State insurance schemes in Karnataka and users' experiences – Issues and concerns

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Abstract

Background: Karnataka has been a forerunner for state-supported insurance schemes. Today, there exists a multitude of insurance schemes, each designed for different populations or purposes (with some overlap). The objectives for these schemes have been to improve access to health care and to prevent catastrophic health care expenses by providing 'cashless' care. This paper presents an overview of state insurance schemes in Karnataka, including their implementation, state finances and users' experiences with accessing them. Issues and concerns arising from the insurance-model in the context of Universal Access to Health Care (UAHC) are discussed.

Methods: This exploratory study used a variety of methods such as literature review, RTI applications, key informant interviews, group discussions, and a small cross-sectional survey of insurance users.

Conclusions: While the current plethora of state insurance schemes provide some access to care for poor populations, the problems are multi-fold and are weakening the public sector in health care provision.

Background

The landmark Alma Ata Declaration of 1978 proposed the goal of 'Health for All' through Comprehensive Primary Health Care (PHC) to improve population health. Its expression of health care beyond the narrow confines of biomedicine and as a human right based on the principles of social justice and equity placed responsibility on governments to reach the goal of 'Health For All'. This view of health care included preventive and promotive care with a community-centric approach and empowerment of communities through education and participation (Lawn et al 2008). In effect, through the Health for All declaration, Alma Ata called for universal health care. However, structural adjustment programs of the 1990s led to further reduction in health budgets,

imposition of user fees, targeted rather than universal programmes, and increased privatisation and commercialisation (Chan, 2008).

More recently, the WHO Commission on Social Determinants of Health (WHO-CSDH) admitted that increased commercialization has undermined the Primary Health Care approach, and that health care should be considered a common good and not a market commodity. The Commission acknowledged evidence that shows a correlation between increased health spending on private care and a decline in health-adjusted life years, and higher public sector spending on health and social insurance correlating with better health-adjusted life years (WHO - CSDH, 2008).

It is only in the last few years that various middle-income countries are exploring options to move towards universal health care, with the WHO calling for the development of health financing systems to deliver Universal Health Coverage (UHC) in order to reduce catastrophic out-of-pocket expenditures on health care (WHO, 2010). Other terms in use that refer to universal health care include Universal Access to Health Care (UAHC); Universal Health Care; and Universal Health Care Coverage. Disinguishing these terms is beyond the scope of this paper, but it is important to note that there are significant differences in meaning and in political affiliations to them. The word 'coverage' primarily considers financial coverage, without necessarily prioritising equality in access and health systems strengthening in areas of quality of care. Critics of the 'coverage' approach view it as a way to promote the neoliberal purchaser-provider split and move towards greater privatization of care. The 'coverage' discourse absents the rights-based approach that considers health as a social goal (as in the Alma Ata Declaration, where public systems take the central role (Indranil, 2011; Jan Swasthya Abhiyan, 2012)).

This paper uses the phrase Universal Access to Health Care (UAHC), as defined by (Shukla, A. et al, 2011) as a system where the:

> *"Whole population of a country has access to the same range of quality services according to needs and preferences, regardless of income level, social status, gender, caste, religion, urban/rural or geographic residency, social or personal background, which is accessible as per need at all times. Such a system offers a comprehensive range of curative/symptomatic, preventive-promotive and rehabilitative health services at primary, secondary and tertiary levels, including common acute life saving interventions."*

The definition contains the principles of quality and equal access to services regardless of ability to pay, and resonates closely with 'Health for All' in the Alma-Ata Declaration.

Government-sponsored insurance schemes for the poor are in the spotlight today. In 2009-10, 24.3 crore people were covered by ESI (Employee State Insurance), CGHS (Central Government Health Scheme) or the new schemes such as RSBY as well as state-sponsored schemes such as Rajiv Arogyasri (AP), Kalaignar (TN) and Yeshasvini (KA). Since then, these numbers have significantly increased with the expansion of RSBY and the launch of new schemes such as Vajpayee Arogyashree in Karnataka.

The Government of India is deliberating the roadmap towards 'Universal Health Coverage' and the Planning Commission sought to define its contours through the health section of the 12th Five Year Plan report (Planning Commission, 2012). This report proposed a combination of insurance and public-private arrangements to meet the gap in care for the poor. At the same time, both the central and state governments initiated schemes to 'cover' people which involved the private sector in delivering health care, especially to the poor. The southern Indian state of Karnataka has been a forerunner in involving the private sector to provide care for the poor with various forms of reimbursement. It brought out a farmers' cooperative based surgical insurance scheme called Yeshasvini in 2003 (http://www.yeshasvini.kar.nic.in/) which later paved the way for the new generation schemes.

Several reports and papers have examined the various coverage schemes in different states throughout the country. Most look at the particular scheme, such as Chiranjeevi of Gujarat (Acharya & McNamee 2009). Other areas of interest are out-of-pocket expenditure following the introduction of such schemes (Selvaraj, S. & Karan, K.A. 2012), type of care (primary, secondary or tertiary care) covered (Shukla & Shatrughna 2011) and the rise in procedures such as hysterectomies (Oxfam 2013). In Karnataka, one scheme, Rashtriya Swasthya Bhima Yojana (RSBY) has been studied for its implementation and equity in enrollment and use (Aiyar, A. et al 2013). However, little research is available that looks at the mutiple changes within a state in health care coverage and delivery, especially within the context of universal access to health care (UAHC). This paper reports on changes in health sector budget allocation and on the arrangements the government of Karnataka (GoK) has entered into with the private sector in the delivery of health care through government-sponsored insurance schemes. The analysis seeks to answer whether Karnataka is moving towards or away from UAHC.

Setting

The state of Karnataka has a population of 6.11 crores (Census 2011) and is divided into 30 districts. While health indicators such as IMR (38) and MMR (178) are better than national

averages (SRS 2012), there are significant disparities between southern and northern Karnataka. Further, Karnataka fares relatively poorly in health indicators when compared with the other southern states.

In this context, the guidelines, finances and implementation of a few insurance schemes in Karnataka have been studied. A cross-sectional survey of beneficiaries of these schemes was undertaken and is reported later in the paper. The insurance schemes examined in this paper are described in Table 1.

Table 1: Insurance schemes in Karnataka

Name	Type of care covered	Type of coverage / beneficiaries	Administrators and Providers
Yeshasvini	Surgical procedures (secondary & tertiary) and associated consultations, discounted diagnostics	Coverage limit of Rs. 1,25,000 per surgery for members of cooperative societies and their families	Third Party Administrator and empanelled hospitals
Rashtriya Swasthya Bima Yojana (RSBY)	Most diseases and conditions that require hospitalization	Coverage limit of Rs. 30,000 annually for upto 5 members of a BPL family	Third Party Administrators, Insurance Companies and empanelled hospitals
Vajpayee Arogyashree Scheme (VAS)	Tertiary and quarternary surgical procedures	Coverage limit of Rs. 1,50,000 annually for upto 5 members of a BPL family	Autonomous trust set up by Health Department and empanelled hospitals
Thayibhagya	Maternity care	Hospital is provided capitation fee of Rs. 3,00,000 per 100 deliveries for BPL women	Health Department and empanelled hospitals

Methodology

As formative research, the methods used were varied and investigative. Available literature was reviewed, along with a basic review of state policies and schemes using information obtained from government websites. A broad review of the state government's health expenditures was undertaken, along with selected services and/or health institutions in Bangalore city and in Raichur district. Quantitative data regarding the various conditions covered and the amounts reimbursed to the various hospitals was sought through Right to Information applications and collecting information from respective offices. Key informant interviews and group discussions were conducted with

various stakeholders. A snowballing technique was employed to select participants for the interviews.

