

Aarogyasri Scheme: A Comparative Study of Two Sectors' Network Hospitals in Hyderabad

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Doctor of Philosophy

In

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By

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I, Ravi Kiran Runjala am hereby declare that this thesis entitled “**Aarogyasri Scheme: A Comparative Study of Two Sectors’ Network Hospitals in Hyderabad**” submitted by me under the supervision of **Dr. V. Srinivasa Rao** is a bonafide research work which is also free from plagiarism. I also declare that it has not been submitted previously in part or in full to this University or any other University or Institution for the award of any degree or diploma. I hereby agree that my thesis can be deposited in Shodhganga/ INFLIBNET.

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has made presentations in the following conferences:

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Further, the student has passed the following courses towards fulfillment of coursework requirement for Ph.D/was exempted from doing coursework (recommended by Doctoral Committee) on the basis of the following courses passed during his M.Phil program and the M.Phil degree was awarded:

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Acronyms

OOPE	Out-Of-Pocket Expenditure
GHI	Government Health Insurance
PHI	Private Health Insurance
CHI	Community Health Insurance
IRDA	Insurance Regulate Development Authority
RSBY	Rashtriya Swasthya Bhima Yojana
VAS	Vajpayee Aarogyasri Scheme
CHIS	Comprehensive Health Insurance Scheme
AAV	Anthyodaya Anna Yojana
BPL	Below Poverty Line
ABL	Above Poverty Line
RACHI	Rajiv Aarogyasri Community Health Insurance
RCO	Revenue Circle Officer
TPA	Third Party Administration
CMRF	Chief Minister's Relief Fund
CGHS	Central Government Health Scheme
ESIS	Employee State Insurance Scheme
RTC	Road and Transport Corporation
AHT	Aarogyasri Healthcare Trust
PAM	PHC Aarogyasri Mithra
ANM	Auxiliary Nurse Midwife
IEC	Information Education Communication
MDG	Millennium Development Goals
OECD	Organisation for Economic Co-operation and Development
UNICEF	United Nations International Children's Emergency Fund

WHO	World Health Organisation
WB	World Bank
NFHS	National Family Health Survey
GDP	Gross Domestic Product
CVD	Cardiovascular Disease
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
NHM	National Health Mission
IPHS	Indian Public Health Standards
AYUSH	The Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy.
ASHA	Accredited Social Health Activist
NSS	National Sample Survey
DOTS	Direct Observation Treatment Short
TB	Tuberculosis
RMP	Register Medical Practitioner
TNMSC	Tamil Nadu Medical Service Corporation
RKS	Rogi Kalyan Samithi
TCC	Telemedicine Consultation Centre
MYH	Maharaja Yashwantrao Hospital
TSC	Telemedicine Specialist Centre
SHI	Social Health Insurance
MMTS	Multi-Modal Transport System

Chapter-1

Introduction

Health is considered as the fourth minimum need next to food, clothing, and shelter (Dhandapani 2012:161). So, no individual should fail to secure adequate healthcare because of their inability to pay for it (*ibid*: 14). In a developing country like India, a huge proportion of her people rely on private healthcare services by making of Out-Of-Pocket Expenditure (OOPE). Similar to India, healthcare allocations in other low-income countries are primarily associated with OOP payment while pre-payment or health insurance is the pivotal mechanism in the higher income countries (Bjorn 2004). Further, Indian's public health care system has constantly been deteriorating in terms of lack of proper financial support from the government, shortage of infrastructure and personnel, absences of its service in remote areas and so on. As a result, people increasingly prefer private health care service for various health care requirements. These private players charge huge money for their service. In the case of bearing the burden of OOPE, one in three persons hospitalised pays OOP money that they procure by borrowing and selling of assets in order to meet their expenditure (Dhandapani 2012: 316).

Basically, our country consists of two quintiles with regard to incurring medical expenditure such as affordable and unaffordable or people of immiseration. The affordable people (rich people) can incur medical expenditure for their treatment while poor people always require external support in this regard. In order to improve the healthcare condition and equal accessibility for all people, the government of India framed various healthcare policies since the Independence. For more than few decades, this country pursued the suggestions of Bhore Committee which was appointed by British Government to carry out a wide-range of the survey across the nation to list out what kind of health service were being more available to the people, what kind of ailments did they suffer from, and so on. Some of its suggestions are still in vogue. For example, Jan Swasthya Abhiyan, an independent commission on health and development, underscored one of the suggestions of Bhore Committee, christened

comprehensive primary health care as the highest priority (Reddy et al., 2011). Since Independence, there have been various committees at the national level deployed by the government of India. Each of them has been appointed to resolve a particular health-related incidence. Such committees since independence up to 1986 are: Mudaliar Committee (1962), Chodah Committee (1963), Mukherji Committee (1965), Mukherji Committee (1966), Jungalwallah Committee (1967), Kartar Singh Committee (1973), Shrivastav Committee (1975), Krishnan Committee (1983), and Bajaj Committee (1986).

Despite several recommendations suggested by the above mentioned committees and their implication, the functioning of public health care has still been suffering due to various reasons. The failure of various public healthcare institutions and programmes has not only reduced allocation but also accelerated the growth of the established private healthcare system. The primary motto of any privately run healthcare system is to earn and provide service to who pays for it, free service has no room in it. Indirectly, it restricts its service to people of immiseration owing to their inability to incur such expensive health care service. However, there has been sustained private sector that started and perpetuating since 1992. It obtained the government's complete support for tertiary/secondary care hospitals from 10th Five Year Plan onwards, regarding grant of land, supply of water, electricity etc., at concessional rates, and permission for duty-free import of equipment with the understanding that they will provide in-patient and out-patient service to poor patients at minimum cost (Kalyani 2015)¹

Due to inefficient public healthcare delivery, costly private healthcare service, and rapidly increased burden of diseases, the poor in the country have remained without the proper financial support, and are getting excluded from adequate healthcare facilities. In this milieu, such people depend on the government or other funding agencies to meet their medical needs. Their needs are presently met through social security. The concept of social security came into existence to meet such medical needs of poor with public funding. The word 'security' in academia has been defined by many eminent scholars in

¹ Currently its position is largely unregulated, expensive, often providers give care of dubious quality (Sengupta 2013).

accordance with their own perceptions. In the words of Guhan 1994, ‘the scope of the term social security was thus expended to include not only contingency related measures but also several programmes aimed at improving endowments, exchange entitlements, real incomes and social consumption’ (Guhan, 1994 and Rao 2005:4). In order to provide social security tutelage, the government has launched various publicly sponsored health insurance schemes. That means the governments of central and states have launched various health insurance schemes for people of immiseration who are generally the people of Below Poverty Line (BPL). Most of such schemes have been operating through the public-private partnership. In this context, the private players became stakeholders of the healthcare service under the insurance coverage.

The health insurance means a kind of financial tutelage, that is, payment made to the health provider in case of sickness or injury (Shihi and Gill 2013)². Besides the public health insurance schemes or government health insurance schemes (GHI), there are other health insurances in India such as Social Health Insurance (SHI), Private Health Insurance (PHI), and Community Health Insurance (CHI). About 10% of Indian population is covered by the insurances in 2000 when the Insurance Regulate Development Authority (IRDA) was introduced. However, the coverage has enlarged to 25% (302 million) by the year of 2009-10 (Yellaiah 2013:8). Though the number of insured people has outgrown over a decade, out of the 25% of the population, 82% of them are covered by public sponsored health insurances while leaving out a large number of people without any health insurance. Some of the public health insurance schemes in brief, are the following: Janarogya Yojana, Rashtriya Swasthya Bhīma Yojana (RSBY), Vajpayee Aarogyasri (VAS), Chief Minister’s Comprehensive Health Insurance Scheme, Comprehensive Health Insurance Scheme (CHIS), Himachal Pradesh Health Insurance, Jammu and Kashmir Government’s Employees Group Mediclaim Policy, Mukhyomantrir Jibon Jyoti Bima Asoni (Assam), Biju Krushak

² Basically, this concept of health insurance is traced back to ancient civilization. In ancient South-East Asian culture including India, there was a tradition of paying to doctor while in good health and discontinuing the payment during periods of illness, but modern system of health insurance in India developed in the industrial era based on European System (Venkatasubramanian Akshay 2010).

Kalyan Yojana, and Rajiv Aarogyasri Community Health Insurance (RACHI). Some salient features of these insurance schemes, in brief, are the following:

1.0. Janarogya Yojna:

It is one of the centrally sponsored health insurance schemes for poor people, which is christened as *Janarogya Yojna*. The scheme was launched in the year 1996 to cover the medical expenditure of poor people in-between 5 to 70 years. It has been organised by General Insurance Company. Under this scheme, there is a provision for coverage of 30% of pre-hospitalisation and 60 days of post-hospitalisation expenditure. In order to run this scheme, the government alone incurs Rs.8, 296 of a medical burden per capita per annum. Though it is a government scheme, this insurance has met with failure as the claim process is taking more than six months.

1.1. Rajiv Gandhi Jeevandayee Arogya Yojana: Maharashtra:

This insurance scheme was launched by the state of Maharashtra for both BPL and APL families to access quality medical care for recognised diseases requiring hospitalisation for surgeries and therapies by network hospitals. The enrollees are patients holding yellow ration card, Anthyodaya Anna Yojana Card (AAY), Annapurna card and Orange Ration card. It excludes people holding white ration card. These recognised diseases include 971 surgeries/procedures along with 121 follow up packages in following 30 identified specialised categories. The sum of the package for an enrolled family for a year is Rs.1.5 lakh. If it is Renal Transplant, it would be Rs.2.5 lakhs.

1.2. Rashtriya Swasthya Bhīma Yojana (RSBY):

The central government is the pioneer of Rashtriya Swasthya Bhīma Yojana (RSBY) in 2008 for delivering secondary health care service to people below poverty line. Presently, there are 2.3 crores of families (7 crores beneficiaries) enrolled in the scheme and entitled to avail this service up to cost of Rs.3000 per family in a year. The premium for each family is Rs.750 approximately, which is shared by 75% from the

central and the rest of 25% by the state governments respectively, but for the northeastern states, it is in the ratio of 9:1. For getting enrolled, each family has to pay Rs.30 as registration fee. This insurance is presently considered as the largest public insurance scheme. The enrollees covered in this insurance belong to unorganised sector. They are entitled to access this service for certain enlisted diseases along with pre-existed diseases. This insurance has succeeded in reducing OOPE burden of the poor people (Jain 2013). Despite its achievements, this insurance has failed with regard to dissemination of its information, making people aware of this service, empanelling and monitoring a large number of private providers.

1.3. Vajpayee Aarogyasri (VAS): Karnataka

This insurance scheme is one of the states funded insurance schemes in India which has been initiated by the government of Karnataka with the aim of improving access of BPL families to quality tertiary medical care for treatment of identified diseases that require hospitalisation, surgery and therapies in enlisted healthcare providers. Under this scheme, catastrophic illness can be covered and treated through universal coverage. Usually, catastrophic illness can wipe out decades of savings of BPL families. The benchmark of enrollees of the scheme is BPL card until biomedical health cards are issued. Each enrolled family is entitled to access the service up to the cost of Rs.2 lakhs as fixed package by the insurance. The insurance provides service for both secondary and tertiary cares for these BPL families. As part of the scheme, every empanelled network hospital requires conducting a health camp at free of cost once a week at a place suggested by the Trust (Aarogyasri Trust). These health camps usually occur in both *Gram Panchayats* and *Municipalities*'. The healthcare providers must organise health camps as suggested by the Trust along with specialists and other para-medical staff and shall work in close liaison with district coordination, the district health officer in consultation with deputy commissioner.

1.4. Chief Minister's Comprehensive Health Insurance Scheme: Tamil Nadu

This insurance was launched by the government of Tamil Nadu for families whose incomes are less than Rs.72, 000 (as certified by the village administrative officers). This scheme has been currently operating through United India Insurance Scheme Company Ltd. Its service delivery is through both public and private network hospitals. Under this insurance, only certain diseases are covered. For instance, the scheme provides coverage of Rs.1 lakh for a family per year on a floater basis for the ailments and procedures. This amount is outgrown from Rs.1 lakh to Rs. 1.5 lakhs for the treatment of certain diseases. In addition, diagnostic services are provided for patients under Annexure-F'. As part of this service, it is mandatory for every network hospital to carry out one health-camp at least once a month. At health camp, after examining the patients if the camp-doctor assumes that the patient required further intensive service, the patient is referred to network hospital for further service. At network hospital, the patients have to display their health-cards at the assistance counter established. Further, patients are verified by the concerned officer who facilitated for cashless facility according to norms of the insurance company. It maintains a 24 hours call center to clarify or solve the problems of the patients across the state.

1.5. Comprehensive Health Insurance Scheme (CHIS): Kerala

This is a health insurance state sponsored scheme for Non-RSBY people with specific character. It was launched on 4th July 2008. This insurance is known as *Kudumbasree in Kerala*, which has specific characters regarding its coverage. The targeted people belong to the BPL category as per the state government's declaration but not according to the Planning Commission, and those who are APL families that belong neither to the state government list nor to the list prepared as per the guidelines of the Planning Commission. For BPL list of state government, each family needs to pay of Rs.100 as premium per annum as beneficiary's contribution, and the rest of the expenses will be met by the state. In a case of the secondary category, the premium amount has to be

borne entirely by the beneficiaries alone. Under this insurance, the hospitalised patient is paid of Rs.50 daily (Gupta and Trivedi 2006: 2527).

1.6. Himachal Pradesh Health Insurance:

The state Himachal Pradesh has also extended the package of the RSBY of the central government for BPL people who are already covered by the RSBY. Under this insurance, the package amount has been enhanced from Rs.30,000 (fixed by RSBY coverage) to 1.75 lakh for a family of five persons per annum. The state incurs the burden of the rest of amount.

1.7. Jammu and Kashmir Government's Employees Group Mediclaim Policy:

It was launched by the state government of Jammu and Kashmir to offer coverage for employees of the state. It has been a manifestation of a productive partnership between a state government and an insurance company (national insurance company).

1.8. Mukhyomantrir Jibon Jyoti Bima Asoni: Assam

This is one of the government sponsoring schemes which was launched by the government of Assam on 25th August 2006. It is a combined insurance scheme which embraces both health insurance and personal accident insurance scheme for all citizens whose names appear on the electoral list of the government of Assam. In addition, it also extended its coverage to the employees of tea companies, who are engaged in cultivation and processing of tea in the state. This insurance is implemented by ICICI Lombard Insurance Company Ltd (ILGICL) through its branch office at Guwahati. It aims to provide health and accident risk insurance coverage to the entire population of 3 crores at a premium of Rs. 25 crores. The sum assured for each person is Rs. 50,000 in the case of accidental death and Rs.25, 000 for any health-related eventuality. There is no third party administration. The District Administration along with Revenue Circle Officer (RCO) as the facilitators would help out the villagers. The settlement would be made within 60 days.

1.9. Mediclaim Policy Insurance (Individual and Group): Rajasthan

This insurance is launched by the government of Rajasthan for government employees recruited on 1st January 2004 and thereafter. This plan covers reimbursement of hospitalisation/domiciliary hospitalisation expenses for illness/ disease of injury sustained by the insured person. Insured patients are entitled to avail indoor treatment in all public hospitals; the government approved hospitals outside Rajasthan and approved private hospitals by TPA within the State. Diseases including injuries arising from an act of foreign enemy, nuclear weapon, pre-existing diseases and diseases those need no urgency of hospitalisation and those can be given treatment at home have been excluded from the scheme. In a case of the claim, patients should send all relevant documents with regard to their treatment in hospitalisation and post-hospitalisation, within 7 days from such service availed, to the TPA. In the case of reimbursement, the patient must submit to TPA their identity cards consisting of photos for further verification. This reimbursement payment is made through TPA to the hospital or to the insured person within 30 days from the date of his/her discharge.

1.10. Sanjivni Healthcare Scheme: Punjab (2006)

This insurance is launched in April through 4,000 odd rural cooperative societies, *Sanjivni*. It has covered nearly 5.73 lakh farmers and their families. For enrolment, any cooperative member aged up to 75 years can join the scheme by paying a fixed annual premium of Rs.300 and avail medical treatment costing up to Rs.2 lakh a year from 150 governments and private hospitals across the state.

1.11. Biju Krushak Kalyan Yojana: Odisha

This insurance was launched by Chief Minister of Odisha, Naveen Patnaik in Angul district to provide people financial support through health and accident insurance. There are many hospitals enrolled in each district under the insurance scheme to deliver healthcare service to insured patients, who belong to the farming community. This insurance has been operating through three zones such as south, central and north of the

state. Each beneficiary has to pay a premium of Rs.30 each year for coverage of an amount about Rs.30,000. This insurance includes coverage for the beneficiary with the head of the household, his spouse and three dependents. It is extrapolated that so far about six lakh families are covered by the insurance scheme.

1.12. Research Queries and Statement of the Problem:

In view of the above discussion, the present study raises the following questions:

- Does insertion of health insurance downsizes the burden of healthcare cost?
- Health insurance has taken business model by different investors, which have huge scope to grow once people psychologically admit its importance and voluntarily adopt in their daily life as they adopt other insurance schemes to attain security. Hence is it a health trend of the society?
- Another dimension is the speedy surge of scores of private health care institutions, and with more or less similar speed, the disappearance of public health care system, in the name of efficiency. Hence, is it appropriate for the government to back out from health care responsibility?
- Then it raises a question that why is the government not using this money to rectify the public health care institution and giving free health facility to the poor?
- Is public health care able to improve efficiency in its service in collaboration with this insurance?

With these questions in mind, the present research attempts to examine the public and private partnership in healthcare system that aims catering to the needs of BPL people in Andhra Pradesh in the name of Rajiv Aarogyasri Community Health Insurance (RACHI) which is one of the best public health insurance systems in India. The details of the RACHI are the following:

1.13. Rajiv Aarogyasri Community Health Insurance (RACHI): Andhra Pradesh

Rajiv Aarogyasri Community Health Insurance (RACHI) scheme, popularly known as Aarogyasri, is the brainchild of the Dr. Yeduguri Sandinti Reddy, a former chief minister of Andhra Pradesh. Prior to this, there was a provision of financial assistance from the CM's relief fund for treatment of dreaded diseases that impinge on peoples of economically vulnerable. This relief fund enabled these people to access efficient and effective healthcare service. This continued for a short period only i.e., from 14th May 2004 to 26th June 2007. In this period, there were 55,361 beneficiaries who received financial assistance to the amount of Rs.168.52 crores sanctioned by the Chief Minister. Of 55,361, the children formed a good proportion of the total of such patients. The health problems of 4,600 children at an average by August 2006 were treated under the Chief Minister's Relief Fund (CMRF) (Shukla, Shatrugna and Srivastavan 2011). The government desired to continue this service for a long time based on a proposal submitted by PK Agarwal, the Principal Secretary, Department of Health. In his word, "this insurance is the flagship scheme of all health initiatives of the State Government with a mission to provide quality healthcare to the poor" (<http://www.aarogyasri.telangana.gov.in/>;28-11-2015). Finally, this insurance scheme for people of immiseration came into operation officially on 1st April 2007.

Initially, this scheme as a pilot project was initiated in three districts-Mahaboobnager, Anantapur and Srikakulam, which were selected on the basis of economic backwardness in the three regions of the state. By July 2008, it covered people of all districts in the state. Basically, this scheme covers massive medical expenditure of BPL people and other economically downtrodden section that excludes those who are already beneficiaries of the services of Central Government Health Scheme (CGHS), Employee State Insurance Scheme (ESIS), Railway and Road Transport Corporation (RTC) (Yellaiah 2013). The number of BPL category people who require financial assistance for meeting their basic needs is huge in the state. Beneficiaries of the scheme are increasing constantly in general and mostly from rural areas. For instance, by September 2008, about 11% of BPL category people have benefited from the scheme.

Out of this 87 % patients are from the rural background (Mitchell, Mahal and Bossert, 2011:16). Currently, its free healthcare service has reached out to the category of people Above Poverty Line (Jain 2013). However, it primarily covers BPL families which account for 87% of the families in the state (Yellaiah 2013:11). Table 1.1 shows the phase-wise coverage of the people under the scheme.

Table 1.1, Phase-wise Coverage of the People in the Scheme

Phase	Districts	Total Families (in lac)	BPL families (in lac)
Phase-I	1. Mahaboob Nagar 2. Srikakulam 3. Ananthapur	31.12	26.67
Phase-II	4. Ranga Reddy 5. Nalgonda 6. Chittoor 7. West Godavari 8. East Godavari	56.09	49.49
Phase-III	9. Medak 10. Karim Nagar 11. Prakasam 12. Kadapa 13. Nellore	44.30	38.44
Phase-IV	14. Adilabad 15. Kurnool 16. Hyderabad 17. Visakhapatnam 18. Vijaya Nagaram	44.56	38.19
Phase-V	19. Nizamabad 20. Warangal 21. Khammam 22. Guntur 23. Krishna	53.04	45.46

Source: Yellaiah (2013)

1.13.1. Eligibility:

As aforementioned there are two categories of people who are eligible for the scheme: Below Poverty Line (BPL) and Above Poverty Line (ABL). Initially, this scheme targeted people Below Poverty Line. But, later on, it included people of Above Poverty Line also. These BPL card holders are identified as targeted people based on criteria of BPL card issued by Civil Supplies Department. Along with this card's holders who are eligible to access this scheme, it also included those who have cards of *Annapurna* and *Anthyodaya Anna Yojana*.

1.13.2. Premium:

In the case of premium, it was Rs.210 only for a family per year in the beginning. Later, it has been constantly increased to Rs. 279 in 2008, Rs.330 in March 2009, and Rs.439 from 5th April 2009 (Reddy and Mary 2013:256). Since 2015-16, the premium rate is fixed at Rs.498 per family by the state government. This premium entitles one to avail service of consultation, examination, in-patient treatment, food, transportation, follow-up treatment for one year for the selected secondary and tertiary procedures. It includes primary healthcare including the screening of patients at the health camps (Govt. of Telangana G.O.MS.No. 60).

1.13.3. Covered Procedures:

The enlisted diseases under this scheme are selected by collaboration between experts of medical science, insurance sector, and government officials and so on. In its inception, 330 diseases/procedures were recognised by the insurance that required intensive and efficient care from the hospitals. For treatment of such diseases the patients are usually required to bear a huge medical expenditure at corporate hospitals. Such procedures until last years were 938 in 29 specialities which included cancer, cardiology, polytrauma etc. Presently, these are extended to 942 by 2016 (Govt. of Telangana G.O.MS.No. 60).

1.13.4. Financial Support:

Unlike other state-run insurances, this insurance scheme has been completely funded by the state government without relying upon the central. Under this scheme, every family is entitled to get Rs.2 lakhs per year. The family can avail the benefit on floater basis i.e. the utilisation of total reimbursement of Rs.1.50 lakhs either individually or collectively by members of the family. An additional sum of Rs 50,000 is provided as a buffer to take care of expenses if it exceeds the original sums of Rs 1.50 lakhs per family. Toward the cost for Cochlear Implant Surgery with Auditory Verbal Therapy the Trust (Aarogyasri Trust) pays up to a maximum of Rs.6.50 lakhs per a case. It is

estimated that about a total of Rs. 17, 250 million has been spent every year on the scheme in addition to Rs. 9, 750 million as the premium for health insurance for BPL families (Jain 2013). On this RACHI, the government of Andhra Pradesh spent approximately Rs.770 million from April 1, 2007, to June 30, 2008, in phase-I and an additional Rs. 550 million in phase-II on premium to start the RACHI insurance scheme. The total payments made on Aarogyasri scheme in Andhra Pradesh is Rs. 47,230 million from 2007 to 2013, of which Rs.10,710 million is paid to public facilities and Rs. 36,520 million to private facilities for their service. This scheme draws 25% of the total state's health budget while covering only 2% of the burden of diseases (Sengupta 2013:11). Another study states that around Rs. 92.5 million is spent in the financial year 2009-10 which accounts for 25% of the sum of health budget allocated to this insurance (Reddy and Mary 2013:249). For the current year i.e., for 2015-2016, the state has sanctioned an amount of Rs.420.66 crores (Govt. of Telangana, G.O.MS.No. 60)³

1.13.5. Public-Private Partnership:

This scheme has been functioning through Public-Private Partnership (PPP) to facilitate the process of health service very effectively. This PPP includes three fundamental elements: the insurance company, private sector hospitals and state agencies involved public healthcare and other health related experts. This model has been developed as healthcare delivery to tie over the constant failure of the public healthcare system. In this model, private players work for achieving the public goals in healthcare. Since 10th Five Years Plan (2002-2007), the government advocated the concept of public-private partnership and it is further strengthened in 11th Five Year plan onwards. According to Reddy and Mary “the approach to PPPs must remain firmly grounded in principle, which ensures that PPPs are formulated and executed in public interest with a

³Government of Telangana, *Aarogyasri Health Care Trust-Implementation of RSBY in the State of Telangana-Co-Branding of Rashtriya Swasthya Bima Yojana (RSBY) with Aarogyasri Scheme-Administrative Sanction Accord-Orders-Issued* (Hyderabad: Health, Medical and Family Welfare (A2) Department, 2015), 1.

url.<http://www.aarogyasri.telangana.gov.in/documents/10181/13460/G.O.MS.No.+60+Aarogyasri-RSBY.PDF/96f6b964-b4a1-4cef-8165-3ab606496aff> : Accessed May 4, 2016.

view to achieving additional capacity and delivery of public services at feasible cost” (2013:256).

1.13.6. Administration:

This insurance scheme has specific administrative activities for not only delivering the service but also sustaining this service. For continuing the administrative activities and delivery of the service, the insurance scheme has four paramount players: Aarogyasri Trust, Insurer, Network Hospital, and Aarogya-Mithra. In other words, these are the key elements of the Aarogyasri. The service of the scheme depends on the active role played by each of them. These elements are elaborated below separately.

1.13.7. Aarogyasri Healthcare Trust:

Aarogyasri Healthcare Trust (AHT) is the ultimate powerful authority which was established by the government. It has specific responsibilities to be discharged. Such responsibilities include overseeing complete process of the scheme, service delivery, overseeing entire insurance program, setting up pricing for procedures, managing the contracts with insurance and network hospitals, approving claims and monitoring. In addition, it also has an indispensable role of ensuring all government departments to be part of this scheme (Shukla, Shatrugna and Srivastan 2011). Moreover, for assisting insured patients it functions 24-hours on toll-free help line.

1.13.8. Insurer:

For the effective delivery of service in this scheme, there has been a supportive functionary of this scheme called ‘insurer’ which is usually selected through a bidding process organised by Aarogyasri Healthcare Trust or RACHI-Trust. The insurer is a governing agency which is allocated certain functions such as claim processing, reimbursement to providers, overseeing hospitals’ service, holding health camps in villages, and employing Mithras in the network hospitals and at field level as well. In

brief, this agency is given overall managerial responsibilities for running this scheme properly, alongside accruing premium from the government.

1.13.9. Network Hospitals:

Network hospitals normally provide care to all people including those under the insurance coverage up to the cost of Rs.2 lakhs. The previous studies noticed that numerous network hospitals have been delivering healthcare service under this insurance. A study has given their number as 342 (Fan, Karan, and Mahal 2012:5) but according to the RACHI's circular dated 22-11-2014, their number is 483. Each hospital for being empanelled into the network of the insurance scheme must have been qualified by fulfilling certain prerequisites such as 50+ (more than fifty) beds, equipped with proper instruments, manpower, operation theatres and so on. Finally, the Trust also includes all government medical colleges, district and area hospitals for delivering its service. In the case of private network hospitals, each of them must carry out a free medical camp in a week (Shukla, Shatrugna and Srivastsan 2011: 39).

1.13.10. Aarogyamithras:

They are employed under the insurance scheme to be helpers and to oversee the complete healthcare process of the patients in the network hospitals. Their primary responsibility is to act as an interface between the service provider and the insured people. They also have the responsibility of conducting health-camps every week. They are accountable to the RACHI Trust. Approximately, there are 4000 Aarogyamithras deployed in the network hospitals.

1.13.11. Health camp:

Conducting health camp is one of the key features of the Trust in which patients would be screened at free of cost at their places. A vital objective of the Trust in this health camp is to bring awareness of the insurance service among people in general and rural masses in particular. All private network hospitals must conduct these health camps

according to guidelines of the Trust. The camp usually held as per the schedule and pre-determined place provided by the Trust. In order to energise the camp, the Trust assists the network hospital with Rs.6000 for each camp. Primary Health Center's (PHC) medical officer shall conduct Information Education Communication (IEC) activities surrounding the camp venue within a radius of 5 Kilometers for 5 days without fail. The PHC Aarogyasri Mithra (PAM), Auxiliary Nurse Midwife (ANMs), Accredited Social Health Activist (ASHA) workers, Anganwadi Workers, Camp-Coordinator and Divisional Team leaders shall involve in the conducting of IEC Activities.

In this camp, the doctors provide free check-ups and free medicine for minor ailments. Such common drugs include anti-inflammatory/antipyretic/analgesic, anti-allergic, anti-amoebic, anti-helminthic/deworming, antibiotic, HI antagonist, antacid, vitamins and Iron supplements. At least, two medical officers from the PHCs shall participate in the camp. Each medical officer can claim incentive up to Rs.250 (for two medical officers). Those patients who are referred shall be given "Registration, Treatment-cum-Referral card" with the details of date for reporting to the hospital, and such card contains hospital's name which they are referred to by the camp-doctors, address of the hospital, name of the consultant, name and mobile number of NAMs (Network Hospital Aarogyamithra). On the back of Registration, Treatment-cum-Referral card eligibility and guidelines are given for patients. The health camps treat 4,000 people daily. It has more scope for women enrolment (Jain 2013:19).

1.13.12. Blemishes:

The RACHI has a special motive of meeting gigantic healthcare needs through enlisted public and private network hospitals. But, it has been receiving enormous criticism by civil right organisations and academic groups from both private and public sectors, with regard to the prevalence of increased OOPE among insured patients. It has been found that the OOPE incurred by patients generally during hospitalisation in the urban setting at an average is about Rs.10, 085, as uncovered expenditure that insurance ignored from its coverage (Mitchell, Mahal and Bossert, 2011:16). But, later studies underscored that

there is not much influence on increase of such medical burden on patients after their coverage into the insurance. According to Selvaraj, and Karan, the medical expenditure covered under this insurance does not make any significant impact on the catastrophic health expenditure of the people (2012). The Planning Commission also commented that it is a ‘cash-cow’ for the corporate hospitals (Reddy and Mary 2013:255). Some other studies have underscored the enhancing inefficiency in delivering healthcare service under insurance coverage. For instance, a study has stated that the coverage of publicly sponsored insurance has outgrown tremendously while the proposition of OOP payment has also enlarged significantly by the year 2009-10 when compared to the year of 2004-05 (Selvaraj and Karan 2012).

1.14. Objectives:

In the light of the above research queries and the foregone discussion on RACHI, the study has set the following objectives:

1. To Study Rajiv Aarogyasri Community Health Insurance in Hyderabad with reference to health inclusion in the combined state of Andhra Pradesh
2. To comprehend services of the private and public network hospitals for RACHI beneficiaries
3. To find out which sector’s network hospitals are delivering the better services
4. To suggest ways for making the RACHI more inclusive health scheme

1.15. Chapterization:

This dissertation has six chapters. The first chapter is an introductory chapter that primarily comprises elementary evidence about current healthcare circumstances and the public healthcare service’s abysmal state of affairs. In current scenario, the governments at central and state levels have initiated several subsidized health insurance schemes for people below poverty line. Among them, RACHI is one of them, which covers the medical expenditure of insured patients. It also critically discusses the history and functions of this scheme alongside its deficiencies. Based on the sources of

several insurance schemes rolled out across India, the study raised few research queries and also set out the objectives to resolve these queries.

The second chapter deals with the review of literature and methodology. In this context, it reports on several of the prior literatures on healthcare. The second part of this chapter consists of the methodology for the study. The study carried out two surveys among the patients of insured and non-insured categories. The surveys had been carried out in two phases covering the hospitalised and post-hospitalised stages. In the stage of hospitalised, a survey was carried out among insured and non-insured patients hospitalised in two network hospitals, CARE Banjara private network hospital and Gandhi public network hospital. For post-hospitalised state, the patients selected for the study had already availed the free insurance service from six public network hospitals and 28 private network hospitals, and are residents of the Khairathabad mandal. Convenience non-random sampling was employed for both stages of survey.

The third chapter discusses primarily three aspects of insured patients such as their socioeconomic profile, details on local healthcare providers and, awareness about the insurance scheme. The socioeconomic profile of the insured patients comprises multiple categories including caste, age, marital status, educational qualifications, family types, economic conditions, occupations of the beneficiaries, earners in each family, and family assets. The second aspect of their local healthcare providers contains category of healthcare providers, seasonal diseases and, medical expenditure of their families, along with sanitary conditions. The final aspect discusses about awareness levels of the insured patients in connection to this insurance scheme.

The fourth chapter comprises two levels of comparison such as hospital level and patient level. At both the levels, the comparison took place between two network hospitals of both the sectors and between insured (RACHI) and non-insured (non-RACHI) patients, towards the services of administration, doctors, nurses, Mithras, Diagnostic centers, and sanitary employees or workers, in addition to the burden of

medical and non-medical expenditure incurred by the insured patients during the hospitalisation.

The fifth chapter deals with the comprehensive treatment procedure of the insured patients who have undergone three stages of healthcare services, which are pre-hospitalisation, hospitalisation or coverage of insurance and, post-hospitalisation. It compared patients based on the type of healthcare service they accessed, in three stages. Firstly, pre-hospitalisation or pre-insurance stage in which, patients incurred all expenditure on their own. Secondly, hospitalisation stage in which, although patients were under coverage of the insurance, few patients incurred such expenditure in order to meet their medical and non-medical necessities. The final stage is post-hospitalised stage in which the coverage of insurance permits only to a particular time period but not a long term where the patient is cured completely. In this stage, the patients grievances were more, with dearth of compulsory financial support to purchase medicine and suffering from minor diseases.

The sixth chapter deals with the perceptions towards and the experiences of the insured patients with insurance in general and with services of the network hospitals in particular. It particularly deals with the services of hospital administration, doctors, nurses and Mithras. It describes patients' experiences in the form of short narratives.

The seventh chapter comprises a summary of all chapters along with the conclusion and suggestions and possible policy implications.

Chapter-2

Review of Literature and Methodology

2.0. Introduction:

This chapter deals with the review of literature and methodology. The domain of health has been a highly researched subject. Medical Anthropology, health economic, Public health policy etc., have contributed very extensively. The present review of literature covers with Indian health sector in providing health care. It also traces the trajectory by which the health insurance emerged in India. It also provided as an outer view of the policy in which public and private players participate together to provide efficient healthcare to the poor people of the country. The review also points out that such insurance scheme is meant to strengthen the public network hospitals as they have been suffering from several inadequacies particularly infrastructure and lack of sophisticated technology.

2.1. Review of Literature:

As the introduction reveals, present study concerns with the people who are BPL and are excluded partially, if not totally, from the public and private healthcare gives particularly when they encounter devastating diseases. In this context, this chapter attempts to gain more understanding about the category of the people and, the public and private healthcare through the review of literature available on the subject. It argues that health exclusion is an important form of social exclusion across the globe and there is a need for the welfare state to develop inclusive policies, programmes and schemes. There are several studies that have critically examined the public healthcare in India that also brought out the lacunae, shortcomings, and efforts of the government. The public and private participation have also been under scan and the functioning of the health insurance schemes supported by the government fund have also been examined. However, there is still a need to examine as to what extent such schemes have been socially inclusive. The BPL category people who deserve proper healthcare are to be

examined as if their health needs are met through the health insurance scheme or not. This chapter will also discuss the methodology which includes the theoretical framework and the strategies employed for the study of Rajiv Aarogyasri Community Health Insurance (RACHI) which is in operation in Andhra Pradesh.

2.1.1. The BPL Category and Social Exclusion⁴:

Poverty and deprivations have multiple ripples of effects on individuals and groups, on their individual and group' physical, psychological and social wellbeing. The entire social phenomenon has been embodied in a social science category called social exclusion which is currently widely accepted as a product as well as a process (Saith 2001) which is recognised more as an outcome of globalization even though it was ever present. It has been there in India in the social institution of caste.⁵ However, the government of India gave a broader category neutralising caste for this global phenomenon as people Below Poverty Line.

2.1.2. Health and Excluded Social Categories:

Health besides economic inequality is an important dimension that pushes individuals and groups to the margins of society to the helpless condition of social exclusion (Popay et al., 2008) which is ignored often. According to Verner and Alda (2004) health and sexuality is one area besides others - socioeconomic background, education, social capital and violence, and employment and economic activity. Thus, the BPL category of people in India is excluded from access to the healthcare. Social discrimination and exclusion are causes for poor health among the ex-untouchables in particular and lower caste individuals in general (Thorat and Sadana 2009). Regarding intake of nutritious food, lower caste children are found with lower indicators of health and wellbeing. It is argued that there are urgent proactive inclusive policies to change current form of discrimination that would only be achieved through antipoverty and education

⁴ The concept was initially developed in France (Lenaoir 1974) and later adopted in Europe and Americas (Silver 1994, De Haan 1997, Estivill 2003).

⁵ It very well fits to the definition of social exclusion in the dynamic concept developed by Room (1995), Bhalla and Lapeyre (1997), Barry (1998), Tania, Grand and Piachaud (2002) and Fischer (2011).

programmes. One more essential issue is to bring awareness among them and ensuring equal access to healthcare to rural people and mostly to people belonging to SC and ST.

In many Asian countries, poverty reduction has been sidelined by inequality and lack of social security. As part of achieving the Millennium Development Goals in such countries especially India, Nepal, Bangladesh, it has been found that ethnic minorities, disadvantaged castes, the ultra-poor, women, and migrants are excluded from education and health provisions (Gardener and Subrahmanian 2006).

2.1.3. Health and Homeless People:

Homeless people in São Paulo, like the BPL in India, suffer from inequities, lack of access to decent living standards, risk of early death and even public policies of assistance and healthcare for them lost continuity (Fiorati et al., 2014). There is a link between health inequality and social exclusion. Ill health prevents participation in work and thus leads to poverty and economic inequality. In the vicious circle poverty promotes ill health. It is argued that present social exclusion studies failed to recognise the crucial causal link to power inequalities across society and has not taken into consideration inequality amongst marginalised groups (Mathieson et al., 2008). Cultural exclusion can result in ambivalence towards education, further entrenching into less income and health inequality.

2.1.4. Health, Exclusion and Old Age:

Old people and women also constitute important categories of social exclusion across the world and they form doubly excluded categories within the excluded categories. It is true even among the BPL families in India. The older persons in Senegal and Ghana are found to be vulnerable and associated not only with financial barriers but also excluded from socio-cultural and political activity. Due to lack of social support, the aged isolated groups among the ethnic minorities, women, and rural inhabitants are excluded in enrolment for social welfare (Parmar et al., 2014).

2.1.5. Health, Exclusion and Women:

Gender is one of the primary concepts in understanding the practice of social exclusion and it occupies important space in Millennium Development Goals (MDG). The three MDGs include (1) eradicating extreme hunger and poverty, (2) achieving universal primary education, and (3) improving maternal health. However, the dimensions ignored include (a) women's control over resources and their access to land and credit, b) decision-making power and the prevention of early marriages and (c) violence against women. The failure of investment on health and education has impacted severely in limiting societal potential and loss of considerable social and economic costs. Finally, this leads to gender difference and exclusion. A research of the World Bank reveals that the progress of redressing gender inequality with regards to mortality risk and participation in education has been of tremendous impact and the removal of a single barrier is sufficient enough to bring change in society (OECD 2010).

It has been observed that gender inequalities in developing countries are leading women to mere participation in economic activities and less access to education and health. Because of lesser priority given to women, they are facing various constrain imposed by social institutions in the form of laws, norms, traditions, and codes of conduct. Such inequality determines less participation for women in economic activities outside the household. The continued discrimination against women decreases measures that established for improving of women's participation or access to education and health (Morrisson and Jütting 2005).

Women are naturally associated with parenting and as such require social protection that should address life course vulnerabilities regarding parenting, disability, illness, and old age. Therefore, there should be minimum labour rights and affirmative action and enforced citizenship rights and entitlements particularly for women. Since the development of a country depends on its access to education, skills and healthcare through cash transfers, affordable service, and inclusive and equitable policies, women should have equal rights. Unless women are included in livelihoods support on

agricultural assets inputs and social cash transfers, people's productive capacity cannot be improved (Babajanian and Hagen-Zanker 2012)

2.1.6. Social Exclusion and International Organisations:

The United Nations Development Programme (2005) states inequality must be examined holistically from different dimensions. The inequalities are interlocked in health, income and education disadvantage of the poor. Programmes must be oriented to the Millennium Development Goals (MDGs). World Bank (2012) highlights the essence of investment in health and education that later accelerate the ability of men and women to have complete and potential participation. Gender gaps in education and health are the bottlenecks to be removed for progress.

World Health Organisation and World Bank (2011) state that about 15% of the world's population is estimated to have been living with some form of disability. The barriers faced in progress include access to healthcare, rehabilitation, support, assistance, environments, education and employment. They feel that the disadvantages associated with disability can be overcome through multiple and systemic interventions. With reference to the Millennium Developing Goals, the UNICEF (2006) has a declaration to transform the lives of millions of children in order to save them from illness, premature death, extreme poverty and malnutrition and also desired to help them gain access to safe water, decent sanitation facilities and primary schooling. Under the MDGs, children in marginalised communities are given entitlement to access essential services such as health care, education, and protection.⁶

The above review of literature makes it clear that poor, ethnic minorities, lower and scheduled castes and tribes, women, children, old persons are some of the important categories of exclusion throughout the world. The welfare state should enact laws, make

⁶ It is estimated that there are 3 million children die each year of vaccine preventable disease (VPDs) with a disproportionate number of these children residing in developing countries. In the case of India, it is mostly due to lack of proper infrastructure and not co-operative of community health workers (Datar, Mukherji and Sood 2007).

legislations and make policies for their inclusion so that the excluded categories may be included for access to healthcare, education, work participation and economic contribution. Millennium Developing Goals can be achieved with bridging the gaps of inequality. In this light, it shall be examined to what extent the healthcare institutions, health insurance policies, programmes and schemes are inclusive of the socially excluded categories in the Indian context.

2.1.7. Insurance Schemes:

Good health is necessary for empowerment, and it helps to minimise absenteeism, to enhance labour productivity and prevent misery (Rao and Choudhury 2012). Since independence India adopted public healthcare policy though it allowed private medical practice, and running of private medical institutions and hospitals. However, as mentioned earlier the privatisation of healthcare has taken place since the 10th Five Year Plan period.

But, the government started a partnership with private players since First Five Year Plan (1951-56) concerning family planning (Deosthali, Khatri and Wagle 2011). As a result of this partnership, India has achieved a better position with regard to reducing child mortality as compared to that of Nepal and Bangladesh (Sengupta and Prasad 2011). On the other hand, several committees highlighted certain essential issues and bottlenecks that caused for the inefficient service delivery through the public healthcare system.

