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# 'Having the card makes us feel worthless': the negative value of government-funded health insurance in India

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## ‘Having the card makes us feel worthless’: the negative value of government-funded health insurance in India

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### ABSTRACT

Since the 2000s, hundreds of government-funded health insurance (GFHI) schemes were introduced in India. These schemes are meant to prevent poorer households from incurring catastrophic health expenditures. Through GFHIs, policy-makers want to mobilize the decision-making powers of private consumers in a liberalized healthcare market. Patients are called upon to act as ‘co-creators’ of healthcare value by optimizing supply through demand. Based on long-term ethnographic fieldwork with insurance users in South India, we argue that GFHIs fail because people experience the value of insurance in drastically different ways that only partly overlap with how the policy assumes they value insurance. In addition, the hollow promises of health coverage can be experienced as so frustrating that signing up for health insurance actually makes people feel devalued.

### ARTICLE HISTORY

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India; poverty; health insurance; value

After long neglect by anthropologists, health insurance has received more attention in the last few years. Research to date highlight how factors such as cost-shifting, moral hazard, and risk (Dao and Mulligan 2016), sexuality and gender (Morris 2008; Patel 2006), kinship and relatedness (Golomski 2015), as well as solidarity and conflict (Bähre 2020a, 2020b) interrelate with insurance. Several anthropological studies look at the everyday articulation of health insurance implementation and related global health policies (Ellison 2014; Foley 2009). The United States has received the most attention because of the highly unequal access to care and the politicization of insurance (Horton et al. 2014). Health insurance in countries of the global south has also been studied by anthropologists (e.g. Dao and Nichter 2016; Ellison 2014; Golomski 2015; Abadia and Oviedo 2009). Work on the social life and the unwanted consequences of health insurance is particularly fruitful (Ahlin, Nichter, and Pillai 2016; Dao and Mulligan 2016; Dao and Nichter 2016). This study contributes to this literature by studying health insurance as a complex social valuing practice (Ecks 2021, Ecks 2022). Value is both a theoretical term and one we encountered during fieldwork in India as the way people articulated their experiences with health insurance.

The question of value is key in health policy: what mode of financing returns the best healthcare value? There are broadly two answers to this question. One sees health as a common

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good and assumes that the best value comes from public spending. The other takes health as a private good and believes that the best value comes from mobilizing private demand in a liberalized healthcare market. The common good argument views the state as responsible for healthcare. The other views private individuals as responsible for obtaining it (Uplekar 2000). One of the chief documents in favor of the common good argument is the Alma Ata Declaration of 1978, which argued that ‘governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures’ (Art. V). Alma Ata advocated that all countries should move towards universal healthcare. Governments should try to achieve ‘a level of health that will permit [all people] to lead a socially and economically productive life’. While putting governments in charge of healthcare, Alma Ata also declared that ‘the people have the right and duty to participate individually and collectively in the planning and implementation of their health care’ (Art. IV).

Since the 1980s, neoliberal policies emphasized this duty to participate individually (Cueto, Brown, and Fee 2019, 179). Neoliberalism puts the duty to participate individually at its centre and aims to minimize public responsibility for healthcare as much as possible. Neoliberalism starts from the principle that top-down provisioning can never return good value on investment because it fails to mobilize the power of individual decision-making in a free market.

Over the past four decades, private sector healthcare has been growing across the world, on the assumption that the free market model works just as well for health as it does for goods and services. In many countries, economic crises made governments cut health budgets. The neoliberal Washington Consensus of 1989 focused on privatization, market liberalization, and deregulation. Neoliberalism left a deep mark on health policies, and many countries privatized healthcare either in part or whole (Basilico et al. 2013). As part of structural adjustments, loans from the IMF and the World Bank were tied to cutting government health budgets and opening up to non-state providers, including NGOs, private hospitals, and private insurance companies (Choudry and Kapoor 2013; Pfeiffer and Chapman 2010). Some of these reforms turned so far away from health as the common good that ‘only people with money will have the right to health’ (Keshavjee 2014, 117).