A small, cross-sectional study was also undertaken in 2012 over the course of approximately six months to document the experiences of insurance users and to obtain self-reported out-of-pocket expenditures in 6 districts - Belgaum, Haveri, Raichur, Davangere, Chitradurga and Chikballapur. The convenience sample resulted in 61 respondents from the 6 districts. This cross-sectional data was collected through the respective district volunteers of the Janaarogya Andolana Karnataka (JAAK), the People's Health Movement chapter in Karnataka. They were trained in using the data collection tool – a structured interview. The data collected was reviewed for inconsistencies and errors and debriefing meetings were held with the data collectors for ensuring integrity of the data. All interviews followed an informed consent process.

Limitations

The majority of officials interviewed were generally not forthcoming with information. The Right to Information applications for the various schemes did not result in the data needed. An RTI application to Yeshasvini Trust for money disbursed and beneficiary information received a response which cited Section 8(1)(j) of the Act (that refers to personal information that has no relationship to any public activity etc.) and "unwarranted invasion of the privacy of the individual beneficiary" to refuse to provide the information, although aggregate data was requested and not individual beneficiary names. Subsequently, a first appeal was filed for the reimbursement data specifying that beneficiary names were not requested. No response has been received to this appeal. Similar responses were obtained from RTI applications for other schemes.

Results

Karnataka Health Budget

The Karnataka State Integrated Health Policy states that *"Equitable proportions of spending will be in the primary, secondary and tertiary levels [of care] (55%, 35% and 10% suggested by National Health Plan – 2002, Government of India) and between rural and urban areas. The Government would seek to implement, to the extent possible, the recommendation contained in the National Health Policy, 2002, to increase the State health allocation to 7% of the total Budget by 2005 and 8% by 2010."* (GoK, 2004)

A recent analysis by the Center for Budget and Policy Studies (CBPS), Bangalore, of Karnataka's health budget shows that overall spending is extremely low (less than 1% of GSDP). The per capita

expenditure of the state health department was Rs 225 in 2008-09. Including other departments that spend on health and the National Rural Health Mission (NRHM) funding, this figure increases to Rs 468 per capita for the same year.

Table 2 shows the budget of the Department of Health and Family Welfare GoK from 2001-02 to 2012-13 and the expenditure under NRHM. State health spending was stagnant during the period of 2001-02 to 2005-06, and increased during the period of 2006 to 2011, just after the launch of NRHM. Although there is an increase in the state health budget in absolute amounts, the increase:

a) does not meet expenditure projections in the State Integrated Health Policy (given above);

b) suggests only a recent recovery to 1990 levels of 1.2% of GSDP (Indira, A & Vyasulu, V, 2001) and

c) remains too low to strengthen public sector health infrastructure and services needed to achieve UAHC (WHO, 2010; HLEG, 2011)

Table 2: State spending on health from 2001-02 to 2012-13

Year	State health budget (in crores)	% of aggregate spending	% of GSDP (at current 2004-05 prices)	NRHM expenditure (in crores)	% of GSDP with NRHM included
2001-02	1085.8	4.9	--	NA	--
2002-03	1004.1	4.2	--	NA	--
2003-04	995.7	3.4	--	NA	--
2004-05	1043.9	3.0	0.63	NA	NA
2005-06	1146.2	3.3	0.59	153.5	0.66
2006-07	1349.6	3.1	0.59	194.3	0.68
2007-08	1832.2	3.8	0.68	275.3	0.78
2008-09	2073.4	3.8	0.67	428.9	0.81
2009-10	2248.1	3.6	0.67	680.6	0.87
2010-11	2796.5	3.9	0.69	752.3	0.87
2011-12 (Revised Estimate)	3328.8	3.9	0.72	434.3 (provisional)	--
2012-13 (Budget Estimate)	4292.7	4.3	0.81	Not available	--

Source: Compiled from Study of State Budgets, Reserve Bank of India (2001 to 2013), Directorate of Economics & Statistics of respective State Governments, Central Statistics Office, Budget Documents of the State Governments , State Finance Accounts and MIS, NRHM (up to 31-03-2012)

The expenditure under different budget heads in the 2011-12 revised budget is shown in Table 3. Medical education, research and training which mainly include tertiary health services, account for 22.11% of the budget, much higher than the 10% given in the Karnataka State Integrated Health Policy. This does not include the funding for tertiary care health insurance schemes such as Vajpayee Arogyashree, or tertiary care institutions under the Dept. of Health and Family Welfare. Taken together, this clearly shows a bias towards tertiary care beyond stated policy targets.

Table 3: Expenditure in 2011-12 revised budget (in lakhs)

Category	Urban health services	Rural health services	Medical Education, research & training	Public Health	General & Other
Amount	56489	20231	73616	15629	166915

Rashtriya Swasthya Bima Yojana (RSBY)

RSBY was launched in 2008 by the Ministry of Labour and Employment, Government of India, to *"provide protection to BPL households from financial liabilities arising out of health shocks that involve hospitalization"* (up to 5 members in a household; coverage up to Rs. 30,000/- per year) for many but not all of the diseases that require hospitalization. The beneficiaries pay Rs. 30/- per year, while a premium is paid by the Central and State governments (85:15 split) to the insurance companies (largely private ones). Insurance companies are selected by the State government on the basis of competitive bidding – the Insurance Company that offers the lowest premium per family is selected (RSBY website).

Empanelment of public and private health care providers is done on the basis of prescribed criteria and efforts are made to reduce travel for the patient. The enrolled beneficiaries get a "Smart Card", which contains biometric data and can be in all the empaneled hospitals by special readers installed. The smart card is portable and can be used in any RSBY empaneled hospital across India. All empaneled hospitals have to be IT-enabled and connect to a district-level server. The entire process is designed to be paperless. Hospital staff select the packages from a list, which results in information being sent to the Third Party Administrator (TPA). The TPA compiles the information and sends it to the Insurance Company. Claims are supposed to be settled within 21 days[1].

In Karnataka, when RSBY was launched, a 'turf war' arose between different government departments. The Health Department was interested in launching its own insurance for the poor, Vajpayee Arogyashree. Eventually, officials decided to implement Vajpayee Arogyashree in the northern districts and RSBY in five districts in other parts of the state (Rajesekhar et al., 2011). In 2012, however, RSBY was extended to all districts of Karnataka.

Although awareness of RSBY was high at 85% among the eligible households in the sample, enrolment was 68%, with the most common problems including delays of several months in issuing smart cards; poor knowledge of how and where to utilise the scheme and therefore access services; lack of training for the hospital staff on how to use the smart card technology; and month-long delays as well as arbitrary caps in reimbursing hospitals for treatment expenses (Rajesekhar et al., 2011).

RSBY Karnataka

Karnataka enrolment data on the RSBY website (accessed 10.02.2013) showed that out of 40,76,642 eligible families, 16,80,913 families were enrolled. The premiums charged to the

1 Interview with Insurance Company representative

government range from Rs. 360 for Bangalore Rural to Rs. 403 for Bangalore Urban, Chitradurga, Kolar and other districts. The published rates calculate to a payment of Rs. 65.97 crores from the government to the insurance companies towards premiums. The insurance companies have to pay a service tax of 12.36% - after this is deducted, the amount received from premiums is Rs. 57.82 crores, which would grow annually as enrollment increases. Of this nearly 58 crore rupees, the amount collected from beneficiaries based on the fee of (Rs. 30 per card), is Rs. 5,04,27,390. This amount goes to the State nodal agency to take care of its administrative expenses, and some part of it goes to the third party agents (TPAs). These TPAs (Third Party Agents) as well NGOs, earn money through administering the scheme.

