

Unwanted Hysterectomies in India: Paid by Public Insurance Schemes

Dr Venkat Pulla[†]

More than 22,000 Indian women aged between 15 and 49, out of 700,000 surveyed women early this year underwent a hysterectomy. This is confirmed by Nationwide Government data published in January 2018. Most of these women are illiterate, and over two-thirds of these surgeries are performed in the private sector. In previous writings, campaigners' wrote about the greed of private doctors in India (Mamidi & Pulla, 2013). Blatant patriarchal values and gender bias has not reduced an iota in the last six decades of social welfare and planning in India. The incidence of violation of women's human rights in general and in particular sexual and reproductive health rights (SRHR) by different sections of the Indian society is on the increase. Unlike in the West —where hysterectomy numbers spike post-menopause, in India, younger women are being forced to undergo the procedure (Roli, 2018). Narendra Gupta, a public health expert who campaigned for the government to conduct the survey, has filed a case in India's highest court in 2013 to win compensation for hundreds of women who underwent surgery unnecessarily in private hospitals seeking to claim from a national insurance scheme. The case is ongoing. The problem is widespread. The survey found that the southern state of Telangana had one of the highest hysterectomy prevalence rates. 'In Telangana, the most vulnerable and tribal women have been victimised' (2018) as per Bharath Bhushan, the founder of the Centre for Action Research and People's Development. This civil society organisation was the first to find hundreds of tribal women in the state, who had undergone

operations 12 years ago. Most women who had experienced the procedure were seeking treatment for only minor ailments. A woman cannot bear children after the removal of a uterus, and the process is often accompanied by the removal of ovaries, which some studies have linked to early onset of osteoporosis and other serious side effects.

National Health Protection Scheme of the current government appears to be causing disastrous results concerning public health particularly people from the marginalised communities. Public health system like the Arogyasri, where unnecessary surgeries and cost escalation has been the significant consequence of private players in the provision of healthcare. This is not a reaction to Mr Narendra Modi's new medical insurance schemes recently announced but a comment on the way that the public system medical insurance has become already a racket of unnecessary hysterectomies in Telangana State through the Arogyasri Insurance scheme. An example of the dangers posed by private players in healthcare through diversion of public funds in the name of health insurance. Supporting private corporate hospitals by neglecting public health facilities is a serious concern, however, by introducing public schemes that can be administered by private operators with no creed and ethics, the governments— both central and the state are erring gravely.

Development insurance schemes operated by the government and also administered by the private agencies with the support of the state, safety nets and welfare measures are becoming a severe threat to the human rights as the governance measures are weak in relation to the framework in which the medical fraternity seems to operate its businesses. I do not see India ever reaching the Millennium Development Goals (MDGs), let alone surpassing them.

[†] Joint Editor in Chief, *Space and Culture, India*, & Adjunct Senior Research Fellow, Institute of Land Water and Society, Charles Sturt University, NSW, Australia, Emails: vpulla@csu.edu.au; dr.venkat.pulla@gmail.com

Box 1**Hysterectomy**

Hysterectomy is a major surgical removal of one or several of the organs: cervix, uterus or womb, fallopian tubes and both ovaries. They are defined as 'radical hysterectomy' (removal of the cervix, upper vagina, lymph nodes, ovaries and fallopian tube), 'total hysterectomy' (removal of uterus and cervix with tubes, and ovaries) and 'subtotal hysterectomy' (removal of the uterus leaving the cervix intact).

Fatal and permanent effects:

Hysterectomies result in sudden onset of menopause causing "hormone imbalance" that requires long-term treatment. Removal of ovaries also increases the woman's risk of death by 40 per cent.

Women suffer long-term depression, increased risk of osteoporosis, heart disease, loss of libido, and live with joint pains.

I use here few narratives from my on-going qualitative research project entitled *Hysterectomies in India by Public Insurance Schemes* conducted in Telangana, India. I argue that the narratives from Telangana villages are no different from the rest of India.

I am robbed of my life and my body. I did not know I was buying death. I thought the operation was going to relieve me from regular pain & death from cancer. I am cheated and ruined. I suffer more now, Ms Lakshmi aged 35 (name changed).

They said you have sores on your ulcer. They asked us to come next day. They asked us for money, and we took the money. Along with the uterus, they removed the appendix also. I do not have children, Ms Jyothi, aged 38 (name changed).