2.1.8. Public Healthcare:

Generally, Health and Life Expectancy in India continues to be largely determined by the lottery of sex, socioeconomic status, caste and place one is born (Patel et al., 2015). A study by Transparency International in 2008 suggests that the health sector is considered as the second most corrupt sector in India (Sudarshan and Prashanth, 2011, and Joumard and Kumar 2015:16). As a result, healthcare delivery has suffered from politicisation, rampant corruption, inadequate infrastructure, unhygienic environment,

authorities subservient to the ruling political bosses (Subrahmanyam 1997). In addition to these, absenteeism of medical personnel and the shortage of drugs are other reasons for its inefficiency (Garg and Karan 2009). Along with that, there has been inadequate care and facilities caused for the health problems of women and children particularly⁷. Further, other factors of failure of public healthcare system include non-functioning of a public hospital, inconvenient timings leading to wage loss, high absenteeism and insensitive attitude of health workers (Patel et al., 2015).

Along with such inefficiencies of the public healthcare delivery, one of the prominent elements causing inefficient and unequal service delivery is financial inadequacy for the public healthcare system. In the case of the private sector also the capital for investment is important besides the availability of skilled personnel and equipment. However, the overall healthcare expenditure that includes both the public and the private sectors was 4% of GDP in 2012 which was half with that of Brazil and South Africa and much lower than China. So, India ranked 184th out of 191 countries in per capita public spending on health (Joumard and Kumar 2015:16). A report shows that there was no change recorded in the total expenditure on health per head between 2004-05 and 2013-14. But, it has also been fallen in terms of total expenditure on health per head in India, from 4.5% of GDP in 2004-05 to 4.0% of GDP in 2013-14 (Patel et al., 2015). According to Prasad and Raghavendra (2012), there has been constant decline in healthcare expenditure over period of time after introduction of SAP, it was 6.5% in the 5th Five year plan and it fell to 5.2% in 8th Five year plan, 4.5% in the 10th Five year plan, and 3.6% in the 11th Five year plan (2012).

⁷ Ramanathan, Dilip and Padmadas (1995) report inadequate surgical procedures in sterilization of women in Kerala. A single team usually with two laparoscopes within a period of two hours performs more than six surgeries though ideally only six are to be performed. Instruments prior to reuse must be boiled for at least 20 minutes. But, their study showed differently. In post-hospitalisation, there are no check-ups by doctors; one bed is used by two patients. They are provided with tablets of ampicillin and painkillers only and they were instructed to approach the local JPHN in a case of emergency and so on. Overall, it shows inefficient healthcare service of the public healthcare delivery.

It is estimated that India must consist of 6% of GDP but the government currently allocates a less amount of money to this health sector (Ravi Kumar 2013). The increment GDP level would have impacted on the healthcare service in the public sector. But, it is immobile at 0.9% of GDP. Of this overall healthcare spending, it is a mere proportion of funding that government has been allocating to its healthcare service. For more than two decades, the increase of the public healthcare expenditure remained unchanged and restricted to 0.9% of GDP, far less than sub-Saharan countries (Akshay 2010). The Central government wants to increase healthcare expenditure 2 to 3% of GDP (Bhat and Jain 2006:62). Because of meager allocation India is one of the bottom-lined countries in the allocation of public funding to healthcare system on an international platform. (Peters, Rao and Fryati 2003:252). As a result of such inadequate funding to the public healthcare system, it has been suggested that the government must increase its expenditure to 6% of GDP by 2020 (Reddy et al., 2011:6).

Even this meager healthcare allocation in public sector has been distributed unevenly among people of various categories. This uneven distribution of public money also differs from state to state within the country. For instance, the states like Kerala, Punjab and Tamil Nadu spend substantial public funding for rolling out their healthcare systems while states like Madhya Pradesh and Bihar spend meager amount of money on their healthcare systems (Peters, Rao and Fryati 2003:252). Again the uneven distribution of public money has rural and urban dimension. It has been suggested there shall be increased in the allocation of budget and equal service distribution between both rural and urban areas, and also to empower the community to hold health authorities accountable (Sengupta 2013).

The primary reason for low spending by low-income countries like India is the result of low revenue collection and low allocations (Rao and Choudhury 2012). Further, sub-optimal spending by public sector, in addition to about 75% of health infrastructure, skilled medical personnel and other health resources are concentrated in the urban setting in the country which consists of 27% of the total population (Ravi Kumar 2013). The doctors also prefer urban setting to provide their services. Its resources are skewed

towards salaries and other consumable expenditure with very little allocations for capital expenditure on building, machinery and equipment (Jain 2013).

The public healthcare system, according to Transparency International as aforementioned, India is the second most corrupted system after the police. The Karnataka Lok Ayukta Estimates that at least 25% of the budget in healthcare is siphoned through corrupt practices involving all categories of government health functionaries (Nundy 2005, and Jain 2013). As a result of this, there are 63.2 million Indians pushed into poverty every year (Nandi et al., 2015). On the other hand, there has been a constant increase of disease burden among the people. The diseases burden in India is 20% of the global burden of disease in 2013. There is only a slight improvement from 21% in 2005. In the case of deaths, it accounts for 27% of all neonatal deaths and 21% of all the child death (younger than 5 years) in the world. There are more than 6% of women who are undernourished, which is among the highest in low-income and middle income countries (Patel et al., 2015).

It has been argued that public healthcare system was a complete failure between 1951 and 1993, with reference to rural people owing to inadequate health infrastructure. Less than 10% of the total budget is allocated for the healthcare of 75% of rural population. Further, rural healthcare suffers due to lack of healthcare related literature, health consciousness among the rural people, poor maternal and child health services, occupational hazards, waterborne infections, malnutrition, very early marriage, and quite common in environment related injuries and diseases in rural areas (Vikhe Patil, Somasundaram and Goyal 2002). So, there is an urgent need of comprehensive healthcare service for rural people by pioneering suitable policies (*ibid*).

Another reason for the inefficient healthcare in India is the migration of skilled persons. For example, Indian nurses join the global nurse workforce; a large proportion of nurses migrated from developing countries to developed countries generally and to USA particularly. In a case of USA, these foreign nurses are encouraged to hold employment based on pre-existing policies that include the promise of better pay, healthy working

conditions, improving living and practice opportunities, free travel, licensure, room, and board (Brush, Sochalski, and Berger 2004). Similarly, there is a migration of doctors to different developed countries. This trend in effect impacts the quality of medical service in India.

2.1.9. Increased OOPE:

In the Indian context, the OOP burden on households became a pivotal source of anxiety in financing the healthcare (Bhate-Deosthali, Khatri, and Wagle 2011). Due to the failure of the public healthcare system, the OOP spending is not only taking away a considerable proportion of the income of the families but also impacting rudely on their economy.⁸ As a result of that, nearly 6% of total household consumption as per the national sample survey (NSS) 61st (2004-05) round, is spent on medical care which includes both institutional and non-institutional in Andhra Pradesh, that is, higher than the all-India average of 4.7% (HRD 2007) (Prasad and Raghavendra 2012).⁹ The number of households belongs to SC/ST, Muslim and the poorest 20% of households would increase faster in the share of out-patient OOPE in total household spending compared to advantaged counterpart groups (Karan, Selvaraj and Mahal 2014).

According to World Health Organisation (2012) India ranks first among the three countries of South-East Asia region in spending of so much of OOPE which is almost

⁸ The disease burden and category of diseases are one of the prominent for making of OOP payment. The prevalence of cardiovascular diseases (CVD) prevalence tends to be increased extensively in the developing countries generally. About 2.6% million Indians are predicated to be dead by diseases by 2020. Such deaths are likely to occur on high scale among young and middle-age individuals. The disease would show an immense effect on Indian economy with 52% of CVD deaths occurring. These deaths are consequences of changing living standards of people with risk factors, tobacco use, overweight, hypertension, diabetes and metabolic syndrome. Remedy is to educate people of risk factors of this disease through establishing proper surveillance system which can carry out periodic survey and provides guidance to people locally about consequences of these deaths (Reddy et al., 2006).

⁹ Both in India and China there is increasing people in falling into poverty as a result of OOPE on their healthcare services. The increased of OOP burden in both countries is from 13.7% to 16.2% in China and from 31.1% to 34.8% in India. Health expenditure is worst and higher in China when compared in India. The conditions of affordability and accessing to the care are probably similar in both countries. Due to the financial hardships in China, being primary reason, that made people not seek healthcare, they are varied that included 30% in rich and 50% in poor respectively whereas in India, there are 37.6% of low-income urban residents and 43.3% of low income rural residents (Yip and Mohal 2008).

60% of health expenditure in 2009 (Kalyani 2015:3124). At present, it is estimated that this OOPE has crossed over 75% of the total health expenditure. As result of such unbearable medical expenditure, a huge population sells out their assets for their in-patient treatment and sometimes forgoes treatment due to the scarcity of financial resources (NSSO 60th Round 2004, and Yellaiah J 2009). About 3.3% of India's population becomes impoverished every year on account of health distress according to the National Commission on Macroeconomics and Health (GOI: 2005:23, Kalyani 2015:3124). Population wise such people are about 39 million (Balarajan et al., 2011, and Jain 2013).

The reduction of OOPE also depends on the control of diseases. Health policies sometimes bypass their attention towards health related issues including water, sanitation and so on. Bain (2004) argues that at the time of launching of RSBY, there were 56% of Indians who had no access to safe sanitation and 8% of people who had no access to safe water facilities. By 2010 among low-income countries there were 8.8% of 884 million people living without access to adequate water service for drinking purpose. This fact is inter-linked with water-related diseases, health costs, and its impact on people's labour productivity. In addition, some of such diseases are non-financed through insurance. As a result of that, it is suggested that proper investment in sanitation and safe drinking-water will help reduce health expenditure burden.

Given the public healthcare scenario Peter (1998) proposed five recommendations to accelerate the growth of the public healthcare system. These are (1) to extend public and private partnership, improve the technical quality of the service, and reduce the OOPE for the poor, (2) to develop a method and strategy to strengthen the private healthcare firm participation to achieve the goals of the public programs, (3) government must restrict and regulate the negative practices of the private providers, (4) healthcare provision must be carefully monitored and evaluated in relevance with cost, access, utilisation, quality and equity, and (5) there is assessment of the size, composition, activities of private providers through a national level study.

2.1.10. Impact of National Rural Health Mission (NRHM):

NRHM is an important government initiative launched in 2005 for meeting the healthcare need of the rural communities. After launching of this programme, there are 1.5 lakh skilled persons newly added to the public healthcare system, increasing both managerial and accountability system of healthcare system at the state, district, block and, facility levels. It also established IPHS standard to guide the stakeholders, utilisation of AYUSH and ASHA an interface, promotion of ROGI Kalyan Samitis, compulsory rural posting for those students desiring to pursue PG course in government institutions, and introduced BRMS course for training of rural students (Modi and Chaudhary 2012). The fund allocation for this scheme is about 10 times higher than the amount provided for RSBY (Duran, Kutzin and Menabde 2013)¹⁰.

2.1.11. Private Healthcare:

As few earlier scholars noticed that the private sector service at the time of independence was permitted to a small proportion of the population. The deterioration of public health services due to reduced investments and expenditure forced people to access healthcare from the rapidly expanding private sector (Bhate-Deosthali, Khatri, and Wagle 2011). The private healthcare system has penetrated into every corner of the country regardless of its geographic variation and population size. Berman and Rannam Eliya in 1993 segregated the private healthcare into three categories such as 1) financial orientation-profit and not for profit, 2) therapeutic system - allopathic, Ayurvedic, etc., 3) complexity of organisation-informal, part time providers to large multispecialty centers (Peter 1998:1471). Another fact is that almost all the qualified private doctors have their practices in urban areas whereas 80% of rural private practitioners are not legally qualified doctors who are less than 40 years age and they are mostly males (Peter 1998: 1473). Each of such providers serves approximately 600 people as against

¹⁰ Patel et al., (2015) stated that after inception of NRHM, there is tremendous growth in the public healthcare infrastructure which includes 7629 sub-centers and 2072 primary health centers between 2005 and 2015. Recently, both the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM) are merged and then formed as National Health Mission (NHM).

with one physician who services 3,500 people in rural and urban areas, respectively (*ibid*: 1474).

It is estimated that people spend for the services of private hospitals to the proportion of 46% on primary healthcare service, and 27% on both secondary and tertiary services of their expenditure on health (Bhat and Jain 2006: 67). Thus, a substantial proportion of total healthcare expenditure is paid to private institutions every year. According to 42nd NSS data on healthcare use, the bulk of the OOPe goes into the kits of the private primary care providers (Peter 1998). In 2006 about 75% of medical expenditure is went to the private healthcare of which the OOPe accounts for a gigantic proportion of 91.4% (Mahal and Bossert 2011). Such expenditure is an unavoidable burden to both middle and low-middle class workers for whom meeting their basic requirements is a huge task.

In a survey conducted in Madhya Pradesh, it was found that 75.6% qualified doctors are working in the private sector. There are three categories of primary healthcare providers: trained birth attenders, unqualified health providers, and qualified paramedical staff. The trained birth attenders have undergone a few weeks training and are allowed for service of home delivery. The unqualified health providers are RMPs who have learnt certain skills through working with qualified doctors for a particular time period of 2 to 5 years. Finally, the qualified paramedical staffs are educated rural youth who were selected by villages' local government to be trained for 6 months at the district level by the state government (De Costa and Diwan 2007).

Patients with certain diseases such as tuberculosis patients overwhelmingly rely on the private sector service. This is because of poor knowledge about the government's Directly Observed Treatment Short- Course (DOTS) scheme. About 60-88% of TB patients consult the private doctors and only 15% patients know about the DOTS programme. It has been found that about 91.5% patients prefer to purchase medicine apart from enrolling in the public program. They have preferred private sector to save transportation cost, flexible timings and better attention of providers. Those who availed

service of the private sector are related to heterogenic economic background and education (Pinto and Udwadia 2010).

2.1.12. Improving the Pubic Healthcare:

Some state governments have realised the fact that the utilisation of the public healthcare system is generally low by women, children and the socially disadvantage sections due to the failure of its affordability, accessibility, managerial and equity. They have tried alternatives to improve the public healthcare as in the case of Tamil Nadu Medical Service Corporation (TNMSC) in Tamil Nadu, Rogi Kalyan Samithi (RKS) in Madhya Pradesh and Telemedicine Consultation Centre (TCC) in Andhra Pradesh. For TNMSC, the government brought out a proper mechanism to cap-up healthcare cost and making essential medicines available to the people. RSK took over Maharaja Yashwantrao Hospital (MYH) as an experiment to levy user charge for the recipients of this hospital service. Finally, TCC has been implemented for improving health conditions of socio-economically depressed people in the district of Mahaboobnager in Andhra Pradesh. Under this scheme, patients have to undergo tests at TCC in the district hospital after which such reports are scanned and transmitted to Telemedicine Specialist Centre (TSC) located in the private hospital in Hyderabad from where doctors would pass out instructions of further treatment to the doctors in District Hospital (Ramani and Mavalankar 2005).

2.1.13. Health Insurance:

Health insurance can protect families from impoverishment and empower the patients to seek healthcare as a right (Gilson 1998 and J. Yellaiah 2013). In order to overcome the inadequate service delivery of the public healthcare system, health insurance uses public funding from the central and state governments. The governments found an alternative to public healthcare with the public and private partnership. They started that health insurance schemes incurs financial burden for patients (Selvaraj 2012:111). This health insurance has been on the rise; since its inception, the hospital admission rates have increased by 2.2 times compared to uninsured patients in 2007 (Devadasam et al., 2010

and, Joseph and Rajagopal 2011). It is because the patients do not spend out of their pocket as they are insured and a major portion of expenditure comes from the government. About 67% of the insured households are protected from the burden of OOP payment and 8% have experienced catastrophic health expenditure in the absence of health insurance scheme. That implies that insurance has increased the accessibility of healthcare service to the people and especially after Insurance Regulatory and Development Authority Act (IRDA) 1999 (Akshay 2010).

By the year 2009-10, there were 25% of Indians (302 million) covered by both private and public health insurances and of them, nearly 82% was covered under the government sponsored health insurance (Yellaiah 2013). Out of 82% such people, there were 32% patients covered by RSBY, followed by 28.34% with coverage of RACHI, 14.7% with coverage of Tamil Nadu, and 18.2% with coverage of private health insurance and so on (*ibid*: 8).

Ekman Bjorn (2004) in his review of 36 separate studies of low income countries finds that there is enhancement of the access to healthcare by poor people as consequence of introducing community health insurance that is locally known as micro-insurance, community health funds, mutual health organisation, and rural health insurance etc. According to him, the health insurance runs generally by two prominent drivers; a) to mobilise additional resources for healthcare and b) to provide financial protection. Health insurance acts as a bridge between patients and providers, maintains proper balance of quality of care, reasonable costs, with effective and accountable healthcare. It came into operation as a result of rising income partly and increase dissatisfaction with publicly financed health service partly. It has been exacerbated during the time of the structural adjustment period in India (Srinivasan 2001). It is impossible to understand its growth in Indian context without understanding the background of its healthcare arrangement, covering provision, financing and regulation.

Comparing various insurance models such as Yeshaswini Model, Aarogyasri Model, along with other social insurance models of ESIS, CGHS, mediclaim, Jan aarogya Bima

Policy, Critical Illness Policy, and Sampoorana Aarogya Bima Policy etc,¹¹ Akshay (2010) observes that there is a tremendous variation in administrative processes of health insurance after the introduction of the Third Party Administration (TPA) implemented through the Insurance Regulatory and Development Authority Act (IRDA) 1999. Based on his experiences he proposed an insurance model of central agency that is framed to strengthen the healthcare system. Under this model, the agency from central level allocates funds to the states' agency and then, state's agency has the responsibility of creating healthcare system framework and insurance as well, in accordance with needs of local people. The responsibility of this insurance must be distributed among different levels of healthcare providers and public organisation. There should be partial finance to the insurance by the government, local government in place, and insurance company. Collection of the premium must be allocated to co-operatives, cut off of long terms government subsidies. The agent in insurance must bring awareness among the people. Finally, third party involvement is required for administrating, monitoring and delivering the cashless transaction. It has a negative side as well that Selveraj and Karan acknowledged that publicly-financed health insurance schemes including RSBY and RACHI, Kalaingamar, and Vajpay Aarogyasri have increased OOPe on healthcare (Vellakkal and Ebrahim 2013).

2.1.14. Impact of Rashtriya Swasthya Bhima Yojana (RSBY):

The government of India has introduced Community Health Insurance (CHI) as part of its national rural health mission to reduce the burden of OOPe payments on households in India (Devadasan, et al., 2010, Joseph and Rajagopal 2011). The RSBY received very high enrolment rate. It has certain merits as well as demerits, and a good number of

¹¹ Subba Lakshmi and Sahoo (2013) have distinguished worldwide healthcare finance mechanism into four categories based on the pattern of financing such as revenue raise from general taxation (e.g. United Kingdom, Denmark), health insurance (social health insurance- Germany and private health insurance- USA), and mix of above three mechanisms alongside government sponsoring health insurance for BPL people. In case of health insurance category, health insurance based on its function and financial coverage has been categorized into four sort or four types such as social health insurance (SHI), Private Health Insurance (PHI), Community Health Insurance (CHI), and Government Health Insurance (GHI). The financial mechanism for these insurances is varied in that pay-roll deduction is meant for SHI, voluntary contribution for both CHI and PHI, and for GHI coverage by tax. The premium is also differed income-related premium for SHI, community related premium for CHI, risk related premium and most inequitable for PHI, and non-contribution for GHI.

beneficiaries seems to be rich whereas the SC and STs are marginally benefitted (Nandi, Ashok and Laxminarayan 2013). The impact of RSBY in the states of Bihar, Chhattisgarh, Gujarat, Kerala, Uttar Pradesh, Haryana, Himachal Pradesh, Jharkhand, Punjab, Uttarakhand and West Bengal is assessed by comparing the difference between 2011-12 and 2007-08. In Gujarat there is an increased utilisation of institutional medical service but there is a marginal increase in the states of Bihar, and UP. On the contrary, there is a drop in the utilisation rate among the rest of the states. In the case of institutional expenditure, it has increased among the states of Bihar, Gujarat, Haryana, Kerala and Uttar Pradesh but declined in the remaining states. In the case of non-institutional expenses, there is increase in all the states. Hence, the proportion of non-institutional medical expenses has constantly been increased with different proportions. The overall performance shows that the poor families have not been substantially benefitted through RSBY schemes (Sinha and Chatterjee 2014). It is expected to cover 37 million poor families and is going to be the world's largest hospital insurance scheme (Nandi et al., 2015).

2.1.15. Evaluation of Rajiv Aarogyasri Community Health Insurance Scheme (RACHI):

According to World Health Organisation (WHO) other states in India to follow the RACHI method of healthcare implemented in Andhra Pradesh for coverage of medical expenditure for BPL people. Prior to this inception of this scheme, Jayati Ghosh Committee which carried out a survey on the farmers' suicides in Andhra Pradesh suggested free care for the poor by private hospitals in order to bring them out of precarious health condition. But now, it is doubted about sustainability (Reddy and Mary 2013). The Indian Institute of Public Health-Hyderabad' report (2009) suggests that ways are to be found for cost-effective, holistic approach, and earmarked a special funding for its sustainability. Further, integration of various levels of public healthcare system, decentralisation of decision making process between state and districts, establishing a mechanism to resolve community grievance at all levels, eliminating all catastrophic expenditure and delivering more comprehensive coverage of health care under this insurance, and reducing variation in treatment costs under the insurance

coverage through effective planning are suggested. It has found that the network hospitals locally are being barriers for its targeted people particularly socially deprived sections like SC and ST.

Similarly, Rao (2011) has pointed out that the coverage of street dwellers and migrant workers who have not proper residential addresses are getting excluded from this scheme. He suggested that there should be a mechanism for delivery efficient healthcare service that integrates primary, secondary, and tertiary care. For improving the service it is suggested to have a system in place called gate-keeping system, referral system, and also encourage people to approach primary and secondary services for treatment of diseases requiring no hospitalised treatment prior to seeking high-level care at network hospitals. This will help to reduce the financial burden on the people (Mahal and Bossert 2011). Though families of BPL are benefitted from the scheme, it is observed that relatively there is the low participation of SC and ST families (Rao et al., 2011). It is also felt that hospitals should be clean with polite staff, and non-government and the poor should also take part in decision making for their healthcare (*ibid*). It is also suggested that there should be more health camp (Kalyani 2015), through which, there can be dissemination of awareness among the targeted population.

2.1.16. Misuses of Insurances and Strengthening of Insurance Schemes in General:

Several researchers such as Fan, Karan, and Mahal (2012), George (2007) Gupta and Trivedi (2006), Jain (2013), Reddy and Mary (2013), Kumar and Sriram (2013), Selvaraj (2012), Selvaraj and Karan (2012) Shukla, Shatrugna and Srivastan (2011), Yellaiah (2013) have pointed out some issues common with all the health insurance schemes including the RCHI. Accordingly, there should be some kind of control over the health-related activities or procedures, surgeries, prescription of drugs etc., by the network private hospitals for the motives of them are not genuine. It was found that a large number of cases of hysterectomy in Chhattisgarh and Bihar were perhaps not necessary¹². It is also felt that the government's money is being siphoned to private

¹² See Editorial of EPW (2012, Sep 22)

hospitals. These hospitals should not view this public money as a source of ‘profit’ but must view as part of their social responsibility (Joseph and Rajagopal 2011)

The Government should bring in a comprehensive scheme and stop piece-meal approach; each state is following its own insurance scheme. There is also a need for amending the Insurance Regulatory and Development Authority Act (IRDA) for controlling the misuse of the insurance schemes by private hospitals and empowering the people. There is a need to cap healthcare costs from escalation, improve the health outcomes of the populations, and encouragement for the promotive and preventive care. Several of the researchers doubt whether the schemes are sustainable given the high costs and financial burden on the governments. Some research scholars like Reddy and Marry have stated that the health insurance can never be a substitute for well-functioning, effective and efficient public care system. Health insurance works best when services are available in the remote corners and poor households can actually exercise choice (Reddy and Mary 2013).

The above review of literature brings home the fact that people in the category of BPL suffer from the exclusion of health care basically for the reasons of failure of the public healthcare and their financial inability to access the private healthcare. The inclusive policy of the state has been redesigned in a way that the public and private partnership through health insurance can ensure healthcare inclusivity. This effort has helped the poor in many ways particularly reducing OOPe through the health insurance schemes, though it is not free from problems and loopholes. In Andhra Pradesh the RACHI has been found to be very effective scheme providing healthcare to the BPL. This scheme has been evaluated and studied by several researchers as mentioned before, yet certain questions raised in the introduction of this thesis are yet to be addressed. However, it must be mentioned that public hospitals in the state are also really providing yeomen service to people with their own limitations and in fact equally good service in some cases, it is necessary to compare them with the private network hospitals such that it can be ascertained what should be role of the private sector in providing healthcare to the poor. It is also necessary to find out reality from the perspective of the beneficiaries

what is the better option for them? and how the scheme can be improved to meet their needs.

2.2. Methodology:

The methodology adopted for examining the RACHI insurance scheme has been employing the theoretical framework of social exclusion and comparison of the experiences of the RACHI beneficiaries in the public and private network hospitals. This chapter provides the details of the review of the literature, the theoretical framework and the methodology as earlier mentioned.

2.3. Theoretical Framework:

The study employs the social theory concerning social inequality existing in human societies that explains using the concepts of social exclusion and inclusion. The inequalities present on the lines of class on the basis of economic inequality, gender, caste, ethnicity and race etc., are understood and explained with the concept of social exclusion. This concept is the brainchild of Rene Lenoir who was an official in French government in the 1970s. He found ten reasons for recognising people of French as excluded like those “ Mentally and physically handicapped, suicidal people, aged invalids, abused children, substance abusers, delinquents, single parents, multi-problem households, marginal, asocial persons, and total social misfits (Nabin Rawal (nd). According to European Foundation, social exclusion means “the process through which individuals (or) groups are wholly or partially excluded from full participation in the society within which they live (Ibid). The meaning of social exclusion depends on the nature of the society or the dominant model of the society from which exclusion occurs and it varies in meanings, according to national and ideological contexts (Silver 1994:539).

By the mid-1980s, social exclusion had not only made its appearance in European Union Documents but also a significant aspect in the academic discussion as changing form of society particularly in the context of post-modernity and globalization

(Rodgers, Gore and Figueiredo 1995). Later on, it became very popular word since the 1990s. In Australia, a large social policy conference adopted this word as an umbrella concept and even recently New Zealand used it for rethinking the direction of social policy. European policy makers replaced the stigmatized concepts such as poverty and deprivation with the concept of social exclusion. As a result, the discursive shift in European Union Social Policy entailed a shift from a focus on 'poverty' to a focus on 'social exclusion', especially since the mid-1990s (Robin Peace 2001:18). The concept gained a widespread applicability after the World Summit and as a result an increased attention has been given to the possible relevance of the concept to social policy analysis in developing countries (IILS 1997, IDS 1998, and Kabeer 2000).

The following definitions provide further understanding of this concept. They also elucidate the complexity understanding the phenomenon of social exclusion. According to Geddes and Benington, 2001, this concept has been labeled as multidimensional concept of exclusion (O'Reilly 2005:81). In this regards, there were at least 51 ways that a person could qualify as belonging to a category of the 'socially excluded'. They are broadly grouped under five headings such as a) those marginalised by choice, b) the socio-culturally marginalised, c) those excluded by age, d) by gender or disability and e) the socio-economically marginalised (Robin Peace 2001:22)

Percy-Smith suggests that there are "Economic, Social, Political, Neighborhood, Individual, Spatial and Group" dimensions to social exclusion. Notably absent from the list is cultural exclusion (2000:9).

Democratic Dialogue states that " Social exclusion is a set of processes, including within the labour market and the welfare system, by which individuals, households, communities (or) even whole social groups are pushed towards (or) kept to the margins of society. It encompasses not only material deprivation but also more broadly the denial of opportunities to participate fully in social and civil life" (1995).

Scottish Office states that social exclusion is complex and its causes are connected and its effects themselves become causes of further exclusion: for example, poverty is both

a key cause of social exclusion and a key effect, action to promote social inclusion therefore needs to be both comprehensive and coordinated: it must address the full range of issues facing an individual, a family (or) a community (1999:1-2).

Jackson argues that there can be simultaneous exclusion and inclusion, that is individuals and groups can be excluded in one domain and included in another. For instance, “social relations of kinship and marriage include whilst they exclude and affirm, as they deny membership rights” (Jackson 1999:129).

Aasland and Flotten state that the concept of social exclusion is no more unambiguous than the concept of poverty and considered it as multidimensional phenomena. They considered several important variables as proxies for social exclusion, such as 1) exclusion from formal citizenship rights, 2) exclusion from the labour market, 3) exclusion from participation in civil society, and 4) exclusion from social arenas (2010).

Francis assumed social exclusion as a concept in its attempt to capture the multifaceted character of social deprivation, especially its institutional and cultural aspects. According to him, there are three queries to understand the meaning of the concept of social exclusion such as, how does it differ from that of poverty? What does it add to our understanding of deprivation? Does it increase our capacity to address such social ills? (1997).

According to Sen, social exclusion must be examined in relation to its utility in providing new insights in understanding the nature of poverty, identifying causes of poverty, contribution to thinking on policy and social action in alleviating poverty (2000).

In summarising the above, one may agree that three paradigms of social exclusion viz. solidarity, specialization and monopoly, based on different notions of social integration, attributes exclusion to a different cause and provides an explanation of multiple forms of social disadvantage. Solidarity paradigm means the breakdown of social solidarity

i.e., the social bond between the individual and society. This solidarity paradigm, with strong antecedents in Durkheim in sociology, views society as something external, moral and normative rather than grounded in individual, group or class interests. Solidarity is arising out of the shared values and rights. Specialization paradigm means that exclusion is a form of discrimination, which occurs when individuals are denied free movement and exchange between spheres, when rules inappropriate to a given sphere are enforced (or) when group boundaries impede individual freedom to participate in social exchanges. Third paradigm means that exclusion is viewed as a consequence of the formation of group monopolies, with resources being controlled by hierarchical and exclusive networks. It considered that social order as coercion imposed through a set of hierarchical power relations. Here, exclusion arises from the interplay of class, states and political power, and serves the interest of the included and the excluded are simultaneously outsiders and dominated (Hillary 1994).

From this discussion the following points emerge. Social exclusion is a process in which individuals and groups fall out of social well-being. The causes of such fallout could be social position which is associated with economic, political, cultural constraints imposed by the society, or individual's behavioral consequences or misfortunes that befall on individuals without the latter's knowledge and conscious efforts or inability to prevent such misfortunes etc. Hence, in this context, is an area where individuals are liable to fall out social wellbeing and the main source of such condition could be economic deprivation and accessibility to the resources. In the Indian context, the BPL is one that is most vulnerable to suffer from exclusion with reference to accessing health given the health care provisions available to them in the country as explained earlier.

According to Sen, there are two types of exclusion which are passive exclusion and active exclusion (2000:15). As a part of theoretical framework, the study used his concept to understand inclusion of the insured patients into efficient healthcare service under this insurance scheme. The concept of inclusion in contrast to exclusion has been viewed in dual terms-passive inclusion and inclusion in real sense of the term. In the passive inclusion, the inclusion is not complete, one has moved from active exclusion to passive inclusion, and the latter is characterized by 'inferable' inclusion (Sen 2000:28-

29). In the inferable terms of inclusion, one who is included still suffers from discomfort (Nevile 2007).

From this theoretical perspective the study has examined the process of social exclusion as detailed in the review of literature on health care in India in local and global contexts. The governments in India have been making efforts to bring in inclusive health care for which new policies are made. Such inclusive policy has been public and private partnership through health insurance schemes. The present concern is to examine the private and public health care as an attempt of the governments for providing inclusive health to its citizens.

2.4.0. Instruments for the study:

Two sets of interview schedules were prepared prior to interviewing the respondents of hospitalised and post-hospitalised. In both the schedules, apart from the personal data, questions are same with reference to admission, treatment of the procedures (diseases), surgeries held or not, experience with the doctors, nurses and other staff, lab technicians, pharmacists, and so on. The questions included were also to procure information about the economic conditions, expenditure on basic needs, expenditure on common ailment; loss of working days due to illness, sanitary conditions of the network hospitals, diagnostic tests, and expenditures of medical and non-medical during the hospitalisation etc., (Annexure 1).

2.4.1. Study area:

The study is located in Hyderabad city. The city under the GHMC consists of Hyderabad and Rangareddy districts with a small spillover in Medak district as well. However, the study has focused on Hyderabad district only.

2.4.2. Survey:

The study depended on a survey and data are collected with a pretested structured schedules developed specially for the study (see Annexure 1).

2.4.3. Sampling Design:

The sampling design adopted for the study is as follows. The data required for the study comprised the beneficiaries under RACHI who are split into two categories - hospitalised and post-hospitalised patients, and non-beneficiaries of RACHI. The RACHI beneficiaries are insured whereas the non-beneficiaries of RACHI are uninsured.

2.4.4. Sample of Hospitalised Patients:

A sample of hospitalised patients is drawn from two hospitals that represent public and private sectors: Gandhi Hospital and CARE Hospital, respectively. These two hospitals have attracted majority of the RACHI beneficiaries in the year of 2010. Hence, the comparison is between these hospitals. The sample size of the hospitalised patients is 200 that are distributed equally between RACHI and non-RACHI as 100 in each case from the two above mentioned hospitals. The sample of 100 is equally divided into 50 each under RACHI and non-RACHI beneficiaries in each hospital. The patients suffering from only cardiac, neurological, orthopedic and kidney or renal problems are covered from above these two hospitals. Table 2.1 shows sample size of hospitalised patients

Table 2.1, Sample Size of Hospitalised Patients

(Percentage in parenthesis)

Diseases	Public			Private			Grand Total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
Cardiac	13(6.5%)	8(4%)	21(10.5%)	43(21.5%)	39(19.5%)	82(41%)	103(51.5%)
Neurological	11(5.5%)	10(5%)	21(10.5%)	6(3%)	5(2.5%)	11(5.5%)	32(16%)
Orthopedic	12(6%)	17(8.5%)	29(14.5%)	1(0.5%)	3(1.5%)	4(2%)	33(16.5%)
Renal	14(7%)	15(7.5%)	29(14.5%)	0	3(1.5%)	3(1.5%)	32(16%)
Total	50(25%)	50(25%)	100(50%)	50(25%)	50(25%)	100(50%)	200(100%)

2.4.5. Sample for Post-Hospitalised Patients:

The database available with the Aarogyasri Trust, Hyderabad, has been used for the labeling of the RACHI beneficiaries. During the year 2010 there were 22, 094 beneficiaries across the Hyderabad City. Out of these, there were 12,981 beneficiaries falling in the areas of Hyderabad district and the remaining of them fall outside the district. The sample size of the post-hospitalised is 132 who received treatment from 6 public hospitals and 28 private hospitals.

2.4.6. Sampling Procedure:

The convenience non-random sampling process has been adopted for the study. Among all the districts of the erstwhile Andhra Pradesh state, Hyderabad city has topped the number of RACHI beneficiaries during 2010 when the study was initiated. In the case of Hyderabad district, Khairathabad Mandal has been selected for the study because it topped the number of RACHI beneficiaries as Table 2.2 shows beneficiaries of RACHI in Hyderabad District in 2010. In Hyderabad district Khairathabad Mandal has a substantial proportion of 2,507 beneficiaries that accounted for 19.2% of the RACHI beneficiaries among the total patients of the district. This Mandal is located abutting to the areas of *Abids, Banjara Hills, Ameerpet, Tank Band, Lakidikapool, Hi-tech City, Yarragadda, Sanath Nagar, Mythrivanam, Film Nagar, Kukatpalli, Bala Nagar, Secunderabad, and Koti*, etc. On verification it was found that about 132 patients in the Mandal had availed the service in about 6 public network hospitals and the remaining patients were served by about 28 private network hospitals.

Given the nature of study, the method of sample drawn for the study employed has adopted convenience non-random sampling in selecting the patients in both the cases of hospitalised and post-hospitalised situations. The total number of patients included for the study is 332 who are split into 200 under hospitalised and 132 under post-hospitalised categories as detailed above. Table 2.2 shows beneficiaries of RACHI in Hyderabad District in 2010.

Table 2.2, Beneficiaries of RACHI in Hyderabad District during 2010

S.No.	Mandals	Population of 2011	Percentage of the Population	Beneficiaries of RACHI
1	Amberpet	1,53,221	3.8	801(6.3)
2	Ameerpet	64,786	1.6	641(4.8)
3	Asifnagar	4,45,934	11.1	150(1.1)
4	Bandlaguda	3,36,816	8.4	110(0.8)
5	Bahadurpura	4,75,957	11.9	350(2.6)
6	Charminar	2,44,795	6.1	764(5.8)
7	Golkonda	2,27,409	5.7	736(5.6)
8	Himayath Nagar	1,10,147	2.7	1,245(9.5)
9	Khairathabad	2,88,909	7.2	2,507(19.2)
10	Marredpally	1,70,692	4.3	586(4.4)
11	Musheerabad	3,46,183	8.6	2403(18.4)
12	Nampally	1,87,733	4.7	164(1.2)
13	Saidabad	3,50,667	8.7	457(3.4)
14	Secunderabad	1,33,257	3.3	381(2.8)
15	Shaikpet	2,60,034	6.6	1063(8.1)
16	Thirumalagiri	2,13,698	5.3	623(4.7)
	Total	4010238	100	12,981(100)

Source: Census of India 2011 and Aarogyasri Trust

2.5. Pilot Studies:

The pilot studies were carried out separately for post-hospitalised and hospitalised respondents. The schedule developed for this purpose was analysed with 20 patients and each interview had taken two to three houses approximately. Prior to each interview, each of these patients was informed of the interview and requested to be available for the interview. Eventually, almost 40 new questions were added to the schedule of post-hospitalised category based on the first-hand information of the beneficiaries. The second schedule for hospitalised beneficiaries was presented with 20 respondents in each of the hospitals after obtaining permission from the authorities concerned. After this pilot study, 36 questions were added to the schedule as a result of interviewing 40 insured patients in both these network hospitals.

2.6. Field Experiences:

The survey carried out among the post-hospitalised patients has informed the real conditions of patients residing in the slums of Hyderabad City. Several Difficulties were encountered in this regards. It was not an easy job to find the addresses based on contact numbers of the beneficiaries provided by the Trust. The uncooperative behaviour of the employees in the public institutions from the GHMC, TRUST for the data, and hospitals was a hurdle for the steady progress of work. Great degree of patience was needed when convincing them positively towards this survey. They were apprehensive about the consequences of the survey as it may affect the image of the institution as a result of negative report. Therefore they wanted to make sure that results of the survey shall not affect them.

The survey among the patients hospitalised in the two network hospitals, there was a hurdle in the private network hospital where the administration refused to give permission. After a long persuasion, they gave permission. However, it fixed a particular time to complete the survey. In this hospital, patients who incurred medical expenditure out of their pocket were quite unhappy with certain queries of the schedule during the interview.

2.7. Selection of Post-Hospitalised Patients:

The addresses and phone numbers of the beneficiaries that the Aarogyasri Trust supplied has helped identifying the respondents for the study. For the reasons that the beneficiaries may have changed their residences, finding exact location of the residence, availability of the respondent for the interview, initial contact through telephone was necessary. After ascertaining about the availability of the respondent a convenient time for the respondent was fixed and the interview was held at his or her residence by reaching various means such as auto rickshaw, Transport Corporation buses, MMTS etc., at the stipulated time. Several of the beneficiaries had changed their residences, some had migrated to far off places, some phones did not work and in a few cases the respondent was not available at the time of appointment also when reached with great

difficulty. Thus 132 respondents could be interviewed over a period of four months for obtaining required data on the post-hospitalisation information. Thus, not more than three to five respondents could be interviewed in a day.

2.8. Hospitalised Patients:

As mentioned before, two network hospitals were selected; Government Gandhi Medical College Hospital and CARE Banjara Hospital. These hospitals were approached with an accredited letter given by the CEO, Aarogyasri Trust. Though it was easy for getting permission for the study from the Gandhi Hospital, it was not so in the case of CARE. It took about a month for the Chairman of CARE to give permission. The Arogya Mithras and the designated employees of the hospitals for RACHI available at the hospitals helped in finding the wards and departments where the RACHI beneficiaries were undergoing treatment. At the departments the sisters (nurses) in-charge of the wards had to give permission for interviewing the patients of RACHI. In the same wards the non-RACHI patients were identified for the purpose of comparison and verification of the information provided by the RACHI beneficiaries.

Chapter-3

Socio-Economic Background of Insured Patients

3.0. Introduction:

The socio-economic conditions of health care recipients who are insured well reflect the fact that the insurance scheme is very inclusive and that the BPL category in theory and practice was eligible for RACHI. The social and economic status of the care recipients also shows corresponding treatment that they have been seeking from the sort of care providers. The BPL normally sought care from local caregivers like RMPs. These two aspects together usually play a cardinal role in every individual's life with reference to health, the economic circumstances of a family or an individual, and the health care service that they strive after. It is, in this context; this chapter scrutinises and juxtaposes the socio-economic matters and health care access preferred by the health care seekers. The literature indicates that there is interconnectivity between economic condition of the patient and the type of healthcare one prefers. The studies also show that there is consanguinity between the people's affordability to access health care and availability of healthcare within reach. The studies have also identified that economic vulnerability has left people to rely on inefficient public healthcare providers. However, there are a few beneficiaries of this public run health care. The dynamics found in availing this facility is that they first approach the private facilities at the initial stage of the disease but eventually would backtrack to public service when it reached the last stage or ran out of hand for the private providers and very expensive of disease cost. But, those economically well off generally incline towards the private healthcare providers at both stages of the disease levels in order to obtain efficient healthcare service.

Beneficiaries of the state's health welfare schemes as they proclaimed in the study had umpteen visits to the local private hospitals before they approached the public network hospitals in order to access cashless service. Either in public or private care there is inadequate service of health delivery at local level. When the case is grim the patient approaches the insurance/scheme for financial abutment and convalescent treatment.

However, in order to avail this service they have necessitated awareness of this service and literacy. This chapter throws light on the socio-economic setting of those who were hospitalised and post-hospitalised. The socio-economic setting covers age, education, family type, earners in the family, economic status and medical expenditure of previous year. In this analysis, an attempt is made to perceive the connection between economy and healthcare and its influence on the type of health care.

Social Conditions

3.1. Social Category:

The sample for this study exhibits the following social categories: Other Caste (OC), Backward Class (BC), Schedule Caste (SC), and Schedule Tribe (ST). However, their representation in the sample is unequal in terms of the category that they belong to. They are 33 OC (14.2%), 163 BC (70.2%), 31 SC (13.4%), and 5 ST (2.2%). A sizeable percentage of representation in the sample as can be seen from Table 3.1 is from BC category. This might be a result of their predominance in the overall population of the region. The next important category is the OC. It implies that these groups have been taking advantage of this scheme considerably. The diminutive sample of SC and ST communities in the sample betokens their low participation in the scheme. The previous studies have also made same observation as there has been bias of health access of insurance among the social groups. As a matter of fact, this insurance, in its spirit and objectives, is meant to all the socially marginalised sections but in practice, they remain at the far end to get benefit of the scheme. In this context, a comprehensive study is a need of the hour to understand which social group avails the scheme and at what proportion. Table 3.1 shows the social category of insured patients.