A Right to Information (RTI) application was filed 4th Oct 2012 for details of funds disbursed in the last year. The response stated that public health care providers received Rs. 4,99,250 and private providers received Rs. 49,51,550. Thus, out of a total of Rs. 54.5 lakhs disbursed, only 9.16% has gone to public institutions. Information collected from officials in Davanagere district in October 2012 is shown in Table 4 (the scheme was launched in Davanagere in November 2011). As an illustration, the premium received by the insurance company for Davanagere district, after service tax deduction, is calculated to be Rs. 2.74 crores from this data. This means that only about 22% of the money from payment of premiums is being used to pay hospitals for health services in Davanagere district.

Table 4: RSBY data for Davanagere district, Karnataka

Eligible families	Enrolled families	% enrolled	Empaneled hospitals		Patients	Payments settled	Pending payments
			Public	Private			
141909	77554	54.65	5	14	859	4899525	1132650

Disease data for 2012 was obtained from 5 districts – Davanagere, Chitradurga, Kolar, Bangalore Rural and Chikballapur. The total cases were 4272, of which major diseases were typhoid (612), dengue (404), hysterectomies (210) and cataracts (158). Diagnosis columns were incomplete, with some entries marked as 'good', 'discharged' etc. Anomalies were noted, such as a patient admitted for dengue for 1 day (Rs. 10,000 claimed) and then for typhoid 10 days later indicating possible mis-diagnosis. These data need to be analyzed in detail.

The data obtained for the RSBY scheme show that low awareness and problems with card usage have led to low utilization of the scheme in Karnataka. The model of payment in RSBY resulted in a payout of Rs. 57.82 crores to insurance companies, of which a small fraction has been used to actually pay for health care.

Vajpayee Arogyashree Scheme (VAS)

The Government of Karnataka set up the Suvarna Arogya Suraksha Trust (SAST) as a separate body under the Health and Family Welfare Department in order to run the Vajpayee Arogyashree Scheme (VAS). VAS was launched in all the districts of Gulbarga Division and later extended to the Districts of Belgaum Division during October 2010. In June 2012, the scheme began to cover all districts of Karnataka. In the city of Bangalore it is implemented by the Bruhat Bengaluru Mahanagara Palike (BBMP). VAS is not a Central Government scheme and is specific to Karnataka.

The coverage limit through VAS is Rs.1,50,000/- on a family floater basis per year, for up to 5 members per family. An additional buffer of Rs. 50,000/- per year for the entire family on a case-by-case basis is available. The Benefit Package under the Scheme currently covers 402 tertiary care procedures, falling under 7 broad categories. They are Cardiovascular Diseases (134 Procedures); Cancer (166 including Surgical Oncology, Chemotherapy, Radiation Oncology); Neurological Diseases (55); Renal Diseases (21); Burns (11); Polytrauma cases (08); Neonatal surgeries (07). Apart from these, 50 follow up procedures are included for Cardio Vascular Surgeries, Urology and Neurosurgeries.

Unlike RSBY, VAS does not use Third Party Administrators (TPAs). Instead, MoUs have been signed between SAST and networked (empanelled) Hospitals. The VAS beneficiaries do not have to pay any premium or fees – all costs are borne by the government. The network hospitals have to conduct health camps on a periodic basis in pre-designated areas and districts, typically at taluk and district hospitals on a monthly basis. In these camps, patients who require specialized care are referred to a network hospital, typically the hospital conducting the camp. VAS has District Managers for the scheme in all districts as well as Arogyamitras posted at network hospitals and at the taluk level to support beneficiaries. As of July 2012, 130 hospitals were empaneled in Karnataka.

Right to Information filings revealed the following information:

1. In FY 2010-11, a total of 4095 cases were processed with a total payment of Rs. 22.84 crores to 53 empanelled hospitals. Of this, the amount paid to public hospitals (Kidwai, Jayadeva and Victoria) is Rs. 1.248 crores and to private hospitals is Rs. 21.595 crores. Thus, the payments made to public health institutions was 5.466% of the total payments made through VAS for health care.

2. In FY 2011-12, a total of 7564 cases were processed with a total payment of Rs. 43.586 crores to 67 empanelled hospitals. Of this, the amount paid to public hospitals is Rs. 2.186 crores and to

private hospitals is Rs. 41.4 crores. Thus, the payments made to public health institutions was 5% of the total payments made through VAS for health care.

The results are summarized in Table 5 below:

Table 5: Vajpayee Arogyashree reimbursement data

FY	No. of hospitals	Cases	Total reimbursements (in lakhs of Rs.)	Average cost / case (in Rs.)	Reimburse-ment to government hospitals (in lakhs)	Reimburse-ment to private hospitals (in lakhs)	% of total reimburse-ment to government hospitals
2010-11	53	4095	2284.40	55785.14	124.86	2159.54	5.47
2011-12	67	7564	4358.63	57623.39	218.57	4140.06	5.02

Nearly 95% of the total reimbursement amount went to private hospitals for each of the years 2010-11 to 2011-12 compared to public facilities. The second year of data (2011-12) also shows an increase in cases and claims as utilization increased across the state. We do not have data or information on how this increase occurred – e.g. whether through creating public awareness or through active solicitation by the private hospitals.

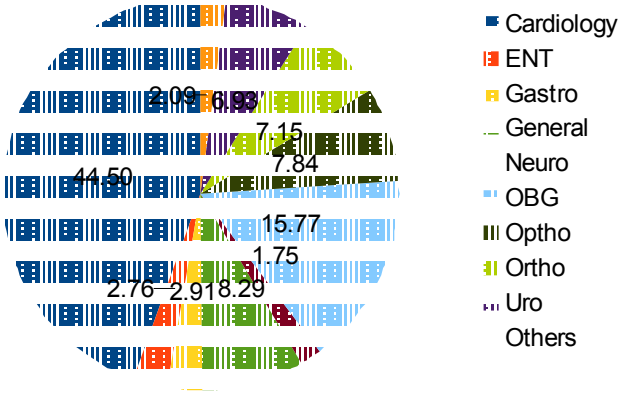
Yeshasvini

The Yeshasvini Cooperative Farmers Health Care Scheme was the foreunner of the health insurance schemes for low income populations. It was launched in 2003 and is open to all members of rural cooperative societies, including Sthree Shakthi groups, Weavers' cooperatives etc. and their families. The scheme is managed by the Yeshasvini Cooperative Farmers Health Care Trust, which is set up as an independent Trust under the Department of Cooperation. The concept was developed by Dr. Devi Prasad Shetty of Narayana Hrudayalaya, Bangalore, who is on the governing body of the Trust along with government officials and other doctors.

Under the scheme, beneficiaries pay an annual premium, which was Rs. 210 in 2012-13, and receive surgical services through 458 network hospitals (both public and private) across the state. Benefits include free out-patient department (OPD) care, and coverage for 805 types of surgical procedures. Obstetric and Gynaecological (OBG) services and deliveries are covered under Yeshasvini. While it is claimed that Yeshasvini is 'self-funded', it received Rs. 40 crore as a government grant in 2012-13 and Rs. 45 crore in the 2013-14 budget.

