Creating Womb-less Generations: Whose Gain and At What Cost?

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Abstract

Several developing countries are using state-funded community based health insurance schemes to alleviate catastrophic health expenditure amongst the poor. However, there is now some documentation of the unforeseen consequences of such interventions. One example is the rise of potentially unnecessary hysterectomies being conducted by private health care providers (HCPs) following initiation of these state-funded insurance schemes in India. Using this example, we discuss the policy issues and ethical dilemmas that arise from the perspective of end-users, policymakers and Health Care Providers (HCPs). The provision of 'free services' increased the rates of hysterectomies, but this increase is amongst a much younger age group and more among women from rural areas, especially in private hospitals.

Hysterectomies make an interesting case for looking at ethical dilemmas and policy-related issues. The existing regulatory bodies in India have mostly been unable to regulate and monitor health care practices. More in-depth studies to create an evidence base on the prevalence of hysterectomies is essential. The ethics of spending public resources on tertiary services at the cost of primary and secondary care need to be reconsidered. These case studies could provide insights for countries that plan on setting-up similar models of public-health-financing for secondary and tertiary care.

Introduction

Several developing countries are using state-funded community based health insurance schemes as a means of alleviating catastrophic health

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expenditure amongst the poor.[1,2] However, there is now some documentation of the unforeseen consequences of such interventions. One example is the rise of potentially unnecessary hysterectomies being conducted by private health care providers following initiation of these state-funded insurance schemes for tertiary care services in India. Using this example, we discuss the policy issues and ethical dilemmas that arise from the perspective of end-users, policymakers and health care providers (HCPs).

Hysterectomies, the surgical removal of the uterus, through the National Health Service (NHS) in the UK, has a lifetime prevalence of 12.2% to 19.9%[3], whereas in countries where the provision is mainly through private providers, for example in the USA the lifetime prevalence rate of hysterectomy was 43% in 1985.[4]

In India, although hysterectomy is done at hospitals in the public sector, in many states, much of these services would be sought from the private sector. Realising the burden of catastrophic health expenditure as a result of seeking tertiary health care services, some of the state governments and the federal government in India have launched state-funded schemes, which engage private providers also. The schemes include the Rajiv Aarogyasri Scheme (RAS) in Andhra Pradesh (AP) and Telangana, the Vajpayee Health Insurance Scheme in Karnataka and the Rashtriya Swasthya Bima Yojna (RSBY) (a national programme). Most of these programmes have been initiated since 2007 onwards, the first one being the RAS in united Andhra Pradesh. These are community health insurance schemes, wherein the government bears the insurance premium, and all Below Poverty Line (BPL) cardholders are eligible for free secondary and tertiary care service (on select procedures), through a network of public and private empanelled hospitals. The HCP gets a fixed cost for conducting these procedures. The provision of 'free services' increased the rates of hysterectomies, as would be expected. For instance, the figures from Panchkula district of Haryana possibly reflects baseline rates of hysterectomies which were in the range of 4 to 6 percent as compared to 10 – 20 percent among many Western Countries.[5] With the

introduction of community-based / government-funded health insurance schemes in many states in India, the hysterectomy rates have increased. Desai S. et al., in a cross-sectional survey in Gujarat, India (2010), showed that 9.8% rural and 5.3% urban insured women (who had insurance as part of a community-based health insurance scheme) had undergone hysterectomies, as compared to 7.2% and 4.0% respectively of uninsured women.[6]

According to Prusty et al., one-third of hysterectomized women were below the age of 40 years, and this proportion was higher in the Southern states of Andhra Pradesh (42%) and Telangana (47%).[7] In fact, these were the states wherein the Rajiv Aarogyasri Scheme (RAS), the first Community Based Health Insurance Scheme was launched and implemented.

Although it can be argued that, the excess number of surgeries under the government-funded Schemes, is a result of a long-pending backlog of those who could not afford surgeries, related relevant information, suggests otherwise: the age group at which hysterectomies are generally done, as per the previously available literature, is among women aged 45 years and above.[5, 8] This is in stark contrast to the current trend wherein a majority of the hysterectomies are performed on women aged less than 35 years, and most of these are done as elective surgeries.[9]

The schemes mentioned above (RAS, Vajpayee Aarogyasri Scheme and RSBY), which were introduced with a righteous intention of reducing catastrophic health expenditure resulting from the tertiary level of care for illnesses among BPL people, are facing criticism for these very reasons. Studies are documenting increased rates of hysterectomies under the Scheme, at a much younger age group and more among women from rural areas, especially in private hospitals. There has been a spate of news reports in the print and electronic media highlighting this issue, across India.[10 – 14] In an environment of inadequate monitoring and regulatory framework, the chances of misuse through the creation of supplier induced demand for profit maximisation remains high.