Despite the rise of neoliberalism, common good policies never went away entirely. An example of this is the rise of Universal Health Care (UHC) as a policy where the state assures its citizens of access to care no matter if they can afford it on their own or not. While the first UHC-type policies date back to the nineteenth century, ‘health for all’ has regained momentum in the 2010s (Sen 2015). Like Alma Ata, UHC also emphasizes strong, people-centered care rooted in the communities they serve (Patel et al. 2015). Margaret Chan, then the Director General of WHO, thinks UHC is ‘the single most powerful concept that public health has to offer’ (Chan 2012). Jim Kim, then president of the World Bank, identified UHC as a key strategy to foster long-term economic growth (Kim 2014). UHC is heralded as a tool for development (Evans, Marten, and Etienne 2012) and as a catalyst for a ‘third health transition’ (Rodin and de Ferranti 2012).

Like Alma Ata, UHC also holds that citizens have to participate in the design and development of health provisions. This requires citizens to work with the state, with financing agencies, and with healthcare providers as ‘co-creators of value’. Most interventions under the UHC umbrella are hybrids of common/private good principles. They combine the state’s overall responsibility for providing healthcare with citizens’ responsibility to become active participants. UHC tries to combine the spending power of the state with the presumed

efficiency of market capitalism. Providing all citizens with equitable access to healthcare has become an explicit policy goal in many countries, including India.

In India, the key sources of healthcare financing are household out-of-pocket (OOP) payments, governmental health provisions, religious charities, private health insurance, and government-funded health insurance. From the 1940s to the 1990s, the politics of health in India were driven by 'common good' ideas. In 1946, the Bhore Committee proposed a comprehensive plan for a government-funded health system that would be open to all citizens. India's public provisions were chronically under-funded, however, and since the 1980s, the first proposals for health market liberalization were made. From the 1990s, health policy leaned towards private good, while retaining an outwardly common good veneer. Even when governmental policies were committed to health as common good, the reality was always that the majority of expenses had to be shouldered by people themselves. Private OOP payments have always been the most important source of financing in India, even during the post-Independence era when successive Indian National Congress governments prioritized building up a public infrastructure.

In this context, catastrophic household expenditures due to high OOP costs are a leading driver of poverty. Catastrophic expenditures happen when the cost of medical treatment is so high that households: have to cut back on essential items, such as food or children's education; take loans at high interest rates; or sell vital assets such as land. In its National Health Policy of 2017, the Indian Ministry of Health and Family Welfare recognized 'catastrophic expenditure due to health care costs' as one of the four most pressing problems in the country's healthcare system (Government of India 2017, 2). In the 2014 draft of the National Health Plan, the government diagnosed a 'failure of public investment in health to cover the entire spectrum of health care needs' (Government of India 2014, 8) and a 'worsening situation in terms of costs of care and impoverishment due to health care costs' (2014, 8). People's OOP expenditures were 'more impoverishing than ever' and treatment in government hospitals could not protect against catastrophic health expenditures (2014, 8). The Ministry estimates that 63 million people in India fall deeper into poverty every year because of OOP health costs (Peters et al. 2002; Shahrawat and Rao 2012). In 2011–2012, 18% of all Indian households experienced catastrophic health expenditures, up from 15% in 2004–2005.

In the 2000s, government-funded health insurance (GFHI) has become a major new policy. GFHIs are hybrids of common good and private good principles. The first India-wide GFHI was Rasthriya Bima Yojna (RSBY). It was launched by the Central Government's Ministry of Labour and Employment in 2008 and subsequently implemented in most states of the Union of India (Ahlin, Nichter, and Pillai 2016). RSBY promised families 'below poverty line' (BPL) up to Rs. 30,000 (\$400) for medical expenses. Families enrolled for Rs. 30 (\$0.41) to obtain a biometric smartcard. They would then take this smartcard to any hospital 'empanelled' in RSBY to claim for expenses. The RSBY smartcard was meant to make claiming and reimbursing benefits 'safe and fool proof' for all participants – the claimants, the hospitals, private insurance companies, and the state governments.