The available reports on the Yeshasvini website, which provide information up to 2009-10, were analysed. In 2009-10, 66749 surgery cases were processed, and claims totaled Rs. 55 crores. Cardiology accounted for 15.96% of cases and 44.5% of amount claimed (Rs. 24.48 crores) and OBG accounted for 24.57% of cases and 15.77% of amount claimed (Rs. 8.67 crores). Figure 1 shows the payments based on specialty. The reimbursements for OPD care in 2009-10 was Rs. 1.35 lakhs.

Figure 1: Yeshasvini payments for surgeries in 2009-10



The payments in the Yeshasvini scheme show a significant tilt towards cardiac procedures.

Thayi Bhagya

The Thayi Bhagya scheme is a maternity benefit scheme started by the Government of Karnataka. It is similar to the Chiranjeevi scheme in Gujarat. It is intended to provide free maternity benefits to women of BPL status, by allowing them to avail maternity services at the nearest registered private or government facility. However, the benefits are restricted to the first two live births. Also, the scheme is operational only in the "C" category districts of Bagalkot, Bidar, Bijapur, Koppal, Gulbarga, Raichur and Chamarajanagar.

Within this scheme, the following criteria are required for hospitals to become empaneled: the hospital should have at least 10 inpatient beds, a functional operation theater and delivery room; 24 hour availability of gynaecologists, anesthetists and paediatricians, and a blood bank. The hospitals must also sign an MoU with the District Health Officer. The mode of payment is capitation of Rs. 300,000 for 100 deliveries which includes both normal and complicated deliveries.

The government hospitals are reimbursed 150,000 of which 50% goes to the Arogya Raksha Samitis (ARS) and the other 50% is shared among the doctors, nurses and staff as per Yeshasvini guidelines. The justification given for the scheme is the shortage of specialists such as gynaecologists, anesthetists and paediatricians in public facilities as well as the ability to 'utilise' the capacities available in the private facilities. The scheme document also declares that the shortage of these specialists is a major barrier to the adequate delivery of maternal and child care services (Government of Karnataka, 2013).

The literature available on this scheme is scarce, but reveals low popularity, due to low knowledge and utilization rates across districts. Private providers have also reported their unhappiness about the capitation mode of payment and the low compensation. In addition, the pre-requisite that beneficiaries have to possess the Thayi card (ANC card) as well seems to be a barrier to the utilisation of the scheme (KHPT, 2012). Another qualitative study has revealed that transportation and other out-of-pocket costs are a deterrent to seeking care. In one case study presented by the report just cited, a woman had to visit 5 facilities due to the complicated nature of her case, for which she ended up paying Rs. 7000 (NRHM, 2011).

Findings

Implementation of the Thayi Bhagya scheme was studied in two districts – Raichur and Bagalkot. In Raichur, beneficiary lists were collected from the RCH officer. The total number of beneficiaries on the list was 79. Only three hospitals have empanelled themselves for the scheme, of which two were new facilities and the third a medical college hospital. The RCH officer, during an interview, attributed this low empanelment to the low compensation offered in the scheme. Five random beneficiaries (Sr. nos. 25, 28, 30, 31 & 51) who were from Manvi Block of Raichur District were selected and interviewed. All the five cases had incurred OoP expenditure ranging from Rs. 500 to Rs. 15000. In one of the cases (31), the hospital mentioned by the beneficiary is different from the one recorded in the list and also not on the list of empaneled hospitals for the district, another two had their deliveries in government hospitals (28 and 30) but they have been recorded as having delivered in private facilities. In one case (51), the beneficiary said that she delivered in a private facility in Pune costing Rs. 15000 and not in Raichur, but the records show her to have delivered in a private facility in Manvi. All of these cases were normal births.

In Bagalkot, information collected from district health officials showed that 50 hospitals were empanelled across all 6 taluks of the district. However, only one private hospital had been empanelled for remote Bilagi taluk, while 10 private hospitals are empanelled in Bagalkot taluk. In total, 9658 normal deliveries and 1377 caesarian deliveries were handled under this scheme in the

months of April to December 2012. Random exploratory interviews with 3 of the beneficiaries of the scheme revealed that none of the women had experienced a cashless delivery – each of them had incurred OoP expenses of Rs. 5000 to Rs. 18000 for the delivery and, in one case, for neonatal care. They were told that they would get Rs. 3000 from the government for their expenses and this would be deducted from their bill. Further, one of the women went to a government hospital, but was subsequently referred to a private nursing home. The other two planned to go to a government hospital, but were directed to private nursing homes by the 108 ambulance service staff as government hospitals were shut down to doctors' strike at the time. One of the families has taken a loan and another has mortgaged land to pay their bills.

The evidence obtained from Raichur for the Thayi Bhagya scheme demonstrates a classic case of 'supplier hold-up', while that from Bagalkot shows that private hospitals there have found the scheme to be a source of funds. The indicators of possible fraud and misuse of the scheme require further analysis.

Cross Sectional Study: Analysis of Karnataka District Data

A small, cross-sectional study was undertaken to determine the out-of-pocket expenditure for users of various insurance schemes. The convenience sample resulted in 61 respondents ranging from 6 districts: Belgaum, Haveri, Raichur, Davangere, Chitradurga and Chikballapur. The respondents had to be an adult member of the household and 35 were male and 26 were female. Respondent ages ranged from a 16-year-old female to a 66-year-old male. The mean and median age of the respondents was 43. Ten respondents were Muslim and the remaining Hindu from a range of castes groups, including those socially marginalized. 50% of the respondents were the head of their households, and household size ranged from 1 to 15 members with a mean of 6 and median of 5.

All households were enrolled for at least one insurance scheme, and three of them were enrolled for two. The respondent was asked to recall the card or scheme used in the last six months. About 49% (30) had used RSBY, 43% (26) Vajpayee Arogyasri, and 8% (5) had used Yeshasvini. Of all users, 46% were male and 48% were female, and four surveys had this data missing. People sought care for a range of reasons, ranging from dengue (2) to cancer (4) to cardiac problems (11) and eye problems (8). About 93% sought care at a private hospital and the remaining from a government hospital. Seeking care at more than one hospital was common (47.5% or 29 people).

The response rate was variable for each question and the number of valid responses is given in each table. The ‘missing system responses’ indicates the number of respondents who did not answer the question or whose answer was not clear. Because of the location, distance and time to follow-up on non-responses, the field researchers were not able to track down all respondents for clarification. A

three page questionnaire was administered after the informed consent process. The questionnaire included an open-ended question to describe the respondent's experience with the insurance scheme in terms of costs incurred and treatment received.

Coverage failure

Only five people or 8% reported that the treatment they received was completely free and 64% or 39 people said it was partially free (Table 6). Three people said it was not free, and the qualitative comments at the end of the survey reveals the complete dissatisfaction experienced. One person was asked to pay Rs 20,000 by the doctor, and when they said they could not afford it, the doctor revised it to Rs 12,000. One issue is the possible corruption in the case of reimbursement when the enrollment is not done at the beginning of care-seeking. For example, in the case of another respondent who was suffering from advanced stage cancer, the family obtained the insurance card after they had already started treatment, and therefore had spent a large amount of money. The family, unusually, advocated for the patient's rights to the level of the Chief Minister, yet still hasn't received full compensation from any source. A third case reveals the corruption that occurs in the process of preparing required documentation for the scheme by the hospital. The respondent's description reveals that there is likely several dangers that need to be recognized in the insurance claims process. The three qualitative responses are given below in the same order.