Policy Context:

We have elaborated the context, content, process and actors using **Walt and Gilson's (1994)** Policy Analysis Triangle Framework.[15]

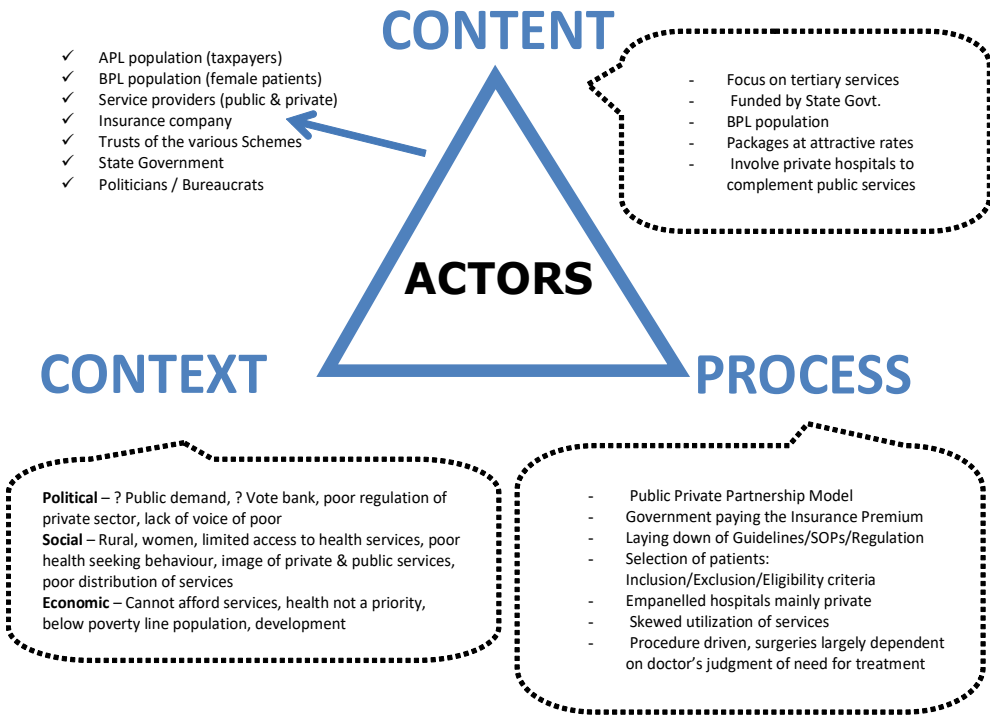


Figure1. Policy Analysis Triangle: Government-funded Health Insurance Schemes and Hysterectomies. Walt and Gilson (1994)

Legend:

APL population: Above Poverty Line population

BPL population: Below Poverty Line population

SOPs: Standard Operating Procedures

The Content, Context, Process and Actors have been culled out from various policy documents, newspaper reports and personal interactions with end-users. Some of the processes mentioned above, i.e. inclusion, exclusion and eligibility criteria for hysterectomies, standard operating procedures

(SOPs), guidelines, regulations and monitoring aspects are not clearly defined. Some of the processes involved too, raise serious ethical concerns. Walt and Gilson argue that much health policy wrongly focuses attention on the content of the reform and neglects the Actors involved, the Processes contingent on developing and implementing change and the context within which policy is developed.[15] In fact, an important factor for poor implementation of some of the schemes may be attributed to, not so clearly developed SOPs and guidelines and a lack of stringent monitoring. Hysterectomies make an interesting case for looking at ethical dilemmas and certain policy-related issues, as they provide a situation where the answers are not so simple and straight forward.