Table 3.1, Social Categories of Insured Patients
(Percentage in parenthesis)

Caste	Private	Public	Total
OC	17 (7.3%)	16 (6.9%)	33 (14.2%)
BC (included Muslims)	87 (37.5%)	76 (32.7%)	163 (70.2%)
SC	9(3.9%)	22(9.5%)	31(13.4%)
ST	3 (1.3%)	2 (0.9%)	5 (2.2%)
Total	116 (50%)	116 0%)	232(100%)

3.2. Gender:

Gender equality is a prominent dialogue trend in the world. Women are anticipated to get equal symmetrical opportunities, status, respect, entitlements, and power on similar lines with the opposite sex. Gender equality in each institution of public and private sector is necessary to accelerate economic position of the country. But, some of the previous studies have underscored gender inequality in accessing healthcare wherein women are grossly over-sighted. Further, women are not coming forward to access healthcare service in time. Persistence of such a culture of self-negligence by women is noted in this study as well. This is reflected with the representation of 136 men (58.6%) in the sample as against 96 females (41.4%) as it has been reflected in Table 3.2. Thus, a high proportion of males have accessed the private network hospitals when compared to the total females. Table 3.2 shows the gender of insured patients.

Table 3.2, Gender Wise Sample of Insured Patients

(Percentage in parenthesis)

Gender	Private	Public	Total
Male	72 (31%)	64 (27.6%)	136 (58.6%)
Female	44 (19%)	52 (22.4%)	96(41.4%)
Total	116 (50%)	116 (50%)	232 (100%)

3.3. Age:

Age is a noteworthy factor that impinges on health and that leads to medical expenditure. There has been a set of earlier studies that underscored the amplifying disease burden along with medical expenditure in accordance with ageing. The children and women require family support both in terms of finance and emotion and also better healthcare. To apprehend which age-group of patients availed this service predominantly, they are segregated into five major age groups: below 5 years, 6-15, 16-30, 31-45, 46-60, and above 60. In the sample, according to Table 3.3 they are 11 (4.7%) in below 5 years, 22 (9.5%) between 6-15, 61 (26.3%) between 16-30, 50 (21.5%) between 31-45, 63 (27.2%) between 46-60, and 25 (10.8%) above 60 years. The age group of the patients between 16-45 years can invest their physical labour to

generate income and procure knowledge that would later be utilised for both their family and bestow to national furtherance. Such people have extensively utilised the service of the public network hospitals. Table 3.3 shows the age-wise categories of insured patients.

Table 3.3, Age-wise Categories of Insured patients
(Percentage in parenthesis)

Age	Private	Public	Total
0-5	11(4.7)	0	11(4.7)
6-15	9(3.9)	13 (5.6)	22(9.5)
16-30	20(8.6)	41(17.7)	61(26.3)
31-45	27(11.6)	23 (9.9)	50(21.5)
46-60	32(13.8)	31(13.4)	63(27.2)
Above 60	17(7.4)	8(3.44)	25(10.8)
Total	116 (50)	116 (50)	232(100%)

3.4. Marital Status:

Quite a few studies have noticed that there is a relation between disease burden and marriage and, after marriage, the women in India encounter with supplementary disease burden. In Indian culture, women invariably have concern towards the rest of their family members' healthcare and well-being rather their own. In this regard, they often disdain or neglect their own health and treatment. Early or child marriages also threaten women' health. In this study, as it is reflected in Table 3.4 there are 165 (71.2%) patients married but 67 (28.8%) patients remained unmarried. It means that two-third of total patients in the sample is married and survived with their partners whereas one-third are not married. Table 3.4 shows the marital status of insured patients

Table 3.4, Marital Status of Insured Patients
(Percentage in parenthesis)

Marital status	Private	Public	Total
Married	86 (37.1%)	79 (34.1%)	165 (71.2%)
Unmarried	30 (12.9%)	37 (15.9)	67 (28.8%)
Total	116 (50%)	116 (50%)	232 (100%)

More married patients have accessed considerable services of the private network hospitals but on the inverse, unmarried patients preferred the public network hospitals

to obtain treatment for their procedures under this insurance coverage. Hence, marriage and private network hospitals' access are indirectly interconnected deeply with each other.

3.5. Religion:

Religion indirectly or directly determines peoples' behavior in any society. In India, religion and social role or social status are associated each other intimately. India is home for Hinduism, Buddhism, Sikhism, Jainism, Islam and Christianity. The sample for the study (Table 3.5) displays 165 (71.1%) patients are Hindu while 61 (26.3) and 6 (2.6%) are Muslim and Christian, respectively. More than two-third of the total patients are adherents of Hinduism while the rest are divided in different proportions among patients of both Christian and Islamic faiths. The Hindus are utilising the private network hospitals in considerable numbers as compared to the rest of sample. In the same way, the Muslims are also substantially utilising the service of public network hospitals. Table 3.5 shows the religion of insured patients.

Table 3.5, Religion of Insured Patients

(Percentage in parenthesis)

Religion	Private	Public	Total
Hindu	84 (36.2%)	81 (34.9%)	165 (71.1%)
Muslim	27(11.6%)	34 (14.7%)	61 (26.3%)
Christian	5 (2.2%)	1(0.4%)	6(2.6%)
Total	116 (50%)	116 (50%)	232 (100%)

3.6. Education:

Education enlightens people to obtain liberation from ignorance and let them live as productive members of society. It spurs people to contemplate rationally and circumvent fusses and antagonism with and among the people in the society over petty issues. It advocates excluded people to be included into the mainstream society by allowing systematic social welfare security and rational dialogue. In this context, India has not attained exhaustive literacy rate on par with the other developing countries, even it has failed in framing policies at multi-level since independence. Within India the

literacy rate among the people of different states is uneven. Even, the state of Telangana also has not attained complete literacy. In addition, there has been an uneven distribution of educated or literate people across the state. More literate people are situated in cities like Hyderabad, while villages are still accounted for fewer literacy rates. Educated means someone who studied particular classes (10th, intermediate, degree and so on). Literate means that person who can read and write. This study has identified heterogeneous level of literate and educated people: with primary, secondary, intermediate, degree, B.Tech, Medical Science (Nurses), post-graduation and, education. Table 3.6 shows the educational background of insured patients.

Table 3.6, Educational Background of Insured Patients
(Percentage in parenthesis)

Education	Private	Public	Total
Illiterate	33(14.2%)	36(15.5%)	69(29.7%)
Primary	16(6.9%)	22(9.5%)	38(16.4%)
Secondary	38(16.4%)	36(15.6%)	74(32%)
Intermediate	7(3%)	11(4.7%)	18(7.7%)
Degree	7(3%)	7(3%)	14(6%)
Technical (B.Tech)	2(0.9%)	1(0.4%)	3(1.3%)
Medical	2(0.9%)	2(0.9%)	4(1.8%)
Post-graduate	0	1(0.4%)	1(0.4%)
Child	11(4.7%)	0	11(4.7%)
Total	116(50%)	116 (50%)	232(100%)

The sample as per Table 3.6 shows 38 (16.4%) with primary level, 74 (32%) with secondary level, 18 (7.7%) with intermediate level, 14 (6%) with degree level, 3 (1.3%) with technical education, 4 (1.8%) with medical education and one (0.4%) with post-graduate education. Further, 11 (4.7%) children have not reached the eligibility to pursue education. Apart from them, there are 69 (29.7%) patients, little over one-fourth of total sample, being illiterate. About two-fourth of patients (48.4%) terminated their education after schooling and not preferred further education. In addition, there are 40 (17.6%) patients proceeded their education beyond the schooling. Of them, there are 7 (3.1%) patients educated in technical and medical fields but the rest of them pursued

non-technical and medical education that included intermediate, degree, and post-graduation.

3.7. Family Type:

The sample patients are segregated in five formal types such as single member family, nuclear family, broken nuclear family, extended nuclear family, and joint family. According to Table 3.7, they are distributed into 8 (3.4%) single member family type, 165 (71.2%) nuclear family type, 7 (3%) broken-nuclear family type, 20 (8.6%) extended nuclear family type, and 32 (13.8%) joint family type. Among them, there have been patients with nuclear family type accounted for considerable proportion of total patients. Table 3.7 shows the family types of insured patients.

Table 3.7, Family Types of Insured Patients

(Percentage in parenthesis)

Family type	Private	Public	Total
Single	4 (1.7%)	4(1.7%)	8(3.4%)
Nuclear	83 (35.8%)	82 (35.4%)	165(71.2%)
Nuclear but Broken	6 (2.6%)	1 (0.4%)	7(3%)
Nuclear and Extension	8(3.4%)	12(5.2%)	20(8.6%)
Joint	15(6.5%)	17(7.3%)	32(13.8%)
Total	116(50%)	116 (50%)	232(100%)

Economic conditions:

Economy is one of the determining factors for ensuring quality healthcare access and better health status. The quality healthcare service has been furnished by private healthcare providers. However, a large proportion of the population which is in unorganised sector enduring with poverty has not been able to access the private health care service. Through this insurance, people of BPL are brought under the coverage of health insurance and licensed to access extravagant healthcare services for complimentary at the private healthcare main-stay. The sample exhibits the subsequent evidence with reference to occupation of beneficiaries, an absolute number of earners in

the family, and their estate, further, the patients' access to amenities and Public Distribution Service (PDS).

3.8. Occupation:

The patients are cataloged as agricultural workers, daily wage labourers, customary workers, private employees, and self-employed or freelance. These can be grouped into earners and non-earners. Among this figure, a large number, 45 (19.4%) patients belonged to the category of wage labourers, followed by 28 (12.1%) who are private employees, and 22 (9.5%) who are self-employees, while 10 (4.3%) are agricultural workers, and 4 (1.7%) are practicing customary occupation. They altogether account for little less than half of the total number of patients i.e., 47%. There are more than half of the patients (53%) are non-earners. They are housewives, children, aged, and students. The aged are in highest proportion with 46 (19.8%). They are followed by 34 (14.7%) students, 28 (12%) housewives, and 15 (6.5%) children. Table 3.8 shows the occupational details of insured patients.

Table 3.8, Occupations of Insured Patients

(Percentage in parenthesis)

Occupation	Private	Public	Table
Agricultural workers	10(4.3)	0	10(4.3)
Customary occupation	1(0.4%)	3(1.3)	4(1.7)
Private Employee	12(5.2)	16(6.9)	28(12.1)
Wage worker	16(6.9)	29(12.5)	45(19.4)
Self-employee or freelance	18(7.8)	4(1.7)	22(9.5)
Housewife	11(4.7)	17(7.3)	28(12)
Child	13(5.6)	2(0.9)	15(6.5)
Aged	22(9.5)	24(10.3)	46(19.8)
Student	13(5.6)	21(9.1)	34(14.7)
Total	116 (50%)	116(50%)	232 (100%)

3.9. Earners in the Family:

Earner requires for every family in order to meet its members' foremost needs in addition to medical requirements. Earlier studies have identified a relation between

economic status and level of earning, as well as between ailment and healthy life. They have shown that a large number of earners make a healthy life of the family. Healthy people can work and earn adequate money for the families. If a family does not have earners then that family slides into economic vulnerability and further goes down to medical vulnerability. Based on the number of earners in the family, the sample has been stratified into five quintiles from none to four earners. Table 3.9 shows that there are 219 (94.4%) patients in whose families the earners are between one to four earners while 13 (5.6%) patients have no earner. These patients had to profoundly rely on welfare programs what public sector is offering. Such public sector provides subsidised schemes such as PDS, public healthcare and, old-age pension. There are 195 (84.9%) patients whose family has one-two earners. This accounts to more than three-fourth of the gross number of patients. It implies that preponderance of families has between one-two earners in the family. They principally relied on the service of the public network hospitals. Table 3.9 shows the number of earners in each insured family.

Table 3.9, Number of Earners of Each Insured Family

(Percentage in parenthesis)

Number of earners	Private	Public	Total
One	49(21.1%)	53(22.9%)	102(44%)
Two	44(19%)	51(21.9%)	95(40.9%)
Three	13(5.6%)	5(2.2%)	18(7.8%)
Four	3(1.3%)	1(0.4%)	4(1.7%)
Zero	7(3%)	6(2.6%)	13(5.6%)
Total	116(50%)	116(50%)	232(100%)

On the inverse, less than one-fourth of patients 22 (9.5%) have earners between three-four in the family, who have utilised the service of the private network hospitals, more than their counterparts in public institutions. Those families that have earners between one or two have depended more on the service of public network hospitals. On comparison, those who have more than two to four earners are able to utilise the service of the private network hospitals. In such circumstance, it may be said that there is a correspondence between the number of earners in the family and the category of healthcare utilisation. That means when the number of earners increases then it is

probable that there is an increase in the optimum standard quality of healthcare. Indeed, economic upswing accords freedom for the people to perpetuate healthy life.

3.10. Economic Status:

It is difficult to appraise the economic status of the family, as respondents are not able to locate themselves in a particular economic category. They are also not able to ideally give the economic figures. But, the economic status can be appraised with the assets that the family has. Some of such assets that betoken economic status are TV, motorcycle, fan, refrigerator, mobile phone, telephone, and own house. In this milieu, the coalition between the possessed assets and the category of healthcare provider accessed are scrutinised. It has been found that 229 (98.7%) patients in Table 3.10 are owning electric fan, followed by 226 (97.4%) having a mobile phone. About 204 (87.9%) patients are owning color TV and 131 (56.4%) are having own house. About 54 (23.3%) are possessing bicycle and 50 (21.5%) are having the refrigerator. About 27 (11.6%) are having the motorcycle, 6 (2.6%) are owning black and white TV, and one (0.4%) is possessing landline telephone connection. Table 3.10 provides the details about economic status of insured patients.

Table 3.10, Economic Status of Insured Patients
(Percentage in parenthesis)

Economic Status	Private	Public	Total
Own House	62(26.7%)	69(29.7%)	131(56.4%)
Color TV	104(44.8%)	100(43.1%)	204(87.9%)
Black and White TV	4(1.7%)	2(0.9%)	6(2.6%)
Telephone	1(0.4%)	0	1(0.4%)
Mobile	114(49.1%)	112(48.3%)	226(97.4%)
Electric Fan	113(48.7%)	116(50%)	229(98.7%)
Bicycle	25(10.8%)	29(12.5%)	54(23.3%)
Motor Cycle	18(7.7%)	9(3.9%)	27(11.6%)
Refrigerator	23(9.9%)	27(11.6%)	50(21.5%)
Auto	0	1(0.4)	1(0.4%)
Land	15(6.5%)	10(4.3%)	25(10.8%)
Plat	0	1(0.4%)	1(0.4%)

Out of all assets and appliances that these patients are possessing, own house, only two appliances are widespread, which are an electric fan and mobile phone. After that, common appliances in possession are color TV, own-house, bicycle, refrigerator,

motorcycle, black and white TV, and telephone. Those who have possessed own house have immensely relied upon the public network hospitals. Contrastingly, there are patients who possessed color TV, mobile phone, and motorcycle have accessed substantially the service of the private network hospitals while those owned the remaining appliances of within the houses confined in the service of public network hospitals. As it is already stated this sample comprised both slums from the city and non-slum people from the villages. Such patients, 25 (10.8%), are possessing asset in the form of land, followed by one (0.4%) patient possessing an auto-rickshaw (three-wheeler), and one more (0.4%) owned a plot or flat.

3.11. Public Distribution System (PDS):

The public distribution system allots food-grains on a concessional rate to the people below poverty line. PDS card issued to these below line entitles other government sponsored programs such as old-age pension, women, and children welfare schemes, membership in DWACRA, loans at concession and free healthcare coverage. One of such welfare schemes of publicly sponsored as mentioned before is RACHI scheme that only allowed people with BPL card initially and later incorporated people Above Poverty Line also. But, this empirical study has concentrated on the people with BPL card. Under this scheme, more than one person in the family is entitled to access this welfare scheme. By this scheme, poor people are emancipated from the burden of abysmal and unpredicted medical expenses as per Table 3.11. The present study has a sample of 221 (95.3%) patients with PDS card who are admitted into the network hospitals based on the criterion of being the beneficiary of PDS scheme. But, the rest of 11 (4.7%) patients are from the APL category. They could avail the facility of the Chief Minister's discretionary provision for coverage of the medical expenses. They are all admitted into the private network hospitals. Table 3.11 shows holders of PDS cards.

Table 3.11, Holders of PDS Cards with regards to Insured Patients

(Percentage in parenthesis)

Card	Private	Public	Total
BPL	105(45.3%)	116(50%)	221(95.3%)
ABL	11(4.7%)	0	11(4.7%)
Total	116(50%)	116(50%)	232(100%)

Health Condition

3.12. Sanitary Conditions:

Hygiene and healthcare are interconnected. Unhygienic living conditions lead to diseases and result in medical expenditure, loss of working days, and thus to impoverishment. To curtail the burden of medical expenditure, one entails maintaining good sanitary conditions and that is possible only through awareness. One of the elements analysing sanitary conditions is availability and accessibility of water sources. It is also necessary to find out what purpose they are utilising water that they procured from various sources. These patients have three distinctive water resources: tap water, ground water and mineral water purchased by OOP payment. The sample consists of 197(84.9%) patients (Table 3.12) who utilise tap water for both drinking and other uses in the house. In addition to them, there are 9 (3.9%) patients who purchase water by OOP payment for meeting drinking needs. Those patients who lived in the city are predominantly confined to the GHMC for meeting the needs of drinking and other domestic use. Table 3.12 shows the divergent water facilities for insured patients.

Table 3.12, Available Water Facilities for Insured Patients

(Percentage in parenthesis)

Type of water facility	Private	Public	Total
Tap water	95(40.9%)	102(44%)	197(84.9%)
Tap and ground water	16(6.9%)	10(4.3%)	26(11.2%)
Tap Water and purchased water	5(2.2%)	4(1.7%)	9(3.9%)
Total	116 (50)	116(50%)	232(100%)

According to Table 3.13 there are 109 (47%) received services of the sanitary employees to pick up garbage from their houses. Each household makes a payment between Rs.20-50 monthly and this amount is auxiliary profits to sanitary employee besides the remuneration provided by the municipality. According to few patients, if they discontinue paying such remuneration the employee withdraws to provide the service. On the other hand, there are patients who deposit their garbage themselves at a common place in the slum, and these are self-reliant households. There are 123 (53%)

patients who are self-reliant. Table 3.13 shows the details of garbage maintenance for families of insured patients.

Table 3.13, Garbage Maintenance

(Percentage in parenthesis)			
Type of Maintenance	Private	Public	Total
Government employees remove	44(19%)	65(28%)	109(47%)
Deposited at common dustbin	72(31%)	51(22%)	123(53%)
Total	116(50%)	116(50%)	232(100%)

3.13. Local Healthcare Providers:

A vast number of Indians avail the service of private healthcare, which has been profited since the 1980s when the neoliberal policies invaded into healthcare affecting the dependency on the public healthcare, as already discussed in the beginning chapters. By adopting multifarious communicative strategies for alluring patients, the private healthcare providers are able to get their consumers from divergent geographical locations in the country. Currently, such healthcare providers encroached a large part of public healthcare delivery. Indian health system fundamentally has been contained by three levels of healthcare providers: primary, secondary, and tertiary. People particularly poor relied on the private healthcare providers extensively such as Registered Medical Practitioner (RMP), and qualified medical practitioner (with MBBS degree). In the sample, there are 209 (90.1%) patients (Table 3.14) who relied upon both healthcare providers. Among them, a sizeable proportion of patients living in the city are able to access the service of qualified medical practitioners.

On the contrary, there are a considerable number of patients with the rural background who are dependent extensively in the service of the RMPs who had unprofessional medical training, to treatment sick-people. Out of 209 (90.1%) patients who availed the private providers' service, most of them have relied on the service of the qualified medical practitioners while a few patients approached the RMPs to obtain the service. In literal sense, an overall two-third of such patients approximately preferred qualified doctors to get service for relief from their diseases which are seasonal diseases. There

are one-tenth (9.5%) patients who depended on public healthcare system which composed of primary healthcare center (PHC), community health care center (CHC), and public general hospital. Among them, a little higher proportion of patients has approached the service of the PHC. Table 3.14 shows about service of local healthcare providers for the insured patients for treatment of seasonal diseases.

Table 3.14, Local Health Care Providers for Curing of Seasonal Diseases
(Percentage in parenthesis)

Local Healthcare Provider	Private	Public	Total
Local private healthcare provider	103(44.4%)	106(45.7%)	209(90.1%)
Local public healthcare provider	12(5.2%)	10(4.3%)	22(9.5%)
Purchase medicine from the shops	1(0.4%)	0	1(0.4%)
Total	116 (50%)	116 (50%)	232(100%)

3.14. Medical Expenditure:

As aforementioned, a sizable proportion of patients depended on the private healthcare providers when they suffered from seasonal diseases. These healthcare providers charged them differently. The private MBBS doctors charge the patients between Rs.100-150 per visit and RMPs charge between Rs.30-60. The patients are also required to incur expenditure on diagnostic tests, transportation and medicines. If a person or more than one person in a family made several (more) visits then that family gets dropped into a vicious circle of impoverishment. The medical expenditure of the sampled patients during the year before the study was held. There are 193 (83.2) patients accounting for more than three-fourth incurred medical expenditure of between Rs.500 to 1,500. Of them, about one-fourth patients' families separately incurred Rs.500. Based on this empirical data, it appears that an average medical expenditure for each family is between Rs.1000-1500. There are 38 (16.4%) patients who incurred medical expenditure between Rs. 1,500-6,000 on their treatment of diseases. For patients living in villages, the medical expenditure was paltry sum during the previous year due to their dependency on RMPs. On the inverse, those patients living in towns and cities have incurred huge amounts for the medical expenditure which is beyond their viability in some cases for their reliance on qualified medical practitioners. Table 3.15 shows medical expenditure of families of insured patients last year.

Table 3.15, Last Year Medical Expenditure of Families of Insured Patients
(Percentage in parenthesis)

Medical Expenditure	Private	Public	Total
Below 500	19(8.2%)	15(6.5%)	34(14.7%)
501-1,500	72(31%)	87(37.5%)	159(68.5%)
1,501-3,000	10(4.3%)	3(1.3%)	13(5.6%)
3,001-4,500	8(3.4%)	9(3.9%)	17(7.3%)
5,001-6000	6(2.6%)	2(0.9%)	8(3.5%)
Nil	1(0.4%)	0	1(0.4%)
Total	116 (50%)	116(50%)	232 (100%)

3.15. The Diseases Suffered by Patients Last Year:

The patients who are agonised by divergent diseases in previous year include 85.6% with fever, followed by 35.8% with cold, 11.3% with body pains, respectively. It is noticed that none was excluded from the list of suffering with fever. Those patients who underwent treatment process for fever have mostly relied on qualified doctors prior to getting admitted into the network hospitals of both sectors for the cure of enlisted procedures. Prior to getting admitted into both sectors' network hospitals, they approached RMP, the qualified medical practitioner (MBBS), and public hospital. With regard to prior admission in the private network hospitals, a considerable number of them depended upon the service of RMP for the cure of their diseases of fever, headache, stomach ache, as well as relied on MBBS doctors. On the inverse, in the case of the public network hospitals, they chiefly approached RMP and MBBS doctors for treatment of cold and, depended on both MBBS doctors and Government service for the cure of their diseases fever and headache. Table 3.16 shows the details of diseases burden and type of healthcare providers last year for insured patients.

Table 3.16, Diseases Burden and Accessed Type of Healthcare Provider
(Percentage in parenthesis)

Ailment	Private				Public				Grand Total
	RMP	MBBS	Govt.	Total	RMP	MBBS	Govt.	Total	
Fever	39(16.8%)	62(26.7%)	15(6.5%)	116(50%)	35(15%)	63(27.2%)	18(7.8%)	116(50%)	232(100%)
Headache	29(12.5%)	46(19.8%)	15(6.5%)	80(38.8%)	23(9.9%)	67(28.9%)	18(7.8%)	108(46.6%)	198(85.4%)
Cold	4(1.7%)	23(9.9%)	10(4.3%)	37(15.9%)	9(3.9%)	30(12.9%)	6(2.6%)	45(19.4%)	82(35.3%)
Stomach Pain	3(1.3%)	15(6.5%)	4(1.7%)	22(9.5%)	0	5(2.1%)	2(0.9%)	7(3%)	29(12.5%)
Body Pain	11(4.7%)	2(0.9%)	1(0.4%)	14(6%)	6(2.6%)	6(2.6%)	1(0.4%)	13(5.6%)	27(11.6%)

3.16. Awareness of the Scheme:

Awareness is one of the foremost elements to transform the boon of the insurance as a gift to the targeted population. The patients came to know about the insurance through family members, neighbors, friends, pamphlets, newspapers, network hospitals, health-camps, local political leaders, PDS systems, local healthcare providers, and private hospitals. The source of information for 75 (32.3%) patients i.e., one-third of the total sample patients is family members only. It implies that family members played a prominent role to bring about awareness to the rest of their family members towards this insurance scheme. In addition to family members, there have been three modes of communication which included the newspaper/media (20.7%), local hospital/clinic (19.4%), and neighbors (14.7%). A few patients have learned about this insurance scheme from the network hospitals (0.9%) when they went for treatment of their diseases which were enlisted under the insurance scheme. Then, they changed from non-insurance state to insured state under the scheme. Table 3.17 shows about awareness of insured patients through various modes of communicable machinery.

Table 3.17, Awareness of Insured Patients about the Insurance Scheme
(Percentage in parenthesis)

Channels of Awareness	Private	Public	Total
Friends	6(2.6%)	7(3%)	13(5.6%)
Family	39(16.8%)	36(15.5%)	75(32.3%)
Neighbor	19(8.2%)	15(6.5%)	34(14.7%)
News/ media	27(11.6%)	21(9.1%)	48(20.7%)
Local Hospitals /clinics	21(9.1%)	24(10.3%)	45(19.4%)
PDS	1(0.4%)	11(4.7%)	12(5.1%)
Network hospitals	2(0.9%)	0	2(0.9%)
Local Political leaders	0	2(0.9%)	2(0.9%)
Health Camps	1(0.4%)	0	1(0.4%)
Total	116 (50%)	116(50%)	232 (100%)

In some cases, the patients approached the network hospitals by systematic selection. Those patients who admitted into the private network hospitals came to know about the insurance by mostly their family members or neighbors or news/media, network hospital, and health camp. Likewise, some of the patients who admitted to the public network hospital came to know about it mostly through communication channels

comprising friends, local hospital/clinics, and local political leaders. Among the four sources of information for those patients who got admitted in the private network hospitals include family members, neighbors, and news/media. Those who accessed the service of public network hospitals came to know about this scheme through local hospitals/clinics. Although some knew the existence of this insurance scheme they were not clear about details of the scheme. Among them, a half of the patients knew that all members of the family are covered by the insurance. So, they were able to access the service of the public network hospitals to the maximum extent.

In addition, about 28 (12%) patients (Table 3.18) agreed that they knew how many members of a family are covered by the insurance but it is not correct as to the number covered. Among such patients, a considerable number of patients relied on the service of the public network hospitals. Out of 28 (12%) patients who claimed that they knew about the number of persons covered under the scheme, there are 15 (6.4%) patients who said that it is four persons in the family, and 13 (5.6%) said that it is only one person from each family to be covered every year. There are 88 (38%) patients who claimed that they were unaware about how many members of a family are covered under this insurance. Without knowing how many members of a family can be covered, a substantial number of patients availed the service of the private network hospitals. Hence, it is learned that those who knew of this insurance and those who became aware of this insurance and had given wrong data of how many members in a family being covered by the insurance are mostly admitted into the public network hospitals whereas those who knew its coverage exactly have accessed the service of private network hospitals. Table 3.18 shows the patients' knowledge about members in a family to be under this scheme.

Table 3.18, Awareness about Members in a Family to be Covered.
(Percentage in parenthesis)

persons covered by insurance	Private	Public	
All	53(22.8%)	63(27.2%)	116(50%)
Up to 4 members	7(3%)	8(3.4%)	15(6.4%)
Only a person	6(2.6%)	7(3%)	13(5.6%)
Don't Know	50(21.6%)	38(16.4%)	88(38%)
Total	116(50%)	116 (50%)	232 (100%)

It is not enough to know about the health insurance but they have to possess health card at the time of availing healthcare under the health insurance. They acquired the health-card of the insurance through various local public employees along with local political leaders. Table 3.19 states that local public employees are PDS dealer, the postal employee, municipal employee, local health worker, and CM camp employee. In addition, the local political leader distributed health-card to the people with the interest of getting votes from the locals as a return favour from them. The data exhibits that 11 (4.7%) patients, having got admitted into the private network hospitals approached the CM-camp office because they were not BPL and hence not eligible for the insurance. Based on their appeals, The CM agreed to extend the insurance coverage. Table-3.19 shows about the details of providers of health-card to the insured patients.

Table-3:19, Providers of Health-Card to Insured Patients
(Percentage in parenthesis)

Health-Card Providers	Private	Public	Total
PDS shop	39(16.9%)	46(19.8)	85(36.7%)
Municipal Employees	32(13.8%)	32(13.8)	64(27.6%)
Local Health Workers	17(7.3%)	10(4.3)	27(11.6%)
Postal	7(3%)	2(0.9)	9(3.9%)
Local Political Leaders	10(4.3%)	26(11.2)	36(15.5%)
CM camp (Non-white Card)	11(4.7%)	0	11(4.7%)
Total	116 (50%)	116 (50%)	232(100%)

Both PDS shops and municipal employees played a significant role in circulating the health card to the people. Such of the patients are accounted for 149 (64.3%), followed by 36 (15.5%) from the local political leaders, 27 (11.6%) from the local health workers and so on. There are patients who acquired this card from PDS shops have mostly been relied on the public network hospitals. Thus, it becomes clear that those who are poor, mostly SCs, illiterate, living in slums, depended on local RMP, possessing own houses, depended on PDS, got admitted into the public network hospitals. Those who are OBC better off in economic, education etc. got admitted in private network hospitals and utilised the RACHI scheme.

Chapter-4

Treatment Process of the Network Hospitals

4.0. Introduction:

The earlier chapter reveals the socio-economic background of the insured patients who availed healthcare service of network hospitals from two sectors under insurance coverage. As it is already stated, the RACHI makes people of economic vulnerable sections access to efficient healthcare service that has always been accessible to people of affluent sections in the society and employees of organised sector. Even it is pro-poor health scheme but to assess whether its targeted people are really benefiting or not. So, this chapter examines execution of the scheme by comparing two network hospitals of two sectors. In particular, it assesses which network hospital is delivering efficient and adequate service to insured patients and also notices the quality of service in accordance with their experiences in the network hospitals. Under this comparison, it is only focused on certain service providers in the hospital based on procured empirical evidences and has also noticed causes for inefficient healthcare delivery and prevalence of OOPE among the patients during hospitalisation.

4.1. Diseases Covered:

The patients of both RACHI and the non-RACHI categories who were admitted into both public and private network hospitals in order to seek treatment to a few common diseases such as heart, neurological, orthopedic and renal systems are selected for this comparative study. Table 4.1 shows clearly about sampled patients of the study. As stated earlier, the private network hospital and the public network hospital were selected for the study based on criteria of delivering healthcare service to similar diseases. However, when the sample was drawn there was unequal representation as far as the diseases are concerned. But, as far as the patients' representation from both the hospitals and from both the categories of patients is concerned the sample was equal for both the hospitals. These patients who were interviewed in two network hospitals are 200, who were distributed, 100 each in the private and public hospitals. Again in each

hospital, 50 each in the RACHI and the non-RACHI category are sampled. Disease-wise, 103 (51.1%) patients were with heart problems, 33 (16.5%) were with orthopedic diseases, 32 (16%) were with the neurological problem, and 32 (16%) with the kidney problem. Table 4.1 shows the distribution of patients in accordance with the type of healthcare coverage, type of diseases they suffered from, and type of healthcare provider.

Table 4.1, Sample Patients with Four Diseases in Two Network Hospitals
(Percentage in parenthesis)

Procedures	Private			Public			Grand Total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
Heart problem	43 (21.5%)	39 (19.5%)	82(41%)	13 (6.5%)	8 (4%)	21(10.5%)	103 (51.5%)
Neurological problem	6 (3%)	5(2.5%)	11(5.5%)	11(5.5%)	10(5%)	21(10.5%)	32(16%)
Orthopedic	1 (0.5%)	3(1.5%)	4(2%)	12(6%)	17(8.5%)	29(14.5%)	33(16.5%)
Kidney	-	3(1.5%)	3(1.5%)	14(7%)	15(7.5%)	29(14.5%)	32(16%)
Total	50 (25%)	50 (25%)	100(50)	50 (25%)	50 (25%)	100(50%)	200(100%)

The difference can also be noted within the hospital. In the case of the private network hospital, the patients were: 82 (41%) with the heart problem, 11 (5.5%) were with the neurological problem, 4 (2%) were with the orthopedic problem and 3 (1.5%) were with kidney problem respectively. But in the public network hospital, the coverage of the diseases is as follows: there were 21 (10.5%) patients with heart and neurological problems while an equivalent proportion of 29 (14.5%) patients were with both orthopedic and kidney problems. A bulk of the patients in the private network hospital had availed the service for their heart-related problems. In contrast, the patients in the public hospital availed this service for treatment of their diseases, are more or less equal in proportion for these four diseases. However, the patients with heart-related problems are accounted for more proportion that was 50% of overall sampled patients in both the hospitals but their proportion was very high in the private hospital, comparatively.

Irrespective the diseases, the patients of insurance (RACHI) and non-insurance (non-RACHI quintiles) are equally distributed between these two network hospitals. The disease wise information with reference to insured and non-insured patients is

concerned; there were three patients with kidney-related diseases in the non-RACHI category in the private hospital. In this public hospital, such patients of both the categories were 29, accounted for a huge number of patients, comparatively.

4.2. Status of Diseases:

At the time interviewer, the patients were in various health-statuses such as serious conditions, normal condition and about to get discharge from the hospital after completion of treatment. In total, there were 140 (70%) of patients in the stage of normal condition, 38(19%) in the stage of grievous condition, and 22(11%) in the stage of leaving for homes (see Table 4.2). Two-thirds of the patients were out of serious condition but still craving for additional in-patient care while one-fifth patients were still in very serious conditions by the time of interview according to Table 4.2. Of those who were in serious condition, the doctor said that there is an uncertainty of recovering health of such patients because such patients may lose their lives in the process of treatment. Such patients are equally distributed between both the hospitals. So, they were in intensive care unit and getting instantaneous treatment to their diseases. They were 28 (14%) patients of the RACHI category while 10 (5%) patients were of the non-RACHI category. Hospital wise, such RACHI patients were 15 (7.5%) in CBH and 13 (6.5%) in GMH. It implies that a higher proportion of such patients are in the care of the private network hospital. Table 4.2 shows that health-status of patients at the time of interview.

Table 4.2, Health Status of the Patients at the Time of Interview
(Percentage in parenthesis)

Disease Condition	Private			Public			Grand total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
Very serious	15 (7.5%)	4 (2%)	19(9.5%)	13 (6.5%)	6 (3%)	19(9.5%)	38 (19%)
Normal condition	26 (13%)	41 (20.5%)	67(33.5%)	31 (15.5%)	42 (21%)	73(36.5%)	140 (70%)
Ready to leave for home	9 (4.5%)	5 (2.5%)	14(7%)	6 (3%)	2 (1%)	8(4%)	22 (11%)
Total	50(25%)	50(25%)	100(50%)	50(25%)	50(25%)	100(50%)	200(100%)

The number of patients who had attained normal stage but required additional in-patient care in the hospitals is 140 (70%). They were not taking treatment for their life-saving but had to be under the surveillance of the doctors for a while to get complete recovery to their diseases. Such patients are 67 (33.5%) in the private network hospital and 73 (36.5%) in the public network hospital. Of them, 85 (42.5%) patients are the RACHI patients who were segregated as 41 (20.5%) patients of CBH and 42 (21%) of GMH. Comparatively, more number of the non-RACHI patients attained normal condition when compared to those of the RACHI category. Such patients of the non-RACHI category are more or less same in proportion to both the hospitals. Finally, a set of patients who had completed hospitalisation and were in the process of getting discharged are 22 (11%) patients in total. They are segregated into 14 (7%) in CBH and 8 (4%) in GMH. By comparison, more number of the RACHI patients are in the serious condition while more number of the non-RACHI patients attained the normal condition. Hospital wise, the patients in the public hospital attained the normal condition whereas the patients in the private hospital were in the process of getting discharged from the hospital. For very serious stage, such patients are same in proportion to both the network hospitals.

4.3. Comparison of Hospitals:

In order to comprehend which healthcare provider appears to be deliverer of efficient and quality healthcare service to the insured patients, a juxtaposition between these two network hospitals-Gandhi Medical College Hospital (GMH) and Care Banjara Hospital (CBH) was undertaken to assess the services provided by hospital administration, doctors, nurses, Mithra, diagnosis facilities, and sanitary workers. Through this comparison, an attempt was also made to find out the reasons for prevalence of OOPE among the hospitalised patients. It is hoped that the findings would further help to formulate policies that can reduce or remove loopholes driving to OOPE of insured patients. Why because, the service of network hospitals is prominent to attain objects of the government through this insurance scheme. If those hospitals fail to delivery efficient service then the entire insurance service would be deteriorated.

4.4. Process of Admission into the Hospital:

The current admission process in the hospitals actually depends on the type of medical expenditure coverage by which the patients are assured. Therefore, it is to scrutinise the admission service provided by the hospitals to the insured patients and uninsured patients. It is observed that the network hospital was likely to show slackness towards the insured patients with regard to providing beds and timely service as most of the patients were illiterate, powerless, marginalised and, rural and slum dwellers etc. Actually, as per the principles of the RACHI Trust, the insured patients are entitled to access free end-to-end' healthcare service under the coverage of the insurance on equal line with service for patients paying from their own pockets for their diseases treatment. But, it was a falsehood practically that has been elucidated below with empirical evidences. In particularly, the public hospital delivered homogeneous admission process to both the categories of patients but difference was started for them with regard to accessing better healthcare service after hospitalisation. On the other hand, it is usually mandatory for all non-RACHI patients to incur medical expenditure themselves during hospitalisation in the private hospital. For the RACHI patients in this hospital, such expenditures are assured by the insurance. But, a few (19) patients had incurred unknowingly consultation fee for doctors due to failure of Mithras' service in the hospital. Such expenditure was not reimbursed to them even after their admission either by network or by the insurance.

The duty of Mithra in the private hospital at the time of admission is to refer RACHI patients for preliminary examination to RAMCO who is selected by a panel of the Trust to be it's represented in the hospital. RAMCO again refers these patients, if they require further intensive examination, to specialists in the hospital who usually can determine whether such patients require inpatient service or not. Based on suggestions of specialists, the RACHI patients were admitted into the hospital but a few patients were admitted into the hospital as their health conditions were in very critical stage. For GMH, the admission process was similar to patients of both the categories who were admitted into the hospital based on recommendation of their doctors. Once, the RACHI

patients admitted into the hospital then the Mithra on duty at the hospital had to send the patients' health history and details of the required treatment to the Trust through internet for free healthcare to the patients. At the Trust, doctors then scrutinised these details of the patients and approved the pre-authorisation request for treatment of the patients send by Mithras. According to an employee in the hospital, this process would take in-between one-week to 10 days. In this regard, finally the RACHI patients met various difficulties in connection to their health and financial issues of their families.

For instance, if the Trust does not approval then this network hospital does not allow the RACHI patients to have accessed to inpatient service in the hospital. In the hospital, a few RACHI patients as already mentioned were admitted without approval of the Trust because they rushed in serious condition to the hospital in order to seek care for their diseases. Then, Mithra had a group call with the concerned doctor in hospital and a doctor in the Trust to get approval for free-healthcare to the patients. In some cases, after examination by doctors, they returned to their homes and waited for approval of the Trust to have inpatient treatment at freebie in the hospital. Some days later, they had received phone calls from the hospital to have inpatient treatment under insurance coverage. That waiting time according to few patients would be one month to two months approximately.

In addition to this waiting period, there are a few patients who waited for availing the service of the hospital even after approval of the Trust due to unavailability of beds in the hospital. For such patients, the hospital arranged a room called "Aarogyasri Waiting Room" which is exclusively for the RACHI patients. No such facilities are available for the non-RACHI patients in this hospital. During the stay in this room, the RACHI patients were not entitled to get free food and other facilities, except doctor's check-ups and diagnostic tests. In this stage, a few patients of the RACHI category had spent OOOPE on some diagnostic tests because, according to few patients, the hospital stated that such tests are not covered by insurance. As a result, they were stressed psychologically and physically. On the other hand, a great priority had been given to patients paying out of pocket for their diseases treatment. Such patients were admitted

into the hospitals directly without following any procedure of the insured. The reason for directly accessing the hospital facilities is paying bills out of pocket. Hence, several RACHI patients confronted unfavorable conditions before they got admitted into the hospital whereas for the non-RACHI patients, every procedure of admission was in their favor. It is found, the reasons for recurrent delay for most of the insured patients was dearth of beds.

In addition to such processes, there is one more essential element to be compared called out patient visit. There are 162 (81%) patients whom were admitted into the hospital on their first day visit itself as per Table 4.3. They were divided into 83 (41.5%) patients in CBH and 79 (39.5%) in GMH. It implies doctors in the private hospital usually prefer immediate inpatient treatment for patients in general and for the non-RACHI patients in particular. Hospital wise, 34 (17%) patients of the RACHI category and 49 non-RACHI (24.5%) patients got admitted, on their first visit to the private hospital. As aforementioned, doctors in this hospital preferred immediate inpatient treatment for the non-RACHI patients as they incurred all expenses out of their pocket during hospitalisation comparatively. Such patients of the RACHI category are few in number. Among them, a few patients sought care in the hospital for treatment of their serious diseases. For GMH, the patients who sought care on their first visit to the hospital are by and large similar in number to both the categories. Table 4.3 shows about the out-patient visits to the network hospitals during the pre-hospitalisation.

Table 4.3, Out-patient Visits of Patients during the Pre-Hospitalised Stage
(Percentage in parenthesis)

Number of visits	Private			Public			Grand Total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
Within same day	34 (17%)	49 (24.5%)	83(41.5%)	38 (19%)	41 (20.5%)	79(39.5%)	162 (81%)
2 -3	6 (3%)	1 (0.5%)	7(3.5%)	9 (4.5%)	9 (4.5%)	18(9%)	25 (12.5%)
4-5	8 (4%)	0	8(4%)	3 (1.5%)	0	3(1.5%)	11 (5.5%)
8	2 (1%)	0	2(1%)	0	0	0	2 (1%)
Total	50 (25%)	50 (25%)	100(50%)	50 (25%)	50 (25%)	100(50%)	200 (100%)

Further, a few patients made several visits during the outpatient stage. Such visits are varied from one category to another category and from one hospital to another hospital.