Table 6: Did you get free treatment?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	no	3	4.9	6.4	6.4
	yes	5	8.2	10.6	17.0
	partial	39	63.9	83.0	100.0
	Total	47	77.0	100.0	
Missing	System	14	23.0		

Total	61	100.0	

Case 1: "We did not know about any scheme. We went from one hospital to another. Finally at xx hospital they asked us to go to xxx hospital, Bangalore. There, the doctor asked for Rs. 20000 [about 315 USD]. We told the doctor we are poor, and he still took Rs. 12000 [USD 200]. During our stay at that hospital, we came to know about [Vajpayee] Arogyasri scheme. When we returned home after the operation we gave the MLA [member of legislative assembly – a local representative] our BPL [below poverty line] card, and discharge card with details of the operation. The MLA returned Rs.8000."

Case 2: [A very poor family working in construction – as told to the interviewer] - He was sick with fever, and went to Davanagere District Hospital and spent Rs. 1200 for tests. He was then referred to a private medical college hospital, Bapuji College Hospital. After tests and medicines (costing Rs. 60,000) [USD 1000], he wasn't getting better. The doctors suggested he go to KMC, Manipal Hospital. There, they stayed for one-and-a-half months where they diagnosed cancer and started treatment. It cost them Rs. 3,20,000 [USD 5000] – they did not know about Vajpayee Arogyasri scheme. After that, they came back home and his condition had improved. They could not bear any more costs. Back in Davanagere, they got to know about Kidwai [State Cancer Hospital] and went there and found out about VAS from another patient. They enrolled him in VAS and were supported for Rs. 17,000. For the remainder of the treatment, Kidwai Hospital began charging him. The patient's brother submitted a memorandum to the CM [Chief Minister], who responded saying his treatment woulid be covered by funds from the CM fund. The doctors argued with the patient and sent him home for 10 days. He has not gone back. The patient's brother filed an RTI asking for the status of money released from CM funds and VAS. They had to take a large loan to save his life.

Case 3: The respondent got a Yeshasvini card. He was admitted to xx Nursing Home, Davanagere with kidney pain. He was charged for all tests and told that the operation will be free. He was wheeled into the OT and a photo was taken with doctors. A claim was made in his name, but he was not operated. This happened with other patients that day. He was sent home and later went to xx hospital for treatment. The doctors asked him not to complain about [the first nursing home]. They operated him and charged him Rs. 1,75,000. He was preparing a police complaint, but the Panchayat intervened and asked him not to do that.

Visits to multiple hospitals for treatment

A large percentage of people (28 out of 61 or 46%) had to seek care at more than one hospital for their treatment. While referral systems are a critical systemic arrangement in health care, the narratives from the respondents reveal the lack of accountability in the referral process, as well as the hardships of long distance travel and the lack of coverage for on-going medicines.

- *"The child has a heart problem. First we went to a private hospital [in Belgaum]. The child's situation only improved as long as it was under medication. Then we went to Belgaum [city]. The situation did not improve, so we came back to the first hospital and finally it was found that the child has a hole in the heart. The hospital suggest we use the Vajpayee Arogyashree scheme. The child was taken to the medical camp organized by* xx *hospital where they advised us to bring the child to Bangalore for an operation."* [Interviewer - The mother being single mother, having lost her husband recently due to accident, hesitates to come to Bangalore and requests for a referral to either Hubli or Belgaum hospitals. Accordingly the child is referred to xx hospital in Belgaum.] *"This hospital suggested that the child is still too small and asked us to come back a year later. There were no charges for the tests done but we were not shown the final bill. Even now, the child is on continuous medication and we continue to spend on medicines. This scheme is not good and useful for poor, because, they say they provide free treatment to this scheme, but they don't do so. They refer to Bangalore hospitals and* xx *hospital [Belgaum] where they make us to pay for medicines, etc."*

Scheme reliance on private hospitals

Nearly 87% of the respondents said that the free or partially free treatment they received was at a private hospital. This is hardly surprising given the high ratio of private hospitals empaneled in the schemes. The rationale for engaging the private sector in providing care under the insurance programmes is the lack of capacity in the government sector. Some of the open-ended responses reveal people's views that a private hospital is inherently charge - driven and that people enter the system because they have insurance but end up spending more than if they had directly gone to government care without insurance.

- *"Only the operation [C-section] was free. At the government hospital, a C-section would be only Rs 3-4000, but we went to a private hospital since we had insurance and wound up spending so much. It seems like government are agents that send us to a private hospital. In this yojana (Yeshasvini), the government spends and we also spend."*

- *"This scheme is beneficial if you get care in the government hospitals not for private hospitals. Though they have the scheme [insurance] they need to pay for treatment in private hospitals. There is no completely free treatment given by this scheme."*

High out-of-pocket (OoP) expenditure

A recent study of five states in India (Prayas, 2011) shows high out-of-pocket expenditure with use of insurance schemes. In fact, of the five states, the one with the highest insurance expenditure by the state showed the highest OoP (Tamilnadu). The data from this survey show a similar trend (Table 6). Not surprisingly, people incurred the highest OoP expenditure in the Vajpayee Arogyashree and Yeshasvini insurance schemes, since they offer a higher level of coverage. People who access Yeshasvini are required to pay 25% of the costs, unlike the other schemes. However, the mean and median differences between Arogyashree and Yeshasvini are very similar, indicating the high OoP expenditure even in a "full" coverage scheme such as Vajpayee Arogyashree. The variability in OoP expenditure under this scheme is very high, with a minimum of Rs 4000, a maximum of Rs 120,000 and a median of Rs 14,000. Across all insurance schemes, the highest individual category of expenditure was for medicines, and this is especially evident in for Arogyashree and Yeshasvini.

It is clear that the majority of people incurred OoP. The insurance schemes as they exist, do not enable people to avoid or overcome many of the barriers to care: distance, need for multiple hospitals to access necessary diagnostics and treatment, and non-coverage of follow-up care, to name a few. Some of the responses of people who had to pay out-of-pocket reveal the hardships endured:

- *"She is alone and has to depend on others. She has no source of income now (she used to run a small shop) and survives on loans. She wants to go for another follow-up, but someone has to accompany her."*
- *"People are not aware about the schemes. Without informing the users, money gets collected but in the records they show schemes being utilized very well."*
- *"In spite of Yeshasvini being there, there were lot of expenses incurred by the family."*
- *"Though these people have scheme cards, they are made to pay. Therefore this scheme is not so useful."*
- *"They are poor and BPL card holder, They have to spend more money on medicines every month."*

- *"He had a heart attack, Haveri Dist Hosp, and was referred to* xx *hospital, Hubli, they gave first aid and told he needs open-heart surgery. They spent some money here but don't know how much. They spent Rs 8000 on food and travel and Rs 5000 on medicines, total Rs 13000. Now spending Rs 600 on medicines OoP. They know that* xx *hospital claimed Rs 95,000 for the surgery because they noticed the amount when they signed. To date they spent Rs 40,000 on hospital costs plus follow-up treatment."* [as told to the interviewer]
- *"Patients have no recourse to post-operative medications, which is very high in our case".*

