Design, Implementation, and Patient Experiences of the Rashtriya Swasthya Bima Yojana and Vajpayee Arogyashree Scheme: A Qualitative Study from Bangalore District, Karnataka

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Over the past decade and a half, growing privatization and commercialization of the health sector, particularly of tertiary care, has ensured diversion of public funds as subsidy for capital costs while increasingly encouraging uptake of private health insurance and promotion of managed care. In India, this involved a substantial transfer of public assets for private interests, with the state retaining only the liabilities for default. Incentives to the private sector included allotment of land, subsidies for medical equipment, tax waivers, and bank loans. The Public Private Partnership (PPP) models in state insurance schemes for health were a part of this trend which was supported by the World Bank as a way to universal coverage and, ‘a promising foundation for a reformed health finance and delivery system’ (Nagpal 2013).

In addition, health insurance, with its third party payment also provided an incentive for cost escalation (Institute of Public Health 2009). States such as Delhi, Andhra Pradesh, and Tamil Nadu were spending well over half of all government expenditure on tertiary care, falling prey to a distorted consumer demand, misguided medical profession, and the medico-industrial complex (Reddy et al. 2011).

This paper asks whether it is the patient demand that is distorted or the very planning of state-led insurance systems. Systems that focus only on secondary or tertiary care interventions (with emphasis on hi-tech interventions) at the cost of primary healthcare do nothing to lower demand for tertiary care by strengthening disease control and prevention programmes. The paper is an attempt to understand how the design and implementation of the Rashtriya Swasthya Bima Yojana (RSBY) and the Vajpayee Arogyashree Scheme (VAS) make such distortions possible. It records people’s experiences with these schemes and how they impacted the public health system in general, and patient rights in particular.

Based on a field study with the above objective, the paper first presents the methodology, then findings on the two schemes, and finally a discussion and summary.

Methodology

The study was conceptualized in a way so as to capture the complexity of the structural, administrative, operational, and service dimensions of the two schemes, and used a combination of qualitative methods to collect data over a five-month period. Based in Bangalore Urban, it followed certain processes and stakeholders in Tumkur, Haveri, Raichur, Bellary, and Bijapur districts.

All six Focus Group Discussions (FGDs) were conducted in Bangalore city: one each with the three unions—domestic workers, construction workers, and auto rickshaw drivers; two low-income communities (Jayanagar and New Byappanahalli); and one with families of patients seeking treatment under the VAS. Between 15–17 respondents participated in each FGD. All FGDs and interviews with community members (12), government officers (6),1 and researchers (2) explored both the RSBY and the VAS.

* Sarita M: Rekha Chakravarthi: Jagrut Mahila Sanghatan, Potnal, Raichur; Domestic workers rights union; National Centre for Labour; FEDINA; Autorickshaw Driver’s Union (ARDU); Communities in Jayanagar, New Bypanahalli; Patients and respondents who shared their experiences and insights.
Interviews with staff/implementers in the scheme explored scheme-specific issues: RSBY Society (2), Suvarna Arogya Suraksha Trust (SAST) (2), SAST staff (5); representatives of VAS empanelled hospitals (6). Representatives from insurance companies and their Third Party Administrators (TPAs) under the RSBY could not be interviewed as these companies had completed their tenure in August 2013 and refused interviews. New insurance companies were selected only in March 2014.

Three district-level VAS camps in Haveri, Raichur, and Tumkur, organized by two empanelled hospitals were observed.

Participant observations were conducted with eight patients seeking care under the VAS over a two-month period.

A Right to Information (RTI) application from the RSBY Society sought data about Memorandums of Understanding (MoUs) with empanelled hospitals, claims processed, and funds released for Bangalore Urban.

FGDs and interview guides and observation checklists were used for data collection. Using an informed consent form, researchers explained the context, purpose, and objectives of the study and responded to questions and clarifications before seeking oral consent from all participants including staff/officers. FGDs and interviews were taped only if respondents consented. As a confidentiality measure, the paper only cites respondents’ generic designations, affiliations, and locations.

Detailed notes were taken during interviews, discussions, interactions, and of observations, which were expanded into full transcripts and analysed separately for the RSBY and VAS. RTI data and material from the RSBY and SAST websites were compiled for mapping the structure and processes in the two schemes.

**Rashtriya Swasthya Bima Yojana**

The RSBY Society under the Department of Labour is the State Nodal Agency in Karnataka that appoints Insurance Regulatory and Development Authority (IRDA) accredited insurance companies through a bidding process and enters into a MoU with insurance companies selected to:

- Empanel hospitals.
- Appoint TPAs to manage claims.
- Conduct awareness and training.
- Enrol beneficiaries.
- Coordinate with the Society and panchayats.
- Issue smart cards.
- Address all issues related to the implementation of the scheme.