Despite much hype when it was launched, RSBY was never very effective. The enrolment process was run by private insurance companies that aimed for high enrolment numbers and low claimant numbers. The government incentivized them to enroll as many people as possible because they got a premium for each person joining. In turn, private insurers did not benefit from anyone making claims. Another drawback was that most actual medical

expenses were not covered. RSBY reimbursed some surgery expenses, but neither reimbursed outpatient treatments nor medications—the two principal sources of household health expenditures (Garg and Karan 2009; Shahrawat and Rao 2012). RSBY has had a mixed impact, with some research reporting positive (Kamath et al. 2014; Sinha and Chatterjee 2014) and others negative consequences (Dasgupta et al. 2013; Selvaraj and Karan 2012; Sinha and Chatterjee 2014). Because of its many shortcomings, RSBY was replaced in 2018 by a new India-wide GFHI scheme, the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PM-JAY). PM-JAY has a wider reach than the RSBY (as covers 50 crore beneficiaries with Rs. 3500 crore of government spending (\$470 million) and provides benefits up to Rs. 5 lakhs (\$6720) per eligible family. However, many doubt that PM-JAY will be any more successful than RSBY because its budget is insufficient for what it sets out to achieve (Mahal and Mohanty 2019).

All the Indian GFHIs are based on the idea that beneficiaries are not getting an indiscriminate government handout but have to be active ‘co-creators’ of healthcare value. This citizen’s duty to participate individually takes several forms. For example, individual co-payments are meant to avoid that people seek healthcare for frivolous reasons just because it is free. Individuals are given a choice of different empanelled hospitals so that they can select the one that offers the best value. GFHIs are supposed to give better returns on investment than direct government provisions because they draw on the decision-making powers of individuals in a free market. GFHIs assume that the citizen, conceived as a rationally choosing homo oeconomicus, operates in a transparent market and has all the necessary knowledge to make optimal decisions. It assumes that RSBY cards would give private people the same bargaining power that cash from their own pockets would. Giving citizens discretionary spending powers would turn them into savvy, rationally choosing subjects whose demand brings down prices and enhances quality by private healthcare providers.

What is missing from the policy discourse is qualitative data on how this co-creation of value works in practice. The people who designed the GFHIs do not consider the gaps between what they think are the value-creating powers of these schemes, and how valuing works in practice. GFHI policies imagine that the value that citizens co-create is about access and quality of care. However, as our ethnographic study of GFHI clients in Karnataka reveals, there are many other value dimensions that people care about that are not considered by policy-makers.

Here we draw on an expanded concept of value as social process (Ecks 2022). Value creation is any action or decision that makes life better. Valuations are contextual decisions about which choice is better or worse for life than others. Any form of valuing needs to find relevant criteria for comparisons between choices. What these relevant criteria are is an upshot of a social negotiation. Valuations work by comparing two or more entities along relevant criteria. Valuations are social processes because they usually involve several transactants, each of whom can use different criteria of what is valuable. Each transactant makes their own value calculation, and what seems ‘worth it’ to one transactant may not look worth it to another. The criteria for comparisons vary by social, cultural, and economic contexts (Espeland and Stevens 1998). In her work on how people in Vietnam evaluate private health insurance, Dao (2020) calls these comparisons ‘anticipatory activities’. As social processes negotiated among different transactants, valuations rest on many factors, including degrees of mutual recognition, transparency of what is transacted, routinization, institutionalization, expertise, and technological complexity. In this study, we analyze how

criteria for value comparisons differ between policy-makers on the one hand, and lay beneficiaries on the other.

For policy makers, all the relevant criteria for evaluating GFHIs are about quality and cost. The value of GFHIs can be measured by the quality of healthcare relative to expenditures, and by lowered costs of healthcare for households below the poverty line. But there are many more ways in which value can be enhanced or diminished. People use them without recognition by policy-makers.

