



HEALTH, CULTURE and SOCIETY

The Best Laid Plans:

Access to the Rajiv Aarogyasri community health insurance scheme of Andhra Pradesh

H. Narasimhan, V. Boddu, P. Singh, A. Katyal, S. Bergkvist & M. Rao

Volume 6, No. 1 (2014) | ISSN 2161-6590 (online)

DOI 10.5195/hcs.2014.163 | <http://hcs.pitt.edu>



New articles in this journal are licensed under a Creative Commons Attribution 3.0 United States License.



This journal is published by the [University Library System](#) of the [University of Pittsburgh](#) as part of its [D-Scribe Digital Publishing Program](#), and is cosponsored by the [University of Pittsburgh Press](#).

Abstract

This paper is a qualitative assessment of a public health insurance scheme in the state of Andhra Pradesh, south India, called the Rajiv Aarogyasri Community Health Insurance Scheme (or Aarogyasri), using the case-study method. Focusing on inpatient hospital care and especially on surgical treatments leaves the scheme wanting in meeting the health care needs of and addressing the impoverishing health expenditure incurred by the poor, especially those living in rural areas. Though well-intentioned, people from vulnerable sections of society may find the scheme ultimately unhelpful for their needs. Through an in-depth qualitative approach, the paper highlights not just financial difficulties but also the non-financial barriers to accessing health care, despite the existence of a scheme such as Aarogyasri. Narrative evidence from poor households offers powerful insights into why even the most innovative state health insurance schemes may not achieve their goals and systemic corrections needed to address barriers to health care.

Keywords: *Health insurance; India; Aarogyasri; qualitative assessment*

The Best Laid Plans:

Access to the Rajiv Aarogyasri community health insurance scheme of Andhra Pradesh

H. Narasimhan, V. Boddu, P. Singh, A. Katyal, S. Bergvist & M.Rao

I. Introduction

In many parts of the developing world, health care expenditure is largely met out of pocket and illness can drive individuals and families into poverty and debt. India ranks third in the World Health Organization's 2012 list of "countries with highest out of pocket (OOP) expenditure on health" in the south-east Asia region with almost 60% of total health expenditure paid by the common man in 2009 (World Health Organisation 2009). Studies have shown that one of the major causes for continued poverty among poorer households in India is debt incurred due to health expenditure (Krishna 2004).

In recognition of the significant financial burdens families living below the poverty line face when coping with serious illness, the Indian state of Andhra Pradesh launched a pioneering new state-wide fully state-funded health insurance scheme in 2007, the Rajiv Aarogyasri Community Health Insurance Scheme (Aarogyasri) to provide treatment for serious and life-threatening illnesses. The specific objectives as stated by the scheme included: to improve access of poor families to quality 'tertiary' medical care (meaning low-frequency, high cost specialist care) and treatment of identified diseases requiring hospitalization through an identified network of health care providers, to provide financial cover for catastrophic illnesses which have the potential to wipe out life time savings of poor families and to provide 'universal coverage' to the urban and the rural poor in the state albeit for the conditions covered in the benefits package (Rao et al 2012).

All families with a 'below poverty line' (BPL) ration card¹, i.e. those on an annual income below INR 75,000 (USD 1384; 1USD = 58.42 INR at 2013 exchange rates) in urban areas and INR 60,000 (USD 1107) in rural areas, and including individuals with pre-existing medical conditions are automatically enrolled and the scheme was estimated to cover approximately 20.4 million poor and lower middle class families, comprising about 85 percent of the state's population in 2009. Enrollees make no contribution, the annual benefit is a maximum of rupees 2,00,000

¹ A Ration card is a card supplied by state governments to citizens in order to procure essential goods at subsidised prices through the public distribution system (PDS) shops, called 'ration shops'. The state provides grains and pulses and other essential items at subsidised rates for predominantly poor, 'below poverty line' households.

approximately (USD 4,500) per family per year and there is no limit on the size of the family. A total of 942 medical and surgical procedures across 31 clinical specialties were provided at the time of the study and the benefits include all inpatient costs as well as associated investigations, food, transport and medicines for 10 days following discharge. One year follow-up packages including consultation, medicines, and diagnostics are also available for 125 procedures requiring longer periods of follow up (see the scheme's website- <http://www.aarogyasri.gov.in>). Aarogyasri has unique features including Aarogyamithras (health system navigators), outreach health camps delivered by participating hospitals to educate, screen and case-find and a state-of-the-art information technology-based management system. At the time of this study, 353 public and private sector hospitals were 'empanelled' (those hospitals that are formally registered) to provide services to Aarogyasri beneficiaries. Thus, Aarogyasri is among the most comprehensive state-funded healthcare schemes in India (Fan, Karan and Mahal 2012).

The scheme exists against a backdrop of published literature highlighting the gap between even the most enlightened health policies and their accessibility especially to the poor (Reddy and Mary 2013). The reasons for the failure of policy to be translated into practice are often complex and include factors related to the health system as well as the wider social dimensions such as poverty and illiteracy. This paper describes, through in-depth case studies, the intricate ways in which Aarogyasri actually works in people's lives, and shortcomings present in the system, which militate against policy translation into effective practice. The paper also suggests some recommendations to provide more access to the poor, for whom the scheme is primarily intended.

