Sustainable Financing and Provision of Healthcare by the Government for its Employees and Pensioners

The West Bengal Health Scheme Story

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The Man Who Ignited the Spark

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How the WBHS was conceived

- The majority of government hospitals were over-worked and understaffed
- Modern treatment modalities for critical illnesses were not available in most of these hospitals.
- There were internationally reputed hospitals like AIIMS, NIMHANS, LVP Eye Hospital, Asian Liver Foundation, Tata Memorial Centre where the employees wanted to visit but could not easily go
- The majority of government employees could not afford expensive treatment in the private hospitals or even in the government hospitals
- So, treatment was available, but government employees could not access them
- Reimbursements for treatment taken was difficult and time consuming as they would be centrally processed at the Finance Department

The Workings of the WBHS

The Hospitals	The Beneficiary	The Health Scheme Authority
• Their Empanelment • Their reimbursements	• The Enrolment • Obtaining Treatment • Their reimbursement	• Administration • Interface with the Health Dept • Interface with the Finance Dept

The Essential Features
For hospitals

- Majority hospitals seeking empanelment were empanelled
- Hospitals were classified into Class A, Class B, Class C and non-empanelled
- The reimbursement was based on the class: 100% for Class A, 80% for Class B, 70% for Class C and 60% for non-empanelled
- The empanelment of hospitals was done by the Health Department using an assessment checklist
- Each empanelled hospital had an unique id number.
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The Essential Features For Employees

- Reimbursement of the cost of all indoor treatment in empanelled hospitals within the state of West Bengal
- The cost of OPD treatment for 15 diseases as specified
- Treatment could also be availed in 10 enlisted hospitals outside West Bengal.
- Claim of only indoor treatment in non-empanelled hospitals within the state
- In 2014, the name of scheme was changed to “West Bengal Health for All Employees and Pensioners Cashless Medical Treatment Scheme 2014” and introduced Cashless Medical Facilities up to ₹ 1 lakh per indoor treatment episode
- For treatment beyond Rs 1 lakh, the DDO of the concerned employee would make the reimbursements
- All employees and pensioners were covered by this scheme, only the pensioner would not be able to draw an advance.

The Essential Features For Employees

- There was no limit to the number of beneficiaries of the employee
- The parents of a female employee were covered
- All diseases were covered including congenital diseases, pregnancy and pre-existing diseases. Only injuries due to intoxications were excluded.
- There was no upper capping of the limit of the reimbursement of the scheme
  - Any beneficiary could be admitted for treatment any number of times
  - Any beneficiary could be admitted for a disease with no upper limit of reimbursement
- For visits to hospitals outside the state, cost of travel as per the entitlement of the employee and one companion was allowed.

The Health Scheme Authority

- Six members- five from Finance Dept, 1 from the Health Dept
- The Health Scheme Authority was vested with the authority to monitor this scheme
- There was linkage with the Clinical Establishment Branch and the West Bengal Medical Council
- Meetings were held every Friday
- Decisions taken were prompt

The Working of the Scheme-Decentralisation

- Being employee friendly was the main intention of the scheme. Employees did not have to run around for treatment and reimbursements
- As the reimbursement was granted by his own Head of Office it was expected that his Head of Office would be sympathetic to him and reimbursements would not be delayed.
- His Head of Office could sanction up to Rs 25,000, his Director up to Rs 50,000 and the Principal Secretary of his department up to any amount
- All payments for reimbursement was processed through his own DDO

The Working of the Scheme

- The patient went to a hospital for treatment- walk in with no prior permissions. Permission was required for availing treatment in out of state institutions.
- Either the beneficiary was advised immediate admission in an emergency or advised tests and further evaluation for admission
- In case of admission, the employee or his relatives had to inform his Head of Office of his admission within 48 hours
- If needed he could take an advance up to 80% of the treatment advised, from his office. Advance was to be provided within 48 hours of the demand placed
- Each disease, investigation and procedure had a unique code number that had to be noted while claiming the reimbursements

The Working of the Scheme

- From the advance received, the bills were to be paid at the time of the patient's discharge
- The reimbursement process was made very simple
  - The employee had to provide the following documents
    - Intimation to his Head of Office within 48 hours of admission
    - The treatment received with unique id certified by the treating doctor in a specified form
    - The details of the treatment received with unique id inclusive of all the bills in a specified form
    - The unique id of the hospital to be provided
    - The bills were to be submitted within 6 months of receiving the treatment
- Reimbursement was also given for the tests and medicines taken 30 days before admission and 30 days after discharge from hospital
- If the bills were large and the patient could not pay, the bills were to be submitted to the WBHS Authority and centrally payment would be processed. No hold up of the patient or the dead body was allowed

The Financials

- In the majority of the schemes of the government, the rates fixed are not viable for the hospitals and they soon stop working for the scheme or provide low quality care.
- No hospital surveyed had any inkling as to the actual costs of treatment. All took costs based on what the other hospitals billed their patients
- Costs were made based on two major criteria
  - Where the patient could be put under a package- most of the surgical cases came under this category. Additional conditions were added whenever the demand arose.
  - Where the patient could not be placed under any package- the bed rates, the procedure rates, the investigation charges and the doctor fees were fixed and the package was created. The cost of the medicines and consumables was to be added
  - If the patient was put for a treatment which did not have any rate, the hospital rate was allowable till the time a rate was fixed by the WBHS Authority