Our fieldwork in India revealed how value matters to people in everyday practice. Households used and invoked value to articulate the meanings they attached and experiences and expectations they had with the RSBY health insurance. Peoples' valuations of health insurance became the core subject of our study. Our key finding is that the people for whom government-funded health insurance would be expected to be highly valuable often find these schemes worthless because they evaluate them along different criteria than the policy-makers.

By participating as rational decision-makers in the market, patients are meant to co-create healthcare value. But the architects of GFHIs never explored if beneficiaries would become co-creators of value in the ways that the policy envisioned it. This omission is all the more glaring as UHC policies put so much emphasis on people's active participation. The way that people value GFHIs overlaps with how policy-makers think they would value them, especially the financial benefits of participation. Valuing RSBY for whether it made healthcare more affordable and accessible was easy for lay beneficiaries. They recognized the dimensions for the practical worth of RSBY coverage and compared its value to both their own household means and to the benefits of other government-funded insurance schemes. But as our fieldwork data show, people's valuing practices go far beyond the criteria deemed relevant by the policy designers. There were other dimensions along which people evaluated the value in RSBY cards. These dimensions existed and evolved in relation to how other social actors central to RSBY-health insurance, such as public officials, doctors, nurses, hospitals, neighbors, family members, the local community and political leaders related to the health card. In people's valuations beyond what the policy intended, RSBY did not simply create and add value but also subtracted and destroyed value. That participation in an insurance scheme that carried next to no financial cost to the beneficiaries could be experienced by them as profoundly devaluing was never envisioned in any of the policy designs.

Our study draws upon longitudinal qualitative and ethnographic data from villages and peri-urban areas in the region of Gulbarga and Mysore districts of Karnataka in Southern India between 2014 and 2019. Karnataka launched RSBY in 2008. The field research included participant observation, case studies, and in-depth interviews to understand how health insurance schemes designed at the state level were perceived and experienced in local worlds.

The households we studied belonged to the social benefits categories recognized by the government of India, either Below Poverty Line (BPL) or Above Poverty Line (APL). We encountered three types of households, (1) that had enrolled in an GFHI but had not used it; (2) that had used one; and (3) that had not enrolled in any insurance scheme. Most of our interviews took place with more than one household member. There was no clear pattern of any gender or age difference in who was silent and who spoke in these households, and we talked to anyone who wanted to talk. In a significant number of interviews,



neighbours dropped in during the interview and added their perceptions and experiences. In the household interviews, we spoke with 138 people, and with many more beyond the household settings. All personal names of respondents were anonymized.

As the household interviews progressed, we began to see patterns in how household articulated their experiences of GFHIs. We discovered a complex language of value that people used to describe their experiences with health insurance. Value emerged as a native concept that people used to make sense of health insurance.

Lay people's experiences of health insurance were strongly influenced by formal providers of various types, especially hospital staff, district health officers, medical doctors, and insurance company agents. We also conducted in-depth interviews with the various providers. The juxtaposition of beneficiaries and providers allowed for triangulation of findings.

For a comprehensive study of experiences with health insurance in Karnataka, we also did participant observation at insurance enrolment stations in the periurban areas of Gulbarga. We observed the interactions among key stakeholders, such as government officials, insurance companies, and the families present at the site of the enrolment.

### Local valuations of insurance

Good insurance covers the right treatment, at the right time, in the right hospital, with no or only minimal out-of-pocket costs. All the people we interviewed in Karnataka valued accessibility, affordability, and quality healthcare. They appreciated that government-funded insurance schemes like RSBY were meant to help them obtain this kind of care. They evaluated GFHIs by several criteria: (1) how much financial ease they provided, relative to household income; (2) the maximum amount of expenses covered; (3) the range and types of illnesses covered; (4) the range and types of hospitals (private, government, charitable) that would accept an insurance; (5) potential transaction costs that could come from using an insurance scheme, including bureaucratic procedures.