This research is based on six case studies of hospitalization in Andhra Pradesh, south India. Systematic reviews of impact evaluations of health care financing schemes highlight that non-financial barriers, such as literacy, location, confidence, and trust are equally important in accessing health care (Ergler et al 2011). This is the first time, to our knowledge, in studies on health financing schemes in India that the effect of these intangible, abstract notions has been documented using appropriate methodology. In all except one case, people sought private medical care. There are various factors responsible for this situation, and the paper discusses these in detail. The paper suggests that future evaluations of public health insurance projects and schemes should ideally include both quantitative and qualitative methods.

Objectives

The main objective of this study was to analyze Aarogyasri using a narrative lens. This complements the quantitative data already available from the research. Though Aarogyasri provides free medical care for the poor in both public and private institutions, it is evident from the data gathered that it is not always reaching the public as intended. Questions arise therefore about reasons for this gap in execution and utilization. Focusing on a few thorough case studies, this paper aims to uncover significant social, economic and cultural factors that hamper access to public health care schemes, factors that usually get missed in large, quantitative studies. Literature available on the critical assessment of Aarogyasri points out the difficulties and drawbacks but does not elaborate on the specific reasons (Prasad and Raghavendra, 2012). This paper adds to the existing information on Aarogyasri in highlighting some factors that contribute to access or lack thereof amongst the people to good, affordable healthcare.

Methodology

Fieldwork was undertaken in Nalgonda, Ranga Reddy and Hyderabad districts by a student trained in anthropological research methods (VB), a native of Andhra Pradesh and fluent in the local language, Telugu, and also hailing from the area. The households selected for this ethnographic study were a subset of the 8623 randomly selected households included in a larger survey carried out as part of the evaluation of the impact of the Aarogyasri scheme. The households fulfilled the following criteria; they were residents of the chosen districts, were below the poverty line, provided a mix of rural and urban and female and male headed households and those which had been

treated under the Aarogyasri scheme and those that had not, had required hospitalization in the previous year and incurred out of pocket expenditure for in-patient hospital care. Using semi-structured questionnaires, the interviewer spoke to the informants in their homes and collected detailed information on their cultural and social background such as caste, education levels, employment, household income, and their trials and tribulations while navigating themselves through the health care maze to get treatment for a specific ailment. Using semi-structured interview method allows the researcher to gain the trust of the informants, and thus in-depth information on the struggles poor people go through to obtain good health care (Barnard 2011). All interviews were recorded on audio. Informed written consent was obtained from all the informants. Ethical approval for the evaluation was given by the research ethics committee of the Administrative Staff College of India which hosted the study.

Information on the health status of all household members, illnesses they suffer from, and the treatment sought and obtained, at private, government or charitable health facilities, was the primary focus of the research. Specific attention was given to their socio-economic status, expenditure on medicines and hospital stay, and the ways in which the expenditure was met by the households. The study looked at six specific health issues; childbirth, injuries due to accident, liver disease, renal failure, cardiac ailment, and anemia. Of the six households, two were headed by women. All the six households were Hindu, although religion was not a criterion for selection. One household belonged to a scheduled caste and one belonged to a tribal community². To protect their identities, in this paper, all informants have been given pseudonyms.

II. Challenges in Accessing Public Health Care Schemes

In this section, we discuss the case studies in detail. The focus is not only on the specific health problems for which care was sought under the Aarogyasri scheme, but also the various impediments people encounter while trying to seek good health care. In particular, we elaborate on the ways by which families meet the costs of treatments, and reasons why they are compelled to incur out of pocket expenditure in spite of a public health financing scheme being available in the state.

Vijay, a native of Nizamabad district, migrated to a suburb of Hyderabad city for work, fifteen years ago. He began working as a construction laborer. He borrowed one lakh rupees from a friend to purchase treatment for his wife who was suffering from a kidney ailment, at a private clinic in the city. The friend who had saved money to build a house loaned Vijay the amount with a verbal understanding that it will be returned soon. Vijay repaid the amount by selling two acres of land for a hundred and twenty thousand rupees. Later his entire family moved to the city. Vijay's wife also works as a laborer in construction sites. Six years ago, the renal disease recurred and Vijay took his wife to the same hospital but this time she received free medical care under the Aarogyasri scheme. He spent around five thousand rupees for other expenses during her stay in the hospital.

Vijay's son Jagdish works as a chauffeur for a software company in the city. He was treated for stomach pain at a private hospital in February 2012. Taxi fares cost approximately twelve hundred rupees. He spent six thousand rupees for hospital stay and diagnostic tests. He was diagnosed with 'kidney stones' (renal calculus) and was advised surgery. Vijay suggested that Jagdish go to the hospital where his wife had been treated previously and

² 'Scheduled castes' (or SCs as they are referred in daily parlance) are formerly 'untouchable' castes that are now classified under a schedule of the constitution of India. 'Tribal' communities are classified as 'scheduled tribes' (STs). Both SCs and STs face significant socio-economic difficulties.

get his treatment covered under the Aarogyasri. Jagdish was in the hospital for a week. After surgery, Jagdish once again went to the same hospital for headache, and had to spend five hundred rupees. Due to recurring health problems, Jagdish is no longer able to work long hours and his income has fallen, from twelve thousand rupees to about nine thousand rupees per month. His wife supplements the household income as a seamstress, earning six to seven hundred rupees a month.