The narratives are similar. Women suffering from routine ailments were told that they

would die if they did not go for surgery. The reasons for surgery came from simple complaints of an aching stomach to even presence of a cyst. Menstrual bleeding, complained by 72.94% and or white discharge, stomach pain by (13%), cysts by (4.26%), and other problems (10.12 %) were good enough reasons for the medical fraternity to undertake hysterectomies on these women. In our previous study (Mamidi & Pulla, 2013), we wrote about the incidence of increased domestic violence over marital sex and the increase of extra-marital liaisons of men. 88 women in one village in Telangana have been victims of hysterectomy. Eight women in a hamlet of 13 families of Lambadi *jati* were operated upon. Six women in one family of Lambadis have been hysterectomised. Overall 35.3 per cent of hysterectomised women were Lambada tribal women while other scheduled tribes formed 17 per cent of the total population in the area that I am talking about in this editorial. This reflects that:

Box 2

Gender vulnerability and tribal marginality plus violation of human rights is rampant in Telangana

As mentioned above, most patients were from the Lambada tribal community, poor and illiterate, aged between 20 and 35 years, Dr K R. Antony, former Health & Nutrition specialist for UNICEF remarks that *Question of informed consent* has never given any credence as the majority of women hold low incomes; and they

cannot read or write. Around half of the women (approximately 53 per cent) have 3 to 4 children, 28 per cent have one or two children. The following narratives further reveal the plight of the women undergoing the operation.

My daughter stopped going to school to

help with household chores because I am not able to handle myself, Ms Sita aged 30 (name changed).

What do I do, I do not feel like earlier. And I cannot have a son. He married another woman Ms. Lakshamma aged 37 (name changed).

These findings resonate our previous joint research conducted in 2005 amongst 728 hysterectomised women in Kowdipally Mandal of Medak district (Mamidi & Pulla, 2013). Central to the process of unwanted hysterectomy is the fact that important initiatives of public insurance schemes launched by the Government in 2003, which aims to pay the premium on behalf of the poor households to insurance companies such as the *Rashtriya Bhima Suraksha Yojana* (RSBY) of the Ministry of Labour and Employment,

Government of India and the Rajiv Aarogyasri Community Health Insurance Scheme, popularly known as *Aarogyasri* in Andhra Pradesh. These schemes provide health insurance coverage for below poverty line (BPL) families from ₹30,000 (RSBY) to ₹150,000 (Rajiv *Aarogyasri*) per family per year to cover for illnesses that require hospitalisation. RSBY scheme, implemented across the states, has 75 per cent contribution from the Central Government and 25 per cent from the State Government. These insurance schemes have become the cash cows for unscrupulous medical practitioners. While Figure 1 displays Lambadi women showing their medical reports on hysterectomies, Table 1 is an illustration of the cost of hysterectomies amongst 728 women in Kowdipally Mandal of Medak district (Mamidi & Pulla, 2013).



Figure 1: Lambadi Women Showing their Medical Reports on Hysterectomies
Source: Author

Table 1: Cost of Hysterectomies in Kowdipally Mandal of Medak District

Total Cost of Operation (in ₹)	No. of Respondents	Percentage of Total
1-2500	4	.5
2501-5000	20	2.7
5001-7500	135	18.5
7501-10000	457	62.8
10001-12500	89	12.2
12501-15000	21	2.9
15001-17000	2	.3
Total	728	100.0

Source: Mamidi & Pulla (2013)

While involving insurance companies in increasing access to healthcare for the poor is an alternative model to make health care possible to marginalised populations and is laudable, it is, unfortunately, one of those schemes where there appears to be no checks and balances. *Aarogyasri* has been a subject of several studies (Mamidi & Pulla, 2013; Mathews, 2012; Prasad & Raghavendra, 2012; Shukla et al., 2011; Vijay, 2012; Planning Commission of India, 2011; MHFW, 2005; Nagulapalli & Rokkam, 2013; Kameswari & Vinjamuri, 2013). In Telangana, this scheme is being used by myriads of private hospitals and health care of them cashing on the schemes. Figure 2 paints the distribution of hysterectomised women by age in Kowdipally Mandal of Medak District (Mamidi & Pulla, 2013). The findings of some of the studies are that:

- The High-Level Expert Groups of the government reported that approach of state-sponsored health insurance schemes are entirely focused on hospital networks instead of primary care services;
- The absence of primary care services is leading to inferior health outcomes, and high health care cost inflation (Planning Commission of India, 2011).
- Furthermore, the financial risk protection to the BPL families is not substantial
- These schemes do not cover out-patient expenses, low-cost high-frequency treatments, and purchase of

prescription medicines by the households.