Ms. Ansuya first obtained an RSBY card in 2015. As a peon (low-skilled janitor) at an Ayurvedic College Hospital, she only earns a monthly salary of Rs. 3500 (\$47), which falls far short of the long list of expenses she has to take care of. Her husband is suffering from paralysis. They both have a range of chronic conditions, including high blood pressure and diabetes, which require regular medication intake. For Ms. Ansuya, the RSBY card had value in helping to ease the financial burdens of healthcare. She found, however, that the card did not help enough: 'The card has eased our burden by just 25%. If the card provided 100% [of expenses], then this help will be meaningful. We are very poor and ill; we have to constantly pay for getting tested and for medication for our chronic problems. On top of this, we have had to pay for pre-tests, for tests, and for treatments that my husband and I have had. My husband was not properly employed and so we do not get any compensation or payment for my husband's disability. It is only my low income [that pays for healthcare expenses]. All these expenses should be taken care of by the card, that would be meaningful help to poor people like us'.

The majority of people we talked to shared Ms. Ansuya's views. For example, Mr. Raju lives with his mother and brother and they have a few small businesses. Mr. Raju once tried to use the RSBY but failed to get any cover. He said it was unclear where and how it could be used, and what conditions would be covered. Recounting the experience, Mr. Raju expressed his disappointment with the RSBY card: 'We came back [from the hospital] and



threw the card away in disgust. We realized that having the RSBY card is like having butter that can only be seen but not be eaten. Mr. Raju compared RSBY unfavorably to another GFHI scheme, called Vajpayee Aaroygshree (VA), which he thought covers more expenses: 'Of course, people really want RSBY to cover all expenses, like VA does. RSBY is no good, it is incomplete and nonsensical that we pay part of it and government only pays the rest of it. It is complete nonsense because it is not a complete help.'

Mr. Sundar's family had once used the RSBY card for a diabetes-related emergency eye surgery. He lamented RSBY's insufficient and unpredictable cover: 'The consultation was covered, but the medicines we had to buy ourselves. Even the injections we had to cover! The hospital administrators told us verbally what the bill would be and then made out a completely different one in writing. And that's after we were told that RSBY would take care of all issues and that we would receive help. If we have to pay such a significant amount ourselves, what is the "help" we receive? Any sensible person realizes that the card is very difficult to use. Many thought that the card is not worth enrolling for.'

Not all cardholders saw RSBY as worthless. Mr. Hanumantappa, a 63-year-old man, managed to use the family's RSBY card for his daughter's eye surgery after a work accident. The expenses of the treatment were low but even then, RSBY did not cover all costs. Still, Mr. Hanumantappa was content enough. He said that the government was trying hard to help poor people with all sorts of benefits. People should be more grateful for what they receive, even if it is not everything they want: 'The government helps us with food and employment, it does all it can afford to do. The public only complains. To tell you the truth, it is the people's fault that instead of making use of the card that the government has given, they are critical of it. The government is doing a good job in helping people like us with health. It is not the government but the public that should be advised'. Others also said that a little help was clearly better than no help at all.

Mr. Somnath, who saved 75% off an eye surgery thanks to RSBY, felt that having the card was not just saving him money but also giving him 'moral support and courage'. Significantly, almost all the households that held RSBY in positive regard had used it for eye surgeries, most commonly for cataracts. It was a common opinion that the card worked best with eye treatments. This association was so strong that some believed that RSBY was designed to cover cataract surgeries. Another reason why so many people mentioned eye surgeries was that eye problems are not as stigmatized as other conditions, such as cancer or any genitalia problems. A beneficiary who had used the card for a hernia operation did not want to reveal this. In our interview, the household head did not want to acknowledge that he had used the card at all, though we knew he had because we had previously interviewed some of his relatives.

The value of health insurance was much diminished by how difficult it was to get claims accepted in private hospitals. Mr. Sanjiv and his father were disappointed when they tried to use their RSBY card: 'Getting medical tests and surgeries does not solve the issue. Payment logistics creates a difficult situation. There is no coordination between different government and medical departments. It is all a mess. We were able to save money but had to pay for certain tests. But there were no clear instructions and information. We are frustrated due to a lack of coordination between different levels and departments. Like finance people are not sure of the empaneled hospitals that accept RSBY and the office that checks finger prints do not have accurate information from office in Bengaluru where all the data on biometrics is preserved. If we carry the card, we can hope to save money but it is a struggle because of

so much of confusion. The government washes its hands of thinking it has done its job by distributing the cards. They need to offer follow-up services for the card to be useful to poor and illiterate citizens like us’.