Table 6: Out-of-pocket expenditure by insurance type

(all column amts in Rs)	**Provider**	**Tests**	**Medicine**	**Food**	**Travel**	**Other**	**Total**
RSBY (n=30)	mean 1,000 median 1,000 min 1,000 max 1,000	mean 1,918 median 1,000 min 400 max 6,000	mean 1,372 median 1,000 min 500 max 3,000	mean 570 median 500 min 200 max 1000	mean 694 median 500 min 200 max 2000	mean 1250 median 1,000 min 500 max 2000	mean 5270 median 4,000 min 0 max 15000
No. cases with data	1	11	9	10	16	6	25
Vajpayee Arogyashree (n=26)	Mean 21 Median 0 min 0 max 150	Mean 9,751 Median 1,900 Min 0 Max 60,000	Mean 27,333 Median 6,500 Min 0 Max 320,000	Mean 6,800 Median 5,000 Min 1,000 Max 35,000	Mean 4,338 Median 2,000 Min 180 Max 40,000	Mean 7,883 Median 7,800 Min 1,000 Max 15,000	Mean 35,066 Median 14,000 Min 4,000 Max 135,000
No. cases with data	7	10	18	12	18	6	26
Yeshasvini (n=5)	Only 1 case with provider fees data of Rs 1,700	Mean 3,033 Median 3,000 Min 2,500 Max 3,600	Mean 7,950 Median 8,500 Min 4,800 Max 10,000	Only 1 case with data on amt spent on food of Rs 1,000	Only 1 case with data on amt spent on travel of Rs 500	No data on other costs	Mean 47,300 Median 13,000 Min 11,500 Max175,000
No. cases with data	1	3	4	1	1	0	5

Changes in health system policies and administration

Human resources and medical infrastructure

Karnataka fares a little better than the rest of India when it comes to rural infrastructure, and is

below national aggregate in urban health infrastructure (RHS Bulletin 2010). State-wide government facilities as of 2010 are shown in Table 3:

Table 3: Government health facilities in Karnataka

Item	Total number	Rural	Urban
Subcentres	8870		
PHCs	2310		27
CHCs	180		
Gov't hospitals (including CHCs)	919 (63741 beds)	468 (8010 beds)	451 (55731 beds)
District Hospitals	19		
Family Welfare Centres			108
Health and Family Welfare Training Centres	4		

Source: CBHI 2011 and CRM Report 2011

There has been a chronic shortfall in human resources, particularly general practitioners and specialists. According to the latest CBHI report (2011), Karnataka has 4,928 government allopathic doctors, serving an average population of 11,933 per doctor. This is much lower than the WHO norm of 1 doctor per 1000 population. Considering only registered allopathic doctors as of 2011 (government and private) this drop to 91,461, which translates to a doctor-population ratio of 1:642 (CBHI HRH, 2011). Most of these practitioners are concentrated in urban areas, resulting in an urban ratio of 1:596 and a rural ratio of 1:7998 (The Hindu 2007). There are vacancies across the spectrum in the public sector, with posts of 899 specialist doctors and 171 MBBS doctors remaining vacant, according to the Health Minister in September 2012 (Mangalore Waves, 2012). Similarly, the state government planning division reports a shortage of these doctors along with female and male health assistants (72.9% and 64.4% with respect to sanctioned posts) and lab technicians at PHCs and CHCs (41.1%) (GoK DoHFW, 2011). In Bangalore city, only one-third of the sanctioned ANM posts in BBMP (Bruhat Bengaluru Mahanagara Palike) hospitals have been filled[4].

Provision of quality health services is primarily dependent on the availability, competence and motivation of health personnel. The absence of a Human Resource policy in Karnataka has meant that there is no clarity in postings, promotions or support for further education of health staff. The need for a Human Resource Development Unit in the Health Department has been raised by many, and also by the Karnataka Jnana Ayogya, GoK (Mission Group for Public Health, KJA, 2013).

Autonomous institutions

In the early 1980s, public sector hospitals around the world came under scrutiny by policymakers due to their size and bureaucratic complexity, inefficiencies and high cost of operation. A policy that has been implemented in a number of countries is the granting of 'autonomy' to these hospitals. The key expectation is that autonomy would enable hospitals to mobilize revenue through user fees and other means and lessen the budgetary burden on governments. Evidence shows that access to the institutions that became autonomous has stayed the same or declined due to user fees (Govindaraj & Chawla, 1996). Karnataka has pursued the conversion of hospitals to autonomous status, stating expected benefits such as encouraging professional autonomy and the adoption of modern medical technology. Autonomous institutions have been encouraged to raise funds through "appropriate" user fees (GoK, 2004).

In Karnataka, a number of autonomous institutions provide health services. The National Institute of Mental Health and Neuro Sciences (NIMHANS), which was formed by the central government in 1974 and given academic autonomy in 1994 (NIMHANS website), was declared an 'Institution of national importance' in 2012 (The Hindu, 2012). Jayadeva Institute of Cardiology, Kidwai Institute of Oncology and Indira Gandhi Institute of Child Health were later granted autonomous status at the state level.

Teaching hospitals met a similar fate. In 1978, a separate Ministry was created for Medical Education (ME) in Karnataka. This resulted in teaching hospitals moving from the aegis of Health and Family Welfare (HFW) Department to ME. In 1996, Vijayanagar Institute of Medical Sciences (VIMS), Bellary and Karnataka Institute of Medical Sciences (KIMS), Hubli were given autonomous status. They were facing severe staff shortages because doctors who were transferred to these institutions were using political connections to get posted in the larger cities of Bangalore or Mysore instead. Autonomy was proposed as the solution (doctors would be permanently posted in one hospital) to improve staffing in these institutions.[5]

In the latest addition to the autonomous trend, District Hospitals are following suit. In June 2007, the District Hospitals of Hassan, Mandya, Belgaum, Shimoga, Raichur and Bidar were transferred from the Karnataka Health and Family Welfare Directorate to the Directorate of Medical Education (Government of Karnataka Order no. 427, 2007). This was done to support the setup of new medical colleges in these six districts, allowing them to meet Medical Council of India (MCI) requirements for hospitals attached to medical colleges. These colleges were given autonomous status along the lines of VIMS and KIMS. Another four district hospitals were also transferred soon

after, for a total of ten district hospitals in the state that are now autonomous.[6]

The transfer of District Hospitals to medical colleges, such as the Raichur Institute of Medical Sciences (RIMS), has led to a number of problems. One is the responsiveness of these hospitals to district needs, such as running National Programmes, providing statistics and responding to current health problems. For example, many of these hospitals are not running the Revised National Tuberculosis Control Programme (RNTCP), but continue to follow the National Tuberculosis Programme (NTP).[7] Further, District Hospitals were attached to medical colleges to ensure availability of specialists in all disciplines. However 798 or nearly 28% of the 2881 faculty posts, sanctioned by MCI for colleges under the Medical Education Department, are vacant. The situation is particularly dire in the new medical colleges, which have vacancies of up to 70% (The New Indian Express, 2013).