- Market forces in private healthcare are of a severe threat to the safety, right to health, reproductive and sexual health rights.
- Women that spoke to NDTV said that they did not visit the government health care centre, they received no care; instead, they were pushed to private doctors, who performed these unwanted hysterectomies on them (Sudhir, 2010).
- There was little consideration of the terms of consent given that the majority of women were from the lower income group and illiterate.

Even in the western world, people do not rely on private insurance to resolve the problems of financial risk protection for the vulnerable people. In an unregulated provider driven market, in India as of now the fears of abuse are serious since Indian healthcare sector is steeped in corrupt practices and is ethically a weak candidate. MHFW (2005) report notably observed that "the rate of hysterectomies being performed among young women is one example of the absence of ethical standards" (p.54). The MHFW further recommended that if insurance and contracting the private sector are to be the new ways of expanding access and financing health, then it is essential that values of probity, nurturing of informed consumers and wider participation through good governance be ensured. The threat of private healthcare to human rights of this scale is a

new challenge posed to the civil society in India. Campaigns are required not only against hysterectomies but also to stop the abuse of state-sponsored health insurance schemes. The

challenge seems primarily to protect women in poverty from exploitation by the profit-driven private healthcare system which is supported by the state.

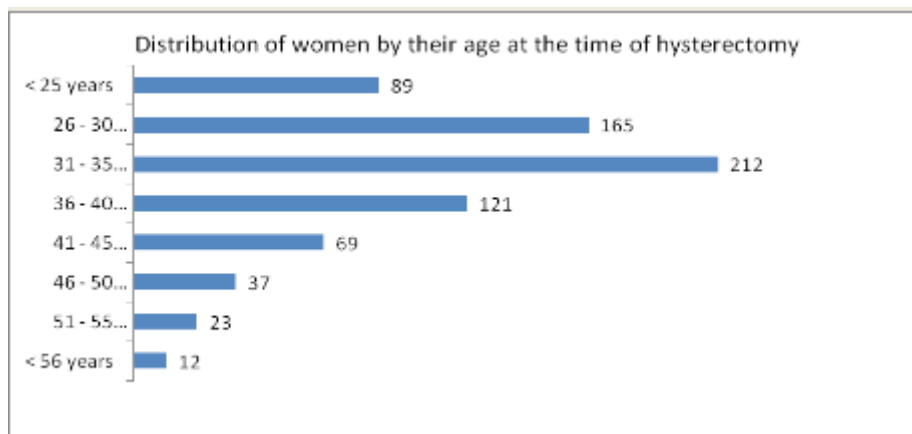


Figure 2: Distribution of Hysterectomised Women by Age in Kowdipally Mandal of Medak District, Source: Mamidi & Pulla (2013)

The discourse on changes today in insurance schemes is limited to specific procedures, coercive surgeries, compensating the victims, and abuses of certain health insurance schemes. The focus is mainly on arresting abuses in government schemes. Accountability of the medical fraternity is a serious matter of concern in a society where doctors are believed as saviours, but in practice are perpetuating morbidity, mortality and exploitation.

Several issues need attention to locate healthcare in human rights perspective and development which is pro-poor. They are:

- Making government responsible for arresting unethical trends of commercialisation of healthcare.
- Making health policy shift from the focus on tertiary care and a network of private hospitals in some towns to primary and secondary care to effective primary and secondary care to prevent poor from becoming seriously ill.
- A responsive policy that allows for programmes that prevent illness, morbidity and mortality on par with global standards, so that right to health and wellbeing is not lost for free and costly surgeries.
- Making informed consent real.

Many questions need to be raised in the context of increasing violation of human rights and more particularly sexual and reproductive health rights of vulnerable women. Patriarchal values at one level and gender bias at the other is pervasive in India. Even after six decades of planned development, the incidence of women's human rights in general and in particular sexual and reproductive health rights (SRHR) are being violated for different motives by different sections of the Indian society. I am not confident that mere tinkering of the situation will help. The current 'development' model in health sector potentially redistributes limited purchasing power, while alienating the poor and kept exploited continuously and victimised by the public-private partnership models with state sponsorship. Further research and interventions in that direction would have significant outcomes in future.