In CBH, the highest number of visit was three times for the non-RACHI patients and eight times for the RACHI patients. For GMH, that was five times for the RACHI patients and only three times for the non-RACHI patients. Overall, the RACHI patients than the non-RACHI patients made more number of outpatient visits to these two network hospitals generally, and RACHI patients in CBH made more number of visits among all the patients in both the hospitals. In some case, a few patients after doctors advised them for inpatient treatment had returned to home in order to accomplish certain their responsibilities as a case of patients in the public hospital as well as the RACHI patients in CBH. Their responsibilities are that handing over the ones of children, livestock and agricultural related duties to kin and neighbours.

A few patients of the RACHI category of both the hospitals returned their homes in order to borrow money from moneylenders and relatives to incur expenditure arising during their hospitalisation. Hence, the RACHI patients confronted various difficulties with regard to process of admission, outpatient visits and their family related responsibilities, as in the case of CBH but both categories' patients had a similar experience as the admission process was similar to them in GMH.

4.5. Doctors Service:

The trained and skillful medical personnel known as doctors are considered pillars for not only rolling out hospitals' services and also for sustain of the entire healthcare system. Without their committed service, the whole hospital service would be futile and insignificant in delivering healthcare to the people. Doctors' service is an important aspect everywhere across the world. Basically, the healthcare service in GMH WAS being delivered by MBBS and PG students with guidance of their faculties. So patients had no satisfaction with this service. In general form, a few patients felt that they are laboratory animals as it is believed that they go by 'trial and error method'. In literal sense, their health is in hands of unqualified medical students. As a result of that, they bothered about proper treatment to their diseases as they had no firm faith in this service. In contrast to the service in GMH, qualified healthcare providers in CBH were

delivering healthcare service to the patients. It is observed that they did not bother about patients' social, religion, and region etc., except their economic conditions.

A few patients had commented that doctors in GMH attain duties occasionally, stay a mere time in the hospital, and come sometimes to the hospital in indefinite timings. They also stated that a few doctors visit hospital once a week to examine the patients. For instance, a woman was admitted in the public hospital for treatment of her neurological problem after a huge rejection by employees as the concerned doctor was irregular to duty in this hospital. During pre-hospitalisation, whenever she approached the hospital she was regularly asked to visit hospital next time as the concerned doctor was absent. In this context, it can be predicted that if a patient fails to avail the doctor's service, then he or she has to wait for next week when doctor attends the duty. As a part of assessing the doctor's service, the number of times doctor visits patient per day is considered one of such measurements. For instance, if doctor visits patient more time in a day then that would indicate his/her concern towards the patient. On the other hand, limited number visits of the doctor only imply a heedless attitude of the doctor towards the patients. This perception may not be acceptable for the health providers. However, when we had gone by the interpretation of the patients, the data show (Table 4.4) according to the patients, 67 (33.5%) patients in CBH and 44 (22%) in GMH claimed that the doctor visited them twice a day, at morning and evening. Of them, more number of such patients were from CBH when compared to those in GMH. By category, the RACHI patients had more visits of doctors than those of the non-RACHI category in both the hospitals.

Another category of patients who had this service once a day are 89 (44.5%). Most of them had this service in the mornings except 2 (1%) patients who had it in the evenings. Hospital wise, they were 29 (14.5%) patients in the private hospital and 56 (28%) patients in the public hospital. It shows, overall nearly a half of the total patients had this service once a day and were mostly pertained to the public network hospital by comparison. According to Table 4.4, more number of patients in the private network hospital obtained a better access to this service while for patients in the public hospital

this service was limited and mostly restricted for one time only. By categorical comparison, the RACHI patients had accessed this service twice a day as compared to those of the non-RACHI category in both the hospitals. On the other hand, the non-RACHI patients accessed this service once a day than those of the RACHI category in both the hospitals. Hence, one may say that daily visits of doctors are very few. Therefore, the patients were mostly not content with the service of doctors in the public hospital. Table 4.4 shows the number of visits of the doctor per a day.

Table 4.4, Number of Visits of Doctor

(Percentage in parenthesis)

Doctor's visits per day	Private			Public			Grand Total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
Morning	12 (6%)	17 (8.5%)	29(14.5%)	25 (12.5%)	31 (15.5%)	56(28%)	85 (42.5%)
Evening	0	2 (1%)	2(1%)	0	0	0	2 (1%)
Morning and Evening	37 (18.5%)	30 (15%)	67(33.5%)	25 (12.5%)	19 (9.5%)	44(22%)	111 (55.5%)
Not started	1 (0.5%)	1 (0.5%)	2(1%)	0	0	0	2 (1%)
Total	50 (25%)	50 (25%)	100(50%)	50 (25%)	50 (25%)	100(50%)	200 (100%)

In addition to a number of visits rendered by doctors, duration of time allocated by the doctor in each visit to the patient is also an important measurement. The duration of time doctor allocated to examine the patient was segregated into three types: 2-4 minutes, 5 minutes and 6-15 minutes based on empirical evidence. According to Table 4.5, the patients who obtained 2-4 minutes of time of doctor in each visit were 29 (14.5%) patients in GMH and one (0.5%) in CBH. Another set of patients who had approximately 5 minutes of doctor's time in each visit was 45 (22.5%) patients in CBH and 39 (19.5%) in GMH. By comparison, the data shows that more number of patients in CBH accessed this service for five minutes approximately while more number of patients in GMH had 2 to 4 minutes of this service in each visit. Finally, a few patients got a privileged chance of being examined by their doctors for six to fifteen minutes approximately were 84 (42%). They are distributed as 52 (26%) patients in the private hospital and 32 (16%) in the public hospital. Overall, the patients in CBH had a change of being obtained more number of doctor' visits and satisfactory time with doctors in each visit when compared to those in GMH.

By category, the non-RACHI patient benefited extensively with allocated time of doctor in each visit than those of the RACHI category as it was in the case of CBH. A few of them had accessed to this service even for six to fifteen minutes of time. For GMH, the RACHI patients obtained this service extensively when compared to those of the non-RACHI category. Hence, overall the patients in CBH experienced better service in connection to the service of their doctors as compared to those in GMH. The non-RACHI patients in this hospital obtained this efficient and satisfactory service among the all patients in both the hospitals. On the other hand, the patients in GMH were unsatisfied and also expecting efficient service further from their doctors. However, in this hospital the patients of both the categories had received an equivalent service generally but a few patients of the RACHI category obtained better service particularly. Table 4.5 shows the duration of time that doctor allocated in each visit to examine the patient.

Table 4.5, Duration of Time Allocated by Doctor for Each Visit
(Percentage in parenthesis)

Allocated time by doctor in each visit	Private			Public			Grand Total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
2-4 minutes	1 (0.5%)	0	1(0.5%)	10 (5%)	19 (9.5%)	29(14.5%)	30 (15%)
5 minutes	23 (11.5%)	22 (11%)	45(22.5%)	22 (11%)	17 (8.5%)	39(19.5%)	84 (42%)
6-15 minutes	25(12.5%)	27(13.5%)	52(26%)	18(9%)	14(7%)	32(16%)	84(42%)
Did not started	1 (0.5%)	1 (0.5%)	2(1%)	0	0	0	2 (1%)
Total	50 (25%)	50 (25%)	100(50%)	50 (25%)	50 (25%)	100(50%)	200 (100)

This interaction between doctor and patient is explored through certain queries such as whether the doctor has asked patient about his or her health condition daily? Is doctor maintaining friendly interaction with patients while delivering his/her services? Does patient trust the medicine prescribed by the doctor? Whether the patient is assured of the recovery of health? Has patient got relief from the pain of his or her disease after surgery? Has patient recognised any change between before and after the treatment or surgery? Does the patient make payment to doctor for the treatment of his or her disease? Through these queries, an attempt was made to analyse the patterns of doctors' service towards the patients. A comparison is also made to discover which hospital's

patients have found it better about the service of doctors. One-third of the patients had no surgery done by the time of interviews (Table 4.6). They were all by and large content with this service in connection to inquiring about their health condition every day and friendliness of doctors. They had also completely trusted the medicine prescribed by the doctors. Table 4.6 shows the relations between patients and doctors.

Table 4.6, Relations Between Doctors and Patients

(Percentage in parenthesis)

Relations	Private			Public			Grand Total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
Enquiring about patients' conditions daily	47(23.5%)	49(24.5%)	96(48%)	48(24%)	46(23%)	94(47%)	190(95%)
Doctors' friendliness	49(24.5%)	49(24.5%)	98(49)	43(21.5%)	43(21.5%)	86(43%)	184(92%)
Patients trusted medicine prescribed by their doctors	47(23.5%)	49(24.5%)	96(48%)	44(22%)	45(22.5%)	89(44.5%)	185(92.5%)
Assurance of doctor for cure of diseases after surgery	34(17%)	45(22.5%)	79(39.5%)	32(16%)	25(12.5%)	57(28.5%)	136(68%)
obtained relief from their pain after surgery	36(18%)	26(13%)	52(26%)	30(15%)	15(7.5%)	45(22.5%)	107(53.5%)
Patients acknowledged the variation in pre and post of surgery	36(18%)	32(16%)	68(34%)	2(1%)	0	2(1%)	70(35%)

Another set of patients, in-between 62-79 in CBH and 45 to 57 in GMH were content with the service of the doctor with regard to assurance of their doctors for complete cure of their diseases and, obtained relief from acute pain after surgery. As per Table 4.6, there are 38 (34%) patients in the private hospital and 2 (1%) in GMH who could experience the quality of this service. They also appreciated the doctor as they were getting recovered after surgery. By category, in CBH the non-RACHI patients had availed better service as compared to those of the RACHI category owing they experienced recovery of their diseases after surgery. They also trusted the medicine

prescribed by doctors. In the public hospital, the RACHI patients had experienced the decreased of their pain because of, they felt, improvement in service delivery by the doctor after surgery, as compared to those of the non-RACHI category. They also experienced better and quality service of doctors after surgery than their counterparts. Hence, overall the non-RACHI patients in the private network hospital and the RACHI patients in GMH had received better service from their doctors. Table 4.7 shows about expectations of the patients from their doctors

Table 4.7, Expectation of the Patient from Doctor

(Percentage in parenthesis)							
Expectations from doctor	Private			Public			Grand total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
Get the immediate cure and leave the hospital fast	0	0	0	2(1%)	1(0.5%)	3(1.5%)	3(1.5%)
listen to complaints of the patients	2(1%)	2(1%)	4(2%)	1(0.5%)	0	1(0.5%)	5(2.5%)
assure and stimulation from doctors	1(0.5%)	2(1%)	3(1.5%)	0	0	0	3(1.5%)
Disclose the exact health status	1(0.5%)	1(0.5%)	2(1%)	0	1(0.5%)	1(0.5%)	3(1.5%)
give some additional time	0	2(1%)	2(1%)	12(6%)	6(3%)	18(9%)	20(10%)
ask patients some more queries	0	0	0	2(1%)	1(0.5%)	2(1.5%)	3(1.5%)
good and quality treatment	0	0	0	1(0.5%)	6(3%)	7(3.5%)	7(3.5%)
Include minor diseases	0	0	0	1(0.5%)	0	1(0.5%)	1(0.5%)
Quality medicine prescription	0	0	0	0	2(1%)	2(1%)	2(1%)
Speed up the service	0	0	0	0	2(1%)	2(1%)	2(1%)
Increase the number of visits per day	0	0	0	0	1(0.5%)	1(0.5%)	1(0.5%)
Not	46(23%)	43(21.5%)	89(44.5%)	31(15.5%)	30(15%)	61(30.5%)	150(75%)
Total	50(25%)	50(25%)	100(50%)	50(25%)	50(25%)	100(50%)	200(100%)

Apart from their experiences with doctors, they had a lot of expectations from their doctors in order to receiving further proper and satisfactory service from their doctors. In this context, there are few queries framed. What is the dissatisfaction with the doctor and what is the expectation from him/her are considered important questions. Both queries dealt similar aspirations of their doctors. The expectations from the doctors are

different from patient to patient, and from hospital to hospital. In the case of GMH, they expected additional service from their doctors that included early recovery from their illness and early discharge from the hospital, additional time might be allocated by doctors to examine the patients, improving the close-interaction between doctor and patient, and non-discriminatory healthcare delivery and so on. As per Table 4.7, they were 11 (5.5%) patients in CBH and 39 (19.5%) in GMH, expecting additional service from their doctors. In this regard, the private hospital alone had one-fifth of such patients.

Patients of both categories in the private hospital had a few expectations only when compared to those in the public hospital. Their expectations included listening to the complaints of the patients, assurance for complete cure of their diseases, disclosing exact health condition of patients to their family members or to the patients concerned. For patients in GMH, such expenditures were many that showing the inefficient service of doctors in the public hospital. In literal sense, the doctors' service have not been enhanced or improved even after this hospital became a network hospital for the insurance scheme. In this context, it can be suggested that this doctor service has to be improved in accordance with patients' healthcare necessities and expectations. Therefore, their experiences with unsatisfactory would turn into experiences with complete satisfactory. Hospital wise, the non-RACHI patients had a lot of expectations than the RACHI patients in both the hospitals. Among all patients in both the hospitals, the non-RACHI patients in GMH had expected a lot from their doctors.

4.6. Service of Nurse:

The service of nurses is considered as one of the paramount services in the whole healthcare delivery of the hospital. They usually have great and unique responsibilities in terms of, to accomplish the tasks assigned by the doctors towards delivering healthcare service to the patients. Unlike doctors, she has to stay with the patients round the clock and are being a first contact person for patients in the hospital. Their primary duty is to administer treatment to the patients by injections and providing medicine.

Generally, the relations between doctors and nurses are hierarchical. So, they can be viewed as doctors are being policy makers while nurses are executors of that policy. Sometimes, the nurses during hospitalisation have to take a mediating role between patients and doctors to convey health complains and changes in health of the patients to doctors. So, the roles of nurses in these hospitals are examined by few queries. Such queries: commitment of nurses towards treatment of the patients, their attitude while delivering the service, their perverse behaviour, and demanding patients for money.

Table 4.8, Services of the Nurses

	(Percentage in parenthesis)						
Service of nurses	Private hospital			Public hospital			Grand Total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
accessing of this service from the first day onwards	46(23%)	50(25%)	96(48%)	50(25%)	47(23.5%)	97(48.5%)	193(96.5%)
Maintaining friendliness	49(24.5%)	50(25%)	99(49.5%)	48(24%)	47(23.5%)	95(47.5%)	197(98.5%)
Perverse behaviour of nurses	1(0.5%)	0	1(0.5%)	2(1%)	3(1.5%)	5(2.5%)	6(3%)
Demand you for money	0	0	0	0	1(0.5)	0	1(0.5%)

According to Table 4.8, there are 193 (96.5%) patients in the hospitals who started accessing this service from the first day of their admission onwards. Among them, 96 (48%) patients were in the private network hospital (CBH) and 97 (48.5%) patients were in GMH. In the private hospital, patients of both the categories had experienced friendliness of nurses while receiving their service. Such patients in GMH were less in number when compared to those in CBH. On the contrary, 6 (3%) patients went through awful experience with nurses while availing their services. Among them, 5 (2.5%) patients accounted for a huge number were the patients of GMH. It implies that more number of patients in the public hospital were underwent a hostile experience with this service, comparatively. Of them, 2 (1%) patients were of the RACHI category while 3 (1.5%) patients were of the non-RACHI category. It shows that even within the hospital a set of patients suffered extensively than other set of patients. In this regard, the non-RACHI patients who suffered were a little higher than the non-RACHI patients. On the other hand, only a patient in CBH went through such experience as a result of his/her

improper behaviour. Such complaints were completely absent among the non-RACHI patients as they had been themselves incurred their medical expenditure. Table 4.8 shows the services of Nurses.

Generally, it is common for nurses to maintain patients' room noiseless in both the hospitals. But, it is observed that nurses in the public hospital exercise always a great authority and dominance over patients, and enjoyed a freedom of doing whatever they liked as a result of absence of proper monitoring for them. In addition to that, they are all members of employer union which usually protect their over-freedom and empower them as well. On the contrary, such unions and over-freedom were absent for nurses in CBH. So, they were all working sincerely under a single monitoring of hospital administration.

Another query is that does nurse serve patients suffering from minor diseases during hospitalisation when the concerned doctor is absent? A few minor diseases that the patients suffered from were fever, headache, stomach ache, and leg pains etc. Actually, such diseases are not covered under insurance scheme. According to Table 4.9, a total of 137 (68.5%) patients suffered from such diseases during hospitalisation in both the hospitals. They were 72 (36%) patients in the private hospital and 65 (32.5%) patients in the public hospital. It shows, a little higher proportion of such patients are pertained to the private hospital. In such situations, nurses in CBH handled those patients very effectively by delivering proper service when compared to nurses in GMH. As a part of that, they even referred such patients to the concerned doctors but service of the nurse in GMH was not much significant as they tried to have sought out to cure such diseases through medication.

In this regard, 112 (56%) patients were under medication in accordance with suggestions of nurses. They were 50 (25%) patients in CBH and 62 (31%) patients in GMH. Nurses provided them medicine without consultation of the concerned doctors as doctors were absent during such times. They were more in number in GMH than those in CBH. On the other hand, a large number of such patients were referred to doctors by

nurses for treatment of such diseases. They were more in CBH than those in GMH. By category, patients who availed the service of nurses for cure of such minor diseases are equal in number to both the categories in GMH whereas such patients are more in number in the RACHI category than those of the non-RACHI category in CBH. In a case of receiving treatment, such of patients of both the categories in GMH had obtained more or less similar treatment whereas for CBH, such patients of the non-RACHI category had received this service with the extra-care and injections when compared to those of the RACHI category. Table 4.9 shows health care delivery of nurses for patients suffering from minor diseases during hospitalisation.

Table 4.9, Treatment of Nurses for Patients Suffering with Minor Ailments
(Percentage in parenthesis)

Treatment by nurses	Private Hospital			Public Hospital			Grand Total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
Not yet faced	13(6.5%)	15(7.5%)	28(14%)	17(8.5%)	18(9%)	35(17.5)	63(31.5%)
Referred medicine	28(14%)	22(11%)	50(25%)	32(16%)	30(15%)	62(31%)	112(56%)
Check-ups, injections and showing more care	4(2%)	7(3.5%)	11(5.5%)	0	0	0	11(5.5%)
Intimate to doctors for additional service	5(2.5%)	6(3%)	11(5.5%)	1(0.5%)	2(1%)	3(1.5%)	14(7%)
Total	50(25%)	50(25%)	100(50%)	50(25%)	50(25%)	100(50%)	200(100%)

There are few patients as aforementioned who were referred by nurses to doctors for further intensive treatment, are 11 (5.5%) patients in CBH and only 3 (1.5%) in GMH. In both the hospitals, more number of such patients were from the non-RACHI category who were referred to doctors as compared to those of the RACHI category. Overall such patients of both the categories had received better service from their nurses for treatment of their minor diseases during hospitalisation in CBH when compared to those in GMH. Among all the patients in both the hospitals, the non-RACHI patients in CBH had received better service from their nurses.

4.7. Mithras:

Mithras, who are deployed by the RACHI Trust in the network hospitals, facilitate delivering efficient and proper healthcare service to insured patients. Their duty is primarily to guide patients who are illiterate and unaware of the procedures for proper utilisation of insurance, and procedures to be followed in the network hospitals as these patients are not properly aware about the service delivery of this insurance and the network hospitals. Mithra in the hospitals mediate between the patients, insurance, and the hospital staff. In brief, they are to enable the patients to get appropriate and quality service from the network hospitals, with their mediation. They generally help patients during the pre-hospitalisation and hospitalisation and to provide money towards travel cost to the patients after the hospitalisation. They assist the insured patients in the admission process, diagnostic tests, clarifying doubts, guiding, providing information, and so on, during the hospitalisation. Their service is not pertained to the non-RACHI patients.

Differences were noticed in executing the responsibilities of the Mithras between these two network hospitals. In the case of the public network hospital (GMH), nurses took over all responsibilities of Mithras except uploading patients' status into insurance website for obtaining authorisation of the Trust for freebie healthcare service to the patients. In this regard, Mithra had no role to play. Nurses had constantly interacted with the patients and also mediated between the patients and Mithras. In literal sense, any information related to insurance coverage was conveyed to the patients through nurses. As aforementioned, these Mithras were not being accountable for the healthcare service to the non-RACHI patients. There are many insured patients who had no idea even about Mithra in the public hospital. All RACHI patients, 50 (25%) in Table 4.10, availed this service during the hospitalisation in CBH. In order to figure out efficiency in service of the Mithras in this network hospital (CBH), the RACHI patients were asked a set of queries, which are: whether the Mithras have helped the patients at the time of admission, diagnostic tests, communicating with the doctor, getting inquired about their condition from them and noted down their complainants. In this context, it only analysed the service of Mithras towards the insured patients in the private hospital

and, ignored the analysis of Mithras service in the public network hospital as the patients were not aware of this service, completely.

It is found that only 39 (19.5%) patients had approached the Mithras for their succor at the time of admission into the hospital, and they were only allowed to get admission after they obtained the authorisation from the Trust. But, the rest of 11 (5.5%) patients rushed in an emergency condition to the hospital and were admitted without having any approval from the Trust. In this condition, Mithras held conference phone call with the concerned doctors in the network hospital and specialized doctors from the Trust in order to obtain pre-authorised approval from the Trust. About 39 (19.5%) patients stated that Mithras' behaviour with them is friendly and they are being available to them round the clock. It implies that nearly all insured patients in this hospital had received timely service and had also experienced Mithras' friendliness while accessing their services. However, not all patients obtained the service completely that meant the service was not available to them to meet all their treatment related needs. A set of patients from 26 (13%) to 33 (16.5%) said that Mithras delivered the services to them for diagnostic tests, procuring information about their treatment process etc. Some of them stated that their Mithras got well in communicated with doctors to get to know about their exact health-status. Table 4.10 shows the service of Mithras in the private network hospital.

Table 4.10, Mithras' Service for RACHI patients in the Private Network Hospital
(Percentage in parenthesis)

Mithra service	Private			Public			Total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
In admission	39 (19.5%)	0	39 (19.5%)	0	0	0	39 (19.5%)
Friendliness	39 (19.5%)	0	39 (19.5%)	0	0	0	39 (19.5%)
Available at 24/7	39 (19.5%)	0	39 (19.5%)	0	0	0	39 (19.5%)
diagnostic tests	33 (16.5%)	0	33 (16.5%)	0	0	0	33 (16.5%)
Communicating with the doctors for solving their problems	29 (14.5%)	0	29 (14.5%)	0	0	0	29 (14.5%)
Enquiring over their healthcare daily	26 (13%)	0	26 (13%)	0	0	0	26 (13%)
Building confidence	26 (13%)	0	26 (13%)	0	0	0	26 (13%)
Noting down patients' complaint	6 (3%)	0	6 (3%)	0	0	0	6 (3%)
Guiding in the hospital	2 (1%)	0	2 (1%)	0	0	0	2 (1%)

Furthermore, there are few patients who obtained assistance of Mithras for meeting their other needs. One contribution of Mithras was to build confidence among the insured patients that the Trust would take care of the patients' financial needs completely as well as the hospital also would deliver required service to the patients. A small proportion of patients acknowledged that Mithra noted down their complaints against inefficient service of the network hospital. A few patients (two) agreed that they had received guidance about how to behave properly in the network hospital. Overall, not all insured patients in the private network hospital (CBH) had received Mithras' service completely while this service was completely absent and had been taken over by nurses in the public network hospital.

4.8. Diagnostic Tests:

The diagnostic tests are usually a necessary component of health care delivery. Patients went through few diagnostic tests both at out-patients and in-patient stages. Such tests mostly included X-ray, scanning, blood test, ecotest, and angiogram. At the time of interviews, out of 200 patients the tests which patients had were: 152 (76%) - blood test, 106 (53%) - scanning test, 122 (61%) -X-ray test and, 56 (28%) - ecotest and 21 (10.5%) – angiogram as per Table 4.11. Overall, more than half of the total patients had undergone different diagnostic tests. The patients in the private network hospital who underwent the tests were 58 (29%) - blood test, 37 (18.5%) - scanning, 46 (23%) - X-ray, 46 (23%) - Ecotest, and 21 (10.5%) - angiogram. In the case of the public network hospital, they were 94 (47%), 69 (34.5%), 76 (38%) and 10 (5%), respectively. It is clear that more number of patients in GMH went through these tests as compared to those in CBH by the time of interviews. By comparison, more number of such patients are pertained to the RACHI category than to the non-RACHI category in CBH whereas for GMH, such patients are equal in number to both the categories.

Even this diagnostic service is free-healthcare for the RACHI patients in both the hospitals and also for the non-RACHI patients in GMH, but a few patients incurred OOEPE on their diagnostic tests. This was the result of ignorance of the RACHI patients,

and negligence of both Mithras and the hospital staff. The cost of such tests was not reimbursed to them even by the time of interviews. On the other hand, it was mandatory for the non-RACHI patients in CBH to incur themselves OOPE on their diagnostic tests as they had no insurance coverage unlike the RACHI patients in the hospital. Such expenditure is generally considered as medical expenditure. By category, in CBH such patients of the RACHI category were one (0.5%) patients-scanning test and 6 (3%) patients-angiogram while such patients of the non-RACHI category were 18 (9%) patients- blood test, 14 (7%)- scanning test, 17 (8.5%)- X- ray, 16 (8%)- ecotest. For GMH, such patients of the RACHI category were 2 (1%) – blood test, 3 (1.5%) – scanning, 3 (1.5%) – X-ray, and one (0.5%) – eco test whereas the non-RACHI patients were 2 (1%), 3 (1.5%), 2 (1%), and one (0.5%), respectively. Among the RACHI patients in CBH and patients of both the categories in GMH, more number of such patients are pertained to the public network hospital. In the public network hospital, a little higher percentage of such patients is belonged to the RACHI category than those of the non-RACHI category. In the case of comparison between patients of the RACHI category in both the hospitals, such RACHI patients in CBH incurred OOPE mostly on ecotest while such patients of the RACHI category in the public hospital incurred OOPE mostly on both scanning test and X-ray.

One important observation made about the diagnostic tests is that there was an inordinate delay in taking tests at the public network hospital. It is due to the fact that there was a heavy rush of patients and there were no adequate number of machines or equipments to meet the demand. It is observed that the patients had to wait in the queue and wait for the reports as well. But in the case of CBH, the RACHI patients did not experience such delays and, same was the case with the non-RACHI patients. In addition, all patients of both the categories in CBH became aware of what tests they have to go through, at the time of their admission itself. But, in GMH the patients of both the categories came to know of their tests, one to two days before the test has done. Table 4.11 shows the total diagnostic tests the patients underwent by the time of interviews.

Table 4.11, Total Diagnostic Tests the Patients Underwent by the Time of Interviews

Diagnostic tests	FREE						Paid						Grand total
	Private			Public			Private			Private			
	RACHI	Non - RACHI	Total	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	RACHI	Non - RACHI	Total	
Blood	40(20)	0	40(20)	45(22.5)	45(22.5)	90(45)	0	18(9)	18(9)	2(1)	2(1)	4(2)	152(76)
Scanning g	22(11)	0	22(11)	35(17.5)	28(14)	63(31.5)	1(0.5)	14(7)	15(7.5)	3(1.5)	3(1.5)	6(3)	106(53)
x-ray	29(14.5)	0	29(14.5)	35(17.5)	36(18)	71(35.5)	0	17(8.5)	17(8.5)	3(1.5)	2(1)	5(2.5)	122(61)
Eco-test	24(12)	0	24(12)	4(2)	4(2)	8(4)	6(3)	16(8)	22(11)	1(0.5)	1(0.5)	2(1)	56(28)
Angiogram	20(10)	0	20(10)	0	0	0	1(0.5)	0	1(0.5)	0	0	0	21(10.5)

4.9. Sanitary Conditions:

The proper sanitary condition in the hospital usually generates and protects the healthy atmosphere. Retaining adequate sanitary condition in the hospital is considered one of the prominent factors of this comparative analysis. Three elements are considered for sanitary conditions in the hospitals for comparison. In particular, the analysis concerns with the service of sanitary employees on the number of times per a day that they swept the rooms of patients, changing the bed sheets and pillow covers, and grievances of the patients about cleaning of bathroom and latrine.

4.10. Sweeping the Rooms:

Although all the patients stated that the service of sanitary employees is available every day but there was a difference with reference to how many times this service is provided in a day. They were 102 (51%) patients who said that this service is provided for two times a day. About 90 (45%) patients obtained the service for three times, 6 (3%) for four times, and 2 (1%) for only one time, respectively. It can be said that more than half of the patients and nearly another half of the patients obtained this service for two times and three times, respectively. With reference to hospitals, 80 (40%) patients in CBH said that this service is provided to them for three times a day while 88 (44%) patients of GMH stated that they received this service for two times only. So, it can be concluded that the private network hospital had delivered quality sanitary service to the patients by providing this service with more number of times as compared to that of the public network hospital. The patients in CBH had received this service three times: morning, afternoon and evening. In contrast, the patients of GMH had received the service two times only: morning and evening.

With reference to the RACHI and the non-RACHI patients, there was a difference again. In the case of the private hospital (CBH), 80 (40%) patients who received this service thrice a day are segregated into 33 (16.5%) the RACHI patients and 47 (23.5%) the non-RACHI patients. In the case of the public network hospital (GMH), those patients who received this service twice a day are 43 (21.5%) patients of RACHI

category and 45 (22.5%) patients of the non-RACHI category. In addition, a small proportion of patients in the private network hospital stated that they obtained this service for more than three times whereas no such service was available for the patients in the public hospital (see Table 4.12). One can infer from this observation that as far as the sanitation is concerned, the service was far better in the private hospital. In this regard, the non-RACHI patients had obtained better service than those of the RACHI patients in this hospital. On the other hand, the public network hospital delivered more or less equal service to patients of both the categories. Overall, this service in the private hospital was efficient and being satisfactory to the patients but the non-RACHI patients received better service than all the patients in both the hospitals. Table 4.12 shows about how many times the patients' rooms are swept by sanitary employees or workers.

Table 4.12, Number of Times the Patients Rooms are Swept
(Percentage in parenthesis)

Number of times	Private			Public			Grand Total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
One	0	0	0	2 (1%)	0	2(1%)	2 (1%)
Two	12 (6%)	2 (1%)	14(7%)	43 (21.5%)	45 (22.5%)	88(44%)	102 (51%)
Three	33 (16.5%)	47 (23.5%)	80(40%)	5 (2.5%)	5 (2.5%)	10(5%)	90 (45%)
Four	5 (2.5%)	1 (0.5%)	6(3%)	0	0	0	6 (3%)
Total	50 (25%)	50 (25%)	100(50%)	50 (25%)	50 (25%)	100(50%)	200 (100%)

4.11. Complain about Unhygienic Conditions in Bathroom and Latrine:

Cleaning of bathroom and latrine is considered a primary measurement to analyse service of these sanitary employees. So, service of sanitary employees is a way significant service for patients in providing a hygienic atmosphere both in bathroom and latrine. If such employees fail to carry out their service then the patients become vulnerable and their health conditions would also be deteriorated. The study shows, there was the prevalence of unhygienic conditions in the public network hospital whereas all the patients in CBH had satisfied with this service in connection to clearing of their bathroom and latrine by these employees. A few patients in the private hospital started that their toilets were cleaned for 4 to 6 times every day. It implies the sustained

of efficient sanitary service in the private hospital. On the other hand, there are few patients in the public hospital who complained about insanitary service in this regard.

They were 37 (18.5%) patients, one-third of the total patients in GMH (Table 4.13) who had complained about bad sanitary conditions of bathrooms and latrines. Out of them, 20 (10%) patients were of the non-RACHI category, and 17 (8.5%) were of the RACHI category. Comparatively, a little higher proportion of such patients were of the non-RACHI category than those of the RACHI category. Such patients of both the categories in the hospital had complained about over-excessing limited facilities by both patients and their assistants, often shortage of water and electricity, and improper cleaning and bad-smell. In literal sense, 14 (7%) patients had complained about excessing utilisation of limited service by both patients and their assistants, 8 (4%) about scarcity of water and shortage of electricity, and 15 (7.5%) about improper cleaning and bad-smell. Hence, improper sanitary service in the public network hospital was appeared even after this hospital became enroller of the network hospitals of the insurance. It can be said, there would be no proper healthcare service to the patients in the public hospital until the sanitary conditions will be improved. Table 4.13 shows about patients' grievances about insanitary sanitary service in connection to their bathroom and latrine.

Table 4.13, Complaints About Unhygienic Conditions of Latrine and Bathroom
(Percentage in parenthesis)

Grievances	Private			Public			Grande total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
Over excess	0	0	0	10(5%)	4(2%)	14 (7%)	14 (7%)
Shortage of electricity and water	0	0	0	3(1.5%)	5(2.5%)	8 (4%)	8 (4%)
Improper cleaning and bad smell coming out	0	0	0	4(2%)	11(5.5%)	15(7.5%)	15(7.5%)
No complaints	50(25%)	50(25%)	100(50%)	33(16.5%)	30(15%)	63(31.5%)	163(81.5%)
Total	50(25%)	50(25%)	100(50%)	50(25%)	50(25%)	(100%)	200(100%)

4.12. Changing Bed-Sheet and Pillow Covers:

Changing of the soiled linen or providing the washed bed sheets and pillow cover daily to patients is a measurement to assess the quality of sanitary employees' service in the hospital. This activity was very common in both CBH and GMH. Every patient in the private network hospital obtained this service daily, between 8 and 9 AM. There was no grievance about this service in the private hospital that implied all the patients satisfied with this service. In the public hospital, only bed-sheet was provided and no pillow cover was given to the patients. No all patients obtained this facility. By the inverse, 40 (20%) patients of both the categories of GMH who only obtained this facility stated that this service is irregular and unequal. The rest of them had no access to such service as a result of the shortage of bed-sheets. The bed-sheets were changed once in two or three days, or after some days or a week. Table 4.14 shows about changing of bed-sheets and pillow covers daily.

Table 4.14, Changing Bed-Sheets and Pillow Covers
(Percentage in parenthesis)

Bed-sheets	Private			Public			Grande total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
Every day (included pillow covers)	48 (24%)	50 (25%)	98(49%)	0	0	0	98 (49%)
once in two days	0	0	0	16 (8%)	7 (3.5%)	23(11.5%)	23 (11.5%)
once in three-seven days	0	0	0	12 (6%)	4 (2%)	16(8%)	16 (8%)
once after 12 days	0	0	0	0	1 (0.5%)	1 (0.5%)	1 (0.5%)
Own bed-sheet	2 (1%)	0	2 (1%)	0	0	0	2 (1%)
Not provided	0	0	0	22 (11%)	38 (19%)	60(30%)	60 (30%)
Total	50 (25%)	50 (25%)	100(50%)	50 (25%)	50 (25%)	100(50%)	200 (100%)

About 23 (11.5%) patients stated as per Table 4.14 that they obtained this service once in two days, followed by 16 (8%) patients once in three to seven days, and one (0.5%) patient once in 12 days, respectively. Out of 40 (20%), 28 (14%) patients are from the RACHI category and, 12 (6%) are from the non-RACHI category. It is noticed that such patients from both the categories in the public hospital went through a similar

experience of complete unsatisfactory. From the discussion with the patients, it is clear that the private network hospital was providing proper sanitary service to the patients of both the categories. Through proper monitoring, its sanitary employees delivered prompt and complete satisfactory service to the patients so that such patients had no complaints about this service. In the case of such service for patients hospitalised in GMH, even though this service was similar to the patients of both the categories but they were not satisfied with this service in connection to cleaning of bathroom and latrine or toilets, and changing of bed sheets daily. Hence, overall the patients of both the categories in CBH experienced efficient and satisfactory sanitary service as compared to those in GMH. By comparison, overall the RACHI patients than the non-RACHI patients in the public network hospital, and the non-RACHI patients than the RACHI patients in the private hospital obtained better service.

4.13. Transportation:

One of the neglected aspects of the insurance scheme is OOP expenditure burden on the patients towards their transportation at the time of admission. In this regard, almost all the patients had incurred OOPE. Their modes of transportation comprised private ambulance, bus, train, car, auto-rickshaw, and public ambulance (108-ambulance). Among all these, most of them (Table 4.15) had reached the network hospitals by buses followed by car, ambulance, train, auto and public ambulance, respectively. One-fourth patients reached the hospitals by buses. If one combined buses, cars and ambulances (private ambulances) together that served to nearly three-fourth of the total patients. The rest, a quarter of the patients, had relied upon trains, auto-rickshaws, and public ambulances. Almost, i.e., 95% of patients had traveled to the network hospitals by their OOPE. Those who utilised an expensive mode of transportation on emergency had to bear this OOPE burden extensively as it was not covered by this insurance scheme. If we compared the patients of both the categories in the private network hospital, the RACHI patients had mainly utilised ambulance and bus while the non-RACHI patients mainly relied on train, car, auto-rickshaw and public

ambulance. Table 4.15 shows the modes of transportation utilised by the patients at the time of admission.

Table 4.15, Modes of Transportation during the Admission

(Percentage in parenthesis)

Vehicle	Private (%)			Public (%)			Grand Total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
Ambulance	11(5.5%)	3(1.5%)	14(7%)	10(5%)	9(4.5%)	19(9.5%)	31(15.5%)
Bus	23(11.5%)	19(9.5%)	42(21%)	19(9.5%)	18(9%)	37(13.5%)	79(39.5%)
Train	6(3%)	12(6%)	18(9%)	3(1.5%)	3(1.5%)	6(3%)	24(12%)
Car	5(2.5%)	8(4%)	13(6.5%)	7(3.5%)	16(8%)	23(11.5%)	38(19%)
Auto	3(1.5%)	8(4%)	11(5.5%)	8(4%)	2(1%)	10(5%)	21(10.5%)
Public ambulance (108)	2(1%)	0	2(1%)	3(1.5%)	2(1%)	5(2.5%)	7(3.5%)
Total	50(25%)	50(25%)	100(50%)	50(25%)	50(25%)	100(50%)	200(100%)

However, the patients had traveled to the public network hospital at the time of admission by expensive modes transportation as compared to those in the private network hospital. In the public network hospital (GMH) a majority of the RACHI patients had relied mostly on buses, auto-rickshaws, ambulances and public ambulances when compared to those of the non-RACHI category. But, a few patients of the non-RACHI category utilised cars to reach the public hospital. As a result of that, they incurred OOPE burden extensively. This money was not reimbursed to them. Table 4.16 shows the non-medical expenditure on transportation to reach the network hospitals at the time of admission.

Table 4.16, Transportation-Expenditure at the Time of Admission

(Percentage in parenthesis)

Expenditure	Private			Public			Grand Total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
Below 500	22(11%)	21(10.5%)	43(21.5%)	22(11%)	21(10.5%)	43(21.5%)	86(43%)
5,01-2,000	24(12%)	21(10.5%)	45(22.5%)	18(9%)	13(6.5%)	31(15.5%)	76(38%)
2,001-5000	2(1%)	6(3%)	8(4%)	6(3%)	10(5%)	16(8%)	24(12%)
5,001-6,500	2(1%)	0	2(1%)	1(0.5%)	4(2%)	5(2.5%)	7(3.5%)
Not spent	0	2(1%)	2(1%)	3(1.5%)	2(1%)	5(2.5%)	7(3.5%)
Total	50(25%)	50(25%)	100(50%)	50(25%)	50(25%)	100(50%)	200(100%)

In this way, as per Table 4.16, 193 (96.5%) patients incurred this non-medical OOPE. Of them, 162 (81%) patients incurred less than Rs. 2000 each and among them, 86

(43%) patients borne less than Rs.500 each, while the rest 76 (38%) had spent within the range of Rs.501-2000. Out of 76 (38%) patients, there were 45 (22.5%) patients from the private hospital and among them, the RACHI patients were little higher than the non-RACHI patients. In the public network hospital, such patients were mostly belonged to the RACHI category. This Table (4.16) also shows that 24 (12%) patients incurred such non-medical expenditure within the range of Rs.2001 to Rs.5, 000. Among them, 8 (4%) were from the private network hospital and 16 (8%) were from the public network hospital. In both the network hospitals, the non-RACHI patients were a huge number of patients when compared to the RACHI patients, in incurring expenditure on transportation.

Further, there were 7 (3.5%) patients who spent a huge amount between Rs.5, 001 and Rs.6, 500 and, three-fourth of such patients were admitted into the public network hospital (GMH). By category, they were more number of patients pertained to the non-RACHI category than RACHI in GMH and, to the RACHI category than the non-RACHI in CBH. Those patients who incurred more than Rs.2, 000 for their transportation to reach these network hospitals had used the car or private ambulance and in addition to geographical distance matters. Overall, those patients who required to incur such uncovered medical expenditure, more than Rs.2, 000 up to Rs.6, 500 were mostly appeared among the patients admitted in the public network hospital as compared to those in the private network hospital. By category, more number of such patients were of the non-RACHI category than RACHI in both the network hospitals.

The above discussion clearly points out the fact that the RACHI patients used cheaper mode of transportation due to their poor socioeconomic conditions and even a few patients used expensive modes of transportation. On the other hand, the non-RACHI patients in CBH were from the higher socio-economic class. Finally, it also reflects that the insurance is an inclusive scheme for the insured patients in CBH as it is able to bring the poor people into its fold, though there is initial financial hardship to reach the hospital. Then, the poor people are ready to spend whatever little they have on transportation at the time of admission into the network hospitals.

4.14. Medical and Non-Medical Expenditure during Hospitalisation:

One of the notable elements to be understood as part of the comparison of the healthcare service between two network hospitals is medical and non-medical expenditure during the hospitalisation which was not reimbursed to them. The insurance scheme assures free health from end to end and as such the insured patients are not to incur any expenditure. The beneficiaries are also informed about all expenditures to be taken care off by the government. But the reality is different. Therefore when the patients were required to pay, it was a painful experience for them.

Medical expenditure in this analysis means, to spend OOP money on both diagnostic tests and medicines while non-medical expenditure means, to incur expenditure on food, fruits and tips. Under the medical expenditure, 54 (27%) patients (Tables 4.17 and 4.18) of both the categories of network hospitals had incurred OOPE over purchase of medicine and diagnostic tests. Among them, 38 (19%) patients incurred such medical expenditure on medicine while 16 (8%) patients over diagnostic tests. It implies a considerable proportion of patients spent OOPE for purchase of medicine. Hospital wise, out of 54 (27%) they were 8 (4%) patients of the RACHI category in the private network hospital (CBH) and 46 (23%) patients in the public network hospital (GMH). It shows that the public network hospital was forcing most of the patients to incur unpredicted medical expenditure from their pocket and it accounts for six times higher when compared to those RACHI patients in the private network hospital (CBH). On the other hand, it was compulsory for the non-RACHI patients to incur themselves such medical expenditure. So, this analysis has not taken into consideration of medical expenditure of the non-RACHI patients in the private hospital for comparison.