In spite of this fall in income, compared to the other households in the study, Vijay's family has little or no debt due to health issues, because it has been able to utilize the Aarogyasri scheme to its benefit. Vijay's long period of residence in the city and his knowledge of the Aarogyasri scheme and the hospitals 'empanelled' to provide care covered by the scheme has worked as his "social capital" (Bourdieu 1977) and has proved advantageous for him and his family.

While Vijay was in some ways fortunate to be in the right place at the right time, it is not such a happy story for many people in the state. Most of the case studies covered in this research show how challenging it could be for people residing in rural areas, and those not conversant with the scheme and the institutions where the Aarogyasri scheme is in effect.

Not knowing the walk or the talk

Chalam, from Marriguda Mandal³ has endured hospitalization and surgeries and an expense of eighty thousand rupees for liver disease. His son had to drop out of college and take up employment to supplement the family income. It all began in January 2013 when Chalam starting suffering from severe pain in his back and abdomen. He thought it was due to the nature of his work; he worked as daily wage laborer in the fields, earning six thousand rupees per month. Chalam visited the local primary health care centre (PHC). After waiting in line for a long time, he was finally seen by a doctor who gave him some tablets and an injection. But by evening, the pain returned. Chalam then did what is common in such instances; he went 'doctor-shopping' (Inhorn 1994⁴). Not finding any relief from the medicine given at the PHC, Chalam consulted a local 'rural medical practitioner' (RMP). This 'doctor' administered an injection and prescribed some more pills, which provided temporary relief for a few days. When the pain recurred, Chalam visited the same doctor and once again received the same treatment. Chalam spent a total amount of eight hundred rupees, two hundred rupees per visit. Continuing his 'quest for therapy' (Janzen 1982), Chalam spent another five hundred rupees at another RMP doctor's clinic. Still finding no respite from pain, Chalam consulted a trained allopathic doctor in a village a few kilometers from Marriguda. This doctor admitted that he can only give temporary relief and suggested that Chalam go to the city, get a scan and consult a good doctor. In return for this advice, the doctor charged six hundred rupees.

Chalam travelled to Hyderabad city, where he visited a private health care facility. His wife Padma had been treated at this hospital some years previously for accidental electrocution. Padma worked along with Chalam in the fields. In 2005, Padma suffered a major injury while digging a well. A crane used to lift mud from the pit suddenly hit the electric wires, and she suffered electric shock. She was hospitalized at a private facility in the city. For her surgery, Chalam spent twenty five thousand rupees, which he had borrowed from a relative. Even though it

³ Mandal is the administrative division consisting of many villages.

⁴ Marcia Inhorn (1994) discusses in detail the 'quest for conception' amongst Egyptian women who sought one healer after another who could help them in their search to conceive. See references for more details.

was a relative who loaned him the amount, Chalam still had to repay the loan at an exorbitant interest rate of sixty percent per annum (five percent per month). It took him three years to repay the amount.

In spite of this past traumatic incident and heavy debt he had incurred, Chalam preferred to go to the same hospital again. He was familiar with the place and trusted the physicians there. When he entered the doctor's consulting room, the doctor recognized him immediately and enquired about the problem. This small gesture further strengthened his faith in the physician. Chalam narrated his travails. The doctor asked him to undergo a scan and other diagnostic tests at a center attached to the hospital. On seeing the reports, the doctor told him that he had 'multiple liver abscess' and needed to be operated upon, immediately. The cost was estimated to be sixty thousand rupees, nearly ten times the amount Chalam had with him at that moment. Knowing his financial situation, the doctor offered to refer his case to one of the public hospitals in the city, and urged him to go there as soon as possible because the condition was serious.

Chalam returned to the village and explained the situation to relatives and friends back home. Pappiah, his friend working as an auto rickshaw driver in the city told him that the treatment offered at the government hospitals was "bad", and that he had taken many patients to these hospitals and they returned as "dead bodies". Other relatives also had a similar opinion about the two major public hospitals in the city and they advised him to get the surgery done at the private hospital instead. There is little trust in government hospitals, the infrastructure available, and the health care practitioners working in these settings. The distrust was significant enough to outweigh considerations of cost and other logistical problems. On behalf of Chalam, Pappiah made enquiries about Aarogyasri and whether this disease, liver abscess, was covered by the scheme, and if yes, the private hospitals in the city which offered treatment for this condition. He was offered conflicting advice from family and friends, some of whom suggested that Aarogyasri was no longer available, and others, that the disease was not covered under the scheme.

Chalam began to make arrangements to meet the expenses for surgery in a private hospital. He borrowed twenty-five thousand rupees from a moneylender by depositing two thola of gold (One thola measures eleven grams of gold). Another individual gave him forty thousand rupees in return for fifteen goats as collateral. Chalam's elder son Dharam who was twenty years old, studied till class ten but dropped out in order to help his family financially.⁵ He worked in a restaurant in Hyderabad for nearly four years. He gave fifteen thousand rupees from his savings. Dharam has since returned to the village and has taken over their traditional occupation of goat-rearing. Chalam's younger son has finished school this year and is hoping to go to college. This will require financial support from the family, which is already in significant debt. It is quite possible that he may not be able to realize his dream.