References

- Illegal Hysterectomies (2010, 6 September). TV9, retrieved 30 December 2010 from, <http://www.youtube.com/watch?v=K1LeCwD2PD4>
- Kameswari, S.V., & Vinjamuri, P. (2013). Medical Ethics: A case study of Hysterectomy in Andhra Pradesh, Life - Health Reinforcement Group, Hyderabad, retrieved 12 January 2018 from,

- <http://kicsforum.net/kics/setdev/hysterectomy-ethics-in-S-T-for-setdev-final-1.pdf>
- Mamidi, B.B. & Pulla, V. (2013). Hysterectomies and Violation of Human Rights: Case Study from India, *International Journal of Social Work and Human Services Practice*, 1, 64 – 75, doi: 10.13189/ijrh.2013.010110.
- Mathews, S.M. (2012). A Critical Analysis of Arogyasri Health Insurance Scheme (A Project of Andhra Pradesh State Government), retrieved 25 June 2018 from, <http://sajitsj.blogspot.in/2012/02/critical-analysis-of-arogyasri-health.html>
- Ministry of Health and Family Welfare (MHFW), Government of India (2005). Financing and Delivery of Health Care Services in India- National Commission on Macroeconomics and Health, New Delhi, 54, retrieved 12 January 2018 from, <http://www.who.int/macrohealth/action/Ba ckground%20Papers%20report.pdf>
- Ministry of Health and Family Welfare (MHFW), Government of India (2009). National Health Accounts: India, 2004–05, New Delhi, retrieved 12 January 2018 from, http://planningcommission.nic.in/reports/g enrep/health/National_Health_Account_04_05.pdf
- Nagulapalli, S., & Rokkam, S.R. (2013). An Analysis of Rajiv Arogyasri Community Health Insurance Scheme, AHCT working paper #1, retrieved 10 August 2014 from, http://www.aarogyasri.gov.in/ASRI/EXT_IM AGES/documents/ASRI_Analysis.pdf
- Prasad, N.P., & Raghavendra, P. (2012). Healthcare Models in the Era of Medical Neo-liberalism: A Study of Arogyasri in Andhra Pradesh, *Economic and Political Weekly*, XLVII (43), 118-126
- Planning Commission of India. (2011). High Level Expert Group Report on Universal Health Coverage for India, New Delhi, retrieved 21 April 2012 from, http://planningcommission.nic.in/reports/g enrep/rep_uhc0812.pdf
- Roli, S. (2005, 17 September). Greedy doctors con 600 tribal women into surgery, *Mumbai Mirror*, retrieved 17 September 2005 from <http://www.carped.org/attachments/article /30/Greedydoctors.pdf>
- Roli, S. (2010, 31 July). The Uterus Snatchers of Andhra, *Times of India*, retrieved 28 June 2012 from, http://articles.timesofindia.indiatimes.com/ 2010-07-31/india/28301543_1_hysterectomy-women-in-rural-pockets-doctors-gain
- Satyameva Jayate. (2012, 27 May). Coerced into Hysterectomies. In *Every Life Is Precious- Episode 04: Does Healthcare Need Healing?* *Satyameva Jayate*, retrieved 28 June 2012 from, <http://www.satyamevjayate.in/issue04/vid eos/p4jHKyDTPx8/>
- Shukla, Rajan, Shatrugna, V., & Srivatsan, R. (2011). Aarogyasri Health Care Model: Advantage Private Sector, *Economic & Political Weekly*, XLVI (49), 38-42.
- Sudhir, U. (2010, 27 August). Womb Removal: Andhra's Big Medical Scandal, *NDTV*, retrieved 28 June 2012 from, <http://www.ndtv.com/article/india/womb-removal-andhra-s-big-medical-scandal-47462>
- Vijay, G. (2012). The Business of Health Care and the Challenge of Health Security: The Case of Aarogyasri Health Insurance Programme in Andhra Pradesh. In Kannan, K. P., & Jan Breman (eds.). *The Long Road to Social Security*, OUP: New Delhi.

Acknowledgements

I acknowledge the work of my colleague Bharath Bhushan Mamidi, who continues to campaign and work in the space of gender, poverty and human rights in Telangana, Andhra Pradesh and Odissa. I am also grateful to my colleague, Joint Executive Editor, Dr Rituparna Bhattacharyya for her suggestions and for retyping this out from a Gmail dispatch.