The premium amount payable (state and Central share) to the insurance company is released based on the number of eligible families enrolled in that district. The role of the State Nodal Agency is:

> Our interaction is only with the insurance company. We do not interact with any other agency. The insurance company in turn has to deal with the TPA and monitor its activities.

—Officer, RSBY Society

In Karnataka, selection of new insurance companies every three years seems to have caused serious disruption. The Society put the scheme on hold from August 2013 for nearly eight months when all activities came to a standstill. Beneficiaries could not use the cards; new cards were not issued nor were old cards renewed.

**BENEFICIARY DATA MANAGEMENT**

The RSBY Society initially used the Below Poverty Line (BPL) data generated by the Department of Rural Development and Panchayat Raj in 2003 by which it identified only 1,700,000 beneficiaries. But soon, the state government extended the scheme to all ration card holders in the state, and by this the figure jumped up to 9,500,000 beneficiaries.

But the Society was ill-prepared to mobilize and manage beneficiary data. Even though it collected application forms from unions of domestic workers and construction workers in 2012, none of the union members had received RSBY cards till date:

> 7–8 labour commissioners were transferred in a single year. There was absolute chaos. It was difficult for me to apprise the newcomer about the scheme and convince him to take any decisions. So those applications are still pending.

—Officer, RSBY Society

**ENROLMENT IN BANGALORE URBAN**

FGDs and interviews with unions of domestic workers, construction workers, and auto drivers in Bangalore Urban highlighted confusion about the process of enrolment, issue of cards, its uses, and the process of seeking treatment.

> Our area leaders asked us to bring all the sangha women for a function where the corporator gave away the cards. We were told we can use these cards even in private hospitals and get treated for big problems.

—Sangha leader, FGD, Jayanagar
Women with RSBY cards had tried using them but failed to obtain any care. Further, the card’s utility was limited as it did not cover outpatient care for which they spent routinely Out-of-Pocket (OOP):

*This card is of no use when I go to the neighbourhood doctor every other month with body ache, headache, fever, cough, and cold. I should get admitted to get any benefit. Who will admit me for such problems?*

—Domestic worker, interview, Jayanagar

The enrolment figure for the RSBY in Bangalore Urban district for the year 2012–13 was 25,687 with a claims ratio of 0.02 (RTI application 2014). Such low enrolment seemed to be a larger pattern as indicated by an earlier study of the RSBY in Karnataka which found that a full 38 per cent of enrolled households had not received their cards even about 5–6 months after the policy had commenced with the insurance company gaining from households that had enrolled but not utilized the scheme (Rajasekhar et al. 2011).

SMART CARDS

One of the main critiques of the RSBY has been the technology-intensive design. The RSBY Society acknowledged that the 32 kb smart cards were subject to a lot of manipulation by vendors who sought to print the card at a later date in spite of being mandated to issue cards on the spot. This problem was reported to the Government of India in 2010–11 following which the scheme was put on hold to ensure that the 32 kb cards were replaced with ‘more durable’ 64 kb cards. As expected the 32 kb cards would be junked:

*Those are all useless. They are not valid any more. We will now be issuing 64 kb cards which are more reliable and durable.*

—Officer, RSBY Society

EMPANELMENT OF HOSPITALS

The RSBY Society did not even have a copy of the MoU between the insurance companies and the empanelled hospitals and placed all responsibility on the insurance company:

*We are not involved in that process. It is up to the TPA and the insurance company. We don’t get into all those details and intervene only if there is a dispute.*

—Officer, RSBY Society

Of the 79 hospitals mentioned on the website as being empanelled in Bangalore Urban, only 21 of them had been reported active. Claims settlement for private empanelled hospitals for the period 2012–13 was Rs 6,649,485 while it was only Rs 360,250 for government hospitals, which constituted only 5 per cent of the total claims. This supports findings of other studies that health insurance schemes were benefiting private hospitals more than government hospitals (Nandi et al. 2012, Dasgupta et al. 2013, Prasad and Raghavendra 2012).

OVERSIGHT AND GRIEVANCE REDRESSAL MECHANISMS

In the complex maze of the RSBY, there seemed to be no system to ensure patient safety, adherence to treatment protocols, or quality of care with the Society absolving itself of all responsibility.