In April 2013, Chalam was operated upon. He was kept under observation in the intensive care unit (ICU) for three days and for about one month in the hospital for post-operative recuperation. Most private hospitals in cities in India do have a canteen but the prices are prohibitive for the poor. Those who are not from the city have to either buy food from street vendors or rely on their relatives or friends. Chalam's sister who lives in Hyderabad helped the family by giving them food. The total expenditure for hospital and treatment was seventy thousand rupees. This is unsurprising since hospital stay is as expensive as surgery especially in private health care facilities. Upon discharge from the hospital, the doctor asked Chalam to come for a checkup after ten days. Chalam has been visiting the hospital regularly since. He has also been taking the medicines prescribed. Until May 2013, Chalam had spent a total of eighty thousand rupees. He is unsure of how long the treatment will last or what the total cost will be.

⁵ Class ten is the end of school in Andhra Pradesh. Students have to go to colleges to pursue an 'intermediate course' for classes eleven and twelve, before they pursue bachelor's degrees or diplomas.

For poor people living in rural India, financial assets in the form of milch and cattle prove vital in needy times. The fifteen goats Chalam owns were valued at about fifty thousand rupees. He also has some immovable property; one acre of dry land and a house. At present, the household has a debt of sixty five thousand rupees. Chalam and Padma are worried about the debt and have reduced household consumption to a minimum.

III. A Barrage of Legal Woes

Sometimes, misunderstandings about legalities connected with the scheme prove to be impediments. Nagesh, a twenty-five year old man belongs to a scheduled caste. He works at a cooking gas agency in Miryalguda. He lives with his wife and newborn child. Nagesh studied till class seven and started working at a welding shop while still only an adolescent. But he was fired since he could not lift heavy machinery. Later he worked in a warehouse as a daily wage laborer (coolie) for about three years. He settled for a job at the gas agency eleven years ago. He earns ten to fifteen rupees for delivery of one gas cylinder. His monthly income is about six to seven thousand. His wife was educated to class four, and she stays at home to take care of their child. In 2012, Nagesh suffered a fracture in his right leg and hand while unloading a cylinder at his work place. Unfortunately, he does not have a ration card because after his parents' death, the card which had been in his father's name was cancelled. He has applied for a new one but it has not yet been issued. Since Aarogyasri is provided only to persons holding a ration card, he was denied access to free health care. As the accident occurred at the work place, his manager compelled him to go to a private hospital not empanelled by the Aarogyasri scheme, fearing that he would be required to "file a case" (formally report the accident) at a government hospital. The manager promised to get two thousand rupees from the owner of the agency as compensation and immediately gave him five hundred rupees for hospital charges. Nagesh was treated for fracture and his hands and toe were bandaged. He was advised rest for two months. Six months later, Nagesh still suffers from occasional pain. He has also incurred huge debts in the meantime. He is yet to get compensation that was promised to him.

During this period he experienced great financial stress because he spent twenty thousand rupees for his treatment. He could not go to work, in spite of being the only breadwinner in the household. He borrowed nearly sixty thousand rupees from local moneylenders. He has been paying only the interest but is unable to repay the capital loan amount. At the moment, the outstanding amount is nearly forty five thousand rupees. He owns no property except for the house. As a result of huge medical expenses and debt, his daily life has been greatly affected. For instance, Nagesh and his family members have reduced consumption of meat. This brings down household expenditure but also has an impact on the nutritional intake of the household members, especially Nagesh's wife, who had just given birth to a child. The couple has also avoided travelling to meet relatives or attend family functions.

Nagesh's woes do not end here. A few months after his accident, Nagesh's wife was admitted to a government hospital for delivery. She was told that she would need a caesarean section due to oligohydramnios (low levels of amniotic fluid in the uterus). On being told that her condition was dangerous, Nagesh was very concerned that his wife may not get good care at a government hospital. So he took her to a private hospital where she stayed for two weeks. Her mother stayed with her at the hospital. This cost Nagesh about thirty thousand rupees; the caesarean section alone cost fifteen thousand rupees and the rest went on hospital stay and medicines. The Aarogyasri does not cover maternity care, so the costs would have to be borne by the family. To save some costs, Nagesh arranged for food to be brought from home. To meet this expenditure, Nagesh took a loan of twenty five thousand from a private moneylending firm, by pawning one and half thola of gold. He withdrew an additional five thousand rupees from his savings. With a monthly income of seven to nine thousand rupees, and a debt of forty five

thousand rupees, and a wife and newborn child to support, Nagesh is in a truly precarious situation.

Nagesh is not alone in facing problems accessing Aarogyasri. His brother Prasad, who stays in a nearby village is in a similar situation. Without a ration card, he too could not get health care under Aarogyasri. He owns a gas welding shop in a village, about fifteen kilometers from Miryalguda. Prasad suffered from stomach pain. Along with Nagesh, he went to a private hospital in Khammam, seventy four kilometers from Miryalguda, by bus, spending a hundred rupees in travel. He was diagnosed with renal calculus (kidney stone) and was told it would cost twenty thousand rupees to operate. Nagesh managed to raise the amount from his brother's wife's relatives. Prasad underwent an operation, and stayed in the hospital for three days.