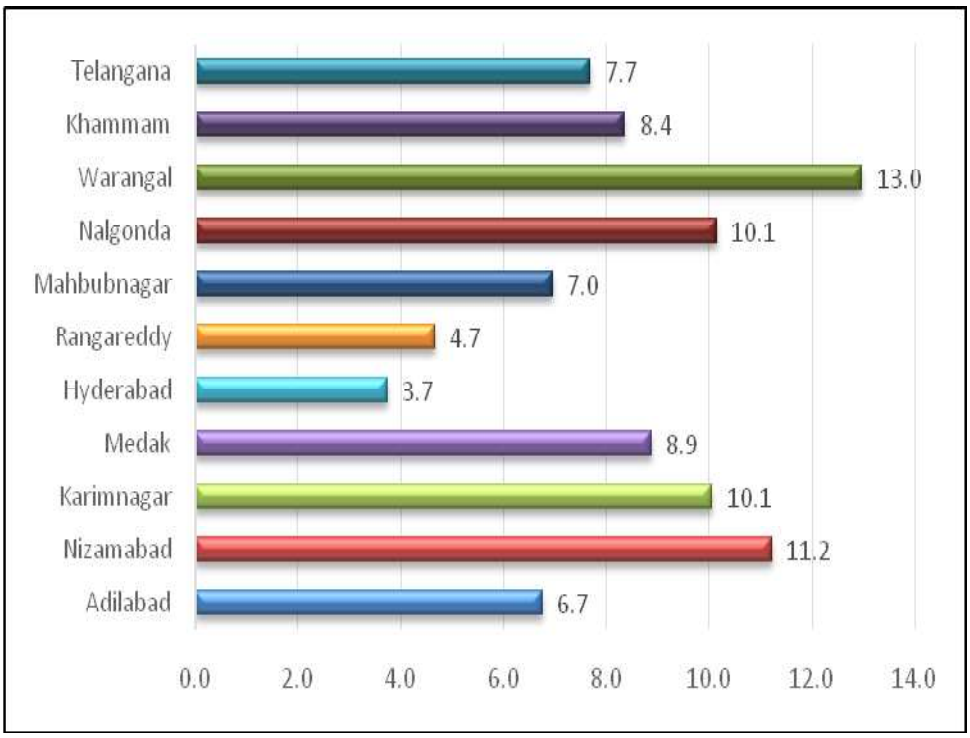
Data and Methods:

NFHS-4 provides data for the 10 districts in Telangana and these were the districts present when Telangana was carved out of the erstwhile united Andhra Pradesh state. We looked at health insurance coverage amongst women in the 15-49 years age group and prevalence of hysterectomies as per NFHS-4 (2015 – 16) data for Telangana. NFHS-4 collected data pertaining to reproductive and child health from 7,567 women in the 15-49 years age group. For the first time in the history of NFHS, district-level analysis is made possible in NFHS-4. A detailed methodology and research design used in NFHS-4 is available elsewhere.[16] We used Chi-Square test and logistic regression techniques to analyse the data, apart from creating univariate and bivariate tables.

Results from the NFHS-4 data:

NFHS-4 data shows that around 55.9% of the above population in Telangana had community-based health insurance, and 4.5% of the population had other forms of insurance. In comparison, 39.6% of women did not have any insurance. The districts of Mahbubnagar (72.2%), Warangal (71.2%), Nalgonda (66.8%), Khammam (63.4%) and Nizamabad (59.3%) had the highest coverage of community-based health insurance for the 15-49 year age group women.

Figure 2: District wise Prevalence of Hysterectomies in Telangana



The districts of Warangal, Nalgonda, Karimnagar, Khammam, Medak and Nizamabad had a significantly higher prevalence of hysterectomies as compared to other districts and also higher than the state average of 7.7%.

Cross-tabulation of district wise prevalence of hysterectomy among 15 – 49 year age group women by health insurance coverage in the ten districts of Telangana showed a significant relationship.

It is evident from Table 1 that the prevalence of hysterectomy varied across districts and was related to health insurance coverage. Chi-square test shows that the prevalence of hysterectomy was significantly different by coverage of health insurance in the districts of Warangal, Nalgonda, Hyderabad, Rangareddy, Mahbubnagar and Karimnagar. The difference in hysterectomy prevalence by health insurance was evident even for the state of Telangana as a whole.

Table 1: Prevalence of Hysterectomy among 15 – 49 years age group women by Health Insurance Coverage in Telangana

District in Telangana	Hysterectomy Prevalence			Total	Chi² Value
	No Health Insurance	Community Based Health Insurance	Other Insurance		
Adilabad	5.5%	7.7%	9.9%	6.7%	0.977
Nizamabad	11.2%	11.5%	4.7%	11.2%	0.859
Karimnagar	7.0%	12.0%	20.4%	10.1%	6.067*
Medak	7.4%	9.5%	11.5%	8.9%	0.44
Hyderabad	1.5%	6.0%	8.3%	3.7%	8.614*
Rangareddy	3.3%	4.7%	10.9%	4.7%	8.558*
Mahbubnagar	3.1%	8.3%	13.9%	7.0%	7.488*
Nalgonda	5.1%	12.8%		10.1%	12.043**
Warangal	2.7%	16.7%	12.0%	13.0%	22.92***
Khammam	7.3%	9.1%	3.3%	8.4%	1.594
Total	4.6%	9.7%	9.7%	7.7%	50.41***

*p < 0.05; **p < 0.01; ***p < 0.001

Table 2: Odds ratio from logistic regression with the prevalence of hysterectomy as the dependent variable and coverage of health insurance as a covariate with and without adjusting for other background variables.

