so reimbursed are not now added to the taxable income of the employees. The term 'employees', it has been specifically provided, is to include "managers/directors" (with their families). The Income Tax Act 1961 already permitted government employees to receive such tax-free reimbursement of medical expenses. This benefit has now been extended to those working in the private sector and in public sector undertakings.

The change in the tax treatment of expenditure on medical expenses has to be seen together with some other decisions of the government to appreciate its full import. Under the scheme to encourage non-resident Indians (NRI) to invest in India, hospitals have been included among the areas qualifying for NRI investment upto 74 per cent. Later the definition of hospitals was enlarged to include 'diagnostic centres' as well in order, as the government press note on the subject put it, "to facilitate the inflow of NRI expertise and investment in the area of medical diagnosis through specialised and sophisticated equipment not readily available in India". Apollo Hospitals in Madras was the first to come up in response to the government scheme, as a public limited company with non-resident investment. Others have since followed in its wake.

In addition to these specific measures to facilitate their growth, the government is only too ready to give the private corporate hospitals legitimacy and respectability. For instance, while inaugurating its Diabetes Foundation, the Vice-President of India acclaimed Apollo Hospitals as "the first fully-equipped, corporate, multi-speciality hospital in India" and added, "I have had the privilege of being associated with the development of this unique all-round medicare facility". What followed was even more explicit underwriting of private medical care at the cost of the facilities provided in government hospitals. The Vice-President said that to depend on the government alone for health services would be to reconcile oneself to mediocrity and paucity of such services. In other words, because government health services are of indifferent quality and inadequate, the government needs to support private establishments such as Apollo Hospitals.

This is a piece of deliberate misrepresentation, for the high-cost private sector hospitals with their high-powered doctors, their sophisticated diagnostic machines and therapeutic aids provide an altogether different type of medical care from that provided by the government health services and to an altogether different class of people. Far from making up for the undoubted deficiencies of the public health services, privatisation of medical care with the active support of the government is bound to further distort the priorities of the government's health policies and thereby further choke the flow of resources and qualified medical personnel to the government health services, rendering them even more unequal to the task of providing health care for the mass of the people.

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Legislation of Abortion in Yugoslavia

Yugoslavia is a country where abortion is legal and very simple. It is sufficient that the woman chooses the hospital and the gyneacologist, pays about 50 guilders for the whole treatment including the anesthesia, and she is back home the next day. All this is due to the very good laws and to a struggle that the women of Yugoslavia won fighting against the conservative behaviour and practice. The struggle for various women's rights including the right to decide about her own childbirth, dates in Yugoslavia from the second world war. In 1952 the interruption of pregnancy was legalised but only for medical reasons. The social reasons were accepted too. From 1960-1978 the abortion had to be approved by a commission, instead of the woman herself. Various commissions had different opinions, which made it impossible for women to use their legal rights. Although the commission approved of 97 per cent of the petitions, in order to lessen the tension for women and to liberate them from the haste, and all the waiting in the medical clinics, women still made further efforts to liberalise the law even more.

A new law was passed in 1978 and according to it the decision about childbirth is a personal matter. A part of the law is about contraception: the rights of people to learn about contraception and the planning of the family is acknowledged. Sterilisation is allowed for persons older than 35 or if there are other medical reasons. The main feature of the law about abortion is that every woman has the right to ask for it, that they are safe financially, and institutions are available, which is very important. And that abortion can be refused for medical reasons. The law makes it possible for a woman to have the abortion after a medical examination on her request, till the 10th week of pregnancy. From the 10th to 20th week and later it is possible only if the commission finds it not dangerous for the women's health. Persons under age can also ask for it, but with the agreement of parents or the person responsible.

After bringing up the free law the number of abortions has increased a great deal, which is alarming considering that Yugoslavia has about 22.5 million inhabitants and the number of abortions done annually is about 300,000. There are some parts of Yugoslavia where the number of abortions is larger than the number of births. In Servia there is one birth to 1.4 abortions, in Croatia one birth to 0.75 abortions. And it is still increasing.