Out of 54 (27%) such patients who incurred OOPE on both medicine and diagnostic tests there are 16 (8%) patients (Table 4.17) who spent exclusively on diagnostic tests. They were segregated as 6 (3%) in the private network hospital and 10 (5%) in the public network hospital. In this milieu, those patients in CBH were all the insured patients who incurred OOPE. On the contrary, 10 (5%) patients in both the categories in

GMH had incurred OOP expenditure and among them, the RACHI patients were more than the non-RACHI patients. But, in the private hospital, the proportion of the RACHI patients was also huge, comparatively. In this regard, there is no comparison between RACHI and the non-RACHI as aforementioned reason. In the case of the amount that they spent, there was a small variation. In CBH the RACHI patients had incurred more on the diagnostic test to the extent of Rs.7, 000-8,000, at the time of their admission into the hospital but in the public hospital (GMH) patients of both the categories had spent less amount of Rs.1, 000-2,500 on their diagnostic tests, comparatively. It shows that even though the proportion of such patients in CBH was small but their incurred expenditure was approximately more than five-times higher when compared to those in the public network hospital. Table 4.17 shows the details about expenditure on diagnostic tests.

Table 4.17, Out-Of-Pocket Expenditure on Diagnostic Tests
(Percentage in parenthesis)

Diagnostic tests	Private			Public			Grand Total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
1000-2500	0	0	0	6(3%)	4(2%)	10(5%)	10(5%)
7000-8000	6(3%)	0	6(3%)	0	0	0	6(3%)
Mandatory	0	50(25%)	50(25%)	0	0	0	50(25%)
Not spent	44(22%)	0	44(22%)	44(22%)	46(23%)	90(45%)	134(67%)
Total	50(25%)	50(25%)	100(50%)	50(25%)	50(25%)	100(50%)	200(100%)

There are 38 (19%) patients in all that incurred expenditure on purchasing of medicine during hospitalisation as per Table 4.18. They were 2 (1%) in the private network hospital (CBH) and 36 (18%) in the public network hospital (GMH). Almost all such patients were from the public network hospital due to non-availability of medicine or shortage of required medicine supply in the hospital. Out of 38 (19%), about 25 (12.5%) patients who spent between Rs.1, 000 and 2,500 were from both the network hospitals. Among them, 23 (11.5%) were in the public network hospital while 2 (1%) were in the private network hospital. A few patients who incurred this medical expenditure beyond Rs.2, 500 up to Rs. 10,000 were only pertained to the public network hospital. Of them, those patients who spent OOPE between Rs.2, 501 and 5,000 are 11 (5.5%) patients, two-third of them were in the non-RACHI category. Table 4.18 shows the details about expenditure on medicine incurred by the patients.

Table 4.18, Out-Of-Pocket Expenditure on Medicine

(Percentage in parenthesis)							
Medicine	Private			Public			Grand Total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
1000-2500	2(1%)	0	2(1%)	12(6%)	11(5.5%)	23(11.5%)	25(12.5%)
2501-5000	0	0	0	3(1.5%)	8(4%)	11(5.5%)	11(5.5%)
10,000	0	0	0	0	2(1%)	2(1%)	2(1%)
Mandatory	0	50(25%)	50(25%)	0	0	0	50(25%)
Not spent	48(24%)	0	98(49)	35(17.5%)	29(14.5)	64(32%)	112(56%)
Total	50(25%)	50(25%)	100(50%)	50(25%)	50(25%)	100(50%)	200(100%)

Two patients who alone spent Rs.10, 000 each were the patients of the non-RACHI category in GMH. Hence, those who incurred OOPE on purchase of medicine are all almost pertained to the public network hospital. In addition, more number of such patients with huge amount of OOPE were the patients of the non-RACHI category in this hospital. The expenditure during the hospitalisation other than medical and diagnostic tests included spending on food, fruit, tips and transport. In the case of food, the expenditures were differently incurred by 143 (71.5%) patients (Table 4.19). Two-thirds of the total patients were required to incur such expenditure as it was ignored by the insurance. Under the insurance coverage, the hospitals of both the sectors are allowed to cater free food only to the patients but not to their assistants. According to the patients, the service of assistants is indispensable during hospitalisation till they get discharged from the hospital. So, almost all patients of both the categories in the public network hospital had to purchase food every day for their assistants. Table 4.19 shows the details of expenditure on food incurred by patients every day.

Table 4.19, Out-Of-Pocket Expenditure on Food Every Day

(Percentage in parenthesis)							
Food	Private			Public			Grand Total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
20-100	1(0.5%)	0	1(0.5%)	13(6.5%)	23(11.5%)	36(18%)	37(18.5%)
101-150	7(3.5%)	9(4.5%)	16(8%)	20(10%)	26(13%)	46(23%)	62(31%)
151-200	10(5%)	20(10%)	30(15%)	5(2.5%)	1(0.5%)	6(3%)	36(18%)
201-300	0	0	0	8(4%)	0	8(4%)	8(4%)
Not spent	32(16%)	21(10.5%)	53(26.5%)	4(2%)	0	4(2%)	57(28.5%)
Total	18(9%)	29(14.5%)	100(50%)	46(23%)	50(25%)	100(50%)	200(100%)

A half of the non-RACHI patients and one-third of the RACHI patients in the private network hospital (CBH) had fallen into a category of purchasing food for the patients' assistance. The data shows that only a few patients of the RACHI category in the private hospital purchased food because in some cases both patients and assistants together shared the food provided by the hospital. A few patients stated that the food that available outside the hospital is costliest and beyond their affordability to purchase. On the other hand, most of the patients in GMH got food from outside of the hospital as it was not costliest and be affordable to the patients. The cost of food at outside of the private network hospital was closely i.e., between Rs.50 to 100 approximately per each meal. So, it was expensive and beyond the affordability of a few patients from the RACHI category in this hospital. As a result of that, a few patients of the RACHI category only purchased the food from outside of the hospital as they had no alternatives to escape such OOPE burden. In addition, the hospital allowed only one assistant to be companion for patients where number of such assistants could be more than one person for a patient in GMH. The cost of food was affordable to the patients in GMH but the OOPE had been increased in accordance with the increased number of assistants for each patient.

According to Table 4.19, in GMH almost all patients except 4 (2%) RACHI patients had incurred this non-medical expenditure. On the other hand, the proportion of such patients was less than half of the total patients in CBH. By category, almost all RACHI patients in GMH had incurred this burden out of their pocket as the food cost was affordable for them while only one-fifth of the RACHI patients in CBH approximately incurred this burden. In addition to that, there are few patients who had complained about the food provided by the hospital. They said that the food is not tasty. There is a difference in spending OOPE on food daily by the patients between these two hospitals. It is noticed that there are 82 (41%) patients in GMH and 17 (8.5%) in CBH who had incurred OOPE between Rs. 20 and Rs. 150 for their food per a day (Table 4.19). Of 82 (41%) in GMH, there are 36 (18%) patients who incurred Rs. 20-100 out of pocket for their food daily, and among them, nearly two-third of them were of the non-RACHI category. A set of patients who spent Rs.150 each for food were more in number from

the non-RACHI category than the RACHI category in both the hospitals. A few patients who spent in-between Rs.151 to 200 are 36 (18%). They were 30 (15%) patients in CBH and 6 (3%) in GMH.

Finally, 8 (4%) patients of the RACHI category spent in-between Rs.201 to Rs.300 for food of their assistants and visitors. Overall, more number of the patients in GMH incurred OOPE on their food while each of patients in CBH spent a huge amount of money on their food daily. By category, more number of the non-RACHI patients in GMH spent this OOPE and more number of the non-RACHI in CBH individually spent a huge amount of money daily on their food. In addition to spending on food, another burden on the patients is to spend on fruits daily. A substantial proportion of patients i.e., 79 (39.5%) in GMH incurred non-medical expenditure on purchase of fruits. Out of 79 (39.5%) as per Table 4.20, the RACHI patients were 35 (17.5%) patients while 44 (22%) patients were of the non-RACHI category. In hospital wise, more than three-fourth of such patients were from the public network hospital. By category, in both the network hospitals, more number of such patients were from the non-RACHI category when compared to those of the RACHI category. Among all the patients in both the hospitals, more number of the non-RACHI patients incurred the burden of buying fruits daily. On the other hand, a few patients in CBH spent OOP money on purchasing of fruits as this hospital provided them fruit-juice daily. They were more or less equal in proportion to both the categories. Table 4.20 shows the expenditure on fruits.

Table 4.20, Out-Of-Pocket Expenditure on Fruits

(Percentage in parenthesis)

Fruits	Private			Public			Grand Total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
20-100	0	0	0	22(11%)	41(20.5%)	63(30.5%)	63(31.5%)
101-150	9(4.5%)	13(6.5%)	22(11%)	10(5%)	3(1.5%)	13(6.5%)	35(17.5%)
151-200	0	0	0	3(1.5%)	0	3(1.5%)	3(1.5%)
Not spent	41(20.5%)	37(18.5%)	78(39%)	15(7.5%)	6(3%)	21(10.5%)	99(49.5%)
Total	50(25%)	50(25%)	100(50%)	50(25%)	50(25%)	100(50%)	200(100%)

Out of the 79 (39.5%) in GMH, there are more than three-fourth of such patients who spent between Rs.20 and 100 for fruits daily and among them, the non-RACHI patients

were nearly two-third of such patients. Further, there is another set of patients who spent between Rs.101 and 200. They were all belonged to the RACHI category in GMH. Overall, more number of the patients in GMH spent OOP on fruits when compared to those in CBH. In both the hospitals, more number of patients of the non-RACHI category spent OOP money on fruits when compared to those of the RACHI category.

One of ignored non-medical expenditures is about travelling of assistant between hospital and home after the patient was hospitalised. A few patients of both the categories in the hospitals stated that their assistants had travelled back to homes after their admission in the hospital. This travelling was not regular or daily. According to Table 4.21, assistants of 31 (15.5%) had travelled back to their homes from the hospitals. They were a huge number in the private network hospital than in the public network hospital. In both the network hospitals, the RACHI patients were huge in number than their counterparts. It is found that none of such patients was appeared among patients of the non-RACHI category in the private network hospital. It implies that a huge number of assistants of the RACHI patients had travelled back to their homes from the private hospital.

Out of 31 (15.5%), 19 (9.5) patients incurred travel expenditure in-between Rs.20-150 while the rest of 12 (6) patients incurred between Rs.151 and Rs.300 per each time. Out of these 12 (6%) patients, three-fourth of such assistants are pertained to the public network hospital. Such aspirations in both the hospitals were exclusively from the RACHI category while none of assistants of the non-RACHI patients incurred such a huge expenditure on their own. By comparison, a huge number of assistants of patients in the private network hospital travelled back to their homes from the hospital. By category, more number of the RACHI patients incurred such expenditure than those of the non-RACHI category in both the hospitals. In addition, such assistants of the non-RACHI category in the public hospital spent OOP hugely among all the patients in both the hospitals. Table 4.21 shows that OOP on transportation for assistants of patients during the hospitalisation.

Table 4.21, Out-Of-Pocket Expenditure on Transportation

(Percentage in parenthesis)

Transport Expenditure of Helper	Private			Public			Grand Total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
20-100	3(1.5%)	0	3(1.5%)	8(4%)	0	8(4%)	11(5.5%)
101-150	5(2.5%)	0	5(2.5%)	1(0.5%)	2(1%)	3(1.5%)	8(4%)
151-200	1(0.5%)	0	1(0.5%)	2(1%)	0	2(1%)	3(1.5%)
201-300	2(1%)	0	2(1%)	7(3.5%)	0	7(3.5%)	9(4.5%)
Not spent	39(19.5)	50(25%)	89(44.5)	32(16%)	48(24%)	80(40%)	169(84.5%)
Total	50(25%)	50(25%)	100(50%)	50(25%)	50(25%)	100(50%)	200(100%)

Tip is one of unavoidable non-medical expenditures for the patients during the hospitalisation. According to Table 4.22, there are 38 (19%) patients who gave tips to the fourth-grade employees to get their service done timely. They did not give tips regularly. They are mostly pertained to the public hospital because giving tips became a common culture in this hospital. By category, they were 19 (9.5%) patients of the RACHI category and 18 (9%) of the non-RACHI category in the public network hospital. In the private hospital, such patient was only one and was from the non-RACHI category. Table 4.22 shows the expenditure on tips in the hospitals.

Table 4.22, Out-Of-Pocket Expenditure on Tips

(Percentage in parenthesis)

Tips	Private			Public			Grand Total
	RACHI	Non-RACHI	Total	RACHI	Non-RACHI	Total	
20-100	0	1(0.5%)	1(0.5%)	13(6.5%)	7(3.5%)	20(10%)	21(10.5%)
151-200	0	0	0	4(2%)	5(2.5%)	9(4.5%)	9(4.5%)
201-300	0	0	0	2(1%)	6(3%)	8(4%)	8(4%)
Not spent	50(25%)	49(24.5%)	99(49.5%)	31(15.5)	32(16%)	63(31.5%)	162(81%)
Total	50(25%)	50(25%)	100(50%)	50(25%)	50(25%)	100(50%)	200(100%)

Out of 38 (19%), 17 (8.5%) patients in the public hospital spent between Rs.151 to 300 approximately for tips by the time of interviews, and among them, nearly two-third was belonged to the non-RACHI category. Hence, nearly one-fifth of the total patients tipped off, and most of them were hospitalised in the public network hospital. In the public hospital, more patients who spent OOPE for tips were from the RACHI category while most of such patients of the non-RACHI category spent huge amount of money for the same.

This comparative analysis explained clearly about quality of services delivery of sanitation employees, doctors, nurses, administration, and Mithras for the patients in the hospital. It also highlighted about sidelined or ignored issues of both medical and non-medical expenditures by the insurance and network hospitals. From this above discussion, one can state that the private hospital (CBH) delivered efficient and quality service to both the categories patients when compared to those in the public network hospital (GMH). In CBH, the patients were also completely satisfied with all services in the hospital. For patients in the public network hospital, the inefficient and improper healthcare service, and OOPE were unavoidable burdens. They had suffered expensively. By comparison, patients of both the categories in each hospital had similar service. In clear sense, the patients of both the categories in the private hospital availed by and large similar healthcare service. It was also similar in the case of those categories in GMH. Overall, the non-RACHI patients than the RACHI patients in CBH, and the RACHI patients than the non-RACHI patients in the GMH had availed better service.

Brief Conclusion of the Chapter

A. Comparison between the Hospitals:

The comparison between two hospitals of both sectors, public and private, had taken place based on certain factors which included service of administration, doctors, nurses and Mithras, alongside both medical and non-medical expenditures. At the time of interview, a larger number of patients were at the stage of getting discharged from the private hospital than patients from the public network hospital. It is also found that the private hospital had provided immediate in-patient admission to the patients of the non-RACHI categories without having made more number of out-patient visits. In the public network hospital, during the pre-hospitalised stage, all patients regardless of insured and uninsured were treated without bias and their medical coverage was also the same. But discrimination has arisen after admission and under the insurance coverage. During the hospitalisation in the private hospital, the patients accessed the service of the doctors

who are well-qualified. It is also found that a considerable proportion of patients in the private hospital overall accessed quality and efficient service of doctors. In literal sense, doctors visited patients approximately twice a day, allocated adequate time in each visit to examine the patients properly, and upheld accurate interaction with the patients. As a result, the patients were completely satisfied with this service. However, a few patients only anticipated additional care from their doctors.

In the public healthcare network hospital, doctors' visits were mostly supplemented by MBBS and PG students under the guidance of their faculties and made one visit mostly to patients in a day. In this context, few patients even complained that their doctors delivered service on indefinite timings and few doctors visited the hospital occasionally and examined the patients only once a week. They also stated that doctors' service is inefficient due to less number of visits and less time spent in each visit. As a result, they had more expectations in connection to additional services from their doctors. In the case of nurses' service in the private hospital; they were all experienced providing service delivery friendly, quality and efficient services while showing extra-care in terms of providing injections and referring patients to the concerned doctors when patients suffered from minor diseases during hospitalisation. Such quality service is lacking among the nurses in the public network hospital and few patients stated they were subject to dreadful experiences under their care.

In the case of diagnostic service, all patients in the private network hospital became aware of the tests that they are supposed to undergo during the hospitalisation, at the time of their admission itself. Each test had taken lesser than an hour or half an hour. But, patients in the public hospital suffered extensively in connection to diagnostic services due to nearly all of them became aware of their tests one-two days prior to the test was done. The tests had taken more than an hour and up to four hours approximately for few of them. The inefficiency in the public network hospital was a result of substantial rush of patients at diagnostic labs and inadequate number of machines or equipments to meet the demand. As a result, patients had to wait in the queue to undergo tests and receive reports as well. In the case of sanitary conditions, the private hospital had maintained proper sanitary condition by its sanitary employees

who swept the rooms of the patients thrice daily, cleaned the bathrooms and latrines for four to six times daily, and provided washed and fresh bed-sheet and pillow covers to patients every day.

Such service is deficient in the case of the public network hospital and its patients grumbled about lack of good sanitary conditions. Nearly one-fifth of the patients complained about prevalence of insanitary conditions in bathroom and latrine, nearly one-third got their bed-sheets between fairly irregular periods of time, and their rooms were swept mostly twice a day by such employees. In terms of medical expenditure, it is empirically evident that the public network hospital suffers with scarcity of medicine and diagnostic machinery while such hitches were not seen in the private hospital. Therefore there was a lot of OOPE burden on patients in the public network hospital with regard to going through diagnostic tests and purchasing of medicine when compared to the RACHI patients in the private network hospital. They mostly incurred OOPE on purchasing of their medicine. For non-medical expenditure which comprises transportation, food, fruits and tips, the patients in the private hospital overall spent lesser amount of money out of their own pockets compared to those in the public network hospital. They used less expensive modes of transportation to reach the private hospital at the time of admission.

In addition, in the private network hospital nearly half of the total patients incurred OOPE burden on food and only a few patients purchased fruits every day. Along with complete absence of the tipping culture in the private network hospital the staff also provided fruit-juice on a daily basis to patients. By comparison, nearly all the patients in the public network hospital spent excessively in order to provide food to their assistants, more than half of the total patients purchased fruits and high prevalence of the tipping culture in the public network hospital. The food which is available at the public hospital was quite economical as compared to that at the private network hospital. The patients had to also tip fourth-grade employees including ward boys and gateman for availing of their service due to dearth of proper monitoring mechanism. Hence, it is empirically shown that the overall service of the private network hospital appears somewhat better and efficient than that of the public network hospital. In other words, patients in the

private hospital obtained proper service whereas increased OOPE burden and a tipping culture in addition to inefficient care were quite common in the public network hospital.

B. RACHI Patients:

There is no similarity in the service delivery of both the network hospitals to insured patients whose medical expenditure is guaranteed by insurance. At the time of interview, it is acknowledged that a considerable proportion of these patients were in critical condition in the private network hospital whereas a huge number of the patients in the public network hospital were in normal condition. At the time of admission, the private network hospital was likely to show slight slackness towards the insured patients in connection to inpatient treatment because they had to obtain pre-authorisation from the Trust based on the report sent by Mithras. At that time, few patients even incurred OOPE for doctor's consultation service. Usually, after a preliminary examination and condition of requiring in-patient treatment by doctors, the patients return to home, wait till approval is done by the Trust until it is conveyed to them by the staff about their hospital admission. According to a small group of patients, they waited for two to three months for the approval from the Trust. Along with this waiting, they also had to wait for availability of bed even after the Trust had pre-authorised the treatment. In the private hospital, if the admission is compulsory but the bed is not readily available, then patient has to wait at the patient's room called "Aarogyasri Waiting Room". During the stay in this waiting room, they are not entitled to have free food, and other facilities except doctors' check-ups and diagnostic tests. In this regard, few patients stayed in this waiting room due to unavailability of beds in the hospital. During that period, they incurred OOPE on their diagnostic tests and medicine.

But, overall they had received better service since the admission into the hospital when compared to those in the public network hospital. On the other hand, in the public network hospital the admission process for the insured patients was similar as it was for the non-RACHI patients. So, they had not borne OOPE burden, and not waited for endorsement from the Trust for their inpatient treatment at the time of admission into the hospital. After admission, there was a process of obtaining approval from the Trust

for insurance coverage for their inpatient treatment on the recommendation of Mithra. In this network hospital, they had to wait for the bed even after they were admitted in the hospital. Aarogyasri waiting rooms were not available in this hospital to accommodate patients seeking inpatient service by the hospital.

In the case of the doctors in the private hospital, they delivered proficient service to the patients since the insured patients availed this service twice a day, with considerable time allocated by the doctor in each visit, and had engaged in a good interaction with doctors. As a result, only few patients anticipated more effective and sophisticated service from their doctors. In comparing this service in the private hospital, the patients in the public network hospital experienced inefficient service from their doctors during the hospitalisation, in terms of having a visit per day, lesser time allocated in each visit, and improper interaction with doctors. As a result, a majority of patients expected better quality service further from their doctors in order to be cured fully.

The service of nurses was also measured. The insured patients in the private network hospital obtained better service from the nurses who responded to them promptly with proper service when they suffered from minor ailments of fever, headache and so on. In such situation, the nurses' service in the public network hospital was only permitted to providing medication to the patients suffering from the above-stated diseases. These nurses in the public hospital provided overall ineffectual service, and had treated patients with a certain amount of rudeness. In addition, they also took over the responsibilities of Mithras by mediating between patients and the Mithra. In this regard, all information of the insured patients was transferred to the patients through nurses. On the other hand, in the private network hospital Mithras had constant interaction with the patients. As result, nearly half of all patients received proper service for their admission, diagnostic tests, etc. So, it is noticed that not all insured patients availed this service comprehensively during the hospitalisation in the private hospital.

As previously mentioned, at the time of admission into the private network hospital, only few patients were compelled to incur OOPE of nearly Rs 8,0000 on their diagnostic tests and medicine whereas the proportion of patients who incurred OOPE in

the public network hospital was much larger. In the case of non-medical expenditure, patients in the public network hospital incurred a lot of OOPE burden on their food, fruits, transportation and tips as compared to those in the private network hospital. Hence, insured patients have been availing quality and efficient and OOPE burden-free service from the private hospital as compared to those patients that underwent treatment in the public network hospital.

C. Non-RACHI Patients:

The non-RACHI patients are also known as uninsured patients who usually have no insurance coverage. It is mandatory for all non-RACHI patients in the private network hospital to incur their medical expenditure on their own as they do not have financial coverage. The empirical data shows that patients regardless of category of medical coverage had received better service from the private network hospital. In certain situation, the non-RACHI patients received more efficient and quality service rather than the RACHI counterparts within the hospital. The non-RACHI patients admitted into the private hospital were treated promptly without the need for more number of outpatient visits, and accessed quality and efficient services of the hospital personnel including doctors, nurses, diagnostic labs, other staff. As a result, the patients had no complaints against the service provided by the personnel. Further, the overall service of the public network hospital is considered inefficient when compared to the private network hospital.

In the case of the public network hospital, they had comparatively made more outpatient visits at the time of admission into the hospital and, also failed to receive proper service from the hospital as the hospital delivered its service at free of cost for all patients. Its non-RACHI patients had several complaints against services of doctors, nurses, diagnostic tests, and other staff because these services led these patients to undergo such terrible experiences during their hospitalisation. They also spent a huge amount of money towards purchasing of food, fruits and tips to fourth-grade employees. In addition they bore substantial expenses for transportation at the time of their admission into the hospital.

Overall, the above sections provide not only a comparison between the non-RACHI patients in two hospitals but a comparison for the total sampled patients. The patients who had received worst service among the patients in two network hospitals pertained to the non-RACHI category in the public network hospital. On the other hand, those that received outstanding and quality service among all patients in both the network hospitals were also surprisingly the same category of non-RACHI patients.

Comparison between the Hospitals (in Table):

	Private Hospital	Public Hospital
Process of Admission	Directly- Non-RACHI patients Follow procedure-RACHI patients	Directly-Both RACHI and Non-RACHI patients
Outpatient visit	1-5 times	1 to 8 times (RACHI-More Visits)
Sanitary Conditions		
1.Sweeping the Room	3 times mostly	Only 2 times
2. Change Bed-sheet Daily	Daily	Only less than a half obtained it but not regularly
3. Complaints about bathroom and Latrine	None	Nearly half of its total patients (about over use of such services by patients and their assistants, shortage of water and electricity, improper clearing)
Service of Doctor		
1.Number of Visits	Two times mostly	One time mostly
2.Time given in each visit	Nearly 5-15 times (mostly)	5 minutes (Most of them)
Existed certain relation	Most of them satisfied with this service which include enquiring about their condition before giving treatment to them, friendliness, felt prescribed good medicine by doctor, assurance about cure of their diseases, felt reduced pain after surgery, etc.	Less satisfaction comparatively
Further expectation	Only 5% of patients expected	Nearly 20% patients expected in connection to getting of immediate treatment, doctor must listen to their complaints, give additional time in each visit, ask them questions while examining them, and increase the number of visits daily.
Service of Nurses		
1.From the first day onwards	Similar	Similar
2.Friendliness	Good	Not all experienced
3.Treatment to minor diseases	More than half of such patients got extra-care (in the form of regular check-ups,	Restricted to medication

	more care, injections, and communicating to concerned doctors)	
4.Unacceptable behaviour	Only a patient (RACHI)	Nearly one-tenth
5.Demanded for Money	None	Only one patient
Transpiration		
Mode of Transportation	Mostly Bus, Train, and Auto	Mostly Private Ambulance, Car, and 108 service
Spent Amount	Nearly all spent less than Rs.2000 each	A quarter of patients spent Rs.2001-6,500 each
Medical Expenditure		
1.Diagnositc Test	6 RACHI patients only spent Rs.7,000-8,000 each. But all non-RACHI patients incurred themselves such burden	10 patients spent Rs.1000-2,500 each
2.Medicine	2 patients spent Rs.1000-2,500 each	36 patients a huge number spent an amount of in-between Rs.1, 000-10,000. Among them, two patients spent 10,000 each.
Non-Medical Expenditure		
Food	47 patients spent Rs.151-200 each but the rest of them shared with their assistants the food provided by the hospital.	96 patients spent Rs.101-150 each daily
Fruits	Only 22 patients spent Rs.101-150 each because the hospital served them fruit-juice daily	79 patients bought fruits daily because they have no such facilities as the patients in the private hospital.
Tips to fourth grade employees	One patient spent Rs.20-100	38 patients gave tips to fourth-grade employees. Among them, nearly a half patients spent Rs.151-300 each.

Comparison between the patients of the two categories in the hospital

A. Private Network Hospital:

	RACHI	Non-RACHI
Process of Admission	Followed Procedure	Without following procedure but by making OOPE
Outpatient visit	More number of such visit	Less Number
Sanitary Conditions	Less Satisfactory but better than the patients in GMH	Fully satisfied
Doctor	Received more number of visits per day	Received more time in each visit, experienced quality interpersonal service, and more number of patients expected quality service further from their doctors
Nurses	Unsatisfactory service	Satisfied with this service in term of immediate service delivery when they suffered with minor diseases
Awareness of their tests and time taken	Similar (All of them became aware of	Similar

for each test	their tests at the time of their admission itself and less time taken for each test when compared to those in the public network hospital)	
Mode of Transportation	Used expensive modes of transportation	Less expensive modes of transportation
Medical expenditure	Only few patients incurred such expenditure on both diagnostic tests and medicine	All have incurred such expenditure
Non-medical	More on food	More on fruits

B. Public Network Hospital:

	RACHI	Non-RACHI
Process of Admission	Directly admitted without process, once they admitted they tried to get coverage of the insurance.	Directly admitted
Outpatient visit	More number of visits	Less number of visits
Sanitary Conditions	Satisfactory but worst when compared to patients in CBH	Less satisfactory
Doctor	More visit every day and obtained more time in each visit, experienced quality interpersonal service.	Obtained less number of visits of doctors every day. As a result, more number of patients have been expecting quality service from their doctors concerned.
Nurses	A Better Service	Not better service
Awareness of their tests and time taken for each test	Similar (one-two days before the test)	Similar (Same)
Mode of Transportation	Less expensive	More expensive
Medical expenditure	More patients spent on diagnostic tests	More on medicine (Two-Rs.10,000 each)
Non-medical	Less Spent	More spent on food, fruit, and tips

Chapter-5

Post-Hospitalised Beneficiary

5.0. Introduction:

This chapter discusses about the insured patients who were discharged from the network hospital after treatment under insurance coverage. It is post-hospitalisation stage wherein the real success of the inclusivity of the insurance scheme can be examined. The chapter deals with the comprehensive analysis of the healthcare that includes losing working days, medication process, financial support for the purchase of medicine, impacting uncovered or ignored medical expenditure on their savings and borrowing patterns, side effects, and uncured diseases if any etc. It tries to find out whether the insured patients have really recovered from the diseases that they suffered from and returned to their normal activities in terms of life style and work, and from the burden of the medical expenditure etc. Besides these, it was found which healthcare provider is more supportive after the hospitalisation of the patient. It examines whether the objectives of the insurance have been fulfilled completely, and the network hospitals have provided the expected service or not. It also tries to find out if the OOPE has pushed them into an inhospitable situation or destabilised them financially and psychologically. The services of network hospitals are analysed through three stages; pre-hospitalisation, hospitalisation, and post-hospitalisation.

5.1. Diseases Categorisation:

The diseases of the patients are categorised into four groups: quintile-I, quintile -II, quintile -III, and quintile -IV. Through this Categorisation, a further classification is followed by the seriousness of the diseases and similarities among them. Quintiles-I and II are categorised based on the seriousness of the diseases whereas quintiles-III and IV, are based on similarities among the diseases. Those diseases which come under the category of quintile-I- fits, appendicitis, hydrocele, thyroid, gastric problem, urine problem, stomach ache, hernia, and paralysis are considered non-serious diseases, and non-life threatening. On the other hand, those diseases under quintile-II such as heart

pain, brain damage, kidney failure, and breast cancer, etc. are considered as grim and terminal diseases. The diseases which come under the category of quintile-III are fractured legs, forehead, and severed fingers. Finally, the diseases of quintile-IV are related to ear, nose, and throat (ENT) and eyes, respectively. The patients distributed among these four quintiles are 38 (28.8%) in quintile-I, 47 (35.6%) in quintile-II, 27 (20.4%) in quintile-III and 20 (15.2%) in quintile-IV. It can be noted that the patients of quintile-II are more in number than the other. A small representation is in category quintile-IV. Table 5.1 gives the details of sampled patients with regard to their diseases and the network hospitals where they received treatment.

Table 5.1, Categorisation of the Diseases in accordance with Healthcare Providers
(Percentage in parenthesis)

Diseases Quintile	Private	Public	Total
I	19 (14.4%)	19 (14.4%)	38 (28.8%)
II	30 (22.7%)	17 (12.9%)	47 (35.6%)
III	13 (9.8%)	14 (10.6%)	27 (20.4%)
IV	4 (3.1%)	16 (12.1%)	20 (15.2%)
Total	66 (50%)	66 (50%)	132 (100%)

As can be noted from Table 5.1, patients of category-II are more from the private hospitals while the patients of category-IV are more from the public network hospitals. It means to say that people preferred the private hospitals for emergency or life threatening situation as it is believed that these hospitals are better than the public hospitals in all respects.

Pre-Hospitalisation

5.2. Pre-Insurance Treatment Stage:

Generally, whenever patients suffer from ailments such as fever, headache, stomach ache, and leg-ache etc., they approach the local health care providers usually RMP. The local health provider could be sometimes MBBS doctor or PHC or sub-centre. But for serious diseases, they seek treatment at the network hospitals for free of cost under the insurance coverage. This is a stage in which the patients seek treatment for their

diseases. With health deterioration, financial deterioration also takes place. How long they rely on the local health providers, who diagnosed their diseases correctly, who has referred them to the network hospitals for further treatment under the insurance coverage and how much they spent for the treatment are the queries for which information has been collected.

The local health providers also served as a source of information about the RACHI. They advised the patients to become in-patient in the nursing home or to be out-patient and receive the service provided by them. Mostly they prefer out-patient treatment at this stage by paying the fixed fee. There is a variation in selecting the type of healthcare provider which is based on the seriousness of the diseases and also convenience. The public or private healthcare delivery institutions are inconvenient to some patients due to the fixed timing and long queues. Since the RMPs are available anytime and there would be no queues and formalities, patients often prefer the RMPs alongside doctors of clinics. They sometimes depend on local healthcare providers for a long time without knowing the disease they suffer from. They keep spending money and hoping to get cured. At this stage, one patient had attended health camp organised by a private network hospital where they came to know about the exact health problem. Table 5.2 shows the details about how they became aware of their diseases.

Table 5.2, Patients Became Aware of their Diseases by Different Healthcare Providers
(Percentage in parenthesis)

Awareness about their diseases	Private	Public	Total
Non-insurance related healthcare providers (RMP, Clinic, NGO provider, Public and private Hospitals)	47(35.6%)	44(33.3%)	91 (68.9%)
Public Network Hospital (insurance related)	8 (6.1%)	14 (10.6%)	22 (16.7%)
Private Network Hospital (insurance related)	10 (7.5%)	8 (6.1%)	18 (13.6%)
Camp of the insurance (insurance related)	1 (0.8%)	0	1 (0.8%)
Total	66 (50%)	66 (50%)	132 (100%)

Table 5.2 shows that there are 91 (68.9%) patients who came to know about their diseases and also about the insurance related healthcare by non-insurance related healthcare providers that include RMP, clinic, NGO provider, public and private

hospitals. Most of them came to know through clinics. Out of the 91 (68.9%) patients, 47 (35.6%) patients had gone to the private network hospitals and 44 (33.3%) to the public network hospitals for treatment under insurance. However, without proper knowledge of their diseases, they approached these network hospitals. As shown in Table 5.2 the rest of the patients came to know about their diseases and service of the insurance, through insurance related healthcare providers which included the public network hospitals, the private network hospitals, and health camps organised by the network hospitals under regulations of the insurance company. It may be noted here that these patients did not remain with these hospitals for further inpatient treatment under the insurance coverage.

In these cases, 8 (6.1) patients out of 18 (13.6%) after coming to know about the diseases in the private network hospitals, left and later approached the public network hospitals for treatment under this insurance scheme. Similarly, 8 (6.1%) patients out of 22 (16.7%) had left the public network hospitals to join the private network hospitals. These transfers with regard to public hospitals took place due to unavailability of required equipment and skilled personnel. For the patients in the private network hospitals, it is due to uncovered-diseases by the insurance stated by such hospitals, according to a few patients.

5.3. Duration of Dependency on Local Health Provides and OOPE:

Usually, the patients depended on the local primary healthcare providers for a long time and thus incurred considerable expenditure. The duration of dependency ranges from a day to 5 years approximately. In total, 85 (64.4%) patients as shown in Table 5.3 availed local healthcare facility prior to admission into the network hospitals under insurance coverage. They availed such services in various time periods. Out of 85 (64.4%), there was only one patient (0.8%) in this stage who availed it for a single day, after the consultation the person rushed to a private network hospital. About 33 (25%) patients depended on local health provider for less than a month approximately, and 48 (36.3%) for one month to a year approximately. Information about patients' seeking

service from the private and public network hospitals reveal the fact that three patients depended on these local healthcare providers for 5 years before they became in-patient in the public network hospitals under the insurance coverage.

Except this, more number of patients did not take a long time consulting local health providers before they approached the private network hospitals as compared to those who approached the public network hospitals. It means that the local health providers convinced the patients to seek better health at their facilities or people realised to seek a permanent solution early. However, some patients did not have treatment at the local level but directly got admitted into the network hospitals are equal in numbers in each sector. The patients who waited at the local health providers spent large amounts over a long period before availing the insurance facility. The spending of such medical expense corresponds with the type of healthcare provider and the period of availing the service. These expenses include both medical and non-medical expenditure. Table 5.3 shows the details about patients relied on local healthcare providers with different durations.

Table 5.3, Duration of Dependency on the Local Healthcare Providers
(Percentage in parenthesis)

Duration of Dependency on Local Providers	Private	Public	Total
One day	1 (0.8%)	0	1(0.8%)
Lesser than` a month	19 (14.4%)	14 (10.6%)	33 (25%)
One month to one year	23(17.4%)	25(18.9%)	48(36.3%)
5 years	0	3 (2.3%)	3 (2.3%)
Not taken any treatment	23 (17.4%)	24 (18.2%)	47 (35.6%)
Total	66 (50%)	66 (50%)	132 (100%)

5.4. Medical Expenditure in Pre-Hospitalisation Stage:

Out of 85 (64.4%) patients who had medical expenditure before they got admitted in the network hospitals, 35 (26.5%) patients incurred between Rs.500 and Rs.5,000 and among them, more number of patients got admitted in the private network hospitals. About 39 (29.5%) patients incurred between Rs.5001 and 25,000, and among them,

more number of patients got admitted in the public network hospitals. Another 5 (3.8%) patients incurred between Rs.25, 001 and 60,000. They all got admitted in the private network hospitals. Finally, 6 (4.6%) patients spent huge medical expenditure between Rs.1 lakh and Rs.2 lakhs during the pre-hospitalisation stage. Among them, a large number of patients had later sought admission in the public network hospitals in order to avail cashless treatment under the insurance coverage. Hence, a prolonged pre-hospitalisation stage is directly related with range medical expenditure. Such medical expenditure yet remains as an uncovered package by the insurance. Table 5.4 shows OOPE during the pre-insurance stage.

Table 5.4, OOPE during the Pre-hospitalised Stage
(Percentage in parenthesis)

OOPE	Private	Public	Total
500-5,000	23(17.4%)	12(9.1%)	35(26.5%)
5,001-25,000	14(10.6%)	25(18.9%)	39(29.5%)
25,001-60,000	5(3.8%)	0	5(3.8%)
One to Two lakhs	1(0.8%)	5(3.8%)	6(4.6%)
Did not spend	23(17.4%)	24(18.2%)	47(35.6%)
Total	66 (50%)	66 (50%)	132(100%)

5.5. Reference of Network Hospitals:

After being treated by local healthcare providers, they were referred to the network hospitals when they did not get relief. These referrals as stated earlier included clinics, RMPs, private hospitals, public hospitals, and camps. Some of them approached the network hospitals on their own and sometimes on the suggestion of family members. A half of the patients (Table 5.5) approached the network hospitals on their own along with their family members' reference, followed by 52 (39.4%) patients referred by Clinics and private hospitals, 9 (6.8%) patients referred by the private network hospitals and medical camps, 4 (3%) referred by public hospitals, and one (0.8%) referred by RMP, respectively. Comparatively, a large number of patients had been referred to the private network hospitals mostly by self and family members, and RMP. On the contrary, a substantial proportion of patients were also referred to the public network

hospitals mostly by the clinic and private hospitals, public hospitals, and the private network hospitals.

Thus the individuals themselves and family members played a significant role in bringing patients to the network hospitals. They came to know about this government's healthcare scheme through print and electric media, relatives, neighbours, and those who already experienced themselves and doctors as explained in the chapter-3. In this regard, the place of living has played a prominent determining role for knowing about the health scheme. It is observed that the villagers are not fortunate enough to know about the government programmes. Table 5.5 shows referral aspect of the insured patients to reach the network hospitals.

Table 5.5, Reference to the Network Hospitals

(Percentage in parenthesis)

Reference to the network hospitals	Private	Public	Total
Self and Family Members	39(29.5%)	27(20.5%)	66(50%)
Clinic/Private Hospital	25(18.9%)	27(20.5%)	52(39.4%)
Private network Hospitals and Camp	1(0.8%)	8(6%)	9(6.8%)
Public Hospital	0	4(3%)	4(3%)
RMP	1(0.8%)	0	1(0.8%)
Total	66(50%)	66(50%)	132(100%)

The local clinics seemed to be the second important source of information and acted as referrals to various network hospitals in Hyderabad. The Registered Medical Practitioner is also significant healthcare provider in general. The network hospitals also provided the information of the health scheme to the patients.

5.6. Private Network Hospitals:

The following is the list of private and public network hospitals where the respondents were admitted using the insurance services.

1. Apollo

2. Basavatharaka Indo& American hospital
3. Care Hospital
4. Good-will Kidney and Surgery Center
5. Hyderabad Kidney Hospital
6. Hyderabad Nursing Home
7. IMAGE hospital
8. Kalyani Hospital
9. KIMS Hospital
10. Krishna Institute of Medical Science
11. Mahatma Hospital
12. Mahaveer Hospital
13. Midwin Hospital
14. New Life Hospital
15. Prime Hospital
16. Princes ESRA Hospital
17. Raghavendra Hospital
18. Rishi Keshava Hospital
19. Sai Bhavani Super Specialty Hospital
20. Sigma Hospital
21. Sri Narayana Hospital
22. Start Hospital
23. Yashoda
24. Sureskha Hospital at Vijayawada
25. SVR Super Specialty Hospital
26. Times Hospital
27. Vasavi Hospital
28. Woodland Hospital

5.7. Public Network Hospitals:

1. NIMS
2. Sarojini Eye Hospital
3. Gandhi Hospital
4. ENT hospital at Koti
5. Government ENT hospital
6. Osmania General Hospital

Under this insurance scheme, the insured patients have the right to choose or find a network hospital accordingly. Those who wanted to get admitted to the public network hospitals the choice was limited as that are not many that are reputed for being inefficient healthcare providers. On the other hand, the choice was very wide for those who wanted to seek admission into the private network hospitals as they are many throughout the state.

Hospitalisation

Patients admitted into the network hospitals to avail services under insurance coverage after undergoing treatment procedures from the local healthcare providers for a while. This stage is very critical to comprehend how services are rendered by network hospitals and, how and where the patients suffered most from the time of admission to the time of discharge from the hospital. The examination of service delivery started from the patients' hospitalised in the network hospitals. The patients underwent multiple problems during their hospitalisation due to the shortage of infrastructure, unawareness of the insurance service, OOPE, and long hospitalisation etc. Both boon and impediments of the insurance service through network hospitals are discussed here by comparing the service between public and private network hospitals.

Public hospitals are basically viewed as inefficient institutions for many reasons such as inadequate and abysmal infrastructure, absence of the concerned doctors, prolonged hospitalisation, corruption, unaccountability of personnel, inadequate diagnostic equipments, unhygienic atmosphere and so on, as found among those going through hospitalisation as discussed in chapter-4. In fact, the inadequate healthcare service in the public healthcare hospitals has already been noted by earlier scholars also. But, there are also some inefficient healthcare providers among the private network hospitals. In these hospitals, there is a delay in admission, and patients are compelled to incur expenditure for diagnostic tests and medicine. Though, the poor patients are allowed to access the better service in the network hospitals but they do not get complete satisfaction. It can be understood that, this service is not reaching to the expected results of what government is aiming for through this insurance scheme service.

5.8. Admission Procedures:

At the time of admission into the hospitals, the patients encountered various problems. They had to face the shortage of beds, absence of doctors, and prolonged out-patient service as discussed in the chapter-4. There are 73 (55.2%) patients (Table 5.6) who got admitted into the hospitals on their first visit itself and, of them more number patients are from the private network hospitals. So, more than half of the patients were not required making several out-patient visits prior to admission and this was true in the private network hospitals. On the contrary, in the public network hospitals, there was always delay in admission. The patients had to make several visits. More number of visits always means more OOOPE which is beyond their ability and it was more with regard to the public network hospitals. The expenditure incurred before admission for such things as transports, food, fruits and so on were not reimbursed under the scheme.