### Valuing awareness

People evaluate government-funded health insurance schemes by quantifiable criteria, such as the amount of financial cover provided or how many conditions are covered. But they also evaluate insurance by criteria that cannot be expressed in monetary value. One of these value dimensions was knowing when, where, and how to use an insurance card. If people do not know how to use it, they cannot become ‘co-creators of healthcare value.’ The majority of our respondents mentioned an extreme dearth of information about RSBY. This knowledge gap had several sources: government officials and RSBY representatives not informing people properly; local politicians and community leaders not playing their part; and lay people themselves not helping each other out.

Mrs. Savitri complained about the lack of information that she was given by RSBY representatives: ‘We were glad to receive the card. But we wish we also had adequate information. Government officials did not share any information. Yes, we might be illiterate, but if you explain things clearly, we can understand. At the time of the enrolment, no one gave us any information. They just handed the plastic card with a pink pamphlet, which was not even in Kannada [the state language]. I cannot read well. There were enrolment officers and our own aganwadi [child health] worker and field key officer, but all they did was take the pictures and thumb print and printed the card. Without information about the card, what value does it have? If public officials only give us the card without telling us how to use it, the card is just plastic material. Sometimes information is also not correct, making us feel that card is of no real value if we do not know how to use it.’

Mrs. Savitri’s family had managed to use the RSBY card twice. She worked as an aayaa (nurse) in the hospital where the treatments were reimbursed. Her workplace familiarity with clinical staff made them help out with the treatments: ‘I know the doctors who run it and so my personal familiarity with the doctor and his wife, who is also a doctor, helped. Even some co-workers helped.’ She felt that this extra support from hospital staff was vital. On its own, RSBY gives far too little information to beneficiaries on how they are supposed to use the card: ‘We do not receive much information and support to use the card. Not in the hospital, not from doctors and nurses.’ She had tried to use the card in other clinics but ‘there is no support and acknowledgment from doctors and staff’.

Even households with higher degrees of education found it difficult to use the card because of the arduous bureaucracy. Mr. Giriappa, who worked as an administrative official in a private company, was able to use the card despite the people who run the scheme: ‘We were able to use the card because I have contacts. Public officials are very callous and ill-informed. If the same public officials who distribute the cards are themselves ignorant about how RSBY works, what is the value of the card for recipients like us?’

When Mr. Rajendra mentioned that he had used the card successfully, he thought that others in his neighborhood might be greatly interested in learning from his experience. But no one showed any curiosity: ‘People just do not debate because it is not in their value system. When someone talks about health, other people don’t connect. You can give biscuit

and tea but still you will not get any response. There is no discussion about any health-related issues’.

Many respondents lamented that local leaders showed no interest in community health and social development. Mr. Girish pointed to the lack of health leadership by local politicians. ‘People are not interested and leaders also do not take any initiative to generate any discussion. There is a lot of ignorance about health issues in general and not just RSBY because local leaders do not get involved in any health-related matters. They will not get any votes talking about health issues. But leaders should be responsible and emphasize the significance of health and have public discussions on facilities, such as health card. If they do not discuss, people will forget about the card and not have enough information how to use it. Politicians are interested in playing politics and in what brings them votes. RSBY card is of no value to them and people will not value it beyond just getting it’.

Mrs. Deva confirmed Mr. Girish’s views: ‘We got the card because the ward office sent an announcement about the enrolment’, Mrs. Deva said. ‘After that there has been no interest from the local leaders. They themselves do not know much of the details. In fact, we see them only a little before the elections. How can we know the value of the card when people who give it do not care to talk about it? It is never a subject of any discussion with them. The card is like a decorative piece that we have kept in that showcase, and that is its value. It is another piece decorating the shelf. If it is not talked about and debated, we can only think that there is no big value that we should pay attention to’.