In Yugoslavia contraception is not very popular, there are not enough services for it and young people are not well-informed about it. Although the number of services is increasing, only 40 per cent of the women use contraception. A lot of women still use abortion as the only method of contraception together with the traditional methods—39,000 abortions have been done on married women out of 40,000 that were done in Croatia. The figures tell us that the planning of the family is not valued. Sterilisation is very unpopular, men do not ask for it at all.

[Abridged from *Women's Network on Reproductive Rights Newsletter*]

Fifth International Women and Health Meet

WOMEN health activists, researchers, and practitioners form all over the world will gather in San José, Costa Rica next spring for the Fifth International Women and Health Meeting. The Centre Feminista de Informacion y Accion (CEFEMINA) is co-ordinating the planning for the conference, which is scheduled to take place from May 23 to 28, 1987. This marks the first time the meeting will be held in a Third World country; the previous four meetings have been held in European cities.

The conference will focus on five main themes: population policies and reproductive rights; community health; environmental health hazards; drugs; and the health care system. The organisers welcome any suggestions for specific workshops to be organised under these categories as well as general input into the planning of the conference. Meetings will be held in Spanish, French or English, with simultaneous translation available for plenary sessions. Childcare facilities for participants' children will be provided.

The conference organisers also urge women who want to attend to begin fund raising immediately to cover travel costs and expenses. Those who can are encouraged to help raise funds for women who cannot cover their own costs.

Eleven national and international women's organisations, including Isis International and the Latin American and Caribbean Health Network which we co-ordinate, are sponsoring the conference. The others are Peru Mujer, Centro Ecuatoriano para la Promoción y Acción de la Mujer, Women's Global Network on Reproductive Rights, International Baby Food Action Network, Health Action International, SOSHIREN Tokyo, Isis WICCE, Dispensaire des Femmes, and the Boston Women's Health Book Collective.

For further information please write to:
CEFEMINA, Apdo 5355, San Jose 1000, Costa Rica.

Ills of Public Hospitals

Recent events have drawn fresh attention to the atrocious state of public hospitals all over the country. The glycerol tragedy which is unfolding every day in the courts in Bombay can well serve as a case study of the degree of inefficiency in these hospitals. Even more disconcerting is the fact that the doctors and the officials appear to be exhibiting a degree of nonchalance which can only be termed inhuman and callous. Officials have admitted that no action was taken other than issuing a routine alert, and that after a delay, even though several similar deaths had occurred in a single ward; doctors have confessed that they did not deem it important to read circulars marked urgent; and units have been found to have continued to use the same batch of suspect glycerol for 48 hours after an order was issued to impound the batch.

It was around this time that the doctors at KEM hospital in Bombay went on unique strike with the sole objective of highlighting the utter lack of adequate and necessary facilities in the hospital. And what they had to tell the patients was indeed a revelation—sub-standard equipment, operating theatres with fungus growth on the walls, machines sitting idle for want of simple repairs, shortages of drugs, and so on.

However, all this attention on the inefficiencies of public hospitals has given rise to a feeling that the only choice then is to make use of private practice facilities, even if one has to foot the fabulous bills later on. In fact, state governments, like Uttar Pradesh have already set in motion, plans to hand over rural health care to private sector.

There cannot be a more mistaken notion than this. The roots of the malady in public hospitals probably lie in the proliferation of private practice and private hospitals. And it is these hospitals which have received enormous support and patronage from the government even as the government-run institutions have lacked both finance and other support. There is need to look more closely and critically at the relationship between the private and public institutions. Today the state is openly admitting its inability to provide welfare services such as health and seeking to move its responsibility to the private and voluntary agencies. Can the government abdicate its responsibility to provide 'welfare'—even if it is rudimentary? Have we as health activists been altogether more concerned about evolving alternatives than with pressurising the government to be accountable?

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