There are 55 (44.8%) patients that constituted for less than half of the total patients who had been made several visits (more than one and up to 25 times) and experienced difficulties in admission. According to Table 5.6, about 44 (33.4%) of them made 2-5 visits, 14 (10.6%) for 6-10 visits, and 1 (0.8%) for 25 visits approximately. Out of 44 (33.4%) patients, more number of such patients visited the private network hospitals as

compared to those who made outpatient visits to the public network hospitals. In the categories of 6-10 visits, and 25 visits, those who visited the public network hospitals are a large number of patients. One (0.8%) patient made 25 visits. This is important to discuss why the public network hospitals wanted their patients to make so many visits. It was mainly because the doctors in the first visited want diagnostic tests to be done for patients, which were undertaken in the hospital itself. The next visit was with the response, then it followed by a review and so on. Table 5.6 reveals the details of outpatient visits to the network hospitals prior to admission.

Table 5.6, Out-patient Visits to the Network Hospitals before Admission
(Percentage in parenthesis)

Outpatient visits	Private	Public	Total
One Time	41(31%)	32(24.2%)	73(55.2%)
2-5 Times	24(18.2%)	20(15.2%)	44(33.4%)
6-10 Times	1(0.8%)	13(9.8%)	14(10.6%)
25 Times	0	1(0.8%)	1(0.8%)
Total	66(55%)	66(55%)	132(100%)

Sk. Yameya Khaled (14) was a patient of ENT problem with the ear ache. He was admitted in the Government-ENT hospital at Koti, after treatment as an out-patient for three months in the same hospital. According to him, he was discharged from the hospital but his disease was not cured. There was again bleeding from his ear in the post-hospitalisation stage. Therefore, he approached a private hospital called Danda Hospital in Bashir Bagh for treatment of his ear problem where he incurred Rs.15, 000 out of pocket for getting complete cure of his disease. Now, he is free from suffering after treatment in the private hospital.

Mogal Sohail (9) is a student and was admitted to a public network hospital called Niloufer hospital which has 500 beds. He was rushed to the hospital but his parents were not aware of insurance service for BPL people. So, he spent a small amount of money out of his parents' pocket. After three days of hospitalisation, his parents came to know that his disease would also be covered by the insurance scheme through one of the co-patients. Finally, he got the insurance coverage. Since then, he did not make any

payment to the hospital till his discharged from the hospital. Muskam Begum (3) is a resident of Hyderabad City who suffered from a heart problem. At the time of admission, her parents did not know about the insurance and hence they incurred an OOP expenditure of Rs.5, 000 for diagnostic tests and other needs. It was only later that her parents came to know about the insurance scheme. The money her parents spent at this stage was not reimbursed by either hospital or the insurance.

5.9. Commencement of Treatment:

Once the patient is admitted to the hospital he/she receives healthcare from day one. But often it does not take place for several reasons. In the case of the public network hospitals, one has to wait for doctors for a long time because the unavailability of doctors or shortage of doctors. It may also be due to doctors' taking long leave. There were 105 (79.6%) patients accessing the service since the day of admission in the hospitals. But, of them 55 (41.7%) patients were from the private network hospitals and 50 (37.9%) were from the public network hospitals who started receiving treatment from the first day. If a patient receives such service every day since admission, it can be accepted as efficient service for doctors and nurses delivered service on stipulated time. On the contrary, there are patients who did not receive this service from the first day onwards, are 27 (20.4%) patients. Table 5.7 shows the details about when started treatment for insured patients after admission.

Table 5.7, Starting of Treatment for Insured Patients after Admission
(Percentage in parenthesis)

Start of Treatment in the hospital	Private	Public	Total
Within a day	55(41.7%)	50(37.9%)	105(79.6%)
Next Day	8(6%)	6(4.5%)	14(10.5%)
Two days later	2(1.5%)	4(3%)	6(4.5%)
5 days later	1(0.8%)	4(3%)	5(3.8%)
10 days later	0	1(0.8%)	1(0.8%)
One Month later	0	1(0.8%)	1(0.8%)
Total	66(50%)	66(50%)	132(100%)

Among the 27 patients, there were 16 (12.1%) patients in the public network hospitals and 11 (8.3%) patients in the private network hospitals. Usually, the insured patients in emergency condition mostly approached the network hospitals to seek free health care service under the insurance coverage. But, some of them had not been accessing healthcare service immediately after being admitted to the network hospitals. In 14 (10.5%) cases the service started next day onwards, and in the case of 6 (4.5%), it started two days later (Table 5.7). Five patients (3.8%) said that their treatment started after 5 days. In one case (0.8%) it took 10 days. One claims that it took one month to start the service. There are a few patients who accessed the service after a long period of time, for the reason that the doctors put patients under observation for a while. There is a clear evidence of lopsided service delivery. The patients who availed the service in one or two days later are equal in numbers in both types of the network hospitals. They were 10 (7.5%) patients in each case.

But, there are patients who got treated after 5 days, 4 (3%) patients in the public network hospitals and one (0.8%) patients in the private network hospital. There was an inordinate delay in the public network hospitals for a long period of time-10 days to one month, the reason being the absence of required doctors and the patients were under observation of the doctors. Such kind of delay led patients to become frustrated, and the result was degradation in health and money.

5.10. Surgery:

During the hospitalisation, one of the aspects is to carry out surgeries for patients requiring such treatment. The empirical data discloses the fact that the network hospitals postponed surgeries for the insured patients. So, carrying out surgery for the patients deemed to be one of the important measures to compare services of the public network hospitals with that of the private network hospitals. The timely surgery is an indicative of efficient service delivery of the network hospitals. Sometimes, neglecting to carry out the surgeries or delay would also cause death of the patients during the hospitalisation. According to Table 5.8, there are 120 (90.9%) patients in total who

underwent surgeries but the remaining 12 (9.1%) patients did not require surgery. The data reveals that the private network hospitals preferred surgeries for their patients while the public network hospitals preferred medication for one-fifth of their total patients, comparatively.

Less number of surgeries occurred among patients in the public network hospitals as compared with those in the private network hospitals. The data analysed is based on the day when the surgery was performed after admission. Accordingly, 7 (5.3%) patients were admitted with serious health problems and they underwent surgery on the first day of the admission itself. Out of them, 6 (4.5%) patients were admitted to the private network hospitals and one (0.8%) in the public network hospital. It can be stated that the private network hospitals are capable enough to handle such issues effectively compared to the public network hospitals. About 81 (61.3%) patients in total had surgeries between 2 to 5 days after the admission. Out of them, 49 (37.1%) patients in the private network hospitals and 32 (24.2%) in the public network hospitals, who had surgery. In this context also, more number of patients were from the private network hospitals underwent surgery after 2-5 days. Table 5.8 provides the details of how many days later they went through surgery after admission.

Table 5.8, How Many Days Later They went through Surgery
(Percentage in parenthesis)

Surgery after admission	Private	Public	Total
Within the day	6 (4.5%)	1(0.8%)	7 (5.3%)
2-5 days	49(37.1%)	32 (24.2%)	81 (61.3%)
6-10 days	6(4.5%)	11(8.3%)	17 (12.8%)
15-20 days	4(3.1%)	4(3.1%)	8 (6.2%)
One month	0	7 (5.3%)	7(5.3%)
Not had surgery	1(0.8%)	11(8.3%)	12 (9.1%)
Total	66(50%)	66 (50%)	132 (100%)

Of being admitted, another set of patients who had accessed this service between 6 and 10 days are 17 (12.8%) patients in total from both sectors' network hospitals. Out of them, 6 (4.5%) patients were in the private network hospitals and 11 (8.3%) in the public network hospitals. An equal number of 4 (3%) patients who are from both sectors' network hospitals had waited for 15-20 days approximately for surgery.

Finally, 7 (5.3%) patients had waited for 30 days approximately in the public hospitals to get the surgery. All patients who obtained this service after 15 days up to one month, needed to go through observation episode according to the instruction of concerned doctors. In this stage, they were allowed to receive medicine from nurses when the pain was unbearable. Hence, in this stage, doctors in the public network hospitals preferred a long episode of observation and also did not prefer surgeries for the insured patients when compared to those in the private network hospitals.

5.11. Duration of Hospitalised:

It is doctors' decision about the patient's duration of stay in the hospital; they determine the health status and they decide when the patient can resume normal work. However, the longer a patient is hospitalised leads to expenditure and dependency on others. On the negative side, healthcare has become a business rather than a service. It would be good business if a patient stays in the hospital longer, as the hospital management would get money. The longer the hospitalisation days for patients was due to various factors and one of its impacts generally is declined or curtailed of spending money on their livelihood. 85 (64.4%) patients had overall hospitalised duration of between 2 to 10 days, followed by 31 (23.4%) patients for 11 to 20 days, 6 (4.6%) for 21 to 30 days, 7 (5.3%) for 45 days, and 2 (1.5%) for 105 days, respectively. Table 5.9 shows the details about the total duration of hospitalisation for insured patients.

Table 5.9, Total Duration of Hospitalisation for Insured Patients
(Percentage in parenthesis)

Duration of the hospitalisation	Private	Public	Total
Within the same day	1 (0.8%)	0	1 (0.8%)
2-10 days	49(37.1%)	36 (27.3%)	85 (64.4%)
11-20 days	13 (9.8%)	18 (13.6%)	31(23.4%)
21-30 days	3 (2.3%)	3(2.3%)	6(4.6%)
45 days	0	7(5.3%)	7(5.3%)
105 days	0	2 (1.5%)	2(1.5%)
Total	66(50%)	66(50%)	132 (100%)

Among a total number of patients who got admitted in the private network hospitals, more than two-third of patients had overall hospitalised days for less than 10 days while the rest of them stayed between 11 to 30 days. On the contrary, about a half of the total patients who got admitted to the public network hospitals had overall hospitalised days for less than 10 days. But, the rest of them stayed for from 11 up to 105 days. Among half of the patients, there are 7 (5.3%) patients and 2 (1.5%) patients who were hospitalised for the duration of 45 days and 105 days, respectively. Hence, the public network hospitals delayed rendering healthcare service to the insured patients. This prolonged hospitalisation caused heavy OOPE, loss of working days.

5.12. OOPE of Hospitalised Patients:

The primary aim of the insurance is to take care of the burden of medical expenditure of the economically vulnerable section. Yet, there is the practice of OOPE among the insured patients due to inadequate service delivery, acute shortage of infrastructure and personnel, long duration of hospitalisation and so on as discussed before. This violates the basic principle on which the insurance scheme has been introduced. The discussion that follows revolves around three expenditures that the patients had incurred during their hospitalisation: diagnostic service, medicine, and tips. Around 54 (41.5%) patients (Table 5.10) had incurred OOP expenditure in this stage. They were 15 (11.5%) patients in the private network hospitals and 39 (29.5%) patients in the public network hospitals. Nearly a half of the total patients had incurred this OOPE in order to avail the service of the network hospitals even after they came into the fold of insurance. Of them, nearly one-fourth of them were in the private network hospitals and the remaining of them were in the public network hospitals.

Their OOPE is divided into two types such as OOPE within the hospitals and OOPE outside of the hospital. Out of 54 (41%) patients, 19 (14.5%) patients have spent for medical requirements within the hospital itself and 35 (26.5%) patients who spent it outside the hospitals exclusively on diagnostic services. These both types of OOPE

have negatively affected the patients' economic conditions. Table 5.10 shows the details about incurred medical expenditure by the insured patients during the hospitalisation.

Table 5.10, Medical Expenditure During the Hospitalisation
(Percentage in parenthesis)

Medical Expenditure	Private	Public	Total
Within the hospital	5 (3.9)	14(10.6)	19(14.5)
Outside of the hospital	10 (7.6%)	25 (18.9%)	35 (26.5%)
Not spent	51(38.5%)	27(20.5%)	78(59%)
Total	66(50%)	66(50%)	132(100%)

5.13. Diagnostic Service:

Even in the hospitals itself, the insured patients incur or pay to the hospitals for the service which actually is supposed to be free. As a result of that, they are forced to borrow money from others. In this regard, some of them even borrowed money at high interest-rates as their incomes were hardly enough to meet their living expenditure and medical needs. There were 19 (14.5%) patients as shown Table 5.11 who incurred medical expenditure to go through diagnostic tests and to purchase medicine during the hospitalisation. The diagnostic tests included X-ray, blood tests, and scanning. Out of 19 (14.5%), the 14 (10.6%) patients were in the public network hospitals and the rest of them were in the private network hospitals. Table 5.10 shows the details about medical expenditure within the hospital.

Table 5.11, Medical Expenditure within the Hospital
(Percentage in parenthesis)

Expenditure within the hospital	Private		Public		Total
	Diagnostic tests (X-ray, Blood test, scanning)	Medicine	Diagnostic tests (X-ray, Blood test, scanning)	Medicine	
Below 500	3 (2.3%)	0	4 (3%)	0	7(5.3%)
1001-2000	1 (0.8%)	1 (0.8%)	3(2.3%)	3(2.3%)	8(6.2%)
3000	0	0	0	2(1.5%)	2(1.5%)
10,000-15,000	0	0	0	2(1.5%)	2(1.5%)
Total	4(3.1%)	1(0.8%)	7(5.3%)	7(5.3%)	19(14.5%)

The patients who incurred medical expenditure are distributed unequally between these two sectors' network hospitals. Nearly two-third of such patients were in the public network hospitals. Among them, 4 (3.1%) patients in the private network hospitals and 7 (5.3%) in public network hospitals had incurred OOPE for diagnostic tests. In addition, one (0.8%) patient in a private network hospital and 7 (5.3%) in the public network hospitals had unequally incurred medical expenditure with regard to purchasing medicine. Hence, a large number of patients in the public hospitals were compelled to incur medical expenditure.

5.14. Medical Expenditure:

The inadequate healthcare delivery has to be understood by scholars, academicians and policy makers so as to frame proper policies. In particular, the government has to develop schemes to cover diagnostic tests completely or to provide an efficient system of diagnostic tests. In the case of private network hospitals, the overall spending of each patient was approximately Rs.500 except two (1.6%) patients who spent an amount between Rs.1, 000 to Rs. 2,000 (Table 5.11). About 10 (7.6%) patients in the public network hospitals had spent less than Rs.2, 000 and the remaining each of four patients had incurred OOPE of more than Rs.2, 000. Basically, all medicine needs to be provided free of cost to the patients by the network hospitals under this insurance coverage. But, some of these network hospitals have violated the regulations.

According to Table 5.11, there was one (0.8%) patient in a private network hospital and 7 (5.3%) in the public network hospitals who were required to incur medical expenditure in order to purchase medicine during their hospitalisation. In the case of this private hospital, the patient only spent between Rs. 1,001 to Rs.2, 000 while 2 (1.5%) in the public network hospitals incurred between Rs.10, 000 and 15,000 approximately. The rest of them in the public network hospitals had spent less than Rs.3000 each. This implies that expenditure on medicines is a trivial issue for the patients in the private network hospitals as almost all such expenditure bear by the

hospitals but very crucial for patients in the public network hospitals. In this regard, there was no-reimbursement made by the hospitals for such patients.

5.15. Tips:

The final element is to spend on tips to class-IV employees for service to be done effectively to the patients during their hospitalisation. The patients had to give tips to employees like ward-boys and gatemen. About 34 (25.9%) patients had spent OOPE on this non-medical expenditure. Out of these 34 (25.9%) patients, 21 (16%) patients gave tips to ward boys and 13 (9.9%) patients bribed the gate-men. Among them, ward boys are more in number who demanded for money from patients for their service, in terms of taking the patients by wheelchair from ward to the rooms of diagnostic tests and Operation Theater. In the case of gatemen, helpers of patients bribed the gate man in order to enter the hospital during restricted timings. In the case of the private network hospitals, such employees who bribed are similar that was one (0.8%) each to ward-boys and gate-men while for the public network hospitals, they were 20 (15.2%) and 12 (19.1%), respectively. Hence, a large number of patients in the public network hospitals were compelled to give tips to the grade-IV employees while the private network hospitals had a very small proportion of such patients as a result of efficient and adequate administrative service.

The findings reveal that OOPE on diagnostic tests, purchase of medicine and bribes giver to class IV employees is more in the public network hospitals when compared to the private network hospitals. According to few patients, both medical and non-medical expenditures are due to shortage of medicines, inadequate infrastructure, acute shortage of skilled personnel, lack of monitoring mechanism and unaccountability of staff in the public network hospitals. Tables 5.10, 5.11, and 5.12 reveal of the OOPE details among the insured patients in both inside and outside of hospitals during hospitalisation.

5.16. Outside of the Network Hospitals:

Sometimes the patients are asked by their concerned hospitals to undergo tests at diagnostic centres which are located outside the hospitals by saying that such tests are uncovered by insurance as well as shortage of required equipments. There are 35 (26.7%) patients who underwent diagnostic tests held outside of the hospitals (Table 5.12). Out of these, 22 (16.7%) patients had scanning test, 5 (3.8%) patients had X-ray test, 4 (3.1%) had the blood test, 3 (2.3%) had all tests, and one (0.8%) had ECG, done respectively. Out of 35 (26.7%) patients, there are only 10 (7.7%) patients who were referred by the private network hospitals and 25 (19%) patients by the public network hospitals. Those patients who were referred by the public network hospitals are three-times higher than such patients referred by the private network hospitals. This shows that the public network hospitals have been referring more insured patients to diagnostic centres located outside of the network hospitals as compared with the private network hospitals. Table 5.12 shows the details of diagnostic tests held outside the hospitals.

Table 5.12, Diagnostic Tests Held Outside the Hospital
(Percentage in parenthesis)

Diagnostic test	Private	Public	Total
X-ray	1 (0.8%)	4(3.1%)	5(3.9%)
Scanning	7(5.4%)	15(11.5%)	22(16.9%)
Blood test	0	4(3.1%)	4(3.1%)
All tests	2 (1.5%)	1(0.8%)	3(2.3%)
ECG	0	1(0.8%)	1(0.8%)
Total	10(7.7%)	25(18.9%)	35(26.6%)

Of the total 10 (7.7%) patients, 7 (5.4%) had scanning test following by 2 (1.5%) patients who had undergone all tests, and one (0.8%) had X-ray done, respectively. It is clear that the number of patients accounted for more than two-third, of such patients were referred for scanning test. At the diagnostic centres, these patients had incurred medical expenditure approximately below Rs.2, 000 for X-ray, below Rs.3,000 for scanning, below Rs.500 for a blood test, Rs.500 for ECG, and between Rs.10, 000 and 15,000 for all tests, respectively.

5.17. OOPE at Discharge:

The insured patients had obtained no reimbursement of their medical and non-medical expenditure by the hospitals but some of the patients asked the hospital to clear all the bills at the time of discharge from the hospital. It is because they spent for diagnostic tests and medicine during the hospitalisation even when their medical expenditures were insured. According to some, these network hospitals invariably suffer from the shortage of required medicines. Some other said that they were compelled to purchase half of the medicines out of their pocket at the time of discharge from the hospitals. The purchasing of medicine at the time of discharge was a heavy burden for the insured patients because the hospitals did not provide full medicines to the patients. It was due to the shortage of required medicine supply as it was the case in the case of public hospitals, and unaccountability as it was the case in the case of private hospitals. According to Table 5.13, there are 20 (15.2%) patients who incurred expenditure for medicine, at the time of discharge from the hospitals. Out of 20 (15.2%), there are 11 (8.3%) patients in the private network hospitals and 9 (6.9%) in the public network hospitals. Thus, a little higher proportion of patients in the private network hospitals falls in this category as compared to those in the public network hospitals. Table 5.13 shows the details about OOPE on purchasing medicine at the time of discharge from the hospital.

Table 5.13, Expenditure on Medicine at the Time of Discharge
(Percentage in parenthesis)

Expenditure on Medicine	Private	Public	Total
Below 500	4(3%)	1(0.8)	5(3.8%)
501-1000	2(1.5%)	1(0.8)	3(2.3%)
1001-2000	5(3.8%)	0	5(3.8%)
3000	0	7(5.3%)	7(5.3%)
Not spent	55(41.7%)	57(43.1)	112(84.8%)
Total	66(50%)	66(50%)	132(100%)

For patients in the private network hospitals, the OOPE accounts for 5 (3.8%) patients (Table 5.13) between Rs.1000 and 2000 while for the rest of such patients it is less than Rs.1000. On the contrary, in the public sector' network hospitals 7 (5.3%) out of 9

(6.9%) patients incurred Rs.3000 as OOPE for each of them. The remaining patients spent less than Rs.1000 each. It shows that fewer patients were asked to buy medicines at the time of discharge from the hospitals. By comparison, more number of such patients were from the private network hospitals when compared to those in the public network hospitals. Hence, the patients in the public network hospitals incurred OOPE extensively except that of, at the time discharge when compared to those in the private network hospitals.

Post-Hospitalised

After hospitalisation when the patients returned home, they experienced various difficulties in terms of their earning lost, spending on both basic needs and medical expenditure. As a result, they faced further economic difficulties. Some of them continued borrowing from others. In addition, there are some patients affected by minor diseases as result of improper treatment of the network hospitals. As per Table 5.14, there are 124 (93.9%) patients who were referred for post-hospitalised check-ups in the network hospitals at the time of their discharge from the hospitals after the course of hospitalisation. They were 60 (45.4%) patients in the private network hospitals and 64 (48.5%) patients in the public network hospitals. A few i.e., 8 (6.1%) patients were not referred for post-hospitalised check-ups by the network hospitals. Out of 8 (6.1%), three-fourth of them were in private network hospitals. Table 5.14 shows the details about the post-hospitalised check-ups for insured patients after hospitalisation.

Table 5.14, Post-Hospitalised Check-Ups after Discharge
(Percentage in parenthesis)

Post-Hospitalised Check-ups	Private	Public	Total
Below month	49(37.1)	61(46.2%)	110(83.3%)
Two-three months	9(6.8%)	3(2.3%)	12(9.1%)
Six months	2(1.5%)	0	2(1.5%)
Not referred	6(4.6%)	2(1.5%)	8(6.1%)
Total	66(50%)	66(50)	132(100%)

About 110 (83.3%) started to have the post-hospitalised check-up before a month after their discharge and 14 (10.6%) patients between two and six months. Out of 110 (83.3%), those who were referred by the public network hospitals are 61 (46.2%) patients while the private network hospitals referred 49 (37.1%) patients. Thus, there are more number of patients of the public network hospitals compared to the private hospitals' patients that attended post-hospitalised check-ups, before a month after their discharge. On the contrary, there are 12 (9.1%) patients who stated to have the post-hospitalised check-ups between one and three months later after their discharge from the hospitals. Of them, those who underwent treatment process in the private network hospitals are 9 (6.8%) patients. There are 2 (1.5%) patients exclusively referred for these check-ups by the private network hospitals after six months since their discharge. Hence, this empirical evidence reveals that follow-up reviews and immediate such check-ups by the hospitals are more for the public network hospitals than the patients of the private network hospitals.

5.18. Check-Up:

These insured patients had made many visits to their respective hospitals as part of the post-hospitalised treatment as suggested by the concerned doctors. As per Table 5.15 there are 90 (68%) patients in all who made post-hospitalised check-ups for less than 5 times and they were equally distributed between these two sectors' network hospitals. In addition, there are 22 (16.8%) patients who made such visits between 6 and 15 times approximately. They were unequally distributed between these two sectors' network hospitals. Among them, the private network hospitals' patients were 12 (9.2%), a little higher proportion of patients when compared with those in the public network hospitals. In addition, there were 4 (3.1%) patients who made these visits between 20 times and 30 times, and they were all treated by the public network hospitals. Finally, a few patients for whom the network hospitals referred for post-hospitalisation check-ups but they did not make any visit to the network hospital. They were 3 (2.2%) patients in the private network hospitals and 5 (3.8%) in the public network hospitals. During the post-hospitalisation period, such patients relied on local

health care providers if they got any health problem. Table 5.15 shows the details of number of post-hospitalised check-ups for patients.

Table 5.15, Number of the Post-hospitalised Check-ups
(Percentage in parenthesis)

Number of visits	Private	Public	Total
1-5	45(34%)	45(34%)	90(68%)
6-15	12(9.2%)	10(7.6%)	22(16.8%)
21-30	0	4(3.1%)	4(3.1%)
Did not go	3(2.2%)	5(3.8%)	8(6%)
Not referred	6(4.6%)	2(1.5%)	8(6.1%)
Total	66(50%)	66(50)	132(100%)

The empirical data shows the patients of the public network hospitals required more number of post-hospitalised visits. The overall picture unveils that the patients of the private network hospitals had less number of post-hospitalised visits compared to the public network hospitals. That implies inefficient service delivery in the public network hospitals that causes encouraging more number of out-patient visits even after discharge from the hospital. For instance, a patient who accessed the service of a public network hospital, ENT hospital at Koti, for the treatment of his ear problem could not get relief even after more than 20 post-hospitalised visits.

5.19. Loss of Working Days:

An important issue that relates to post-hospitalised medical treatment and visit to hospitals is the loss of working days. Immediately after hospitalisation, every patient wanted to secure two basic needs: health recovery and financial wellbeing. During the hospitalisation, not only the patient but their attendants also lost working days. This was repeated again in post-hospitalisation visits. During this period, patients lost working days that affected their family income. There were 50 (38.1%) patients (Table 5.16) who lost working days in different periods of time after hospitalisation. They were actually earners for their families even before they got admitted into these network hospitals under insurance coverage. Out of 50 (38.1%) patients, 28 (21.3%) patients availed services from the private network hospitals and lost working days due to

physical unfitness. They took rest as advised by doctors. Table 5.16 shows the details about loss of working days of insured patients after discharge from the hospitals.

Table 5.16, Loss of Working Days after Hospitalisation
(Percentage in parenthesis)

Loss of Working Days	Private	Public	Total
Below 30 days	1(0.8%)	1(0.8%)	2 (1.6%)
A month	19 (14.4%)	17 (12.9%)	36 (27.3%)
Two-three months	6(4.6%)	1(0.8%)	7(5.4%)
One year	2(1.5%)	3(2.3%)	5(3.8%)
Not effected or lost	38 (28.7%)	44 (33.2%)	82(61.9%)
Total	66 (50%)	66 (50%)	132(100%)

The rest of 22 (16.8%) patients who availed the healthcare service from the public network hospitals also lost working days. Out of 50 (38.1%) patients, 36 (27.3%) patients lost working days after hospitalisation for a month. They were followed by 7 (5.4%) for two-three months, and 5 (3.8%) for one year approximately. In a case of the public network hospitals, such patients were 17 (12.9%) for a month, one (0.8%) for two-three months and 3 (2.3%) for one year approximately, while for the private network hospitals, they were 19 (14.4%), 6 (4.6%) and 2 (1.5%), respectively. In comparison, more number of patients who lost one year approximately were treated in the public network hospitals. In addition to them, there were a few patients who had not worked both during the pre and post hospitalisation periods. They were students, housewives, children, and old people and so on. Hence, more number of patients who had worked before hospitalisation had lost working days immediately after their discharge from the private hospitals. On the contrary, the public network hospitals had a more number of non-earners as compared to those in the private network hospitals.

5.20. Medication:

Event after hospitalisation the medication continued for several cases for a certain period of time. Those patients who had been under medication, had to earn money themselves to corroborate themselves for purchasing their medicines. At the time of data collection, there were 47 (36%) patients under medication supported financially by

two providers: family and hospitals. Some of them were able to support themselves. Table 5.17 shows the details. Out of 47 (36%) patients, 22 (17%) patients were from the private network hospitals and 25 (19%) patients were from the public network hospitals. Only in 3 (2.3%) cases, the hospitals provided the medicines: one (0.8%) patient of the private network hospital and two (1.5%) of the public network hospitals. However, these 3 (2.3) patients themselves bore the expenditure of their conveyance to the hospitals. Out of 47 (36%) patients, 44 (33.3%) patients relied on family. Among 44 (33.7%) patients, there are 10 (7.6%) patients who relied on self, 29 (22%) on family, and 5 (3.8%) borrowed money from others.

In the case of the private network hospitals, 10 patients (7.9%) relied on family support, 7 (5.5%) relied on self, and 4 (3.1%) borrowed from others. In the case of public network hospitals, there were 19 (14.3%), 2 (1.5%), one (0.8%), who depended on themselves, family members, and others respectively. Thus, more number of the patients supported themselves financially for their medical needs after discharge from the hospitals. It was noticed that due to efficient healthcare delivery of the private network hospitals these patients became self-reliant compared to those patients of the public network hospitals. Table 5.17 shows the details of financial support for insured patients with regard to medication after hospitalisation.

Table 5.17, Financial Support for Medication of Insured Patients after Hospitalisation
(Percentage in parenthesis)

Financial Support for Purchasing Medicine	Private	Public	Total
Family support	10(7.6%)	19(14.4%)	29(22%)
Self	7(5.3%)	3(2.3%)	10(7.6%)
Borrowing	4(3%)	1(0.8%)	5(3.8%)
Network hospital	1(0.8%)	2(1.5%)	3(2.3%)
Not medicated	44(33.3%)	41(31%)	85(64.3%)
Total	66(50%)	66(50%)	132(100%)

The patients depended on medicines in various proportions. Four (3.1%) patients in the private network hospitals and one (0.8%) patient in the public network hospitals borrowed money to buy medicine. It shows that such patients suffered a lot during the stage of recovery. It was, it is observed, due to lack of earners in those patients'

families. It is also observed that those who had treatment from public network hospitals allocated a large portion of their total family earnings to purchase medicine. In literal sense, a large number of patients from the public network hospitals depended on their families during this post-hospitalised stage. This implies that sometimes the cost of medicines that were prescribed by doctors during post-hospitalisation visits was one of the causes for allocating huge amount of money from total family earnings. Finally, the financial support for all patients who required medication in the post-hospitalised stage was a difficult task as they all fell below the poverty line. This expenditure affected financial allocation for the basic needs in the family. This medical expenditure was too burdensome for the patients of public network hospitals as they depended on their families much more when compared to those of the private network hospitals.

5.21. Borrowing Money:

The patients had borrowed money to purchase medicine although they were entitled to access free medicines at the network hospitals. It happened due to lack of proper awareness. They borrowed money during the three stages of pre-insurance coverage, insurance coverage, and post-insurance. Lenders for them were money-lenders, friends, family members and relatives. Among 132 patients, there are 74 (56.1%) patients who borrowed money from the aforementioned personnel during these stages: 30 (22.7%) in the private network hospitals and 44 (33.3%) in the public network hospitals as per Table 5.18. Out of 74 (56.1%) patients, 45 (34.1%) patients borrowed from local money lenders, 16 (12.1%) from friends, 10 (7.6%) from relatives, and 3 (2.3%) from brothers. It shows that more than half of such patients borrowed money from money lenders on higher rates of interest and one-fifth borrowed from the friend in order to meet their medical expenses. Actually, this medical expenditure had to be covered by insurance.

As per Table 5.18, there are 16 (12.2%) patients who borrowed from the money lender, 5 (3.8%) patients from relatives, 8 (6%) from friends, and one (0.8%) from a brother in the case of the private network hospitals. For the public network hospitals, they were 29 (21.9%) patients who borrowed from money lenders, 5 (3.8%) from relatives, 8 (6.1%)

from friends, and 2 (1.5%) from brothers. Hence, patients of the public network hospitals were accounted for a huge number of patients who had mostly borrowed from moneylenders in order to meet expenditure in connection with their treatment during the three stages of pre-hospitalisation, hospitalisation and post-hospitalisation. As aforementioned they had not borrowed money from these personnel in a single year but in different years from 2008 to 2011. The years of 2008 and 2009 were belonged to the stage of pre-insurance coverage, followed by 2010 as the year of insurance coverage and 2011 was the post-insurance coverage, respectively. Table 5.18 shows the details about the lenders for insured patients in three stages.

Table 5.18, Lenders for Insured Patients in Three Stages

(Percentage in parenthesis)

Borrowed money	Private				Public				Total
	Money lender	Relative	Friend	Brother	Money lender	Relative	Friend	Brother	
Pre-insurance	10(7.6%)	0	2(1.5%)	1(0.8%)	11(8.3%)	4(3%)	0	0	28(21.2%)
Insurance	2(1.5%)	5(3.8%)	6(4.5%)	0	17(12.8%)	1(0.8%)	8(6.1%)	2(1.5%)	41(31%)
Post-insurance	4(3.1%)	0	0	0	1(0.8%)	0	0	0	5(3.9%)
Total	16(12.2%)	5(3.8%)	8(6%)	1(0.8%)	29(21.9%)	5(3.8%)	8(6.1%)	2(1.5%)	74(56.1%)

They were 28 (21.2%) patients in the pre-insurance stage, 43 (32.5%) patients in the insurance stage and 3 (2.3%) in the post-insurance stage, respectively. In these three stages, nearly two-third of patients borrowed money during their hospitalisation in order to meet their expenses. In two stages of pre-hospitalisation and hospitalisation, patients of the public network hospitals borrowed money heavily compared to those in the private network hospitals because they incurred expenses on diagnostic tests, medicine,

other non-medical needs, and so on. In the case of borrowers of the post-hospitalised patients, more number of such patients belonged to the private network hospitals when compared to those in the public network hospitals.

They utilised the borrowed money for various purposes including medical and non-medical needs. They borrowed money mostly to meet needs such as diagnostic tests, medicine, treatment at local healthcare providers, transportation and, basic needs (see Table 5.19). In the case of the pre-insurance stage, they spent money they borrowed for treatment by the local healthcare providers, diagnostic tests and medicine, and transportation. In the insurance stage, they had to spend OOPe as required during hospitalisation. In the post-hospitalisation stage, they only spent money on the purchase of the medicines. Among them, more than two-third of such patients in three stages had spent OOPe on diagnostic tests and medicines. Table 5.19 shows the purpose, for which money was borrowed in three stages.

Table 5.19, Purpose of Borrowing Money in Three Stages
(Percentage in parenthesis)

Purpose of borrowing	Private			Public			Total
	Pre-insurance	Insurance	Post-Insurance	Pre-Insurance	Insurance	Post-Insurance	
Treatment at local healthcare providers	2(1.5%)	0	2(1.5%)	0	0	0	4(3%)
Diagnostic tests and medicine	11(8.4%)	10(7.6%)	0	14(10.5%)	18(13.6%)	0	53(40.1%)
Medicine	0	0	2(1.6)	0	0	1(0.8%)	3(2.4%)
Transportation and basic needs	0	3(2.2%)	0	1(0.8%)	10(7.6%)	0	14(10.6%)
Total	13(9.9%)	13(9.8%)	4(3.1%)	15(11.3%)	28(21.2%)	1(0.8%)	74(56.1%)

In these three stages, those patients who borrowed money and accessed the services of the private network hospitals had mostly spent on diagnostic tests and medicines in both pre and insurance stages, and for medicine in the post-insurance stage. In the public

network hospitals, they mostly spent money on diagnostic tests and medicine in the pre-insurance stage, for diagnostic tests and medicine in the hospitalised stage and for medicine in the post-hospitalisation stage. Hence, patients of both sectors' network hospitals had mostly allocated and spent money for both diagnostic tests and medicine during pre-hospitalisation and hospitalisation stages. Overall, those in the public network hospitals spent OOPE heavily when compared to those in the private network hospitals.

5.22. Savings:

The medical expenditure borne during these stages affected the pattern of savings of the insured patients. Savings influenced the process of a repayment mechanism for borrowed money. In order to comprehend how healthcare expenditure had influenced the saving pattern of the insured patients, a comparison of savings between the conditions at the time of pre-insurance and conditions at the time of post-insurance stage is necessary. Some saving was usually common to every family in order to meet unexpected or emergency needs that they would face in future. Not only for this purpose but also to improve assets such as land and other property to create security for their children, the savings are made according to Table 5.19, 22 (16.7%) patients had some savings prior to falling sick and coverage of the insurance. Ten (7.6%) of these patients were from the private network hospitals and 12 (9.1%) from the public network hospitals. Out of 22 (16.7%) patients, 8 (6.1%) patients saved money every month while 14 (10.6%) patients saved it yearly. Table 5.20 shows the savings patterns of families of insured patients before insurance coverage.

Table 5.20, Savings of the Patients before Insurance Coverage
(Percentage in parenthesis)

Savings	Private	Public	Total
500-1000(monthly)	2(1.5%)	1(0.8%)	3(2.3%)
2000-3000(monthly)	5(3.8%)	0	5(3.8%)
4000-5000 (yearly)	0	4(3%)	4(3%)
10000 approximately (yearly)	3(2.3%)	7(5.3%)	10(7.6%)
Not spent	56(42.4%)	54(40.9%)	110(83.3%)
Total	66(50%)	66(50%)	132(100%)

They had savings with LIC and banks. They preferred LIC if it was yearly saving and preferred banks if their savings were monthly. Out of 10 (7.6%) patients in the private network hospitals, 7 (5.3%) patients followed monthly savings and 3 (2.3%) patients followed yearly savings. In contrast to this, there were 12 (9.1%) patients in the public network hospitals, and in them, one (0.8%) patient had monthly savings and 11 (8.3%) had yearly savings. It means that there were more patients in the private network hospitals with monthly savings. The same were in the public network hospitals with yearly saving. They saved money monthly between Rs.500 and Rs.3, 000 and the yearly savings between Rs.4000 and 10,000. Table 5.21 shows the changes of saving patterns of insured patients in the post-hospitalised stage.

Table 5.21, Savings of the Patients after Insurance Coverage
(Percentage in parenthesis)

Saving Patters after Hospitalisation	Private	Public	Total
Stopped saving	7(5.3%)	3(2.3%)	10(7.6%)
Declined savings	1(0.8%)	2(1.5%)	3(2.3%)
No change	1(0.8%)	7(5.3%)	8(6.1%)
Newly started	3(2.3%)	0	3(2.3%)
Saving increased	1(0.8%)	0	1(0.8%)
Not saved from the beginning	56(42.4%)	54(40.9)	110(83.3%)
Total	66(50%)	66(50%)	132(100%)

After hospitalisation, some of them could not save money as they had to repay to lenders from whom they had borrowed. Their income also drastically fell due to unemployment and spending on medication and other factors. There were 10 (7.6%) patients who discontinued savings after their hospitalisation: 7 (5.3%) patients in the private network hospitals and 3 (2.3%) patients in the public network hospitals. For 3 (2.3%) patients, the savings declined after hospitalisation: one (0.8%) patient in the private network hospitals and 2 (1.5%) in the public network hospitals. In the case of 8 (6.1%) patients, there was no change in their savings: one (0.8%) patient in the private network hospitals and 7 (5.3%) patients in the public network hospitals. Finally, there

were 3 (2.3%) patients of the private network hospitals who had recently started saving and one (0.8%) patient's savings increased.

The comparison between private and public hospitals' patients reveals some variation in saving patterns. For instance, nearly two-thirds of such patients in the private network hospitals discouraged savings after hospitalisation due to decline in earnings of the family, and the expenditure on post-hospitalisation needs which included non-medical needs. However, a few patients in the sector recently started saving. In some cases, no change in savings occurred, while in some other cases savings declined. In the public network hospitals, there were two-thirds of such patients who continued the same amount of money savings. The rest of them 5 (3.8%) stopped savings and their savings declined. But none of the patients in the public network hospitals initiated savings newly after hospitalisation. In this regard, it is observed that sometimes the non-medical expenditure among the patients in the private network hospitals deterred savings during post-hospitalisation, while it was not so much the case among the patients of the public network hospitals.

The processes of repayment to lenders, and uncovered medical expenditure in the post-hospitalisation stage also affected meeting the basic needs along with savings. According to Table 5.22, there were 13 (9.8%) patients whose expenditure on basic needs declined after hospitalisation due to aforementioned reasons of the post-hospitalised medical needs mostly. Seven (5.3%) patients in the private network hospitals and 6 (4.5%) in the public network hospitals fall in this category. A little higher number of patients in the private network hospitals got affected in this regard when compared with those in the public network hospitals. This expenditure burden has in general curtailed partially the allocation of money to their basic needs. Also, in order to repay the borrowed money, patients also curtailed expenditure on quality of intake food, attending parties, visiting relatives, smoking cigarettes, drinking alcohol, and spending money for friends. Table 5.22 shows the changes of money allocations to their basic needs after hospitalisation.

Table 5.22, Changes of Expenditure on Basic Needs and Habits
(Percentage in parenthesis)

Changes of expenditure on needs and habits	Private	Public	Total
Total curtailing	7(5.3%)	6(4.5%)	13(9.8%)
Low grade rice	5(3.8%)	2(1.5%)	7(5.3%)
Less party	7(5.3%)	4(3%)	11(8.3%)
Less visiting to relatives	4(3%)	2(1.5%)	6(4.5%)
No smoking	2(1.5%)	1(0.8%)	3(2.3%)
No drinking	2(1.5%)	2(1.5%)	4(3%)
Curtail friend circle	0	2(1.5%)	2(1.5%)
No movies	1(0.8%)	0	1(0.8%)

In the case of the private network hospitals, they mostly curtailed expenditures on the quality of rice, attending parties, and visiting relatives. Hence, those patients after discharge from the private network hospitals had curtailed expenditure even on their indispensable needs when compared with those in the public network hospitals in order to purchase the borrowed money and to meet medicine expenditure.

5.23. Medical Sufferings:

The network hospitals provided cure or relief to health problems to the best of their ability. It is supposed that the network hospitals cannot cure diseases of the patients completely and the patients continue to rely on the healthcare providers even after hospitalisation under insurance coverage. Generally, the patients expected that after treatment of their ailments they would return to normal health and resume daily activities and not visit hospitals repeatedly. Further, if they continued to depend on healthcare providers like clinics at the local level, etc., to which they made payment out of their pocket; it is believed that the insurance did not met their expectations. The healthcare expenditure pushed patients into a vicious circle of economic vulnerability. Under this parameter, according to Table 5.23, there were 13 (10.1%) patients i.e., one-tenth of the gross number of patients, who again returned to healthcare because their diseases/ailments were not completely cured. The ailments with which they suffered after hospitalisation in the network hospitals were headache, swelling of ears, throat pain, stomach pain, suffering from the same heart problems, increasing body size, and

leg pains etc. Table 5.23 shows the medical problems of insured patients in the post-hospitalisation stage.