### Valuing respect

Policy-makers thought that GFHIs would enhance poor people’s market participation as empowered consumers. As co-creators of healthcare value, they were supposed to be taken seriously and be respected when going to private hospitals. Yet it was a widely shared experience that GFHIs failed to raise poorer people’s social status.

Mr. Shivakumar tried to use the RSBY card on several occasions, but failed repeatedly, not just in getting treatment costs covered but also in being seen as a full citizen: ‘We went to the hospital with the card. Not only could it not be used, but the doctors did not even acknowledge us as patients, although we were carrying the card. They kept saying: “wait amma, wait appa”. They should be interested if we have the card or not. They do not ask. When we tell them, they ignore us.’ Being promised greater social recognition and then be treated with as little respect as previously was a hurtful experience. For Mr. Shivakumar, the card was worse than worthless because it diminished his sense of social standing: ‘We brought the card home and tossed it on the shelf. It is eating dust there. How can we value the card when the doctors and nurses—who should acknowledge the card and respect us when we bring the card—do not value it themselves? Having the card makes us feel that we do not have value’.

Mr. Sanjiv used the card for his father’s hernia and kidney surgeries. He felt lucky that RSBY covered a substantial share of the medical expenses. He still felt that the card did not translate into more social recognition from clinical staff. They did the treatment required of them, but they did not value them as much as private patients who could pay with their own money. Clinical staff could earn money on the side by sending paying clients for extra diagnostic tests or asking them to buy extra medications. Those who came with RSBY cards were regarded as too poor to afford these extras, hence they were far less valuable clients:

‘Clinical staff are always trying to make money. Patients are a source of money for them. Patients with RSBY cards do not get much attention because we are “free” patients.’

### Valuing inclusion

Anthropologists working on moral economies in peasant societies describe the ideology of the ‘limited good’ (e.g. Dundes 1992; Foster 1965). Life, and everything that sustains and nourishes it, is imagined as a strictly limited quantity that cannot be expanded. In a world of the limited good, another person cannot have whatever one person has. Possession of a life-giving good effectively means dispossessing someone else of it. An ideology of the limited good is typically found in pre-capitalist economies that do not share capitalist doctrines of ‘limitless’ growth. Yet our ethnography of how people in Karnataka value RSBY cards expresses an idea of healthcare financing as a limited good. And it was this false perception that contributed as yet another criterion for valuing the RSBY card that was not intended or anticipated by policy-makers: people tried to increase the value of health insurance for themselves by consciously withholding information about it from local others. As a limited good, people did not want to share information with others about how to use insurance cards. Many also concealed from others when they had used insurance successfully in the past for fear of diminishing its value for themselves in the future. The belief was that others using it and knowing more about it would diminish the value of their own card. Households believed that the effectiveness of the card and even money allocated to the card would diminish if other households used their cards. This secrecy was itself borne out of a lack of understanding how government-funded health insurance worked. The way that RSBY enrolments are designed is that all eligible households in a locality were asked to queue at the enrolment station on the same day (Ecks 1969). The procedure is so open and public that people know exactly who else went to get a card, hence they should be in a good position to share insights with each other. In practice, however, people avoid sharing any information with others for fear of diminishing their own healthcare value from the card.

During our interview on RSBY, Ms. Seetha said that her son was sick and she wanted to try the RSBY card for his treatment. She requested that she could be in touch with one of us (Kulkarni) to get directions on how to use the card. In the conversation that ensued, Kulkarni expressed her confusion about why Ms. Seetha would want to talk to her rather than to her relatives and neighbors—who also, we both knew, had the card. In reply, Ms. Seetha not only lamented the lack of information that the public officials gave about how to use RSBY. She also lamented the pettiness of her neighbors and relatives, who would consciously withhold information about how to use the RSBY card: ‘No one talks about the card’, Mrs. Seetha complained. Many other respondents mentioned this in our interviews. For Mrs. Savithri, people did not want to share valuable information with each other: ‘There is no sense of community, although we live so close by. There is a feeling that sharing information about the card will diminish the benefit for them.’