Accountability of services can also be measured by assessing the capacity to respond to public health needs. Autonomy has not improved this. Malnutrition is an extremely pressing problem in the state and one that a civil society campaign brought to the forefront in 2011 after starvation deaths in Raichur. A complaint was converted to a Public Interest Litigation (PIL) in the Karnataka High Court. An interim judgment (2011) stated that Nutrition and Rehabilitation Centres (NRCs) should be set up in District and/or Taluk Hospitals in severely affected areas. This has yet to happen in the hospitals run by the Medical Education Department – only in the 2013-14 budget estimate have funds been allocated to set up NRCs (DME Budget Estimate, 2013). A visit by the National Commission for Protection of Child Rights (NCPCR) to the Raichur District hospital in February 2012 found that *"...there is no specific protocol for the management of severely malnourished children. The hospital basically treats some of the associated complications of malnutrition, and not the malnutrition itself, and discharges the children to the families. Further the staff is unwilling to shoulder the responsibility of managing severely malnourished children because of infrastructural issues."* (NCPCR, 2012, p.25)

Career progression became a serious issue for Health department doctors with the transfer of 10 District Hospitals to the Medical Education Department. They could now only rise to the taluk level, as district-level positions were no longer available[8]. They have been demanding a return of these hospitals to the H&FW Department. A series of protests, resignation drives etc., culminated in a state-wide strike by the Karnataka Government Health Department Officers and Employees' Welfare Samiti on February 8th, 2013, which led to drastically reduced operations or shutdowns in all government hospitals for 4 days (The Hindu, 2013). The government responded to the issue and

a cabinet sub-committee voted unanimously on February 13th to merge the two departments (The Hindu, 2013).

BMCRI

In November 2006, the Department of Medical Education issued a Government Order (GO) converting the remaining medical colleges under its direct control – Bangalore Medical College and Research Institute (BMCRI), Mysore Medical College and Research Institute (MMCRI) and Government Dental College into autonomous institutions. The reasons given were to improve facilities and fill up vacant posts. (GO no. HFW 19 MPS 2005, November 2006) This order was opposed by Medical Education employees and later the Health and Family Welfare Employees Association as well. In letters to the Chief Minister and Governor, they raised concerns about the by-laws being framed, which would allow for higher fees from medical students and the collection of user fees from poor patients. Issues were raised about the lack of transparency, outdated Cadre and Recruitment Rules and certain undertakings made to make these institutions financially self-sufficient within 5 years.[9]

A PIL was filed in the High Court of Karnataka against the GO issued by the government. While the Court dismissed the petition, the possibility of free or subsidised health care being denied to the poor was raised. The Advocate General, appearing for the Government of Karnataka, submitted that the concerned institutions would continue to provide medical services to the poor and BPL as before and that all efforts would be made to enhance the quality of services to the poor. (Bhat, 2007) .

Within two years, the hospitals under BMCRI began charging patients for health care beyond the token fees that were collected earlier (Gayathri, L, 2008). These user fees have steadily increased over the years. Even BPL patients are charged for many procedures, and only allowed a 50% discount, so BPL patients are still paying significant out-of-pocket expenses.[10] In one interview, a senior government official admitted that concessions on diagnostic tests for BPL patients had been removed at a large autonomous hospital in Bangalore.

By 2011, the government grant to BMCRI was Rs. 110 crore. The cost of running BMCRI and associated hospitals was Rs. 160 crore, with about Rs. 8 crore coming from user fees. The administration chose to raise user fees to increase this share of the revenue to Rs. 10 crore (Yasmeen, A, 2011). As discussed earlier, global evidence has shown that user fees constitute only a small fraction of hospital revenues, yet adversely impact access to these hospitals. This holds true

in the case of BMCRI as well.

BMCRI hospitals have also been beset by human resource issues. Norms have been flouted while making appointments, and establishing the retirement age, for example (Charan, S, 2010). Shortages persist even in areas where there are applicants. Nurses are not being hired as per requirements, with the government finally issuing a notification on January 7th, 2013 inviting applications for 600 nurse positions and 120 paramedical positions. However, 450 nurses working on contract basis in these hospitals for more than 5 years were not regularized. These nurses received a monthly stipend of Rs. 7000 (110 USD) and often worked 12-hour shifts with no paid leave. Some of them have crossed the age of eligibility to apply for permanent positions (The Hindu, 2013).

Involvement of private sector

In addition to contracting services and empanelment of private hospitals in the insurance schemes discussed above, there has been an increasing involvement of non-profits in delivering services that were formerly provided by the State. PHCs have been handed over to NGOs, emergency ambulatory transport (EMRI (108)) services are being run by GVK, a private company, and telemedicine facilities have been set up in districts in partnership with Narayana Hrudayalaya. Under NRHM, doctors and nurses are being hired on a contractual basis, non- clinical services are being outsourced and private hospitals have been empanelled for various schemes. The Yeshasvini scheme, which insures farmers for health services in private facilities, was one of the first of its kind in the country and other insurance schemes have followed. Grievance redressal mechanisms have been handed over to the non-profit sector, with NGOs operating Citizen Help Desks (CHDs) in all District Hospitals (GoK, 2011).

A joint study by Karnataka State Health System Resource Centre (KSHSRC) and Deloitte Touche Tohmatsu India Ltd. reviewed existing PPPs in the state with the objective of drafting a PPP health policy for the state. Eight PPP models in the state were studied and it was found that monitoring and supervision was incorporated in only 2 of them. None of them had grievance redressal mechanisms or defined quality/accreditation standards (KSHSRC et al, 2012). In spite of these serious shortcomings, the report continues to promote the advantages of PPPs and lays out the framework for a state PPP health policy. While the suggested policy incorporates some pre- requisites for a PPP, it has few solutions to offer for the already identified gaps and does not provide a role for the community in monitoring or grievance redressal.

The draft PPP health policy has not been approved by the government. In the meantime, some PPP

arrangements have lapsed (superspecialty hospital in Raichur) or have been reversed, as in the case of the superspecialty hospital in Indiranagar, Bangalore which is now being run directly by the Health and Family Welfare Directorate (The Hindu, 2012). On the other hand, the GO no. 143 calling for private agencies to run public health facilities is still in effect and the government has entered into an agreement with Karuna Trust and ARTIST (Asian Research and Training Institute for Skill Transfer) to manage 72 FRUs (First Referral Units) in the state (The Hindu, 2013).

Discussion

> *"Decades of appallingly low investment in the public health sector has left India with a crumbling health system and despite efforts in recent years to strengthen it – most notably through the National Rural Health Mission – India has one of the lowest levels of government investment in health in the world. The gap left by the public health system combined with a government policy of proactively promoting the private sector has led to the proliferation of private health providers which are unregulated, unaccountable, and out of control"* (Oxfam, 2013).

As recently as March 14, 2013, the United Nations Development Programme (UNDP) ranked India 136 out of 187 in the human development index, with a score of .554 - well below the average (.64) of countries in the medium development category (UNDP, 2013). Poor access to social services, health care, and an inadequate PDS (public distribtion system) has led to the failure of the Indian state to reduce rates of malnutrition, anaemia and mother and infant deaths to the targets within the MDGs and the Eleventh Plan documents (Planning Commission, 2012). In December 2014, the Health Ministry announced a budget cut of 948 million USD (http://in.reuters.com/article/2014/12/23/india-health-budget-idINKBN0K10Y020141223).

In this context, the government's approach to improving access to health care has been to involve the private sector to fill unmet demand for medical treatment and to make achieve universal access to health care. While this may be necessary in the short term as millions of people are without access to curative care, there does not appear to be any long-term vision or plans to provide the complete range of prevention, screening, management and follow-up for the range of needs from chronic conditions, infectious diseases, and acute/emergency needs (these are not mutually exclusive categories). The provision of treatment through the private sector, with poor accountability and little regulation may create problems for the poor as the data in this formative research indicates. As Amartya Sen remarked in a workshop of the Kolkata Group a few years ago,

"No country has been able to have a transition from bad health to good health on the basis of private healthcare" (The Statesman News Service, 2013).