As per guidelines, complaints are entered in a portal on the RSBY website and an automatic Unique Complaint Number (UCN) is generated with an acknowledgement email or phone call to the complainant. When quizzed about how people without access or skills to use computers can register their complaints, the officer interviewed agreed that this was a difficult system:

*People have to register their complaint on the web based grievance redressal site. The concerned person can approach the District Key Manager (DKM), the insurance company, the TPA, or even the general public and seek their help to register their complaint.*

COMMUNITY NARRATIVES ABOUT THE RASHTRIYA SWASTHYA BIMA YOJANA

Preceding narratives indicate that the Society had been dogged by administrative problems, faced challenges with mobilizing and managing beneficiary data, and suffered disruptive processes that had put the scheme on hold for nearly eight months. The unions of informal sector workers found the scheme completely useless. They suggested cancelling these multitudes of schemes and investing all those resources in extending the Employee’s State Insurance (ESI) to workers in the informal sector:

*Be it the RSBY or VAS, they are all piecemeal and do not provide comprehensive healthcare. There are more exclusions than inclusions. The ESI model will work best for the informal sector as there are no exclusions and one can avail services from OPD to surgery. This has been our long standing demand.*

—Representative, construction workers’ union, Bangalore
A representative from the domestic workers union was unequivocal in her condemnation of the scheme:

*In the name of insurance, people are being cheated. According to me these insurance schemes and cards are all bogus. It is a big fraud. These are ways of exploiting the poor and eating public money in the name of the poor.*

A representative from the construction workers’ union asked a fundamental question:

*If the government hospitals work well—if the doctor is present, examines and treats patients with respect and care, and we get tests, treatment, and medicines in the government hospitals why do we need these schemes? All this has come up because the government system is not functioning.*

**Vajpayee Arogyashree Scheme**

The VAS (vide GO No. HFW 216 CGE 2008, Bangalore dated 20 February 2009) is implemented through the SAST registered as a separate body under the Indian Trusts Act. An Implementing Supporting Agency (ISA) manages day-to-day functioning, and has appointed its own staff to undertake a range of activities—mobilizing communities, organizing camps, processing pre-authorization for procedures, screening, and settling claims of the empanelled Network Hospitals (NHs).

The scheme was first started in the Gulbarga division covering 1,439,000 BPL families in February 2010, then extended to the Belgum division in the month of August 2010 covering 1,691,000 BPL families, and subsequently to the Bangalore and Mysore divisions in June 2012.

A total of 79 government and private hospitals have been empanelled. The NHs conduct taluk- and district-level health camps every week/month to recruit patients under the scheme.

The official documents of the VAS are very revealing. A camp guideline makes clear that:

*…the Scheme dramatically taps the hitherto untapped vast tertiary healthcare requirement…leveraging Public Private Partnerships to stimulate latent demand…*

—Annexure II on VAS health camp guidelines in the MoU

The SAST’s stated position was also unambiguous:

*The essence of PPP is that private players should not be affected unnecessarily and adversely by this process. So we should ensure that they do not lose anything.*

—Officer, SAST

The entire discourse and care provision under the VAS is underpinned by costs and package rates—costs related to patients’ travel, stay, and food; costs of diagnostics; costs of treating complications. In fact, one of the heads of an empanelled private NH described it aptly when he said:

*Now my entire concentration is on whether I will cross that 40,000. What suture I will use, what utilities I will use inside the surgical package. Now if I am focusing entirely on the economics of the surgery then how will I focus on the treatment of the patient?*

The SAST considered itself to be a ‘purchaser of health services’, and therefore, its primary concern was to negotiate package rates and prices:

*The government is a purchaser of health services. We negotiated and fixed a reasonable price. They agreed to the rates mainly because of the volume. We have been able to provide beneficiaries that will increase their viability. Otherwise why would they agree to these rates? All these big hospitals have grown because of government schemes like Yeshasvini and Vajpayee.*

—Officer, SAST

Therefore, the VAS by design, allowed the NHs to pursue numbers and ‘volume’ to stay viable. This is particularly evident when one observes processes under the cardiac packages of the scheme that are reminiscent of a production/assembly line system in a factory consisting of five fixed stages: a battery of tests (ECG, ECHO, TMT followed by an angiogram); diagnosis of ‘x’ number of blocks with ‘y’ percentage of block in each; pre-authorization approval for angioplasty with stent or ‘open heart surgery’; surgical intervention; and discharge (after three days in case of angioplasty/stent and seven days in case of open heart surgery).

Specialty interventions other than cardiac did not seem to lend themselves to such simplistic and clean service cycles. There were messy complications that needed longer duration of hospital stay and had lower recovery rates. Therefore, it made business sense to treat cardiac cases, where package rates were viable and the service cycle less messy. This created a huge incentive for NHs to comb through various district-level camps to bring in as many cardiac patients as they could to make a ‘reasonable profit’.