We also found many instances of people who were neighbours, or relatives staying in the same compound, and yet who had no knowledge of others also having the card. There was a striking absence of sharing information. This avoidance of sharing insights was not always strategic, it could also be due to miscommunication or lack of opportunities to meet and talk. Mr. Govind once needed surgery. He had enrolled in RSBY but did not use the card because he did not know that it could be used for surgery expenses. It was only when

we interviewed him that he remembered that he actually has a card: ‘Oh, we have used this card!’ During our conversation, Mr. Yogesh dropped by. He was Mr. Govind’s older brother and lived close by. Hearing us talk about RSBY, he interjected that he also has this card and has used it. Both men were genuinely surprised that they both had RSBY cards but had never shared any knowledge about it with each other; ‘We could not remember using the card’, Mr. Yogesh said. He regretted that they had never spoken about it to each other: ‘It would have helped my younger brother for sure, but we just do not have any conversation and memory about the card. We just began to remember because you visited and are asking about the card.’

### Valuing the public sphere

In some cases, this lack of communication came from low educational levels and from not understanding how health insurance works. The opposite could also be true, that higher educational attainment made people think they did not need to talk to others. As one respondent with a higher level of schooling remarked: ‘Some people here are smart. They want to keep all the valuable information to themselves. And they have less of a helping nature.’

Mr. Girish, a 65-year-old retired clerk, thought that the profound lack of peer-to-peer communication about RSBY was emblematic of lack of local leadership and lack of community spirit more broadly. Health, as a common good, required a sense of altruism and willingness to share, but this was sorely missing nowadays: ‘There is no sense of community. Local leaders are concerned about winning elections and do not see health as a hot button issue and there is no public togetherness and unity on health matters. There are only selfish individual interests around and no one wants to work toward cause of the common good. There are so many pigs in the block! And no one complains. I am saying and complaining and there is no action of local leaders and so no one collectively gets together. Here they all are thinking of their own selfish interests.’

### Value diminished

India’s government-funded insurance schemes combine common good and private good principles. They were designed because the state felt responsible to give poorer citizens better access to quality healthcare. Yet they also depart from former government-funded health provisioning by making individuals responsible for choosing between providers and for making decisions about how to spend their allowance. The state withholds funds for public health infrastructure and steers individuals to spend public money in the private sector. Instead of reducing social inequalities through direct government investment, neo-liberalism wants to responsabilize individual citizens (Gupta 2012, 241–242). GFHIs are a kind of state-driven market liberalization that aims to turn citizens into co-creators of healthcare value. However, the designers of these policies never explore whether this actually works on the ground. What our ethnography of health insurance in Karnataka shows is that people do not become co-creators of value because GFHIs are too obscure. For people to participate ‘individually and collectively in the planning and implementation of their health care’ as the Alma Ata Declaration envisioned it, would require far more public

knowledge about how insurance schemes work. Programmes like RSBY failed because lay people were never put into a position of becoming the co-creators of value the policy envisioned. The creation of rational, savvy healthcare customers in a liberalized market could never work because people were given far too little information and resources about how to be knowledgeable participants. Individuals are asked to co-create healthcare value by their decision-making in the market, but the lack of transparency makes this impossible. In the process, people indeed engage in valuations but with often very different criteria than the policy-makers. People apply criteria for what adds or subtracts value that was not part of the design. Some of these valuing practices directly undermine the effectiveness of the scheme, such as the idea that sharing information about RSBY detracts from the value of one's own card. Similarly, the medical community that is supposed to honor the cards instead adopts an attitude of 'poor medicine for poor people.' If policy-makers want to with people as co-creators of value, they have to listen to what they value, and be willing to change their approach when it turns out that what people actually value is not what they had envisioned.

### Ethical approval

Ethics for this project were reviewed and approved by the University of Chicago and the University of Edinburgh.

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