Nagesh's sister Satya has a twelve-year old son Madan. The boy suffers from seizures which began when he was an infant. He was taken to a hospital where the family was told that 'in utero, he had ingested amniotic fluid', and hence the condition. A number of diagnostic tests were done, and it was concluded that due to "nerve tightening" (nalaru bigusuka poinay), something had got "locked in his brain" which resulted in seizures.

When Madan was taken to a Government children's hospital in Hyderabad, doctors prescribed some medicine and asked them to visit after two years. Satya and her husband were in deep financial trouble during that period. Therefore, they continued the same medication for a further year and went back to the hospital after three years. Once again, doctors prescribed medicines, and sent them back. A few years later, Satya's husband died. When Madan was around ten, Satya took him to another hospital further away for treatment, hoping that the treatment there may be free, but it was not. From then onwards, the family has been visiting the hospital once in three months. They spend six thousand rupees for medicine and doctors' consultation fees. Though they have a ration card, seizures are not covered under the scheme.

As is evident from Nagesh's case study, the lack of a ration card and fear of legal repercussions if injury due to occupational risks is treated by Aarogyasri may be further barriers to accessing the scheme. Furthermore, maternity care and treatments for chronic diseases such as seizures which may not require inpatient hospital care are not covered by the scheme, but may result in significant expenditure for the family.

Take Rama Rao, for instance. He migrated with his family, consisting of his wife, a daughter and a son, from Guntur to Hyderabad ten years ago. He worked as a security guard in an apartment for a salary of five thousand rupees per month. He was given accommodation in the cellar of the apartment. His family lived there for about seven years. His wife supplemented the family income by washing clothes in residents' homes. Recently, Rama Rao started feeling severe pain in his chest and consulted a local doctor. As advised, he took painkillers for ten days. He had to spend five hundred rupees (ten percent of his monthly income).

Later, he went to a private hospital in the city, through Aarogyasri. After getting a scan and other diagnostic tests done, Rama Rao was told there was no cause for worry, and was prescribed medicines. But he had to pay for medicines, because he was told that medicines are given free only if a patient undergoes operation. He spent about a thousand rupees. But after a while, Rama Rao started feeling breathless. Eventually he quit his job and moved to a smaller dwelling.

Three years ago, Rama Rao's teenage daughter took ill. Rama Rao took her to a nearby hospital where a doctor examined her and said that she suffered from mental illness and had to be hospitalized. Not knowing whether mental illness was covered under Aarogyasri, nor having time to consult anyone, he spent six thousand rupees for hospital stay and medicines for five days, having borrowed the money from one of his neighbors. Rama Rao repaid it in two months. After this episode, Rama Rao took his daughter to government hospitals, in an attempt to reduce the household expenditure for treatment. The doctors prescribed some pills. Following a symptom-free month, she started feeling ill again. The family consulted a psychologist near Secunderabad, referred by relatives and neighbors.

For the last three years, Rama Rao has been taking his daughter for consultation to the psychologist. It costs him five hundred rupees every month. Her condition is stable but she has dropped out of college and is living at home.

About a year ago Rama Rao's wife was also hospitalized for appendicitis for which he pawned some jewelry in a private finance firm and borrowed fifteen thousand rupees. Rama Rao is unable to repay the loan and recover the jewelry. He is in financial distress because, after surgery, his wife is unable to work and supplement the household income. Managing household expenses, rent, his daughter's treatment and other small expenses with his meager salary as a guard is proving to be a huge challenge. Rama Rao says that his health condition is not good either. He takes painkillers and "forces" himself (zabardasti) to go to work.

IV. Preconceived Notion about Private and Public Health Care

A further point that came to the fore during this study is the role of individuals, and particularly private health care providers, in promoting their services to clients, and creating fear and panic about state health care institutions. This is evident in the case of Veeramma who was persuaded by a private physician to go for childbirth at a private hospital. The delivery in a private facility cost her and her husband Mahesh fifteen thousand rupees.⁶

After four years of marriage to Mahesh, her cousin, Veeramma gave birth to her first child, a girl, at a private hospital in a town five kilometers from their village. As in the case of Chalam, Veeramma went to the same hospital for her second pregnancy, as the place and the people were familiar. Mahesh spent a thousand rupees for six months of pre-natal care. When Veeramma did not go into labor by the due date given, she was referred to another female doctor in the town of Kodada, which is twenty kilometers away. Both the doctors insisted that Veeramma should not go to a government hospital. The doctor said the fetus had "turned in the opposite direction" (pindamaddamtirigindi), which could be fatal for her and the fetus, and therefore she had to undergo a caesarean.

Veeramma and Mahesh became worried, and consulted a local RMP known to them. After examining Veeramma, the RMP said there was no cause for worry. The couple informed the doctor at the private hospital that they had not prepared for hospitalization, and therefore, would return the next day. The doctor objected and prevented them from going back. Though they were not happy with it, they agreed and the caesarean section was conducted. After undergoing surgery, Veeramma is unable to do any physical work or lift heavy objects, a particularly difficult problem for a poor Indian woman whose responsibilities require her to undertake labor-intensive household work. She suffers from back pain and severe leg pain. She takes pain killers purchased from a local pharmacy. Sometimes her husband also uses these painkillers to get relief from body pain, a result of heavy agricultural work.