In Bangalore, super-speciality hospitals like Narayana Hrudayalaya, Sagar, Vydehi, and BGS account for 40 per cent of the treated cases and 43 per cent of the approved amounts. In spite of this, the average amount spent by patients in these four hospitals ranged from Rs 58,827 to Rs 69,832 (Rajasekhar and Manjula 2012).
The officer interviewed agreed that the scheme had been skewed in favour of hospitals providing cardiac care leading to deep resentment among those providing non-cardiac care such as cancer and neurosurgery:

To some extent the criticism that this scheme is tailor-made to help a group of people is true (laughs). This was expressed by several private hospitals. They felt that cardiac care hospitals had hijacked the scheme and others were left in a lurch.

These hospitals were upset with ‘unviable’ package rates and alleged that the expert committee’s recommendations for package rates had been ‘downgraded’ without any explanation:

The package rates have no scientific basis. The Trust has not shared the expert committee’s recommendations and is not revealing who down-regulated (sic: downgraded) them. These are completely unviable. With great difficulty we can operate upon the patient for 40,000.

—Private NH administrator

These NHs, therefore, had no incentive to conduct camps and recruit patients. Combined with unviable packages they had to deal with a high proportion of BPL card holders, which they had not bargained for:

We realized that almost everybody, including government servants, had BPL cards. We initially thought, the BPL category would be 30 per cent or less. So we would still have 70 per cent who would be paying patients. But 8 out of 10 elective surgeries now are being covered under this scheme.

—Administrator, Private NH

Some others raised concerns that BPL card holders were not truly the ‘poor’:

I have had BPL card holders come to the hospital in SUVs. That’s when I realized that this scheme is a fraud. Anyway ours is a charitable hospital. Our focus is on the poor irrespective of government schemes. So it made no sense for us to continue this scheme.

—CEO, Private NH

HEALTH CAMPS

Health camps are a mechanism to help all NHs recruit patients under the scheme. The scheme provides NHs a sum of Rs 5000 for each camp. In 2011–12, the SAST’s camp expenditure came to Rs 7,446,460. In addition it had spent Rs 10,853,971 for publicity:

This is an opportunity for the private hospitals to publicize, canvass, and make their presence felt. In fact, the scheme has also advertised the services and facilities of the NHs in its 2014 calendar.

—Officer, SAST

Health camps were conducted only by private NHs. Camp observations revealed health camps to be a fertile ground for private NHs’ aggressive ‘marketing teams’ to comb and pick patients who would give them the best chance of a profit. There was active recruitment of ‘viable’ patients. For instance, the marketing team actively intervened to obtain a BPL card for patients with a clear indication of surgery under the scheme:

You go to the taluk office and call the hospital’s field coordinator. He will talk to the food inspector there and ensure that your BPL card is issued. In Bangarpet, I have gotten the BPL card done in one day.

—Marketing executive to a patient, Raichur health camp

But ‘unviable’ patients were quietly allowed to fall through the cracks as in the case of a 35-year-old single woman with a kidney problem whose BPL card listed her as ‘daughter’ instead of ‘wife’. On knowing that without such a correction she could not access treatment, the woman broke down:

I have no one to do all the running around. I don’t have the strength to do it. What do I do? How will I get treatment?

But there was no support forthcoming from the NH’s marketing team that actively excluded ‘unviable’ patients such as the 60-year-old critically ill female 4th stage cancer patient brought to the camp in an auto and in no condition to walk. There was neither a stretcher nor a wheel chair at the camp. The patient was neither shifted to the examination room nor did the NH-doctors examine her. They only read her reports while the patient waited in the auto for half an hour while the marketing executive explained to her son why she could not be referred to Bangalore:

We can’t give guarantee that she will survive or reach the hospital alive. We have strict guidelines that we should not refer critical patients from the camp. What’s the use in taking patients who may not survive? There is no guarantee that such patients will survive. To top it, this is an oncology patient. This is not possible at all.

SEEKING CARE IN EMPANELLED HOSPITALS

Of the eight patients followed-up under the study, four were recruited by the NH in district-level camps while
the remaining four were ‘walk-in’ patients who went to the NH on their own.

As per the MoU of empanelled NHs, scheme patients either from camps or ‘walk-in’ are eligible for ‘consultation, medicine, diagnostics, implants, food, cost of transportation, hospital charges, post hospitalization cost up to 10 days, making the transaction truly cashless’. The MoU specifies that ‘under no circumstances, should the Provider charge any money within the treatment period as covered under the package’.

However, patient experiences revealed several violations of these guidelines along with those related to quality and continuum of care, patient rights, and principles of non-discrimination and equality.