Table 5.23, Medical Problems after Hospitalisation

(Percentage in parenthesis)

Medical Problems in Post-Hospitalised Stage	Private		Public				Total
	6 months	2 years	Two months	6 months	One year	2 years	
Headache	1(0.8%)	0	1(0.8%)	4(3%)	0	0	6(4.6%)
Swelling flows out of ears	0	0	0	1(0.8%)	0	0	1(0.8%)
Throat pain	0	0	0	0	1(0.8%)	0	1(0.8%)
Stomach pain	1(0.8%)	0	0	0	0	0	1(0.8%)
Suffering with same diseases	0	1(0.8%)	0	0	0	0	1(0.8%)
Increasing body size	0	0	0	0	0	2(1.5%)	2(1.5%)
Leg pain	0	0	0	1(0.8%)	0	0	1(0.8%)
	2(1.6%)	1(0.8%)	1(0.8%)	6(4.6%)	1(0.8%)	2(1.5%)	13(10.1%)

At the time of fieldwork, these patients were not allowed to access the network hospitals, as the insurance coverage was over. It was observed that one (0.8%) patient is still getting medicine from the public network hospitals while the private network hospitals withdrew from their service. Nearly two-third of such patients belongs to the public network hospitals, and that means these hospitals did not provide efficient service when compared to those in the private network hospitals. Those who are discharged from the private network hospitals were suffering from only three health problems such as headache, stomach pain, and suffering with the same old disease while the patients of public network hospitals were suffered from multiple problems such as headache, swelling from the ears, throat pain, increasing body size, and leg pain.

Overall Comparison between Two sectors' Network Hospitals

	Private Hospitals	Public Hospitals
Hospitalisation		
Reference	Mostly self and Family members	Mostly Clinics, Private Hospital, Public Hospital, Health-Camp, Private Network Hospital
Outpatient visit	One-fifth of its patients made 6-25 times of such visits. Among them, a patient made it for 25 times approximately	Mostly five times
Started access this service	Immediately	Few patients waited for five days up to a month approximately
Surgery done after admission	Mostly 10 days later after admission	One-fifth its total patients had it 15 days to one month later after their admission due to shortage of required equipments
Duration of Hospitalisation	10-20 days approximately	21 days up to 105 days for one-fifth of its total patients
Medical Expenditure	One-fifth of patients (mostly at diagnostic centers outside of the hospitals)	Two-third of patients (Mostly at diagnostic centers and among them, two patients incurred Rs.10,000-15,000 each)
OOPE at the time of Discharge	One-fifth of patients	Less than one-fifth of patients
Post-Hospitalisation		
Reviews started	After Two to Six months	Within a month (mostly)
Number of such reviews	One to five of such reviews maximum	21-20 times for few patients
Loss of working days after hospitalisation	Only few members	More patients
Medication (at the time of interview)	Mostly self-supporting	Family supporting (because of not working as yet)
Borrowed Money (During the Hospitalisation)	Few patients (Medical Needs)	More patients (Medical Needs)
Borrowed Money (Post-hospitalisation)	Four Patients (Treatment at local healthcare provider and medicine)	One patient (Medicine)
Savings (Pre-hospitalisation)	Nearly one-fifth of the patients	More than one-fifth of patients
Savings (Post-Hospitalisation)	Few patients' savings declined and stopped (few patients started savings and increased savings)	Unchanged the saving patter (for most of them)
Reduced expenditure on basic needs and habits (Food, Habits include drinking, smoking, and parties outside)	Little higher proportion of patients	Less number of patients
Suffering with minor diseases	Three patients	10 patients

Chapter-6

Experience of the Patients with the Insurance

6.0. Introduction:

This chapter examines the RACHI through the beneficiaries' experiences during the process of treatment of dreadful diseases in the network hospitals. These multiple experiences are of the two stages of treatment: hospitalised and post-hospitalised. The experience is in fact about the overall treatment delivered by the four prominent categories of personnel in the network hospitals: hospital administration, Mithras, doctor, and nurses. The experiences in connection with the four services are both in the private and public network hospitals are examined in this chapter. According to the Oxford Dictionary Thesaurus, experience means 'practical contact with and observation of facts or event' (page no. 311). It is the primary information of a particular action or feeling. These experiences suggest a solution for overcoming conundrums that have formed bottlenecks of the services. In this regard, the chapter explores experiences of the patients who underwent treatment process for their dreaded diseases in the network hospitals. These experiences were both positive and negative.

Currently more than three-fourth of the state's BPL population has been enrolled under the insurance scheme according to sources. They are being served through the network hospitals. However, it is found that the expectations of the insured patients had not been met adequately. If the insurance had accomplished expectations of a large number of people then it could be deemed that has positively impacted on people's life and the burden of OOP money was overcome. So, scrutiny of consumers' or recipients' experiences through comparative study helps to comprehend both sides of the experiences to contribute to the ameliorating efficiency of service for the benefit of patients.

The comparison helps to understand the functional reasons or causes for the prevalence of inefficiency in the network hospital service and how this inefficient service of the

network hospital affect the peoples' health and their families' economic. This comparison hopefully helps the tailor-made solution to improve efficiency in the service provided by the network hospitals. Here the question is about the performance or service delivery of four categories-doctors, nurses, Mithras and admission of the network hospitals that are indispensable. The public hospitals joined with the insurance scheme without resolving their shortcomings along with the private network hospitals for service delivery. On the other hand, the private hospitals usually that are interested in earning from the patients are required to equip themselves to offer facilities properly to the insured patients that has been undermined by the government.

6.1. Post-Hospitalised Patients:

The patients passed through three stages of the service: pre-insurance or pre-hospitalisation, insurance coverage for hospitalisation and post-insurance or post-hospitalisation, respectively. The post-hospitalised patients had exhaustive experience which is irreplaceable for it merges both well-off and wretched experiences. According to some of the patients, the fortunate experience is that they got the cashless service through the private players, which they did not expect due to their economic condition. Lamentable or bad experiences are with reference to consultation fee paid to the doctor, inconvenience, and discourtesy of the service personnel, inadequate overall service delivery of the hospitals and so on.

Initially, they had doubts about the intentions of the government for the launching of the insurance scheme. In this context, their perceptions towards the scheme were that it was to lure the poor for political mileage. About 124 (93.9%), a substantial proportion of the insured patients, perceived that the intention of the government was to benefit the poor people as per Table 6.1. Among them, a sizeable proportion 63 (47.7%) patients who accessed the service of the private network hospitals asserted that only the insurance was able to extricate poor from the unpredicted medical expenditure. On the other hand, those patients who had a gloomy perception towards this insurance had mostly accessed the service of the public network hospitals. There were 8 (6.1%) patients who stated this

scheme was launched to reap the political benefit. Among them, more than half that is 5 (3.8%) of such patients availed the service of the public network hospitals under the cashless insurance coverage. Hence, those patients who have been relying on the service of the private network hospitals stated that the insurance was launched for helping the poor from the heavy and unbearable medical expenditure and not for political gains. On contrary, those who relied upon the public network hospitals were exceedingly discontent and asserted that this insurance was initiated to reap votes from the poor.

Although many perceived that the government's intention for launching the insurance scheme is pro-poor, they had different perceptions towards the implication of this insurance. This insurance caters to the needs of insured patients through network hospitals. So, if network hospitals cannot provide healthcare service efficiently, then the entire service of the insurance would be in vain and people lose faith in the government and its service to the poor. In this regard, there were 99 (75%) patients who stated that this insurance was efficient and it catered quality service and should be continued permanently. Among them, a considerable proportion, 51 (38.6%) patients accessed the service of the private network hospitals.

In this regard, there is a close correlation between the category of healthcare provider and the extent of satisfaction the patient expected. On the contrary, based on bad experiences with the network hospitals, about 31 (23.4%) patients stated that this insurance must make certain changes in order to deliver efficient healthcare service. Among them, 17 (12.8%) patients availed service of the public network hospitals. For efficient healthcare delivery by the public network hospitals, the government must ameliorate the conditions in the hospitals by allotting sufficient capital, change infrastructure, and deploy sufficient manpower and so on. A small proportion of patients, i.e., one (0.8%) in the public network hospitals and one (0.8%) in the private network hospitals had bad experiences with the performance of the insurance due to inefficient service delivery of the network hospitals.

Although this insurance intends that all those enrolled should avail cashless healthcare service through network hospitals but according to a few patients they felt discriminated while accessing services of the network hospitals. They felt that healthcare service provided by the network hospitals has not been efficient enough as they were compelled to incur certain expenditure due to improper monitoring and surveillance by the insurance service delivery system. According to few of them, they were discriminated from accessing efficient healthcare service, based on their economic circumstance, were yet in unhygienic condition in the hospital, and were suspected to impolite behaviour by the health personnel. Eleven (8.3%) patients said that they had discriminatory experience during their hospitalisation. Among them, 7 (5.3%) a substantial proportion of patients were suffered during the hospitalising in the public network hospitals with impolite behaviour of the service personnel. The remaining 4 (3%) of such patients in the private network hospitals were discriminated by employees because their economic backwardness and were housed in insanitary conditions. Table 6.1 reveals the multiple perceptions of post-hospitalised insured patients about the insurance services.

Table 6.1, Multiple Perceptions of Post-Hospitalised Insured Patients Towards the Insurance
(Percentage in parenthesis)

Queries	Opinions	Private	Public	Total
Perceptions towards launching of the insurance	Pro-poor	63(47.7%)	61(46.2%)	124(93.9%)
	Political purpose	3(2.3%)	5(3.8%)	8(6.1%)
	Total	66(50%)	66(50%)	132(100%)
Perceptions towards this insurance scheme delivery	Good	51(38.6%)	48(36.4%)	99(75%)
	Required efficiency in its delivery	14(10.6%)	17(12.8%)	31(23.4%)
	Bad	1(0.8%)	1(0.8%)	2(1.6%)
	Total	66(50%)	66(50%)	132(100%)
Feeling of discrimination in the network hospitals	Yes	4(3%)	7(5.3%)	11(8.3%)
	No	62(47%)	59(44.7%)	101 (91.7%)
	Total	66(50%)	66(50%)	132(100%)

About 101 (91.7%) patients, on the inverse, experienced no discrimination in the service of this cashless insurance during hospitalisation in the network hospitals. In this context, they gave a positive notion of the insurance as it had been able to rescue people themselves below poverty line from the liability of medical expenditures. The empirical

data shows the fact that those patients who accessed the service of the public network hospitals were relatively less content due to the inefficient healthcare delivery. The reasons for this feeling were: inefficient service delivery by the public network hospitals, unaccountability of hospital administration, doctors, Mithras, and nurses. Hence, the policy makers and public agencies are obliged to pay attention to these reasons in order to improve efficiency and quality of healthcare delivery.

6.2. Experiences of Insured Patients of Post-Hospitalised:

The network hospitals are expected to meet all medical needs comprehensively for the insured patients. However, what has been noted is that some patients still relied on the local healthcare providers due to the inefficient service delivery in hospitals even after discharge. This meant that these patients during post-hospitalisation approached and depended on unqualified or qualified local practitioners to mitigate some of the sufferings (diseases) for which they have already availed the insurance service from the network hospitals. This implies that although these insured patients were treated in network hospitals they were not completely healed and were coerced to incur expenditure at the local level. Usually, it is understood that each network hospital after enrolling the insured patients has to comprehensively cure diseases of the insured patients.

The post-hospitalisation experiences are constructive and gloomy with respect to the hospitals. The patients with positive experience asserted that the insurance scheme is peerless and efficient healthcare service is provided through the network hospitals. The patients with negative or gloomy experiences, on the other hand, said that it is the inefficient scheme which must be improved to deliver proper healthcare through the network hospitals. The administration of the hospital has certain problems in terms of sanitation, diagnostic tests, ward-boys and so on. About 107 (81.1%) of post-hospitalised patients have expressed complete satisfaction with the service of the doctors, followed by 96 (72.7%) with nurses, 95 (72%) with Mithras, and 88 (66.7%) with hospital administration, respectively. Thus more than three-fourth of the patients

have expressed contentment. Most of the patients were completely satisfied with the service of the doctors among all services of the hospital. On the other hand, administrative service has been adjudged as less satisfactory for insured patients. But, for the success of the insurance, each and every service must be satisfactory for the patients.

Regarding normal satisfaction, a small proportion of the patients have expressed normal satisfaction. When it is segregated according to the four services of the hospital, this satisfaction was expressed by 39 (29.5%) patients with hospital administration, 23 (17.3%) with doctors, 35 (26.5%) with nurses and 24 (18.1%) with Mithras, respectively. Among them, those patients who expressed this normal satisfaction with hospital administration and nurses together accounted for one-third of the total of insured patients. This indicated that hospital administration and nurses had not completely satisfied the insured patients.

Racharla Narsing Rao (45 years old) is a resident of Chintal Basti, Khairathabad, who is a self-employed worker. He was admitted in Mahaveer Hospital, a private network hospital for treatment of his cardiac problem, and was discharged. He has certain complaints with post-hospital service that the network hospital provided. After discharge from the hospital, he made 12 post-hospitalised visits to the hospital for check-ups. During this post-hospitalisation stage, he was required to undergo certain diagnostic tests and purchased medicines as well. Since he was no longer under insurance coverage he had to pay for doctor's consultation service. His complaint was that the network hospital has not been providing cashless diagnostic service and free medicine for insured patients during the post-hospitalisation. According to him, there are affluent people who can afford to take care of themselves but they are also accessing this insurance service alongside poor people which is resulting in a financial burden on the state exchequer.

Yasmeen Begum (3 years old) who is a child of the parents who reside at Karmika Nagar colony in Youself Guda, principally relied on private healthcare providers in the

locality for the treatment of her heart problem. The ailment is a serious one and could not cure by local healthcare provider and later she was taken to a public network hospital for treatment of that problem. During the in-patient period, her parents had awful experiences not only with the service of the nurses but also with other hospital staff. According to her parents, those patients who have political backing were availing the diagnostic service promptly without following the queue, and even nurses did not bother to instruct the patients to follow the queue. Finally, they inferred that the service of nurses was unimpressive and unaccountable, and in addition, the word boys demanded for money for their service.

The primary aim of the insurance is to cover medical expenditure and to provide complete satisfaction through the service providers but that has not been accomplished due to inefficient service delivery of the network hospitals at least in some cases. Hence, the hospital administration among the other services must satisfy patients with its service; the patients who had not been satisfied were 13 (9.9%) with Mithras, 5 (3.9%) with hospital administration, 2 (1.6%) with doctors, and one (0.8%) with nurses, respectively. Among them, the insured patients had bad experience mostly with the service of the Mithra.

Tulasi (18 years old) studied up to 10th class and lives with her parents at Lakshmi Narasimha Nagar located in Youself Guda. She suffered from ear problem for few years. Before approaching the insurance, she visited the local healthcare providers several times. She spent Rs.2000 approximately for the treatment of her ear problem but could not get any relief. Later, she approached the Prince Esra Hospital a private network hospital after knowing that the hospital has professional and quality doctors. She visited the hospital for 10-15 times before she got admitted into the hospital due to under-construction of some blocks of the hospitals and shortage of beds. According to her, Mithra is only accessible during day-time for a particular time period, which was between 8.30 AM and 5.30 PM. If any patient comes at night seeking admission into the hospital under insurance coverage, then he/she has to wait till 8.30 AM of the next day.

She was completely disappointed with the service of Mithra. She was compelled to incur certain medical expenses for diagnostic tests and, had to return medicines supplied during the hospitalisation to the hospital at the time of discharge for which insurance actually sanctioned bills. When she questioned the Mithra about the return of medicines, she was scolded in the presence of the remaining patients in the room. As a result of that, she needed to incur a medical expense of Rs.1, 500 for purchasing medicine at the time of discharge. On the other hand, Mithra has sanctioned Rs.50 under insurance for travelling back to her home from the hospital at the time of discharge. She claims it was insufficient to bear whole conveyance cost. In addition, she also noticed that a set of villagers suffering who were admitted into the network hospital under the insurance coverage. They have not expected to spend so much money while being admitted in the hospital and the Mithra sanctioned insufficient travel expenses. In order to arrange money to meet such needs, they faced numerous problems and sometimes they begged other patients. Even though they complained to the Mithras about their difficulties but they did not care about them.

It can be summed up that a substantial number of insured patients were although completely satisfied with the service of the doctors but not by other services. A few patients were satisfied with hospital administration but were disappointment with Mithras. With regard to complete satisfaction with the service of the private network hospitals, 57 (43.2%) patients were content with doctors, 56 (42.4%) with nurses, 54 (40.9%) with hospital administration, and 52 (39.4%) with Mithras, respectively. This indicates that more than three-fourth of the patients were satisfied completely with the service of the doctors when compared to the remaining three services. More number of patients were satisfied with doctors in the private hospitals when compared with those who treated in the public network hospitals. Such patients in the public network hospitals accounted for two-third of the patients. Overall, these four services in the public network hospitals failed to deliver efficient service to the insured patients. The chapter-4 delineated the reasons for efficient delivery of the private network hospitals and, also the reasons for the failure of the public network hospitals. In addition, a little higher proportion of the insured patients was discontented with these four services in

the public network hospitals as compared to those in the private network hospitals. Table 6.2 shows the details about various perceptions of insured patients towards the service of network hospitals.

Table 6.2, Various Perceptions Towards Service of Four Aspects in the Network Hospitals
(Percentage in parenthesis)

Type of Satisfaction	Administration		Doctor		Nurse		Mithra	
	Private	Public	Private	Public	Private	Public	Private	Public
Completely	54(40.9%)	34(25.8%)	57(43.2%)	50(37.9%)	56(42.4)	40(30.3%)	52(39.4)	43(32.6)
Normal	11(8.3%)	28(21.2%)	8(6%)	15(11.3%)	10(7.6%)	25(18.9%)	11(8.3%)	13(9.8%)
Bad experience	1(0.8%)	4(3%)	1(0.8%)	1(0.8%)	0	1(0.8%)	3(2.3%)	10(7.6%)
Total	66(50%)	66(50%)	66(50%)	66(50%)	66(50%)	66(50%)	66(50%)	50(132)

Few patients had gone through bad-experiences with service of the doctors in the public network. For instance, Dasari Vijayalaxmi (38 years old) is a married woman who runs a petty vegetable shop at her house located in Baba Sailani Nagar in Borabanda. She has suffered from a disease called ‘Ventral and scar hernia with mesh. She was treated at Gandhi Medical Hospital, a public network hospital. Prior to her admission to the network hospital, she received treatment from Rajaswari, a qualified healthcare practitioner who runs a clinic in this slum. Vijayalaxmi spent about Rs. 5,000 approximately. But, she did not get relief and finally she approached the public network hospital. During the pre-hospitalisation, she visited the hospital between 4-5 times. In each visit, she was advised by the hospital staff to come again as the doctor concerned was absent. Even after admission to the hospital, she says she did not have a proper check-up by either nurses or doctors. After getting discharged, she made 3-4 visits to the network hospital for post-hospitalised check-ups. In these visits also, she was advised by the hospital staff as was done at the time of pre-hospitalisation. As a result of that, she again relied on the local healthcare provider who is an unqualified medical practitioner (RMP). This RMP provides his service at a minimal fee. So far, she made approximately more than 10 visits. In each visit, she was paying between Rs.400 and 500 to this healthcare provider.

6.3. Hospitalised Patients:

According to some scholars (Hooda 2015), causes of inefficient service are the results of inadequate service provided by the personnel in addition to the lack of infrastructure, improper equipment, and lack of financial support and so on. This study agrees with these findings so far as public hospital is concerned. In addition, the study finds that the private network hospital is far better than public hospitals. The experiences of the patients are categorised into four: completely satisfied, simply satisfied, bad experience, and no comments. Among them, those who exercised the option of ‘no comment’ are uncertain or do not want to divulge their opinion about the service. A large number of patients who were completely satisfied account for nearly a half of the patients. A substantial proportion of 52 (52%) patients experienced satisfaction with the service of doctors followed by 47 (47%) patients with hospital administration and 41 (41%) with nurses, respectively. But, there were less than a quarter of the patients who had such experience with the service of Mithra.

The administration covered admission process, and diagnostic service, and sanitary service so on. Those who stated that their hospital administration service is satisfactory and all these sub-services are delivered satisfactorily. The empirical evidence reveals the fact that more than half of patients were completely satisfied with the service of doctors while nearly a half of patients had such experience both with the services of hospital administration and the service of the nurses. In addition, the Mithras had in general failed to render service to the complete satisfaction of the patients. The major priority of the government is to deliver insurance service to the complete satisfaction of poor patients. The service includes comprehensive coverage, efficient service delivery, well-timed and convenient healthcare etc. This was catered to people who are economically excluded. But, such ambition of government is yet to be met in certain respects due to the inefficient and lopsided healthcare delivery by the network hospitals. The prevalence of inefficient service in some areas by the network hospitals was the result of inadequate monitoring, inadequate health care service, and so on. These issues have already been detailed in the previous chapters.

Of all the patients, a large number of patients were not completely satisfied. They had normal or casual or bad experience, 53 (53%) patients with the administration, 48 (48%) with doctors, 58 (58%) with nurses, and 31 (31%) with Mithras, respectively. Specifically, those who had bad experiences or had grievances or complaints were 3 (3%) patients against both administration and doctors, 2 (2%) against nurses, and 6 (6%) against Mithras. Overall both bad and normal satisfaction expressed by more than half of patients were with reference to nurses and administration while nearly half, and more than a quarter had such experience with doctors and Mithras, respectively. This implies that the insurance succeeded in a half but not completely as a result of inefficient service delivery. In addition, one-fifth of patients were ambiguous about expressing their experiences towards the services of Mithra and nurses. Table 6.3 catalogs experiences of the insured patients admitted in two network hospitals with regard to the services of doctors, nurses, hospital administration, and Mithra.

Table 6.3, Satisfaction Levels of the Patients with the Four Services in Two Network Hospitals
(Percentage in parenthesis)

Satisfactions	Administration		Doctors		Nurses		Mithra	
	Private	Public	Private	Public	Private	Public	Private	Public
Complementary	44(44%)	3(3%)	43(43%)	9(9%)	39(39%)	2(2%)	17(17%)	0
Normal	5(5%)	45(45%)	6(6%)	39(39%)	11(11%)	45(45%)	25(25%)	0
Bad experience	1(1%)	2(2%)	1(1%)	2(2%)	0	2(2%)	1(1%)	5(5%)
No comments	0	0	0	0	0	1(1%)	7(7%)	45(45%)
Total	50(50%)	50(50%)	50(50%)	50(50%)	50(50%)	50(50%)	50(50%)	50(50%)

The patients had different experiences with regard to their contentment with healthcare provider when they accessed the service. In the case of the private network hospitals, more patients were completely satisfied with the services when compared with those in the public network hospital. Out of the half of patients who had expressed complete satisfaction with the healthcare service of both the network hospitals, such patients who obtained the service exclusively from the private network hospital were 44% patients with hospital administration, 43% with doctors, 39% with nurses, and 17% with Mithras. Comparatively, they had experienced most satisfactory and equitable service from the private network hospital. This can be connected to their specialised service with fully equipped professional or skilled personnel, and sophisticated technology and etc. Regardless of normal or usual satisfactory service that is accrued to Mithra, all

patients in the private network hospital had expressed satisfaction when compared to the healthcare service provided by the public network hospital. This empirical evidence unveils about the divergence of healthcare service delivery in both the network hospitals from both the sectors for insured patients who were paid by the government. There is a need for the government's intervention to remove such lopsided service delivery for insured patients through network hospitals under the insurance coverage.

Several patients were not completely content with the service of the public network hospital. Such patients were 45 (45%) patients with hospital administration, 39 (39%) with doctors, and 45 (45%) patients with nurses. It shows that almost all patients in this hospital had normal satisfaction with its service. In this regard, there were differences among the insured patients on the kind of healthcare provider. A vast proportion of patients received adequate and efficient healthcare service from the private network hospital while the efficient service through the public network hospital was absent. The efficiency of the private network hospital included sophisticated technical support, administrative efficiency, on-duty and skillful personnel, a liability of all departments in the hospital, and so on. On the contrary, the reasons for unsatisfied healthcare delivery through the public network hospital were shortage of beds, lack of equipment and infrastructure in addition to insufficient financial allocation, unaccountability and absenteeism of personnel. Hence, the private network hospital is able to render satisfactory service and also reach out to meet implanted goals of the government through this insurance scheme.

The patients were divided on the basis of their normal and complete satisfaction with the services in the hospitals. In addition to this dichotomy, a set of patients underwent bad experience mostly with the services of the public network hospital: 2 (2%) patients with the administration, 2 (2%) with doctors, 2 (2%) with nurses and 5 (5%) with Mithras. There were various reasons for this unsatisfactory health care service in accordance with the type of healthcare provider or the type of network hospital. In the case of the private network hospital, there are a few patients who faced different and inadequate administrative services.

Gidde Vikas is a one-year schedule caste child, a resident of Musheerabad and suffering with a heart problem. According to his parents, he must undergo open-heart surgery. He had treatment by local healthcare providers continuously for six months prior to admission into the hospital. Finally, the child was admitted into CARE, private network hospital. After the medical examination carried out by the concerned doctor he was sent back home due to non-availability of the bed. After few weeks, he returned to the hospital after a call received by his parents from a staff member of the hospital. Even after arrival to the hospital, he did not get bed immediately but he waited at the 'Aarogyasri Waiting Room' for few days until a bed was made available for him in the hospital. During his stay in the Aarogyasri Room, he was not covered by the insurance. He was compelled to bear all non-medical expenditure towards food, fruits and so on.

Yusuf (six months) is an infant who was admitted in CARE, private network hospital for treatment of a hole in his heart. Prior to this admission, he had gone under treatment by doctors at Kurnool spending Rs.6, 000 but he did not get well due to inadequate equipment and improper treatment in the hospital. He was later shifted to the present hospital under insurance coverage. At the network hospital, all family members initially faced difficulties due to non-availability of bed after his admission into the hospital. He was allotted Aarogyasri Room wherein the hospital provided free accommodation for patients like him until they got a bed in the hospital. Adding to this, they incurred medical expenditure out of pocket for a diagnostic test called angiogram. Another difficulty was that his parents were unable to interact with doctors who speak English.

N. Suresh (30) is a schedule caste person and a resident of a village in Khammam District. Initially, he availed healthcare service from two hospitals prior to approaching the CARE private network hospital. He spent Rs.25, 000 out of his OOP at these hospitals. While he was accessing the service of this network hospital, food was not served to his assistants who stayed with him. He borrowed money from a moneylender for his food and everyday needs. In addition, he also underscored that whatever food the hospital served to both the RACHI and non-RACHI patients is not tasty. So, he suggested that hospital must extend its service in covering food for patients' helpers

under insurance coverage besides improving the quality of the food. This helps patients to be free from the burden of OOPE during hospitalisation.

Ravindhra Rao (55) is a breadwinner for his family, belonging to the Backward Class, and a resident of Warangal District. During the pre-insurance stage, he approached Jaya Clinic for the treatment of his heart problem where he spent Rs.2000. Later he approached the CARE private network hospital, where he complained about the admission procedure for insured patients when compared with that for non-insured patients. He went through various stages of healthcare treatment as a part of a long administrative procedure, which for non-insured patients he observed was very easy. As a result, he felt that it becomes very difficult for patients with a rural background and illiterate or who studied up to the primary level. He hoped that this hospital must make this administrative procedure easier for all patients in general and insured patients in particular.

Rama Devi (34) is a Backward Class, unemployed and staying with three of her family members. For the last few years, she has been suffering from neuron problem and admitted into CARE on her first visit as she was rushed to the hospital with serious condition. She had to make OOPE of Rs.3000 for a diagnostic test while the rest of her diagnostic tests were done free of cost at the time of admission into the hospital. She waited for reimbursement of her expenditure on the diagnostic test from the hospital till the end of her hospitalisation. Finally, she was told that such medical expenditure must be incurred by the hospital.

In the case of Mithra, more number of patients were unhappy with their service. Nagamma (53), an illiterate, upper caste, unemployed woman reported her experience. She arrived from Khammam District for the treatment of her neuron-health problem in CARE, under the insurance coverage. Before approaching this hospital, she had treatment for her disease from clinics in Khammam, besides a RMP in her village and, also spent Rs.25, 000 approximately for treatment of her diseases at these local healthcare providers for three years. She finally got admitted into the CARE private

network hospital. She was ready to get discharged at the time of data collection. Even the doctor advised her to leave but she could not leave as she did not have money to reach to her home. Whatever money the Mithra would sanction towards her transport charges under the insurance was insufficient to meet her needs. So, she requested a staff of hospital authority to allow her to stay in the hospital for a night until the arrival of her relative. She will have to travel for 10 hours by bus. But the hospital staff asked her to vacate the hospital on that evening itself or to pay Rs.5, 000 for staying on that night in the hospital. In this regard, she had expected help from the Mithras but, in vain.

Erramma (65) who belongs to the Backward class resides in Kadapa District received treatment at CARE for a heart-problem. Prior to admission into this hospital, she had treatment at a private hospital and spent about Rs.26, 000 which she borrowed from others. It was a heavy burden for her family members to pay the money back to the lender after her hospitalisation. Eventually, she was admitted into this private network hospital under the insurance coverage. In the hospital, the problem that she faced was to recognise the Mithras who usually came in a normal dress like other staff. According to her, Mithras and other hospital staff looked alike so she could not recognise them properly to discuss about her treatment.

In the case of the service of doctors in the private network hospital (CARE), there were some of the patients who met with difficulties while accessing this service. For instance, Venkateswara Rao (30) is not only the head but also breadwinner of his family and got admitted to the CARE private network hospital for treatment of his cardiac disease. During the pre-insurance stage, he received treatment for his disease by two clinics and a private hospital by the spending of Rs.45, 000 approximately out of his pocket. During the hospitalisation under insurance coverage, he faced difficulties because of a communication barrier with doctors. According to him, doctors spoke either English or Hindi while delivering their service to the patients because of which patients could not have properly interaction with doctors to explain them about their condition.

Venkata Subhayya B (52) belongs to Backward Class, also approached the CARE private network hospital for treatment of cardiac problem under the insurance coverage. During the pre-insurance coverage, he received services of two private hospitals, one in Thadipatri and another in Kadapa and spent Rs.8, 000 approximately out of his pocket for treatment for the same problem. Later, he got admitted into this private network hospital. He said that he got disappointed with the service of a doctor. He wanted to know exactly what was his disease's present condition and the process of treatment. But he was not informed. He expected that treatment procedure adopted for patients by doctors must be kept transparent between doctor and both patients/ and their families.

Although few patients remained with discontented or had no satisfaction with the public network hospital while numerous of them had no comment on Mithras. Finally, the service of the public network hospital remained unsatisfactory for the insured patients due to improper service delivery when compared to the private network hospital. With regard to its administration, Sukkubai Mulkapuram (65) comes from a Backward Class category. She is a resident of Hyderabad. She had broken ribs that come under orthopedic disease category. Initially, she went to a private hospital and incurred expenditure around Rs.10, 000, and later shifted to the public network hospital. During her stay in the Gandhi public network hospital, she realised that the doctors were neglecting her case or they were lax for she did not have political support. She discerned that those patients who had the political support of MLA and Mayor were accessing to this hospital service very swiftly. So, she argues that political support is mandatory even for insured patients to have efficient and immediate service.

Nagamani (65) is an aged woman and dependent on her family members to meet both basic and health needs. She belongs to Backward Class and, is residing in a place called Ibrahim Patnam in Hyderabad. She once availed treatment at the Gandhi public network hospital for her fractured head without insurance coverage but did not get the cure. Again, she approached this hospital under insurance coverage. She paid Rs.500 for bandages at the time of admission into the hospital, which she did not expect.

According to her, this unexpected medical expenditure enhances the burden for patients covered by the insurance.

Chempula Laxmi (25) is a wage labourer and belonging to Backward Class category. She is illiterate and came from Mahaboob Nagar District. Initially, at the pre-insurance stage, she accessed the service of a private hospital called Pulla Reddy hospital and spent Rs.15, 000. During hospitalisation in the Gandhi public network hospital, she got frustrated with prolonged treatment in this hospital for she had completed more than a month of stay in the hospital by the time the interview took place. As a result of that, she had to bear both medical and non-medical expenditure besides losing working days of both her and her husband who is the breadwinner of their family. In addition to this, she handed over the rearing responsibility of her children to relatives during her hospitalisation. Therefore, a long hospitalisation caused this insured patient falling into a vicious cycle of poverty.

Shik Babu (30) was rushed to the Gandhi public network hospital for treatment when he met with an accident in which his right leg was fractured. During the hospitalisation, he experienced inadequate service of this network hospital. There was no bed readily available and irregular spending money OOP even though he was an insured patient. He was asked to sleep on the ground till someone got discharged after admission into this hospital. He purchased medicine at a shop located in the premises of the hospital due to shortage of medicines provided in the hospital as prescribed by the concerned doctors.

Koshmula Sandhya (30) is a schedule caste woman, who was rushed to Gandhi public network hospital after meeting with an accident. She suffered from a fracture in her right-leg. During the hospitalisation, she had to make an OOPE of Rs.500 for various tests. She also paid Rs.800 to ward-boys and grade-IV employees at the time of surgery. She said that money is yet to be reimbursed. She suggested that OOPE during the hospitalisation under insurance coverage should be completely eliminated.

In the case of Mithra, all patients in Gandhi Hospital had failed to avail this service properly. For instance, Nagamani (65) is an aged woman dependent on the rest of her family members for her basic and health-related needs. During the course of in-patient treatment, she faced very bad experiences with regard to the service of Mithra, which was very poor. They were supposed to mediate between patients and the network hospital, and Trust but failing to monitor services for the insured patients during hospitalisation.

In addition, there are a lot of insured patients who were disappointed with ineffective healthcare service delivered by doctors in the public network hospital. Kammari Pedda Lakshmi (50) belongs to the goldsmith caste and earns Rs.1,500 per month. She got admitted to the Gandhi public network hospital for treatment of a vertebrae problem with which she had been suffering for few months. During the pre-insurance stage, she availed the service of a public hospital located near her residence but could not get cured. Later, she sought free healthcare service under the insurance coverage by getting admitted into this public network hospital. The difficulty that she faced during her hospitalisation was that the doctor went on leave for weeks continuously. In his absence, nurses took over all the responsibilities of doctors by providing medicines to patients.

Sayed Soheb (6) was admitted to the Gandhi public network hospital for treatment for a neurone problem under the coverage of insurance. The health problem with which he has been suffering since his birth was treated earlier by local healthcare providers. Finally, he approached this public network hospital to seek healthcare under the insurance coverage but underwent various difficulties. These included a shortage of required equipment and irregularity of the concerned doctors. During the hospitalisation, he was compelled to make OOP over a diagnostic test called MRI. His parents waited patiently for a long period of time to get reports of the diagnostic tests and consulting the concerned doctors with the report. According to his parents, the concerned doctor attended duty once a week and that caused prolonged hospitalisation.

They requested that there must be an efficient diagnostic service and availability of doctors.

Malluri Shrawanthi (22) is a housewife and suffered from vertebral pain for 11 months before she was admitted into the Gandhi public network hospital. Prior to this, she received treatment from three healthcare providers available locally and spent about Rs.5000 in total. During the hospitalisation, at the time of the interview she accused the health care provider for the long time treatment and she had already completed a month of hospitalisation. Her emphasis was on prolonged hospitalisation due to an irregular attendance of medical staff and inadequate service delivery by doctors. She wanted to know about her exact health problem but failed to know about it even after a month of the hospitalisation.

Srinivas (45) is an insured patient admitted in the Gandhi public network hospital for treatment of his fractured left leg after several trials and errors at private health care providers. He is a petty entrepreneur running a bookbinding business through which he earns Rs.9, 000 per month approximately. At the time of pre-hospitalisation, he was treated by Dr Raghavendra and he spent Rs.10, 000 approximately just in a day. After that, he was admitted to the Gandhi public network hospital. He felt disappointed with the behaviour of a doctor who scolded his wife for a minor mistake of not following his advice. He scolded like 'I will slap on your face'. Doctor behaviour was improper and he lacked patience. Srinivas was very unhappy that the doctors did not disclose their plan of treatment.

Bikshapathi (60) is a schedule caste person and earns monthly Rs.3, 000. He has been suffering from the neurological problem for the last 15 years approximately. He depended on healthcare providers available locally and spent Rs.10, 000 till he was admitted to the Gandhi public network hospital. He was totally dissatisfied with the service of the doctor because he had no time to explain or disclose his health condition. Further, the doctor did not even treat minor problems such as fever and headache.

Rajendhra Singh (35) is an illiterate, wage labourer and had been suffering from a problem with his right kidney for six months. In pre-insurance stage, he approached two private clinics and one government/public hospital for treatment. He spent Rs.10, 000 approximately for various tests and medicine. For availing proper healthcare service under insurance coverage, he got admitted into the Gandhi public network hospital. He complained that the doctor did not give him sufficient time while examining him. The doctor visited him only once in a day and also ignored treating his minor problems like fever, headache, and stomach ache, and so on. There were burdens of extra-OOPE and long hospitalisation that he experienced during hospitalisation.

Kakaiah (70) is an aged person, head of the family and was admitted to the Gandhi public network hospital for treatment of a heart disease. Earlier, he got treated in a private hospital at Nalgonda for three days. Later, in order to have free treatment under insurance, he approached Apollo a private network hospital at Banjara Hills but was not treated by the hospital as such disease was not covered under the insurance in the hospital. Finally, he got admitted to this public network hospital. He was not satisfied with the service of doctor because the doctor visited him four times in a day while he was in Intensive Care Unit (ICU). It is surprising that even such frequent visits of doctor did not satisfy him. He felt that he needs extra service from the doctor concerned in order to get him immediate relief.

Chapter-7

Conclusion

Social security is a vital instrument of welfare provision in a state like India where an overwhelming proportion of people rely on public welfare schemes. In this context, health care is one of the requisite elements of the welfare state since it is considered as one of the four minimum necessities including food, clothing and shelter. A welfare state thrives on delivering efficient and quality healthcare to all its citizens without any prejudice. Among the low-income countries like India, the healthcare apportion is immensely allied with OOP payment (Bjorn 2004). Presently, underprivileged people are significantly retreating from accessing the affordable healthcare system of the state to expensive healthcare services in the private healthcare system due to an unproductive and inefficient public healthcare system. Even though, a few committees including Mudaliar Committee, Chodah Committee and etc., have recommended vital points for improving the public healthcare system.

In order to tackle face current healthcare demands of the people, both central and state governments introduced various health insurance schemes. Through the coverage of these schemes, people under BPL included in the efficient healthcare service of the private players, from which they were hitherto excluded. Aarogyasri Health Insurance scheme is one of such government schemes, which has been benefiting BPL families since 2007 in undivided Andhra Pradesh. Earlier studies have acknowledged that there has been an inappropriate healthcare service delivery under this insurance scheme generally and more so with the services of network hospitals. Such inefficient service is discerned by a handful of scholars as high OOPE still incurred by insured patients during hospitalisation (Mitchell, Mahal and Bossert, 2011:16), the insurance scheme being a cash-cow for corporate hospitals (Reddy and Mary 2013:255) and not having made any major impact on the overall catastrophic health expenditure of people (Selvaraj and Karan 2012:19).

Based on these detractors, the present study framed the following research queries: Is public healthcare able to improve efficiency in its service in collaboration with insurance? Does insurance decrease the burden of healthcare cost? In order to find answer to these queries, this study has set the following objectives: studying RACHI insurance scheme in Hyderabad with reference to health inclusion in the combined state of Andhra Pradesh, studying RACHI service by comparing private and public network hospitals for RACHI beneficiaries, and finding out which sector's network hospitals are delivering better service, and also suggesting ways for making RACHI a more inclusive health scheme. Thus, this study mainly endeavours to evaluate which network hospitals' services are being more inclusive for the insured patients under the coverage of this inclusive welfare scheme. In order to realise the above mentioned objectives, the study carried out a survey to interview 332 patients who availed the services of the network hospitals of both the sectors-public and private. Of them, the post-hospitalised patients are 132 while the rest of 200 patients are hospitalised patients. They were represented equally from two sectors' network hospitals. They were sampled for the interviews by convenience non-random sampling.

7.1. Background of the Beneficiaries:

They had diverse socioeconomic credentials and availed divergent healthcare services. By comparison between the private and public hospitals, the beneficiaries of the private network hospitals under this insurance scheme were mostly from OBC, BC, and ST categories. Most of them were males, above 45 years of age and were married. Most of them were literate and some had pursued higher education as well. They mostly hailed from nuclear family backgrounds and a few of them belonged to broken nuclear family system. In occupation-wise, they were mostly agricultural labourers, self-employed and students in addition to having three to four earners in each of their families. For accessing healthcare services for treatment of seasonal ailments, they mostly relied upon the private healthcare service in their vicinity at the local level and, a few of them spent roughly Rs. 1,500-6,000 in the previous year. They mostly utilised tap-water for both drinking and other family necessities. Most of them disposed off garbage from their houses every day. Overall they were in a more economically upward condition

when compared to those surveyed in the public network hospitals. Even though they are beneficiaries of this Aarogyasri Insurance or RACHI, they are not well informed and aware of the insurance service details such as most of them were not aware of how many members of a family can be covered by this insurance scheme. Among them, those patients who became aware of this scheme were made aware through their family members, neighbours, news/media, network hospitals and health camps.

In comparison with those in the private network hospital, the beneficiaries of RACHI in the public hospital had divergent socio-economic background and accessed various categories of healthcare services at local level. By comparison, majority of them were comparatively representing Schedule Caste category and women, aged between 6 and 45 years. A huge number of them were children and were in working age. They were mostly Hindus in their religious belief while a few of them were Muslims. Most of them studied up to the second standard. They mostly hailed from the extended nuclear and joint families. Occupation-wise, they mostly carried out customary occupations. Some were also employed in the private sector. But at large, most of the patients were housewives. One to two members in the family were earners. They relied on municipal tap-water facility for drinking purpose and other family necessities. They also relied on the public workers to remove the garbage from their houses. Like patients in the private network hospital, they also relied mostly on the private healthcare providers locally to get cure from their diseases including fever, headache etc., for which each of them in the previous year incurred OOOPE burden of around Rs. 1,500. Most of them became aware of the Aarogyasri Insurance Scheme through private hospital/ clinic, PDS dealer, and political leaders.

7.2. Hospitalised Patients:

To comprehend acquaintance of the beneficiaries with this scheme, the study perused the process of service delivery of two network hospitals from two sectors, public and private. It compared their services at two levels such as hospital and patient. At the hospital level, the admission process was miscellaneous to both the categories of patients in both the hospitals. At the time of admission, all patients of both network

hospitals excluding the RACHI patients in the private network hospital were admitted directly into the hospital without pursuing the pre-authorisation process of insurance. The RACHI patients in the private hospital had to get pre-authorization consent from the insurance in order to access inpatient treatment whereas this process had to start after admission for the RACHI patients in the public network hospital. As a result, the RACHI patients of CBH had made several outpatient visits amongst all the patients in both the network hospitals. After admission into the hospital, the service was by and large identical for both the categories' patients in each hospital.

Predominantly, the service of personnel; consisting of doctors, nurses, Mithras and sanitary employees or workers was analysed to differentiate the better healthcare provider under the insurance coverage. In the case of the private network hospital, the service of doctors was efficient owing to the fact that they visited patients approximately twice a day, allocated adequate time in each visit to examine the patients distinctly, and upheld accurate interaction with the patients. As a result, the patients were completely satisfied with the service. However, a few patients only anticipated additional care from their doctors. About the services of nurses, these patients felt that they have been obtaining better service from their nurses right from the admission into the hospital and also experienced their friendliness throughout. Particularly, when they suffered from few petty diseases such as fever, headache etc., during hospitalisation, nurses delivered them extensive care beyond simple medication when compared with counter-group.