The majority of reimbursement money (government funds) is paid to the private sector under the insurance schemes. The effects of channeling government funds into private sector health care facilities and not government health care facilities will likely weaken the latter. Additionally, as costs rise, more and more government money will be diverted from the public sector to the private sector. Some schemes such as ESI and CGHS, inspite of having their own health infrastructure, have empanelled private hospitals. The diversity in the adminstration of the schemes lends to the complexity of understanding their impact on cost – some use TPAs, others do not.

The existence of multiple schemes that vary in treatments reimbursed, caps, whether medicines are covered or not, make for a confusing and hetergenous landscape for users. Some schemes reimburse the cost of medicines and others do not. Caps also vary considerably - In one example, ESI reimbursed Rs. 11 lakh for a month of neonatal care in a private hospital[2]. The BBMP Managed Health Care system covers health-care expenses of about 25,000 BBMP employees

The findings of Thayi Bhagya indicate a ‘supplier hold-up’ in which private facilities, knowing that the public health system is already weak, do not sign up to participate and therefore limit service availability to the population. Further, Thayi Bhagya operates on a capitation fee basis, where hospitals are paid Rs. 3,00,000 for 100 deliveries. This is in contrast to RSBY (run by the Labour department), where births are reimbursed on a fee-for-service basis with C-sections compensated with higher fees than normal deliveries. Thus, there is a conflict in the functioning of RSBY and Thayi Bhagya and no incentive or compulsion for private hospitals to join Thayi Bhagya. The fee-for-service approach leads to unnecessary C-sections, which the capitation mode was designed to avoid.

The reimbursements to public facilities through insurance schemes present a paradoxical situation. Instead of direct investment to strengthen public sector insitutions, the government is using insurance, thereby incurring the additional costs of the administration charges for intermediaries. This undermines the ability of institutions to build capacity over time with the security of a minimum budgetary assurance. Further, the move to empanel public facilities indicates a possible move towards a ‘managed care’ model in which the public systems are pitted against private facilities for funding.

2

- Patient interview

The high levels of anaemia, malnutrition, communicable and non-communicable diseases in the population require an increased focus on primary and preventive health care. Instead, the Karnataka state health budget shows a clear bias towards secondary and tertiary care which deviates from recommendations in the state health policy. All the schemes are designed for hospitalization and tertiary care rather than primary health care. Even within tertiary care, only specific conditions are covered. The rationale for the choice of selected conditions/procedures needs further analysis and some investigative work needs to be conducted to determine if there is active lobbying for these conditions and by whom. It is baffling to see that cardiac conditions account for more than two-thirds of the conditions treated in the 3 hospitals for which data was available[3]. More data is required to determine whether this was a latent disease load that was waiting for the scheme or a supplier induced phenomenon, due to the fee-for-service orientation of the schemes. This data, as well as interviews with private doctors, indicate 'cherry picking' of those procedures that are most profitable. Overall, this focus and increased budgetary allocations for tertiary and secondary care weakens the fabric of government services across the entire continuum of care.

Out-of-pocket expenditure continues to beleaguer care-seekers. Patients seeking care through insurance schemes have sometimes had to bear expenses for ‘non-covered’ aspects of the insurance schemes, further adding to OoP expenses and making care unaffordable. Evidence of this is seen in an evaluation of the Rajiv Arogyasri community health insurance scheme in Andhra Pradesh, where almost 60% beneficiaries of Arogyasri incurred a median out-of-pocket expenditure of Rs. 3600 (USD 77.3) with transport, medicine and pre-diagnostic investigations being the major reasons (Rao et al., 2010). In our cross-sectional survey, only 5 out of 61 respondents received completely free treatment – of the 26 Vajpayee Arogyashree beneficiaries interviewed, all had incurred out-of-pocket expenditure with a median of Rs. 14,000 (min 4000, max 135000). If care-seekers face high OoP expenses when they attempt to avail services, the financial distress is significant. Many take loans, and they may not return for needed care, reducing continued access to care. These findings agree with that of another done by PRAYAS, that found significant increases in OoP expenditures betwene 2004-2010, following the introduction of insurance schemes (Out of pocket spending in health care, Results of study in five states of India” by Prayas- Chittorgarh, India)

The data raises doubt about the Karnataka government’s engagement with the private sector and its impact on public health goals and services, particularly with regard to UAHC. Despite rolling out several of the schemes, the government public health system is not improving. In fact, it is further weakening, especially in the areas of providing universal coverage, assuring quality of care and providing free care for vulnerable populations.

Insurance schemes have compounded the problem, with multiple schemes run by different departments, competing for the same populations often with overlapping medical conditions or procedures in their coverage list, and with varying policies, eligibility and reimbursement rates. In

3

- RTI filings

our cross-sectional survey, more educated patients mentioned that they 'shopped' for the best package – for the less privileged, the confusion has only increased.

The survey also revealed the travails of patients in this fragmented system. Patients and their families have often gone to various government and private hospitals and incurred significant OoP expenditure before hearing of a scheme. After using an insurance scheme and getting treated, some have still not recovered the costs – there is no retroactive flexibility in terms of an existing condition. People need to travel far distances for follow-up as there is no counter-referral to local hospitals in these schemes. Several of the private hospitals hold screening camps and then refer patients in other districts to Bangalore. Also in the absence of continuum of care, post operative follow up and coverage of medicines are found wanting. The multiple systems of health provisioning, with their different standards and guidelines, available schemes etc. must be integrated to provide a continuum of care for care-seekers in Karnataka.

Finally, the long-standing and little discussed trend of covertly converting hospitals to "autonomous" status, has increased cost and has not reduced the problems of fragmented care and poor quality of care.

Conclusion

"The dream of public health is the dream of social justice" (Beauchamp 1973).

The dimensions of equity, access and universality are essential for a social good like health (Shuftan et al, 2011). Commitment to social justice lies at the heart of public health and is for the advancement of the human well-being beyond the narrow confines of medical care to the larger societal determinants of health (Braveman & Gruskin, 2003). But market mechanisms emphasize that people are entitled to that which they have acquired by their own individual efforts. It emphasizes individual responsibility and minimizes collective responsibilities and obligations. These are often counter to public health and social justice goals.

As previous sections have highlighted, Karnataka's health system is characterized by weak, underfunded and fragmented government health services. The increasing reliance on the private sector, with the justification of the lack of capacity with the public sector health system, has led to undue stress on tertiary/quaternary care of certain cherry picked disease conditions; supplier hold-up; continued OoP expenses; sub-optimal outcomes and malpractices (due to lack of regulation), new problems with access to health care and a lack of vision and road-map for comprehensive health care for all.

A strong public sector health system is needed to prevent potential health threats rather than scrambling later for control of outbreaks. Pro-active public action can substantially improve the health of general populations rather than the reactive mechanism of combating diseases at the individual level. The present trend of involvement of the private sector is more geared towards individual care rather than the overall improvement of population health. This runs contrary to the requirements of public health. Governments have the authority and responsibility for assuring the conditions in which people can be healthy and it has to be exercised. Unfortunately, instead of moving towards universal health care, a basic need of millions, Karnataka is embracing a model of “Some care for some of the people, some of the time”, which is a far cry from the goals of Universal Access to Health Care.

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Paper
- Separate the results from discussion/ analysis. Reference to other studies such as by Prayas to highlight out of pocket payments should be made in discussion not where you report findings of your cross section study.
- Be selective and reflective in using quotations from respondents. Avoid listing all responses.

Include legends for tables and cross reference these in main text/ body of your paper.
- Clearly present your findings specific to the methods used- for example, separate findings from review of literature, primary research, and any other formative research.