**Segregation of ‘Scheme’ Patients**

Some NHs provided dormitory-like accommodation rented close to the hospital for the ‘poor scheme patients’. The dormitory observed was dark and dingy, a striking contrast to the five-star like hospital. But patients accepted such segregation as their lot:

*We have to go by the rules of the place isn’t it? If this hospital has rules that we should stay here, then we have to. They are giving us free food, stay, and treatment. What more can we ask for?*  
——Father of an 8-year-old girl with hole in heart

**Co-payments for Tests**

Patients reported being asked to pay for certain diagnostics, particularly angiograms. This was in violation of the guidelines. A walk-in patient from Raichur underwent an angiogram in a private NH after which he was advised an angioplasty with stent. He refused to undergo surgery and was, therefore, asked to pay Rs 6000 for the angiogram.

*Because I refused surgery, I had to pay for the test. If I had gotten the operation done then the hospital would have claimed the amount through the scheme.*  
——Walk in patient, 69 years, Raichur

*You decide right away whether you want to undergo angiogram or not. In case after angiogram doctor advises surgery and you decide not to undergo then you have to pay for the angiogram.*  
——Marketing staff to patient’s son, private NH, Bangalore

In a third instance, a patient with breast cancer shared her concerns about co-payment:

*A woman admitted in the same ward as me has been taking treatment for two years but hasn’t got better. But if you say that you are not getting better here and want to go elsewhere for treatment, they ask you to pay and leave.*  

**Violation of Ethical Procedures**

The Mou prescribes a format for seeking written informed consent. None of the patients or their attenders had either read the consent form nor had any one read it to them before they signed it. Attenders reported that the treating doctors spoke to them and explained the procedure:

*The doctor told me that even though he is 100 per cent sure, there is always a chance that things will not go as planned.*  
——Patient’s husband, government hospital

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Of the eight persons, seven consented to the procedure, while one refused. This was the 69-year-old walk-in patient from Raichur. When asked why, the patient said:

*I was anxious. I saw that they do the operation for everyone. Whatever be your condition they will get money only if they do operation. That's why I refused. I wanted to approach another doctor and see what he says.*

This patient asked for the CD of the angiogram to seek a second opinion but was refused. Some hospitals were also using coercive methods to ensure adherence to treatment as patient default attracted financial losses. For instance, the patient from Raichur undergoing chemotherapy for cancer of breast reported:

*They have taken my BPL card. They gave only the Xerox of the ration card. They said they will return the ration card only after I finish the chemo.*

**Duration of Stay and Default**

Recruiting patients from various districts across the state and bringing them all the way to Bangalore for surgeries was a viable business model for NHs. But for patients and their families, it was totally unviable. Staying away from work for days on end meant losing wages and jeopardizing their jobs. This in turn, had a direct bearing on decisions related to treatment, particularly of poor women patients:

*It is too much distance. Last time we were there for three weeks. I couldn’t go to work. This time I don’t know how long it will be. There is no one else to go with her. We have decided to try naati medicine here.*

—Brother of patient with cancer of breast

Distance in this case was directly responsible for defaulting on treatment.

**Post-surgical Complications**

According to the VAS guidelines, any complication arising during hospitalization was the responsibility of the NH. But if the patient returned with a complication after discharge, the hospital was not expected to provide care. This reflected an arbitrary understanding of what a follow-up entails in terms of time or complications. Some complications arise during surgery, some immediately after, and some at a later time. Continuity of care was a casualty in the scheme causing extreme distress to patients and their families.

Two of the eight patients suffered serious post-surgical complications—one immediately after an angioplasty, the other a month after open heart surgery. Both were from villages out of Bangalore.

Soon after angioplasty and stent, the walk-in patient from Kadur suffered a stroke:

*We saw him about two to three hours after surgery. He was conscious. Then I noticed that his mouth was drooping. I thought it may be because of the AC in the ICU. When he was being shifted to the ward I asked him to straighten his left leg. He tried but couldn’t. I went and informed the doctor. He checked and said he has had a stroke.*

—Patient’s brother-in-law

But there was no intervention from the hospital to deal with the complication and the patient was discharged the very next day. The researcher had to persuade the family to return for follow-up. The patient had been immobile after the stroke and had difficulty passing urine. When they came to the hospital for follow-up, the patient had not passed urine for three days. The urologist said that there was ‘problem with the kidney’ and there was little one could do and suggested they return home. The patient passed away three days later.