Mahesh was told that the operation would cost fifteen thousand rupees. He borrowed the amount from his friends. Veeramma stayed in the hospital after delivery for ten days. She said that the paramedical staff took good care of her. The couple were pleased enough to give a gift of five hundred rupees to the staff. Food and medicines cost Mahesh an additional three thousand rupees. It took him six months to repay his friends.

The tendency to go to private health care facility for "good care" is linked to widespread mistrust and fear people have about state health care facilities, often fuelled by fear generated by private health care providers. Both Mahesh and Veeramma's parents assumed that she would not get good care at a government hospital although they

⁶ Aarogyasri does not cover childbirth.

had no first-hand experience at a government maternity hospital. As a consequence, in spite of being poor, they turn to private health care and get into debt.

Alone and helpless

Women who are heads of households without any male support, aged, and living in rural areas, are particularly disadvantaged, in getting good health care. Bhagyamma is a seventy year old widow. She has no children. She worked as an agricultural laborer, for daily wages, but for the last two years, she has stopped work due to advancing age. She is managing her expenses from the money she had saved. In April 2012, she fell ill and spent twenty five thousand rupees in a clinic in Manchala village. Bhagyamma was ill for nearly ten days. She thought she “was about to die”. A relative living nearby happened to call on her, and shocked to see her so ill, took her to a hospital. An RMP in the village said Bhagyamma was suffering from fatigue and she had to be administered fluids immediately. He treated her for two days in the hospital and for about fifteen days at her house for which he charged twenty thousand rupees. Bhagyamma pleaded with him to lower the charges. Eventually she had to pay fifteen thousand rupees. He also prescribed medicines, which she purchased from a private medical shop for about ten thousand rupees. Bhagyamma does not have any source of financial support. Sometimes neighbors give her food. She also goes to the owners of the fields in which she used to work, and collects rice and vegetables as bhiksha (alms). She gets an old age pension of two hundred rupees per month from the government.

Bhagyamma has a ration card but did not have anyone to look after her or help her navigate through the health care system, and so she had to suffer, being alone at home for ten days. She said she would have died if her relative had not taken her to the hospital. There is a PHC in the village about three kilometers from her house but there is no transport available to get there. The RMP’s clinic was closer and so she was taken there in a cycle-rickshaw.

Whenever she feels weak, Bhagyamma takes the same medicine prescribed. Life after the illness episode has become hard because she spent her savings of nearly seven years on this particular incident. She has reduced her household expenditure to a great extent and she spends only twenty rupees a day for food and other expenses. One can only speculate on how little food is likely to be available at such low costs, not to mention the severe lack of nutrients in such a diet. Bhagyamma never attends any family gatherings and weddings because she cannot afford to.

V. Discussion

The case studies illustrate vividly that, irrespective of their financial status, the poor, like others, would not hesitate to spend money to obtain good health. They borrow large sums from moneylenders or acquaintances, at high interest, pawn their jewelry, sell land and animals, in order to get treatment at private health care facilities. Schemes intended to prevent poor people from falling further into impoverishment are, however, still unable to achieve their aims, as we have shown in this paper.

The second point that comes through very clearly in these case studies is the lack of awareness about the scheme, the procedures covered, and not covered, amongst the general public, particularly those living in rural areas. Some of them do not know or do not enquire if the hospital or the ailment is covered under Aarogyasri, and are consequently denied Aarogyasri care even when they may be entitled to it. This is due to widespread confusion about government rules and regulations. The pervasive lack of confidence among the poor to seek information is illustrated by the case of Nagesh who did not have the confidence to ask what legal forms he would have to fill at the hospital for getting injured at work, and whether indeed his employer would be required to meet the liability. Nagesh’s experience also shows the culpability of employers in accidents that happen at workplaces. Employers’ obligations to provide health care are not clarified by public health finance schemes. Health care is assumed to be an

individual and familial responsibility, absolving employers of any role in enabling their employees to obtain affordable treatment. In the case of Rama Rao's daughter, it was not clear whether mental illness was covered or not.

This confusion exists not just among the general public but even amongst health care practitioners and institutions with regard to the illnesses that are covered under Aarogyasri. Are seizures covered? Are caesarean sections covered? Such questions linger in people's minds even as they struggle through the maze that the state health care system is.

The case studies also highlight a third point, the mistrust and fear about state healthcare facilities and schemes. Van Hollen (2003) in her ethnography of childbirth practices in Tamilnadu describes in detail the humiliating ways in which women from particularly lower socio-economic backgrounds are treated in health care facilities, not only by biomedical practitioners but also by paramedical staff. From being called "bad mothers" for refusing to give colostrum to new born babies (which conflicts with local cultural practices) to being taunted with sexual innuendos while undergoing sterilization procedures, women endure significant physical and verbal abuse in these hospitals, more so because they are seen as mere recipients of state largesse. Such experiences serve to intensify the feeling of mistrust and fear about public health care facilities. This feeling is widespread, and vested interests are able to exploit this to their advantage, particularly in rural areas. There is a widespread perception that private health care is better than state health care. But 'private' health care is not a homogenous entity; the quality of care and expertise varies (Nandraj 1994).