	Health Insurance	
	Not covered (Reference category)	Covered
Unadjusted OR	1.0	1.95***
Adjusted OR #	1.0	1.66**

A logistic regression with hysterectomy (0=Hysterectomy not done; 1=Hysterectomy done) as dependent variable and availability of health insurance as a covariate showed that there is a 95 % higher chances of hysterectomy being done if there is health insurance coverage and the difference is statistically significant with 99.9% confidence. After adjusting for background variables such as place of residence, age, education, availability of toilets, electrification of household, religion, number of household members and wealth index also, there was a statistically significant association between health insurance coverage and hysterectomy with a 66 percent higher chance of hysterectomy for those women who are covered by health insurance, which was also statistically significant.

Discussion

Hysterectomies: Whose Gain and at what cost?

Health Care Provider (HCP) – Patient Relationship

The Win-Win situation: From the patient's perspective, one could argue that it is the right of a woman to get rid of an organ that is giving her some discomfort, the utility of which is complete as far as she is concerned. The possibility of achieving this without impoverishing her family is an additional bonus. To the surgeon/gynaecologist (HCP) performing a surgery on which they are assured of the payment seems to be a win-win situation to both parties, at least to begin with!

Information asymmetry: is one of the reasons cited for market failure in health.[17] A patient presenting with uterine bleeding or some other symptom is often unaware of the underlying aetiology, pathology and prognosis. This lack of awareness creates information asymmetry, which one hopes is bridged by the doctor to some extent. In reality on the doctor's part, many a time, little information exchange happens due to reasons such as lack of time, provider insensitivity to the ethics involved, an assumption of illiteracy or inadequate education and thus a waste of time to explain. Hence therapeutic decision making hardly considers the patient's views and is often the doctor's alone.

Many a time, a decision to perform or not to perform a surgery is primarily taken by the HCP. Also, the fact that a patient has approached a particular HCP, s/he has done so, with utmost faith in the HCP is quite natural.

Right to sufficient information and the right to make an informed choice – the patient needs to have adequate knowledge about available alternatives for surgery -the conservative line of management instead of resorting to hysterectomy in the first place and side effects and long term implications of a hysterectomy, before making a decision. It is essential that a beneficiary gets all the necessary and relevant information and also has the total freedom to make her/his individual choice. The decision, whether to retain or get rid of the uterus, should be an informed choice of the woman, which, in many instances, does not happen.

Policy Maker (politician/bureaucrat) perspective: introduction of newer schemes/ programmes potentially offers short term solutions. But in a setting with inadequate or no research, monitoring, evaluation or assessment, the populace remains uninformed about the problems that were created in this process and what long term issues were worsened in the quest for short term solutions.

The fact that many women in India get married at younger ages and complete families in their twenties could be contributory to hysterectomy decisions being made at early ages. However, cases cited in news reports often mention that women who have undergone hysterectomy through these schemes are severely 'debilitated' and unable to return to their previous jobs, thus losing their ability to earn their livelihoods. Why a hysterectomy should result in such disability and morbidity is unclear and needs to be explored further.

Rajiv Aarogyasri Trust (the Trust managing the RAS) in AP, having noticed this trend, has restricted a set of procedures, including hysterectomies to be conducted only in Government Hospitals empanelled in the Scheme and not the private hospitals. This was implemented in the RAS in AP since 2011.

Tertiary Health Care at the cost of Primary Health Care?

In a larger policy perspective, the world over, it has been argued that, unless we strengthen Primary Care, there is no major incremental benefit by just making provision for tertiary care facilities.[18, 19] The underlying assumption in launching many of these Schemes in India, wherein, tertiary care is being provided free of cost and a significant chunk of the budget being allocated, is the assumption that primary and secondary care (including obstetric care) is already being fully extended to the BPL population and is universally available. But this is far from the truth. The public healthcare system in rural areas is reported in the Eleventh Five-Year Plan to be in 'shambles'.[20] Hence it needs to be ascertained if this expenditure on tertiary care is at the expense of Primary care. The WHO Report 2008, highlighted the potential of primary prevention and health promotion in reducing the global disease burden by up to 70%.[21] The need for tertiary health care could be reduced if primary and secondary prevention is strengthened, and social determinants of health are tackled. In India's federal structure wherein state governments develop their health policies and budgets, with central financial support, this becomes even more relevant.