A 70-year-old patient from Haveri who underwent an open heart surgery suffered an infection in the sutures on his right leg, associated with features of sepsis. The family called the hospital and was told that they should seek care from local providers. He was never visited by the NH hospital personnel even though he was recruited through a camp. The patient was disheartened:

*I really don’t know what their responsibility is. They just do surgeries and then forget about the patient.*

Presently, the SAST has decided to involve district hospitals for subsequent follow-up of cardiac patients. It is proposed that the district surgeon will nominate one physician who will be paid an honorarium of Rs 100/patient/follow-up visit. This was part of the SAST’s fulfilment of World Bank milestones to strengthen ‘follow up procedures of top ten procedures of cardiology’ (SAST 2013c). It is not clear what follow-up protocols are in place for other specialties.

**FUNCTIONING OF THE TRUST**

If there were problems in scheme implementation on the ground, there were also several issues about the SAST’s functioning and the decisions made by its Board and Committees, raising questions about whose interests
they were serving, what impact it had on patient care and outcomes, and the extent to which the Trust was transparent and accountable in its functioning.

Board Composition

The composition of the Board itself was a cause for concern. The SAST did not seem to have any clear criteria or process for selecting members from civil society, the private sector, or the research community. For instance, representation of Narayana Hrudayalaya, the largest NH in the scheme, on the SAST Board constituted a conflict of interest. The officer in the SAST agreed that the scheme was taken over by one or two individuals dealing specifically with cardiac care:

These schemes are hijacked by two people who are sitting in all places. Their voices carry weight and they push their agenda. There is no regulation or control on them.

Protest by NHs under the Scheme

When the government announced the Rajiv Arogyasri scheme for the APL category, 15 of the 79 empanelled hospitals protested. In their memorandum to the SAST, they demanded revising package rates and settling pending claims, while also raising questions about lack of transparency in the Trust’s functioning, arbitrary decision making, and poor capacity of Trust doctors to process pre-authorization of complicated cases (The New Indian Express 2014, Kachhap 2014).

While the private hospitals seemed to be holding the Trust to ransom, they were also raising important questions about the Trust’s capacity and style of functioning. The officer in the SAST pointed out that these were a handful of hospitals whose profit margins were threatened:

The real issue is not package rates. Their hidden grouse is that they will lose profit margins with the new Above Poverty Line (APL) scheme that is going to be introduced soon. Till the APL scheme was announced there was not even one representation asking for revision.

While this was true, the Trust side-stepped issues related to its own functioning.

Keeping the NHs ‘Happy’

The Trust’s public posturing against protesting NHs contrasted with a slew of decisions taken by the Board and the Empanelment Committee in recent months that was clearly to keep the private NHs ‘happy’:

- The Trust’s double-speak was evident and there was no doubt as to whose interests it was anxious to protect:

I held a breakfast meeting with the major players in Taj hotel. I also had a meeting on 30th December with all 40 hospitals in my office and assured them that their interests will be protected in the APL scheme. We have agreed that they can charge APL patients who choose semi-private or deluxe rooms.

—Officer, SAST

Allowing NHs to charge APL patients meant leaving the field open for further manipulation by the NHs’ aggressive marketing teams.

- Presently all patients seeking treatment under the scheme could avail of free diagnostics, irrespective of whether or not they were covered under the scheme subsequently. However the Trust decided that NHs could charge patients a ‘minimum’ amount for diagnostics which was in complete violation of the scheme’s guidelines that said all transactions are cashless.

85–90 per cent diagnostics under the scheme are for patients who don’t get covered, which is an unnecessary expense. Therefore, we immediately decided to allow hospitals to charge patients a minimum amount so that hospitals need not suffer.

—Officer, SAST

While there was no clarity on what that ‘minimum’ amount constituted, patients’ experiences revealed that NHs were not reimbursing costs even for those covered under the scheme.

- The Trust cleared 3000 pending claims by approving 50 per cent randomly while the rest were scrutinized and approved by consultants/specialists and Trust doctors (SAST 2012). Of the total 558 cases pertaining to 2010–11 and 2011–12, 516 cases were cleared and Rs 26.54 million released. The Trust drew much appreciation for its ‘proactive action that helped strengthen the backbone of PPP’ (SAST 2013c).

Claims had been pending because of incomplete, inadequate documentation. The private hospitals said they could not trace these patients and are not able to produce documents. So we formed an investigation committee which verified with the patients that procedures had been done and based on their report, we settled all those claims.

—Officer, SAST
It was surprising that the Trust had been able to ‘trace’ the ‘untraceable’ patients, check on their welfare, and quickly dispose-off the 3000 odd pending cases. However, the underlying reasons why these cases had been kept pending were not addressed at all. Instead, the officer had instructed Trust doctors not to raise ‘unnecessary’ objections:

I have made a strict rule that individual doctors do not raise objections. Payments will not be withheld for more than seven days and will be made through RTGS [Real Time Gross Settlement]. With all these decisions, the NHs are very happy.