Hospitals and doctors are often chosen on the basis of previous experience and interaction, as well as distance to the facility (Narasimhan 2013). Even if the costs are high, such institutions are therefore preferred. It's only a savvy man like Vijay who has access to a wider network in the city, and understands how state health care schemes operate, and is able to utilize it to his advantage. This brings us to the fourth point, which is the advantage people living in urban areas have over those residing in rural areas. Although Aarogyasri provides free diagnostic tests, these are available only in empanelled hospitals in urban areas, so that inevitably rural families would have to refer themselves to the rural RMP, and incur costs. Even if the diagnosis is made, Aarogyasri treatment can be availed only in the city. Clearly, there is a strong need for free, good quality primary care to assess early symptoms, carry out diagnostic work up and confirm diagnoses.

These case studies also highlight that geographical locations play a major role in accessing good health care, not just in terms of physical distance and transportation facilities, but also in terms of knowledge acquired about health care schemes, and ability to manoeuvre oneself within the system as required. Such issues will not have been captured in a quantitative study; a qualitative approach brings out the complexities hidden under the rubric of increased household debt. The Aarogyasri scheme which focuses on "serious illness" does not cover uncomplicated deliveries. However, it is not only life threatening illness requiring tertiary level health care that imposes huge financial burdens on families. Maternal and infant mortality rates remain high in India and the widespread belief that private facilities provide safer maternity care than public sector hospitals compels even the poor to seek private care for childbirth, as Veeramma and Mahesh's case study proves.

In a society such as India, where close links between kin are crucial for not just financial reasons but also have social and psychological meaning, to decide not to visit relatives, as Nagesh and his wife did, in order to pay off debt incurred due to surgery which went uncovered by a scheme as comprehensive as Aarogyasri, is quite telling. Family members play a huge role in providing care for their kin who are ill. Those from rural areas who come to Hyderabad city to avail Aarogyasri for treatment have to depend on their relatives for food, transportation and hospitality. These costs cannot be calculated nor can they be brushed aside as insignificant. Medical procedures take a toll, not just in terms of finances, but also emotionally, and socially, in stretching poor people's meager

means, to help others like them. Amongst the cases covered in this paper, Bhagyamma is among the most vulnerable. She has a ration card but is old, alone, illiterate and has no knowledge or support to help her use it. The scheme needs to take a holistic approach with the Aarogyamithra, the local PHC, the ASHA worker (accredited social health activist) all working together to support people like her and enabling her to utilize Aarogyasri.

These examples also bring out the hidden social consequences of the failure, in some sense, of public health finance schemes on individual families. Chalam's sons may probably not acquire higher education or be able to get away from so-called 'traditional occupations' like goat-rearing. Nagesh and his siblings seem to be in a cycle of suffering, perhaps due to their lower social standing, both in terms of caste and class. As a single woman without any immediate kin to take care of her, Bhagyamma is leading a very fragile existence and is probably starving. Aarogyasri does not pay for medicines if there is no hospitalization. Nonetheless the costs are huge, as we saw in Rama Rao's example. For a public health finance scheme to be effective in a country such as India, it has to widen its definition and also explore methods to bring in costs such as procurement of medicines under the scheme, not just surgeries. Only an in-depth case-study approach as highlighted here could have opened up these facets, which would have easily gone missing in tables and numbers, and quantitative assessments.

Implications for policy and practice

There is a great interest both within India and outside in understanding the impacts of the Aarogyasri scheme. Many states, and even the central government, are believed to be looking at the scheme to see if this can be replicated across the country. In this paper, a case-study approach from an anthropological perspective has illustrated in detail, both successes and problems in accessing health care, including that which is provided under the umbrella of the Aarogyasri scheme. While the scheme is clearly welcome and helpful to those in desperate need of hospital care, public awareness of what it covers and how to access it remains poor, and its 'reach' is far from equitable. This is despite the fact that a toll free phone service (104) is available to provide information regarding the scheme. Our findings suggest that the phone line service needs to be more widely advertised. Given the increasing penetration of mobile phones in the state, an effort could be made to reach the poor through such media, by sending periodic updates (Times of India, 2013). Information about Aarogyasri, and hospitals and health conditions covered by the scheme could also be uploaded on the internet in local languages, and also publicized via the vibrant radio and TV in Andhra Pradesh, as well as the print media. However, it must be acknowledged that such technologies evade a significant number of the poor, the illiterate, and those living in rural areas with lack of proper infrastructure, including internet connection and electricity. For the most vulnerable citizens of the state, other options need to be explored, such as a role for community health workers to monitor the health and social needs of such individuals and households in the community.

General medical practitioners and primary health centers should be regularly updated regarding the scheme, so that they are able to improve the health literacy of the population, and in particular, are able to support people such as Bhagyamma who are unlikely to own a mobile phone or know how to access a phone line for information. Many medical practitioners practicing in rural areas, the RMPs, are known and trusted by the people. Their role in informing and encouraging the public regarding their health care entitlements and how to access them needs to be recognized. Women's self-help groups (SHG) are another trusted source of information and may be ideally placed to

help their communities understand how to access Aarogyasri services.⁷ Although one of the features of the scheme is the Aarogyamithras appointed in villages and in networked hospitals to help the poor navigate themselves through the complex medical care system, no household in this case study mentioned contact with this cadre of health worker. This well-intentioned aspect of the scheme deserves to be strengthened. It is possible that Aarogyamithras need further training to reach out to the communities rather than assume that the community will come to them.