The Financials

- A very simple technique was used to calculate the different rates
  - The rates were collected from 6 or more reputed hospitals and diagnostics centres of Kolkata
  - The median rate was calculated, to rule out outliers
  - 30% of the median rate thus obtained was discounted as the patient would be paying upfront and the patient was a walk-in
  - In case of cardiac surgery, uro-surgery, neuro-surgery and orthopaedic surgery, the costs were taken from reputed practitioners
- Hospitals were happy with the rates and the costs were significantly low, though not non-viable

Preventing Misuse- from Employees

- One month cooling period after enrolment, but this could not be completely ruled out
- The GPF number of an employee was his unique id /1 as all the employees have this. His family was given the number as wife /2, children /3 and so on.
- Enrolment was done by the Head of Office of an employee so that it was quick and the details were authentic. In any discrepancy, the Head of Office was held personally responsible for fraud.
- The system of reimbursement was used to ensure employees went through their bills and disputed any unwanted inclusions

Preventing Misuse- from Employees

- The Treasury Officers put in the data on their system during the payment of the reimbursement where the id of the beneficiary, the amount reimbursed, the code number of the disease and the id of the hospital was entered.
- Flags were raised if any beneficiary had more than 2 reimbursements in a month from the same hospital or beneficiary from one family. Unusual diseases were also scrutinised.
- The reimbursements of over Rs 5 lakhs were scrutinized from the backend and the actual bills in hard copy was requested from the hospital, if required.
- Every month data was collected from the backend of each hospital about the number of beneficiaries treated, the total reimbursements and the type of cases reimbursed.
- Any discrepancy was brought to the notice of the Health Scheme Authority and immediately action was taken

Preventing Misuse-from Healthcare Providers

- Majority of the Healthcare Providers accepted the scheme without any difficulty as they were getting the payments without any problem and the rates were remunerative
- In a very few cases, the greatest challenge was innovative methods that were used by doctors to artificially increase the reimbursements. The CEOs of the hospitals were called to ensure that processes were strictly followed.
  - Clubbing of different clinical processes- for the second condition 60% was allowed, none for the rest
  - Use of expensive antibiotics- Any antibiotic costing more than Rs 10,000 per day had to be certified by the physician and the hospital microbiologist that it was essential for the patient
  - Use of costly medicines- Any treatment costing more than Rs 25, 000 per day had to be certified by the physician and the CEO of the hospital that it was essential for the patient

Preventing Misuse-from Healthcare Providers

- Use of anti cancer drugs- Any treatment costing more than Rs 5,000 per dose had to be certified by the treating doctor and the CEO of the hospital that it would prolong the life of the patient by at least 6 months and provide him with a better quality of life
- Use of stents- Any use of more than 1 drug eluting stent should be certified by the cardiologist and the cardiac surgeon of the hospital that more than 1 stent was a medical requirement for the patient
- Use of double chamber pacemakers, sophisticated hearing aids and others- The treating doctor had to certify that these were medically essential for the patient and no other equipment could be advised.
- All the certificates had to essentially bear the full signature, names and the registration numbers of the physician concerned so that action could be taken in case of falsifying the condition of the patient. Explanations such as physiologically better world not do.

- Complications were there were evidences of medical negligence were not reimbursed
- Random medical audits were done and discrepancies were dealt with strictly
- There were a very few problems in the beginning, but when action was started and CEOs were called and show-caused, the conditions abruptly stopped.

The Costs of Running the Scheme

- The costs involved by the government when it gives one instalment of DA to its employees Rs 6,000 crores.
- Mr Samar Ghosh told me that consider the employees are being paid one extra instalment of DA so that they can sleep better at night without worrying for their families health and treatment costs
- The initial estimated cost per year was Rs 300 crores that was 5% of the cost of a DA instalment
- Employees have to forego Rs 300 per month i.e. Rs 3600 every year to be able to ensure the treatment of themselves and their dependents in the best of hospitals in West Bengal and India

The Data Obtained

- More than 4 lakhs employees enrolled now
  - Recovery from the employees Rs 144 cores
- Beneficiary Pool- about 12 lakhs @ 3 beneficiaries per employee
- Expenditure- About 72 % under the cashless scheme i.e. less than Rs 1 lakh reimbursements.
  - Total reimbursement for all cases was Rs 200 crores during 2018-19
  - It was Rs 182 crores in 2017-18
  - Government has to pay additionally about Rs 50 crores now.
  - But revisions for medical allowance are due under the 6^{th} Pay Commission. So the scheme is expected become a cash surplus scheme in future once the medical allowance is increased.

Experiences While Administrating this Scheme

- Positive
  - Many people have got the benefit from this scheme. The number of cases of angioplasties and non-emergency surgeries had shot up during the 1st year
  - A number of cases of cancer, renal disease and organ transplantation had got the benefit
  - Hospitals were happy as they were getting patients. E.g. Surgical treatment for parkinsonism, cochlear implants
- Negative
  - The rates have not been enhanced since 2013
  - Decisions have to be taken very quickly, as health care is a matter of life and death

Any Questions, please


THANK YOU
Very
Much!