- The Empanelment Committee changed norms that could seriously impact the quality of care and patient outcomes, and which violated existing MCI/other treatment guidelines:
  - It permitted a surgical oncologist and radiation oncologist to administer chemotherapy (SAST 2014).
  - It approved a gastroenterologist to perform onco-surgeries in violation of the VAS guidelines which permit only onco-surgeons.
  - It allowed ENT surgeons to perform head and neck cancer surgeries.
  - It allowed orthopedic surgeons to do spine surgeries in consultation with neurosurgeons (SAST 2013a).

Based on recommendations from the World Bank consultant, the Committee decided to provide 2 per cent of the package amount as incentive to National Accreditation Board for Hospitals & Healthcare Providers (NABH) accredited hospitals (SAST 2013b).

These decisions contrasted with the Trust’s declared inability to control and rein in NHs engaging in cherry-picking. The officer of the SAST confessed that the Trust had been unable to curb such tendencies, indicating that it was willing to look the other way while NHs engaged in unethical practices:

These private hospitals have a marketing team which is much stronger than their treating team (laughs). I had to suspend one of the hospitals for organizing their own camps. We try to control them but they continue such practices. They also have a system of paying cuts to local private practitioners.

Irregular Empanelment Procedures

The SAST in its eagerness to expand its empanelled network, had empanelled a private hospital in Hyderabad that had been de-empanelled from the scheme in Andhra Pradesh (SAST 2013b), while the government’s super-specialty hospital in Raichur had been locked up for two whole years. The Committee also downgraded some of the empanelment criteria (SAST 2012):

- Reduced bed-strength from 200 to 100.
- Allowed empanelment of only one super-specialty hospital.
- Reduced criteria for specialist doctors from five years of experience to a limited experience of having treated 100 cases of oncology and 50 cases under cardiology.
- Allowed super-specialists with MCH or DNB without experience.
- Allowed specialists with PG having experience of five years instead of 10 years (SAST 2013a, SAST 2013b).
- Allowed appointment of one doctor between three empanelled NHs in a district.

Pauperizing Public Health Services

While several efforts were made to make the private NHs ‘viable’ and ‘happy’, the scheme had little to offer the government system. All it offered was petty incentives for supplying patients to NH camps thus reducing all levels of government functionaries to agents of the NHs. Further, the SAST drew on specialists and super-specialists from government hospitals to provide expert opinion in complicated cases (SAST 2013d). But there were no resources set aside for the system/institution. However, the protest by private NHs pushed the SAST to seriously consider and empanel government facilities. The SAST empanelled 24 of the 46 medical colleges in the state under the scheme to ensure ‘equilibrium between the private and the public’. It also committed resources for strengthening institutional capacity where government-empanelled hospitals could utilize 30 per cent of the package money as incentive for all categories of staff and the remaining 70 per cent as untied funds to upgrade services, for repairs, to buy equipment, and so on.

It was indeed ironical that the SAST was gate-keeping public funds that rightfully belonged to government hospitals. In addition, there was reverse pressure on the government systems to cough up funds:

BBMP [Bruhat Bengaluru Mahanagara Palike] committed 300 million to the SAST to extend the VAS to the informal sector workers in Bangalore Urban. We spent 40 million on appointing a vendor to issue smart cards, for setting up a data centre, and
distributing cards to 76,000 beneficiaries. But there are no funds to pay the deposit of 50 million to the SAST. That’s why the cards have not been made functional.

—Representative, BBMP

In the face of a financial crunch, the fact that BBMP had spent Rs 40 million in ‘preparation’ for a tertiary-level scheme when their primary- and secondary-level facilities were defunct, unable to meet even basic maternal and child care needs of the community, was an illustration of misplaced priorities and how resources were being diverted from government facilities and ‘non-profitable’ disease prevention activities to ‘profitable’ tertiary care services in the private sector.

**Discussion and Summary**

The preceding sections illustrate how the two health insurance schemes in Karnataka adversely impacted access, continuity and quality of care, and patient rights.