Aarogyasri is a well-intended scheme, with much scope to be built on and strengthened so that equity of access to its services is achieved (Nambiar 2013). However, not only those health care needs covered by Aarogyasri, but all health needs including safe maternal and child care may result in financial and social catastrophe, especially in the most vulnerable households. Andhra Pradesh's health policy leaders are urged to take the lessons learnt from these case studies, to examine the persistent financial and non-financial barriers to health care faced by the most vulnerable communities despite the provision of a visionary scheme such as the Aarogyasri and to design an evidence-based strategy to provide universal health care coverage to the populations they serve.

Acknowledgements

The study was funded by the International Development Research Centre, Canada; the Wellcome Trust; the UK Department for International Development; the Rockefeller Foundation and the World Bank. We gratefully acknowledge the financial support of these organisations, as well as the enthusiastic encouragement received from them throughout the study. Our thanks also go to Adrian Renton, Amit Samarth and Adam Wagstaff for their support to the larger study, of which these case studies form a part, and to the Administrative Staff College of India Hyderabad for its administrative support. We are grateful to Jay Bagaria for her help during the early stage of the development of the study proposal. Finally we thank PV Ramesh without whose constant support, guidance and encouragement, this study would not have been possible.

References

- Aarogyasri Health Care Trust (2014, February 7). Retrieved from the Aarogyasri website <http://www.aarogyasri.gov.in/>
- Barnard, H. Russell. (1995). *Research Methods in Anthropology: Qualitative and Quantitative Approaches*. Walnut Creek: Altamira Press
- Bourdieu, Pierre. (1977). *Outline of a theory of practice*. Cambridge: Cambridge University Press
- Ergler, Christina R, Patrick Sakdapolrak, Hans-Georg Bohle, and Robin A Kearns. (2011). Entitlements to health care: Why is there a preference for private facilities among poorer residents of Chennai, India? *Social Science and Medicine*. 72: 327-337. doi- 10.1016/j.socscimed.2010.09.042

⁷ Self-help groups consisting of women obtain finance through state-sponsored micro-credit schemes to undertake an economic activity. Many State governments recognize these groups as important catalysts for socio-economic development.

Fan V, Karan A, and Mahal A. (2012). State Health Insurance and Out of-Pocket Health Expenditures in Andhra Pradesh, India. CGD Working Paper 298. Retrieved from Center for Global Development website: <http://www.cgdev.org/content/publications/detail/1426275>

George, A. and Aditi Iyer. (2013). Unfree markets: Socially embedded informal health providers in northern Karnataka, India. *Social Science & Medicine*. 96: 297-304. <http://dx.doi.org/10.1016/j.socscimed.2013.01.022>

Inhorn, Marcia. (1994). *Quest for Conception: Gender, Infertility and Egyptian Medical Traditions*. Philadelphia : University of Pennsylvania Press.

Janzen, John. 1982. *The Quest for Therapy in Lower Zaire*. Berkeley: University of California Press

Krishna, Anirudh. (2004). Escaping Poverty and Becoming Poor: Who Gains, Who Loses, and Why?. *World Development*. 32: 121–136. doi:10.1016/j.worlddev.2003.08.002

Nambiar, Devaki. (2013). India's "Tryst" with Universal Health coverage: Reflections on Ethnography in Indian Health Policymaking. *Social Science and Medicine*. 99:135-142. doi: 10.1016/j.socscimed.2013.08.02

Narasimhan, HariPriya. (2013). "Where there is no doctor: Narratives on biomedical healthcare practitioners in Chennai, South India". In Arima Mishra and Suhita Chopra Chatterjee (Eds.), *Multiple Voices and Stories: Narratives of Health and Illness* (pp. 143-172.). New Delhi: Orient Blackswan.

Nandraj, Sunil. (1994). Beyond the law and the lord: Quality of private health care. *Economic and Political Weekly*. 29:1680-1685. <http://www.epw.in/>

Prasad, Purendra, N and P. Raghavendra. (2012). Healthcare Models in the era of Medical Neo-liberalism: A Study of Aarogyasri in Andhra Pradesh. *Economic and Political Weekly*. 47: 118-126. <http://www.epw.in/>

Rao, Mala, S. S. Ramachandra, S. Bandyopadhyay, A. Chandran, R. Shidhaye, S. Tamisettynarayana, A., ...S. I. Bangdiwala. (2012). Addressing the healthcare needs of people living below the poverty line: A rapid assessment of the Andhra Pradesh Health Insurance Scheme. *National Medical Journal of India*. 24: 335-341. <http://www.nmji.in/>

Reddy, Sunita and Immaculate Mary. (2013). Aarogyasri Scheme in Andhra Pradesh, India: Some Critical reflections. *Social Change*. 43: 245-261. <http://sch.sagepub.com/doi:10.1177>

Rohit PS. (2013, October 19). Andhra-Pradesh-tops-in-mobile-subscribers. *Times of India*.

Van Hollen, Cecilia. (2003). *Birth on the threshold: childbirth and modernity in south India*. Berkeley: University of California Press.

World Health Organisation. (2009). *Health Accounts*. Retrieved from World Health Organization website: <http://www.who.int/nha/atlas.pdf>