Conclusion

There are no effective regulatory bodies that set standards or monitor and evaluate health care practices in India. The existing regulatory bodies, such as the Medical Councils and Medical Associations have mostly been unable to regulate and monitor health care practices.

These need to be debated and addressed to ensure that the schemes are sustainable and the right beneficiary gets the right choice of treatment. More in-depth quantitative and qualitative studies in this area to create an evidence base on the prevalence of hysterectomies is essential. The ethics of spending public resources on tertiary services at the cost of primary and

secondary care need to be reconsidered. These case studies from India could provide insights for countries that plan on setting up similar models of public health financing for secondary and tertiary care.

References

1. Carrin G., Waelkens M-P., Criel B. Community-based health insurance in developing countries: a study of its contribution to the performance of health financing systems; Tropical Medicine and International Health, Vol. 10, No. 8, p 799 – 811, August 2005. Available at: http://www.who.int/health_financing/documents/tmi-community_insurance.pdf, last accessed on 13.05.2013.

2. Ranson M. K., Reduction of catastrophic health care expenditure by a community-based health insurance scheme in Gujarat, India. Bulletin of the World Health Organization, 80, 613 – 621. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2567585/pdf/12219151.pdf, last accessed on 13.05.2013.

3. Redburn J. C. and Murphy M.F.G., Hysterectomy prevalence and adjusted cervical and uterine cancer rates in England and Wales. British Journal of Obstetrics and Gynaecology, April 2001, Vol. 108, p. 388 – 395. Available at:http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2001.00098.x/pdf last accessed on 13.05.2013.

4. Pokras R, Hufnagel V. G. Hysterectomies in the United States. Vital Health Stat 1987; 13 (92): 1 – 32.

5. Singh A. and Arora A. K., Why hysterectomy rate are low in India, Indian Journal of Community Medicine, July 2008, Vol. 33, Issue 3, p 196-7. Available at: www.ijcm.org.in; last accessed on 13.05.2013.

6. Desai S., Sinha T. and Mahal A., Prevalence of hysterectomy among rural and urban women with and without health insurance in Gujarat, India. Reproductive Health Matters, 2011; 19 (37): 42 – 51.

7. Prusty R. K., Choitani C. and Gupta S. D., Predictors of hysterectomy among married women 15 – 49 years in India. Reproductive Health, 2018. 15:3; DOI 10.1186/s12978-017-0445-8.

8. Centres for Disease Control and Prevention 2004. Fact Sheet: Hysterectomy in the United States, 2000 – 2004. http://www.cdc.gov/reproductivehealth/womensrh/00-04-FS_Hysterectomy.htm. Content source: Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion.

9. Varshney V., Gupta A., Pallavi A., Universal Health Scare, Issue date: September 30, 2012; available at http://www.downtoearth.org.in/content/universal-health-scare. Last accessed on 13.05.2013.

10. Kaisar, E., Chattisgarh doctors remove wombs to claim insurance, in Hindustan Times. 2012: Raipur.

11. Deepak T., Medical rip-off: Doctors rob 6,000 women of their wombs to claim insurance benefits, in The Week, Independence Day Special, August 19, 2012.

12. Yogesh J., Raman K., Diagnosis of a prolapse, in The Hindu. 2012.

13. Bhardwaj, A., How surgical fraud counts vary, in Indian Express. 2012: Dhamtari, Raipur, Gariaband.

14. BBC World Service, Rajasthan, The Indian women pushed into hysterectomies, February 6 2013; by Jill McGivering. Available at: http://www.bbc.co.uk/news/magazine-21297606; last accessed on: 13.05.2013.

15. Walt G. and Gilson L., Reforming the health sector in developing countries: the central role of policy analysis. Health Policy and Planning; 9 (4): 353 – 370. Oxford University Press 1994.

16. National Family Health Survey (NFHS-4), 2015-16: India. Mumbai: IIPS.

17. Introduction to health economics, 2nd edition; edited by Guinness L. and Wiseman V; Open University Press, McGraw Hill Education; eISBN: 978-0-33-524357-0.

18. Wanless D. Securing our future health: Taking a long term view. Final report. London: HM Treasury; 2002.

19. Wanless D. Securing good health for the whole population: Final report. London: Her Majesty' s Stationary Office (HMSO); 2004: 14.

20. Planning Commission, Government of India. Eleventh Five Year Plan (2007 – 2012), Vol. II, Social Sector. New Delhi: Oxford University Press; 2008.

21. World Health Organization. Primary health care (now more than ever) – The World Health Report 2008. Geneva: WHO; 2008.