The RSBY in Karnataka presented a picture of disarray, lost time, inefficiency, and wastage of resources. Considering the RSBY’s poor enrolment and low utilization rates (Rajasekhar et al. 2011, Rajasekhar and Manjula 2012, Selvaraj and Karan 2012), it seemed a colossal waste of resources to put in place a Society with its own staff and consultants, a total of four insurance companies with their own TPAs and vendors, not to mention other government staff who play important roles in scheme implementation. Further, the ‘business model’ of the RSBY had a serious flaw which exerted pull in opposite directions:

*The insurance company is interested in increasing enrolments so that more premiums will come into its bank accounts. But there is a disincentive for utilization as its profits come down. On the other hand, hospitals receive funds only if they show utilization. So there is a misalignment of incentives between the insurance companies and hospitals.*

—Researcher, Bangalore

The RSBY’s grievance redressal system was absurd and the administrative structure opaque and complex, designed to keep each level administering the scheme—the State Nodal Agency, the TPA, empanelled hospitals, vendors—unaccountable. The RSBY was a classic illustration of the purchaser-provider split, an outcome of the managed care model that several researchers and activists have been warning against.

The RSBY narratives from this study beg the question: Why continue to pump in resources for insurance companies, TPAs, cards, and vendors when those funds can clearly be used to strengthen the public health system?

It was unethical that policy makers were side-stepping these questions and continuing to invest public funds in the RSBY even in the face of overwhelming evidence which illustrated that the RSBY had no scientific basis, had been ineffective, was wasteful, and had led to fragmentation of the public health system, fraud, and serious violations by private players (Nandi et al. 2012, Dasgupta et al. 2013, Prasad and Raghavendra 2012, Singh 2012, Guha Roy 2012, Mamidi and Pulla 2013, Bhardwaj 2012, Dhar 2013, Jain and Kataria 2012, Planning Commission 2012).

The design and concept of the VAS plays to the logic of the market where a ‘win-win business model’ is proposed for PPP. On one hand, it is able to attract private hospitals by providing an opportunity to expand their ‘markets’ at the cost of public money and on the other, it is a face saving front for the Trust to be seen as ensuring treatment for BPL patients. The overriding concern was to ensure financial ‘viability’ of NHs where the government machinery and public money is put at the disposal of private hospitals to increase their ‘volumes’ and thereby, profit. If in the process patient rights are violated, safety of patients is compromised, the public health system gets fragmented and deprived of its rightful share of resources, this is to be viewed as collateral damage. The VAS represented a dangerous combination of a reductionist approach to patient care and a pursuit of ‘viable business models’. The VAS had no oversight measures to curb NHs’ profiteering tendencies, had no independent grievance redressal mechanism, and had no mechanisms to audit deaths and complications under the scheme. As a result, patients’ safety, dignity, and survival were compromised. Patients had no access to an independent assessment untied to targets, viability, or profit; could not seek a second opinion; and did not have access to records or care for complications. Patients completing the ‘service cycle’ were all ‘closed’ cases. It was nobody’s concern if they developed complications, other health problems, or died. The bottom-line was clear: deliver assembly-line ‘packages’ with as little cost as possible so as to be ‘viable’.

A fatal flaw inherent to all PPP’s was illustrated at every step of scheme implementation and design—breaching of the boundary between partnership and collusion, where regulations are manipulated to suit the interest of the private partners, often violating ethics of medical practice and patient rights. This was evident in the composition of the Board as well as its decisions. The Trust and its
Governing Board functioned as an autonomous entity beyond any form of democratic control. The presence of a NH on the Board indicated a conflict of interest, which perhaps explained the skewed focus on cardiology and several decisions taken by the Board to protect and serve private NH interests rather than the patients’.

Both the RSBY and VAS painted a picture of complex, opaque, fragmented systems, designed to serve profit interests at the cost of continuum and quality of care, patient rights, safety, and dignity.

The study brought to the fore the voices of communities and unions of informal sector workers who raised fundamental questions about why governments were pursing insurance schemes even in the face of their collective failure to deliver.

Amidst growing global evidence that indicates that tax-based healthcare models founded on the principles of equity and universality are the way forward (Anon 2011, Reddy et al. 2011), it is time researchers and policy makers answered communities’ fundamental question: Why continue to waste money on piecemeal, fragmented schemes and cards when the same money can be used to strengthen the government system to provide comprehensive universal, equitable, quality healthcare for all?

NOTES

1. District Health Officers (2), Taluk Health Officer (1), Bruhat Bengaluru Mahanagara Palike (BBMP) representative (1), and PHC Medical Officers (2).

2. Arogyamitras (4) and VAS district manager (1).

3. Administrators of private empanelled hospitals (2), government (1), marketing staff (2); and doctors attending camps (1).

4. Patients came from Raichur (3), Haveri (2), Bangalore city (2), and Kadur (1) whose ages ranged from 32 to 70 years. Two were women and two each were agricultural labourers and small-scale farmers. Others were a petty shop owner, a field worker in a union, an auto driver, and an untrained medical practitioner.

5. Now called Narayana Health.

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