The service of Mithra is a prominent service to be examined under this comprehensive healthcare service of the insurance. There are only 26-40% patients out of the total 50% in the private hospital, who availed this service for their admission, diagnostic tests and other purposes. In addition, Mithra' service was also unsuccessful at interceding between patients and doctors, in building confidence in the patients, and being accessible to patients round the clock. Finally, it is also perceived that they availed satisfactory service from sanitary employees, who swept their rooms thrice a day, cleaned bathroom and latrine (toilets) four to five times a day, and provided them

washed bed-sheets and pillow covers daily. As a result, the patients had no grievance against this service.

In comparison to the service of the private network hospital, the services of doctors, nurses, Mithras and sanitary employees or workers in the public network hospital were substandard that led patients to finally have discontented experience with overall service of the hospital. Particularly, it was shown empirically that the anticipated services of patients under this insurance scheme were unmet by doctors who did not provide regular service in terms of making only one visit per day, allocation of very little time in each visit, improper examination and providing suitable medication to the patients, and so on. Few patients underwent experience of hostile and unproductive healthcare delivery by the nurses. Nurses' service was only permitted for providing medicine to the patients when the patients suffered from minor ailments. In addition, the service of Mithra was utterly unseen because there was no straight interaction between Mithras and patients. Their commission was merely to upload all data of the patients on website for getting approval from the Trust.

Every-information in connection with their treatment under the insurance scheme was conveyed to patients through nurses only. From the admission, the patients had experienced unsatisfactory sanitary services. Prevalence of insanitary atmosphere in bathroom and latrine was frequently cited by patients. The evidence thus points to inefficient healthcare service delivery by doctors, nurses, Mithras and sanitary employees in the public network hospital though this hospital was also included in the insurance service. For diagnostic tests, all patients in the private hospital became aware of their diagnostic tests during the admission itself. As a result of that, they were well-prepared physically and psychologically to confront such tests during their hospitalisation. The time taken for each test was below 30 minutes approximately. On the other hand, the patients in the public network hospital became aware of their diagnostic tests only one to two days prior to the test has done. In addition, a few patients stated that their tests took approximately two to three hours to be completed. One important observation made about the diagnostic tests is that there was an

inordinate delay in taking tests at the public network hospital. It is due to the fact that there was a heavy rush of patients and there were no adequate number of machines or equipments to meet the demand. It is observed that the patients had to wait in the queue and wait for the report as well.

One of the inherent shortcomings for patients was OOPE on both medical and non-medical requisitions during hospitalisation. In this regard, medical expenditure included OOPE on diagnostic tests and medicine while non-medical expenditure included OOPE on transportation at the time of admission, food, fruits and tips. For medical expenditure, a huge number of patients incurred OOPE on both diagnostic tests and medicines during their hospitalisation in the public network hospital when compared to the RACHI patients in the private hospital. On the other hand, it was mandatory for the non-RACHI patients in the private hospital to incur themselves OOPE on their diagnostic and medicine and they had a chance in accordance with their necessities to spend money on non-medical expenditure. In the case of non-medical expenses, the expenditure on food, fruit and tips was considered unavoidable necessities for patients in the public hospital. In this hospital, almost all patients incurred OOPE on food, more than three-fourth on fruits and nearly one-fifth on tips, respectively. Even at the time of admission, they used expensive modes of transportation to reach the public hospital when compared to those in the private hospital. In contrary, less than half of the patients in the private hospital spent money on food and fruits. However, there was absence of tips culture in this hospital. Overall, a huge number of patients in the public network hospital spent a lot of money on both medical and non-medical needs, comparatively. Hence, it can be concluded that the patients in the public network hospital had an agonising experience with inefficient service of the personnel and unbearable OOPE burden, as compared to those in the private hospital.

The second level comparison is among the patients of two categories. In the private network hospital, the RACHI patients had to follow certain procedures or references from Mithra through RAMCO to specialised doctors who confirmed inpatient treatment for them. At the time of admission, few of them incurred outpatient consultation fee due

to their unawareness about comprehensive coverage of the insurance, and inadequate service of the Mithras. They had to obtain approval of the Trust for their treatment in the hospital. Once the confirmation was done by the Trust, then they were entitled to access this service for freebie. So, they made several outpatient visits. On the other hand, the non-RACHI patients admitted directly into the hospital as they had been incurred their medical expenditure out of pocket.

In network hospital, the non-RACHI patients had overall received efficient service from doctors, nurses, Mithras and sanitary employees as compared to their counterparts. On the other hand, the RACHI patients obtained better service from the personnel when compared to patients of both the categories in the public network hospital. In the case of medical and non-medical expenditures, as it is mentioned already it was mandatory for the non-RACHI patients to incur all expenditure on their own. For the RACHI patients, even though this medical expenditure was assured by the insurance but few patients were compelled to incur such burden for both medical and non-medical needs at the time of their admission due to their unawareness, and carelessness and slothful service of Mithras. For non-medical expenditure, more number of RACHI patients incurred OOPE on their food while more number of the non-RACHI patients incurred OOPE on fruits. Hence, the RACHI patients were safeguarded money-wise through the insurance scheme but they received inefficient service and incurred a lot of OOPE burden when compared to the non-RACHI patients in the hospital.

For the public network hospital, the juxtaposition had started for patients after their admission was completed owing the hospital provided them homogenous admission. In order to seek admission, the RACHI patients comparatively made more number of outpatient visits than the non-RACHI patients. During the hospitalisation, they had experienced quality sanitary service which meant, having fewer complaints about this service, rather than their counter patients. They also obtained a better service from their doctors as well as nurses than the non-RACHI patients who were still anticipating additional service from their concerned doctors. As it is above stated, they became aware of their tests one or two days prior to the test was completed. For diagnostic tests,

the RACHI patients had confronted an unnecessary delay for scanning test but at the same time also received quality and efficient service for the rest of their tests, comparatively. For OOPE on both medical and non-medical necessities, the RACHI patients went through an experience of little burdensome as compared to the non-RACHI patients who incurred a lot of OOPE encumbrance for the same. Overall, except OOPE on diagnostic tests, the RACHI patients had received better healthcare with a little burdensome of OOPE when compared to the non-RACHI patients in the hospital. Hence, the private network hospital delivered better service to the insured patients as compared to that of the public network hospital. Particularly, the non-RACHI patients than the RACHI patients in the private network hospital and the RACHI patients than the non-RACHI patients in the public network hospital had obtained better service.

7.3. Post-Hospitalised Patients:

The health care service delivery for insured patients primarily consisted of three stages of treatment: pre-hospitalisation, hospitalisation and post-hospitalisation. The pre-hospitalised stage is one of the predominant stages where patients could be misguided resulting into horrendous medical expenditure due to consultation fee and tests which can be avoided if rightly guided. In this stage, they become conscious about their diseases mostly by non-insurance healthcare providers containing RMPs, doctors in Clinic and NGO's healthcare provider, and hospitals of both the private and public sectors. Such patients mostly approached the private network hospitals and sought in-patient care at freebie under insurance coverage. On the other hand, there are few patients who were dependent on the local healthcare providers for a long-standing of one month to five years approximately in order to get cure to their diseases, which was out of coverage of insurance. Among them, five patients incurred this OOPE burden between one to two lakh rupees approximately and were all later admitted to the public network hospitals. Even though insurance ensured the coverage of medical expenditure for the insured patients, but few patients incurred OOPE burden at this stage as a result of being unaware of the insurance service as well as long time trust in their local healthcare provider. But, one-third patients deprived of relied on these local healthcare

providers, approached directly to the network hospitals in general and mostly to the private network hospitals in particular. Finally, those whoever depended on these local healthcare providers a short time were mostly admitted in the private network hospitals as compared to their counterpart.

There was a divergence among patients in connection to their admission in the network hospitals. A considerable proportion of patients who obtained reference from clinic/private or public hospitals and health camps were mostly admitted in the public network hospital. One-fifth of them obtained admission after 6 to 25 times of outpatient visits and among them, one patient had alone made 25 visits. In this regard, it is observed they went through a lot of hardship in terms of financial deficit, breakdown of family affairs, and ruining their health conditions. By comparison, the patients who had references of self and family members mainly approached the private network hospitals to avail free healthcare service under this insurance service. Such patients had not only spent lesser amount of money at local healthcare providers but also made less number of outpatient visits to these network hospitals as compared to their counterpart.

Once the admission was over, there was variance concerning service delivery to the patients by the network hospitals. By comparison, all patients in the private network hospitals started availing healthcare service since the first day of their admission, but a few patients had this service five days after their admission. Not only that, they mostly underwent surgeries 10 days after the admission and, were hospitalised mostly for less than 20 days each. On the other hand, there was an interruption in service for patients in the public network hospital after their admission, in terms of starting to access the services five days to sometimes one month after the admission for few patients. Further, one-fifth of the patients underwent surgery after approximately 15 days to one month after their admission. Eventually, the total duration of hospitalisation for one-fifth of respondents in these public hospitals was between 21 days up to 105 days. It implies that the service in the public hospitals is unimpressive and inefficient.

During the hospitalisation, they were compelled to incur the OOOPE burden in order to accomplish their treatment in the hospital. This expenditure was raised as a result of dearth of diagnostic equipments and medicine in addition to following a culture of tipping to fourth-grade employees. This OOOPE burden extensively appeared among the patients in the public network hospitals as compared to their counterpart. As a part of OOOPE on diagnostic tests and medicine, a considerable proportion of patients in the public network hospitals agonised with this burden of OOOPE due to dearth of diagnostic equipments and supply of medicine. In this regard, two patients of these hospitals even spent OOOPE of between Rs.10, 000 to Rs. 15,000 each for their medicine during their hospitalisation. But, none of their expenditures were reimbursed to them either by the concerned hospital or by the Trust. By comparison, a tiny proportion of patients in the private hospitals spent OOP money on their diagnostic tests and medicine as a result of inappropriate monitoring mechanism on the service delivery to the insured patients. A higher proportion of patients in the private network hospitals than those in the public network hospitals spent OOP money on medicine at the time of their discharge from the hospital. It implies that OOOPE expenditure during the hospitalisation was an inescapable encumbrance for the insured patients in both the sectors' network hospitals. Overall, the public network hospitals led the insured patients to face greater problems during the hospitalisation due to dearth of proper equipments and medicine supply alongside other unavoidable non-medical expenditures.

Hospitalisation stage also affected or determined the patients' conditions in the post-hospitalised stage, which has been taken into consideration as a part of comparison between these sectors' network hospitals. Such aspects encompassed post-hospitalised visits, financial support for purchasing medicine, fluctuations in saving and borrowing patterns after hospitalisation, and grief from ailments of throat pain, stomach ache, headache etc. If patients were affected as a result of conditions of unbearable OOOPE, financial hardship, and grief from illness after hospitalisation, then, the insurance service or service of network hospitals etc. are considered inefficient healthcare providers. The public network hospitals allowed the insured patients to have the post-hospitalised check-ups immediately after hospitalisation and also allowed few of them

to have more number of visits. In this regard, few patients made visits totaling 21 to 30 times approximately. On the other hand, the private network hospitals only permitted the patients to have such service after two-six months of their discharge and allowed these patients to have this service for only one to five times. In addition, there was more number of patients who discontinued work for a while after discharge from the private network hospitals whereas few of such patients after discharge from the public network hospital discontinued work for a long period of time because the public network hospitals had also a huge number of non-earners included students and housewives, etc., than their counter group. In this regard, few patients from the public hospital discontinued working for one year approximately due to improper service of the hospital.

In a case of financial support for medication of the post-hospitalised, such patients in the public network hospitals had relied extensively on their family members due to their inability to work. By comparison, such patients from the private network hospitals were mostly self-reliant since they returned to work immediately after a short time of rest at their homes. Even though, a huge number of patients from the hospital discontinued to work for a long time period of two-three months than those of the public network hospitals. One of the prominent complications that insured patients underwent at this stage was fluctuations in savings and borrowing patterns after hospitalisation. Among the aforementioned three stages of pre-hospitalisation, hospitalisation and post-hospitalisation, a huge number of patients borrowed money during their hospitalisation in order to meet certain ignored and neglected medical and non-medical necessities by the network hospitals. Such patients hugely appeared in the public network hospitals due to incomprehensive coverage and improper monitoring of the insurance, and dearth of required machinery. But, only few patients continued the culture of borrowing from moneylenders after the hospitalisation. Such patients were in relatively higher proportion in the private network hospitals when compared to those in the public network hospitals. Hence, inadequate service of the public network hospital compelled the insured patients extensively to go for borrowing money from moneylenders than their counterpart.

In the case of savings, one-fifth of the patients in the private network hospitals and more than one-fifth of patients in the public network hospitals had saved a little amount of money monthly as well as yearly prior to the coverage of the insurance. After coverage of the insurance, there had been fluctuations in their savings in terms of stopped savings, declined savings, increased savings, and newly started savings. After hospitalisation, there were no noticeable changes occurred in savings of the insured patients in the public network hospitals while there were tremendous fluctuations taken place in the savings of the insured patients in the private network hospitals. According to few patients, such fluctuations occurred among the patients after being discharged from the private hospitals due to increased consumption level of their families along with decline in earnings of their families in this stage.

Finally, it is also acknowledged that there was curtail of expenditure on their basic needs and habits after hospitalisation. Those needs and habits included food, drinking alcohol, smoking and attending parties, etc. Such patients were probably equivalent to both sectors' network hospitals. In addition, a small proportion of patients had suffered from minor diseases caused by improper treatment of the network hospitals at this stage. Three-times higher of such patients pertained to the public network hospitals than those in the private network hospitals. Hence, the public network hospitals overall delivered inefficient healthcare service to the insured patients as compared to those in the private network hospitals. Further, it also caused for unbearable OOOPE burden among the insured patients during the hospitalisation, who were still dependent on their families for purchasing their medicine and suffering from ailments in the post-hospitalised stage.

These insured patients had variant perceptions regarding insurance and service of the network hospitals based on their experiences as hospitalised and post-hospitalised patients. In the case of post-hospitalised patients, they had divergent perceptions towards inception of this insurance scheme. By comparison, the patients in the private network hospitals perceived that this insurance was initiated with the motive of being pro-poor and rolling out very effectively whereas a little higher proportion of the patients in the public network hospitals felt that it was for political gain and so, required

certain modifications to become effective as healthcare provision for people underneath poverty line. In addition, they had various perceptions towards the services of the hospital also. The vital services of the network hospital generally are service of hospital admission, service of doctors, service of nurses and service of Mithras, which were measured by using a scale that captured notions of being complete satisfaction, normal satisfaction, bad experience and no comment.

For the post-hospitalised patients, more than three-fourth of the patients in the private hospitals stated that they are completely satisfied with these four services. Among them, such patients were hugely satisfied with the services of doctors and nurses, but there were less number of patients who had this experience with the service of Mithra. On the other hand, such patients in the public network hospitals were nearly half or more than half. It implies that the public network hospitals could not make all insured patients satisfied completely, and nearly half of them had experiences covering normal satisfaction and defective service. In addition, both categories of hospitalised and post-hospitalised patients stated that the service of Mithra is worst and must be upgraded if the Trust wants to deliver efficient healthcare service through its network hospitals. The hospitalised patients also had various perceptions or experiences with these four services in the hospital. By comparison, almost all patients in the private network hospital stated that they are completely satisfied with these four services. Among them, a higher proportion of patients had this experience with the service of doctors while only a small proportion of them with the service of Mithras. On the other hand, for the patients in the public network hospital, they experienced normal satisfactory service with these four providers in the hospital due to unaccountability of personnel, dearth of required equipments and infrastructure in hospital. Among them, a considerable proportion of the patients stated that they are completely unaware of the Mithra service in the hospital, as well as less satisfaction with the service of hospital administration.

The study highlights the fact that the private healthcare which gradually emerged as an efficient system of health care in India threw the common man as an excluded category until this insurance was launched, as far as health particularly life threatening diseases

are concerned. While the public hospitals failed to meet the needs, the private hospitals remained out of reach due to unbearable costs. At this juncture, the state's inclusive policy made the insurance as an inclusive scheme of healthcare for the BPL category. The insurance scheme that is restricted to the BPL excluding initially those above poverty line does not discriminate any person on the basis of caste or class or gender or religion. Thus, the beneficiaries of RACHI, as the study has revealed, are found to have come from all kinds of backgrounds. In this respect, RACHI is an inclusive scheme that has once for all obliterated the exclusivity so far as health care is concerned. The private hospitals which excluded the poor no longer deny access to the poor once they are covered by the RACHI. Though the public hospitals that earlier could not handle certain categories of diseases are able to serve efficiently under the RACHI coverage. Thus, the public hospitals became inclusive as much as the private hospital due to the inclusive nature of the RACHI. The study has revealed the fact that the RACHI patients have been able to get better treatment than the non-RACHI patients in public hospitals. However, the non-RACHI patients have been able to get better treatment when compared to the RACHI patients due to certain procedural constraints and partially failure of Mithra' service in the private hospital.

As far as OOPE is concerned; the RACHI has become a scheme of 'passive inclusion' for the BPL. The beneficiaries feel the burden of OOPE due to unexpected spending of money on diagnostic tests, consultation fee paid to the specialists etc. during hospitalisation. The expenditure in the post-hospitalisation stage, which is purchasing of medicines and consultation, has become a burden. In this way, the RACHI is an 'unfavorable inclusion'. Poverty continues to hurt them, leaving expenditure on health a huge burden. The BPL people are included only for sometime and not for the entire life. One can term the RACHI a total inclusive policy when the BPL's health care is assured for the full lifetime of beneficiaries. The private hospitals though reduced the OOPE of the non-RACHI patients compared to those of the RACHI patients and public hospital patients, their patients are not able to regain their economic standards. They are unable to make savings, clear the earlier debts etc. In this way, the RACHI patients of the public health care are in a better position. Thus, it becomes questionable which category

of hospitals are more inclusive in terms of restoration of complete health is concerned. But, so far as satisfaction is concerned, the rate is high with reference to private hospitals. Therefore, given the scenario one may conclude that RACHI perhaps can be classified as a scheme of ‘unfavorable term’ according to the terminology of Amartya Sen (2000:28-29).

Suggestions:

In light of the above, the below suggestions are made for improving healthcare service provision:

- ❖ The government cannot ignore the importance of improving public hospitals with adequate financial support; number of personnel required who should be accountable for each issue in the hospital as is the case in private hospitals as it would be unpredictable about how long this insurance scheme will be sustained.
- ❖ The public hospitals must not entertain any corrupt practice and delay service by the personnel in the hospital.
- ❖ In the public hospital, the medical staff must be present on time and must change their motive of delivering their service to the insured patients.
- ❖ With the financial assistance given by the insurance for treatment of insured patients, the public hospitals should acquire advanced equipments and enough medicine supply which can be used for diagnostic service and reduced medical burden of patients, and thus OOPE can be reduced or eliminated.
- ❖ When public hospitals are well maintained, there will be no need to depend on private players of health care for rolling out of public healthcare services.
- ❖ Each private network hospital must be completely accountable to respective authority appointed by the government and strictly follow the regulations agreed upon.

- ❖ Mithras should take feedback daily from the patients in order to meet their needs and expectations in the case of the private network hospital and should directly contact the patients in the public network hospital in order to deliver efficient service to them.
- ❖ The Trust or the government must extend its financial assistance to the patients during hospitalisation to meet needs of their families if such patients are breadwinners of their families.
- ❖ The Trust should encourage patients of Above Poverty Line to bear at least half of their medical expenditure and the rest of half must be borne by the government under this insurance scheme.
- ❖ The Trust should ensure its team properly oversees the insurance service through the network hospitals and also on healthcare service to the insured patients in the hospitals in order to eliminate OOPE burden of the insured patients, thus the insurance scheme will be appreciated for comprehensive coverage of health insurance scheme.
- ❖ If the Trust finds any network hospital causing OOPE burden to the insured patients, the Trust shall take proper action immediately against that hospital. The OOPE must be reimbursed to the patients concerned at the time of discharge.
- ❖ The government should consider establishing pharmaceutical shops outside the hospital to provide medicine at concessional rates ranging from 50% to 60% and sometime free for patients Below Poverty Line after hospitalisation under the insurance coverage in order to reduce extra-OOPE burden in the post-hospitalised stage.
- ❖ The government should also allow patients to have free-transportation through the public transportation, bus or train, for hospitalisation as well as for post-hospitalisation visits without payment of travel cost, in order to reduce the burden of OOPE for insured patients.

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**First Schedule-I
(Hospitalised patients)**

Respected Sir/ Madam,

This is Ravi Kiran Runjala pursuing PhD course in University of Hyderabad. As part of agglomeration of empirical information, I have selected a field study on those patients who are beneficiary and non-beneficiary of Rajiv Aarogyasri Community Health Insurance (RACHI). So, kindly cooperate with me.

Permanent Address

-----Dist.

Patient type (RACHI/Non-RACHI)

Phone Number

Schedule No.....

Type of Hospital (Public/Private)

I. Introduction of the Respondent:

1. Name of the Respondent : _____
2. Age : _____
3. Gender : _____
4. Caste : _____
5. Sub-caste : _____
6. Religion : _____
7. Married/Unmarried/Divorce : _____
8. Education : _____
9. Occupation : _____
10. Permanent Address : _____
11. Head of the family : _____
12. Head's Occupation : _____
13. Post-surgery of pre-surgery condition : _____
14. Disease or illness : _____
15. Type of the family : _____

II.Details of the family:

S.N	Name	Age	Sex	Education	Married	Occupation	Earns	Disease (last year)	Treated Doctors	Health expenditure in last year

III. Economic Status of Respondent's Family:

16. Do you have own House?

a) Yes b) No

17. If yes, are you staying in that house?

a) Yes b) No

18. Do you have any property?

a) Yes b) No

19. If Yes,

S.N	Items	Cost of Property	Lease Out/lease in	Yearly Income
1	Shop			
2	Dry Land			
3	Wet			
4	Plat			
5	Other			
	Total			

IV. Basic Healthcare Service:**A. Expenditure over Basic Needs of the Family:**

20. How much do you spend for daily needs in a month or for a year?

	Item	Spending	Declining due to health expenditure
1	Food		
2	Clothes		
3	Rent		
4	Water		
5	Electricity		
6	Education		
7	Medicine		
8	Other Expenditure		

38. From whom did you borrow that money?

a) Money Lender

b) Friend

c) Family members

39. For what purpose did you borrow that money?

40. If it is for health problem for which health problem did you spend that money?

B. Before Approached to RACHI

41. Did you borrow money for treatment of your disease prior to approach RACHI?

a) Yes

b) No

42. If yes, how much?

43. If yes, who did lend you money?

a) Local Money Lender on interest?

b) Friends

c) Family members

d) Sold assets

e) Spend saved money for different purpose

f) Bank under the crops loans

44. Did you pay interest on borrowed money?

a) Yes

b) No

45. If yes, How much?

46. If yes, did you repay that amount yet?

a) Yes

b) No

47. Is your family getting any disturbance because of it?

a) Yes

b) No

48. If yes, what are them?

C. During Hospitalisation

49. Have you borrowed money for purpose of present hospitalisation? (Include borrowed money and interest)

a) Yes

b) No

50. If yes, for what purpose did you borrow?

51. If no, did you plan to borrow money to meet needs of your hospitalisation?

a) Yes

b) No

c) Borrowed money but not on interest

52. If yes, from whom?

53. Is it on interest? (Includes Interest rate)

a) Yes

b) No

54. For what purpose, do you want to spend that money?

a) Food

b) Medicine

c) Transport

d) Bribe to doctor/nurse

e) others

55. Does this include family needs also?

a) Yes

b) No

c) Not on interest

56. How much money do you want to assign for basic needs of your family?

S.N	Earning capacity of a person in the family	How much monthly
1		
2		
3		

57. How much do you repay that money?

a) Sell asset

b) After got complete cure than start working

c) Not yet decided

VI. Loss of Working Days:

58. Did any of your family members suffer from lose earning?

a) Yes

b) No

59. If yes, how much per person?

60. How much per person in family lost earning per day?

VII. Awareness about Scheme:

61. How do you know about RACHI service?

- a) Friend b) Family c) Neighbors
d) Newspaper/Media

62. When did you know about it?

- a) After admission into the hospital
b) Before admission into the hospital

63. Do you know that how many members in a family are supposed to be covered under this scheme?

- a) Yes b) No

64. If yes, specify?

65. if it is non-beneficiaries, can you share your opinion towards it?

VIII. DISEASE-Before RACHI:

66. How long have you been suffering with the disease in monthly or yearly?

67. Have you visited any hospital for treatment of your disease before RACHI service?

68. If yes, what are the hospitals treatments?

S.N	Name of the Hospital	Treated Doctors and their Qualification	How much you sent	Inpatient	Outpatient	Time period	Satisfaction
1.	Hospital: Text: 1. 2.	Name: Qualification:					
2	Hospital: Text: 1. 2.	Name: Qualification:					

a.Highly satisfied

b. satisfied

c. Not satisfied

d. Don't Know

69. How much did you spend over this disease in total?

Amount:

IX. Network Hospital (Present Treatment):

70. Name of the Hospital :

71. Date of admitted into the hospital :

72. What is Status of the Disease?

a) Very serious

b) Not very Serious

c) After surgery
about leaving for home

73. Had you taken RACHI service before to this same disease?

a) Yes

b) No

74. If yes, where did you have taken treatment?

a) Private

b) Public

75. How much days, had you been hospitalised in the hospital?

76. Did you spend any amount of money over there?

a) Yes

b) No

77. If yes, how much did you spend?

78. for what purpose?

X. Process of Admission into the hospital:

79. Who did refer you to this network hospital?

a) By health camp

b) Directly he or she approached to the network hospital for treatment

c) By family members

d) Suggestion of neighbors

e) By friends

f) Unknowing person who have already taken service of RACHI

80. Whom did you meet initially to get admission into the network hospital?

a) RACHI Mithra

b) Hospital Staff

c) Doctor

81. How many days did you wait to get admission in the hospital as inpatient?

- a) Within a day
- b) After 2-3 days
- c) 4-5 days
- d) More than five days, specify_____

82. Do you want to share your experience when you just interacted with hospital to seek admission? (like how much time they let you wait)

83. Did you spend any amount of money at the time of admission?

- a) Yes
- b) No

84. If yes, how much and for what purpose did you pay?

85. Did you face any problem regarding to getting admission into hospital?

86. Did they provide you necessary information regarding your treatment?

- a) Yes
- b) No

87. Did the hospital administration support/assist you always since your admission?

- a) Yes
- b) No

88. Did you face any pressure from administration to pay for service provided by hospital?

- a) Yes
- b) No

89. If yes, what are those services?

90. Did you get bed immediately?

- a) Yes
- b) No

91. If no, Why?

92. Did you get food from hospital without charge?

- a) Yes
- b) No

93. If yes, how much time, is it in a day?

94. Did you get any problem regarding to food?

95. Would you like to make a comment on administration of hospital?

XI. Sanitation in Hospital:

96. Do employees clean your room year day?

a) Yes

b) No

97. If no, why once in days?

98. Do they clean the floor with phenol every day?

a) Yes

b) No

99. If No, Why?

100. Do they clean bath-room every day?

a) Yes

b) No

101. If no, Why?

102. Are you getting any problem in availing of bathroom?

a) yes

b) No

103. If yes, what kind problems are them?

104. Are they providing you clean bed-sheet every day?

a) Yes

b) No

105. If no, why?

106. Do you want to make comment over sanitation condition of the network hospital?

XII. Relation with Mithra:

107. Do you know Mithra?

a) Yes

b) No

c) No Idea

108. Did Mithra help you regarding to your admission?

a) Yes

b) No

109. Does Mithra behave with you friendly?

a) Yes

b) No

110. If no, Why?

111. Does Mithra come and ask you about your health condition every day?

a) Yes

b) No

112. If no, why?

113. Does Mithra available to you for every time?

a) Yes

b) No

114. If no, Why?

115. Does mithra assist you during your diagnostic tests which held in the hospital?

a) Yes

b) No

116. If no, Why?

117. Does Mithra note-down all complaints you lodged against hospital?

a) Yes

b) No

118. If yes, what are them?

119. If no, Why?

120. Do you think that Mithra is worthy enough to solve your problems?

a) Yes

b) No

121. If No, Why?

122. Does Mithra able to communicate with doctors concerning about your health problem?

a) Yes

b) No

123. Does Mithra or Hospital disclose the information about money that RACHI trust has sanctioned for your treatment?

a) Yes

b) No

124. If yes, how much is it?

125. If no, what is the reason?

126. Does Mithra given you any suggestion about how to behave in hospital?

a) Yes

b) No

127. If yes, what are they?

128. Can you make any suggestion or comments on Mithra performance in the network hospital?

XIII. Relation with Doctor:

129. Who are the doctors presently treating you?

	Name of the doctor	Qualification of doctor	Your opinion
1			
2			
3			
4			

130. How much time does doctor spend with you every day?

131. How many times per a day does doctor examine you?

a) Morning and evening

b) Morning only

c) Evening only

d) Afternoon

132. Does doctor ask you about your condition before prescribing medicine or refer to any further treatment?

a) Yes

b) No

133. Does doctor behave with you friendly?

a) Yes

b) No

134. Do you trust in medicine prescribed by doctor?

a) Yes

b) No

c) Not yet started

135. If no, why?

136. Are you expecting some more care from doctor's side?

a) Yes

b) No

137. If yes, what kind of care are you seeking?

138. Did you pay any amount of money to doctor during surgery?

a) Yes

b) No

139. If yes, how much did you pay?

140. Did you find any variation after bribe or before bribe?

a) Yes

b) No

c) No Idea

141. Did doctor assure you about care of your disease after surgery?

a) Yes

b) No

c) No comment

142. Did doctor meet you after surgery to know about your health?

a) Yes

b) No

c) No comment

143. Have you found any change in doctor's treatment from pre to post-surgery?

144. After surgery, did you get relief from your pain or problem?

a) Yes

b) No

145. Did you get the discharge date?

a) Yes

b) No

146. Did doctor suggest you for post-surgery outpatient check-up?

147. Could you make any comment on doctor's service with regard to your treatment?

XIV. Relation with Nurses:

148. Did they start your medication from the first day onwards?

a) Yes

b) No

149. If No, why?

150. Are nurses behaving with you friendly?

a) Yes

b) No

c) No comment

151. Do they respond you in your critical condition?

a) Yes

b) No

c) Sometimes

d) Responds immediately when you pay bribe to her

152. In this those critical condition, what did they do?

153. Are they ever behave with you rudely?

a) Yes

b) No

154. If yes, what is the reason?

155. Do nurses demand you ever for money?

a) Yes

b) No

156. If yes, how much did they demand?

157. Do you feel that paying would change behaviour of nurse?

a) Yes

b) No

XV. Diagnosis Service:

158. Have you had any diagnostic tests before coming under fold of RACHI?

a) Yes

b) No

159. If yes, what are those tests?

S.N	Test	Date/mon/year	How much for each test	How many times	In total, how much money
1					
2					
3					
4					
5					

160. After getting covered in the RACHI, did you go for any diagnostic test?

a) Yes

b) No

c) Few

161. If yes, what are they?

S.N	Name of the Test	Free/pay	If paid, do you think that money would be reimbursed to you	How many days before doctor/nurse told you about the test?	How much time it has taken in each time	Your suggestions/ opinion on it
1						
2						
3						
4						
5						

162. Did you feel that you have faced discomfort or discrimination while you were undergoing with such tests in network hospital?

a) Yes

b) No

163. If yes, what are those problems?

164. Do you feel that is consumed huge time of your for diagnostic tests?

a) Yes

b) No

165. If yes, explain?

166. Would you like to give me suggestions for better diagnostic service of network hospital?

XVI. Expenditure:

167. Did you spend money from your own pocket for transport to hospital from home at the time of admission?

a) Yes

b) No

168. If yes, how much?

169. Items used during hospitalisation and money spent on them?

S.N	Items	Cost	Each Day
	Food		
	Fruit		
	Transport		
	Cloth		
	Bribe		

170. Are you getting all medicine at free of cost?

a) Yes

b) No

171. If no, why?

- a) Some medicines are not available in the hospital
- b) Medicines are not free from hospital medical shop
- c) No comment
- d) Other specify

172. Are you spending money over medical purpose?

a) Yes

b) No

173. If yes, how much did you spend until now?

174. If yes, what are the medical spending, list them out in table below?

S.N	Medicine	Each day	Cost
1			
2			
3			
4			

175. Did you give money to any person in the hospital?

a) Yes

b) No

176. If yes, for whom have you given?

- a) Doctor
- d) Gate keeper

b) Nurse

c) Ward-boy

177. For what purpose did you pay them?

178. Altogether, how much did you spend from your pocket since hospitalisation to until now?

XVII. Opinion:

179. Are you satisfying with service of hospital administration?

a) Highly satisfied b) Satisfied c) No satisfied d) No comment

180. Are you satisfying with service of doctors?

a) Highly satisfied b) Satisfied c) No satisfied d) No comment

181. Are you satisfying with serviced of nurse?

a) Highly satisfied b) Satisfied c) No satisfied d) No comment

182. Are you satisfying with service of Mithra?

a) Highly satisfied b) Satisfied c) No satisfied d) No comment

183. Do you think that it needs modification for better service?

a) Yes b) No c) No Comment

184. If yes, why?

XVIII. Comment or Suggestion if you have any?

Schedule-2

(Post-Hospitalised Beneficiary of Aarogyasri Community Health Insurance)

Date:

Respected Sir/ Madam,

This is Ravi Kiran Runjala pursuing PhD course in University of Hyderabad. As part of agglomeration of empirical information, I have selected a field study on those patients who are benefited by Rajiv Aarogyasri Community Health Insurance (RACHI). So, kindly cooperate with me.

I. Basic Information of Beneficiary:

1. Wing Name : _____

2. Name of the Slum : _____

3. Name of the Respondent : _____

4. Age : _____

5. Gender : a) Male b) female

6. Marital Status :

a) Married b) Unmarried c) Divorced d) Widow
e)Widower f) Other Specify

7. Religion

a) Muslim b) Christian c) Hindu d) Sikh e) Buddhist
f) Other Specify

8. Caste

a) SC b) ST c) BC d) OC

9. Sub-Caste :

10. Occupation :

11. Are you literate? : _____

12. Where did you study?

- a) Private b) Government c) Semi-Government

13. Up to which standard did you study?

S.N	Educational Qualification	Yes/No	Private/Govt.
1	Primary		
2	Secondary		
3	Graduation		
4	Post-Graduation		
5	Technical (B.Tech and M.Tech)		
6	MBA		
7	M.Phil		
8	P.hD		

14. How many wives/husbands apart from the present do you have?

- a) One b) Two c) Three d) Four

15. How many marriages do you have in your whole life?

- a) Only one b) Two c) Three d) Four

16. Who is the head of your family?

- a) Himself, or Herself b) Husband c) Father d) Mother
e) Brother f) Sister g) Other Specify

17. If the subject is not the head of the family, what is occupation of head of your family?

18. Type of family (based on Census Data, NFHS and Anthropological Data)

- a) Nuclear b) Nuclear but Broken c) Joint d) Nuclear
e) Other Specify and Extended

19. How many languages do your family members speak for communication?

- a) Telugu b) Hindi c) Urdu d) English
e) Others specify

20. What is your mother tongue?

- a) Telugu b) Hindi c) Urdu d) English
e) Others specify

21. What is your colloquial language in this slum to speak for communication?

- a) Telugu b) Hindi c) Urdu d) English
e) Other specify

22. Basic Information of all members in the family (excluding subject)

S.N	Name of the family member	Age	Gender	M/UM/D/	Standard	Occupation	Monthly pay (in Rupee)

M=Married, UM=Unmarried, D= Divorce (as per Kuppuswami)

II. Healthcare Service and Sanitation:

Health Facilities:

23. Do you have the following health facilities in your area or slum?

- a) PHC b) CHC c) Hospital d) ICDS (ANM)
e) RMP

24. Which health facilities would you like to prefer to avail of?

- a) Private b) Public

25. Do you suffer from / any health problem in the last two years? (Including respondent and his/her family)

- a) Yes b) Public

26. If yes,

S.N	Name of Disease	Type of healthcare facility availed a. Public b. Private	If private (local RMP, Clinic, Hospital)	government	Level of satisfaction

A-Not satisfied, B-Partially satisfied, C- Complete Satisfied, D-No Comment

Sanitation:

27. What kind of water facilities do you have and how you are using them according to your family need?

- a) Tap Water b) Bore-well c) Both

28. Do you buy water?

- a) Yes b) No

29. If yes, for what purpose are you using it?

- a) Drinking Purpose Only b) Household and Domestic Purposes c) Both

30. How much do you pay for water per liter?

Time	How many liters	How much money
Per day		
Per month		

31. Management of daily waste?

- a) Government employee b) Common Dustbin in their slum c) Individual Disposed

32. Do you pay for this daily waste management?

- a) Yes b) No

33. If yes, How much (Rs)?

34. Where do you have latrine?

- a) At home b) Outside (common structured latrines) c) Open
d) Others specified

III. Acquired Assets:

35. Do you own a house?

- a) Yes b) No

36. If yes, are you staying in the same owned house?

- a) Yes b) No

37. Are you staying in rented house?

- a) Yes b) No

38. What type of house are you staying in? (Included both rented and owned houses)

- a) House/Flat with two bed rooms (with kitchen and bathrooms)
b) House/Flat with two pucca rooms (with kitchen)\
c) Hose/Flat with one pucca room (with kitchen)
d) House/Flat with one pucca room (without kitchen)
e) Slum/Jhuddi Jhopri/Kutchra

39. List of things in the house

S.N	Valuable things of the house	Yes	Number	Tentative cost
1	Car/Jeep/Van			
2	Colour or B/W TV			
3	Telephone? mobile Telephone			
4	Electric Fan/Cooler			
5	Bicycle			
6	Radio/Transistor			
7	Scooter/Motor Cycle			
8	Fridge			

40. Do you or your family have other properties?

a) Yes

b) No

41. If yes, specify

S.N	Other property	a)Yes or b) No	Size	Tentative Cost (present)
1	Dry Land			
2	Wet Land			
3	Plot			
4	Shop			
5	Others			

IV. Basic Information about BPL Card in India

42. Do you know what the BPL/Ration/PDS card is?

a) Yes

b) No

43. Do you have this card?

a) Yes

b) No

44. Do you know what the colour of this card is?

a) White

b) Green

c) Blue

d) Red

e) Pink

45. What kinds of benefits are you getting through PDS?

S.N	Items	Yes	No	In Kilos or in liters
1	Kerosene			
2	Oil			
3	Rice			
4	Wheat			
5	Sugar			
6	Dhal			
7	Others Specify			

46. Did you even use this card for any purpose other than PDS?

a) Yes

b)No

47. If yes, what kind of services do you avail of, now?

- a) Health services of public sector through public hospitals
- b) Get membership in Micro-Finance (SWOCRA)
- c) Get loans from bank
- d) Aarogyasri Scheme
- e) Getting money from local lender (describe it clearly with short notes)
- f) Education sector
- g) If others specify

V. General and Health Expenditure of a family:

48. General Expenditure (monthly or yearly)

S.N	Items	Regular Expenditure	Charged Expenditure due to treatment
1	Food		
2	Dress		
3	Religious Festivals		
4	House Rent		
5	Education		
6	Municipal Tax		
7	Electricity		
8	Water Monthly		
9	Health Expenditure		
10	Other Specify		

49. Health Expenditure (this year, if not, last year) (excluded respondent)

S.N	Items	Amount (in rupees)
1	Transport	
2	Outpatient	
3	Doctor Consultation	
4	Tests(Diagnosis)	
	ECG	
	X-ray	
	BP	
	Blood	
	Scanning	
	Other Tests	
5	Bribe	
	Doctor	
	Nurse	
	Ward Boy	
	Gate man	
6.	Medicine	
	Total Amount per year	

VI. Awareness of Rajiv Aarogyasri Community Health Insurance Scheme (RACHI)

50. Did you hear about this scheme? (If Q 43 is answered option do not ask this question)

- a) Yes
- b) No

51. If yes, how did you come to know Aarogyasri Health Insurance?

- a) Health camps of network hospitals
- b) Local health services providers (ANM, so on)
- c) Local political leaders
- d) Family members
- e) Friends
- f) Pamphlet Distribution
- g) Public address system/Mike announcement in auto
- h) Dandore/bear of tom-tom
- i) Playing of audio-visual media (cassettes, audio CD, and DVD's)
- j) Scroll in local cable network
- k) News/advertisements in local details
- l) Posters
- m) Banners
- n) SHG Meeting
- o) Village Meeting
- p) any other hospital
- q) Neighboring family members
- r) Through network hospital (after admitted into the hospital)
- s) Local clinics

52. by whose help, you got this health card?

- a) Local health workers (ANM, etc)
- b) Anganwadi worker
- c) PDS
- d) Municipality worker
- e) Local Political Leaders
- f) Others Specify

53. Did you pay bribe for this card?

- a) Yes
- b) No
- c) No response

54. If yes, how much did you pay?

55. To whom, have you paid?

- a) Health workers (ANM, etc.)
- b) Local Political Leaders
- c) Anganwadi Workers
- d) PDS
- e) Others Specify

56. Do you know how many members are supposed to be covered under this scheme?

- a) Yes b) No c) No Idea

57. If yes, How many

- a) All family members (Irrespective of size of a family)
b) Up to four members in a family
c) Up to six members in a family
d) Up to ten members
e) Others Specify

58. if no, why?

- a) No need to know it
b) I don't have right to ask about
c) This is a government matter so it is better not to involve in it
d) I want to know but don't know whom shall I ask for?
e) I tried to ask of it but hospital or other official rejected my request
f) No Comment

59. How many persons in your family are ensured to healthcare under this insurance scheme?

- a) Yes b) No

60. If yes, how much it is?

SN	Specific Details	
1	Number of persons in your family are covered under this insurance scheme	
2	Amount	
3	Time Period	

VII. Condition of disease prior to surgery:

61. For which disease, did you undergo surgery?_____

62. How long, have you been suffering with this disease?

- a) Days_____
- b) In months_____
- c) In Years_____

63. How many years prior to surgery, have you used medicine?

- a) Days_____
- b) In months_____
- c) In years_____
- d) Specify if it is more than five years_____

64. How did you aware of your disease?

- a) In network hospital after admitted into the hospital
- b) In health camp conducted by network hospital
- c) By local family doctor (RMP/local clinic/government hospital/private hospital) (Dr. Name_____ and Qualification_____ if possible)
- d) If any specify_____

65. Prior to fallen into coverage of insurance, how much money did you spend on treatment of your disease?

S.N	Basic Information about treatment	An average money he/she spent on the disease per each time	How many times you went for surgery
1	Doctor's Consultation fee		
2	Doctor's name and Qualification		
3	Medicine		
4	Tests		
5	An average money overall he/she spent		
6	Others specify		

66. How many days and how much money you had lost by not earning due to sickness before surgery?

- a) Days_____
- b) Average money_____
- c) Though I had been suffered but also continued working daily for my livelihood

67. Did this health expenditure affect your family basic need?

- a) Yes
- b) No

68.If yes, what are these?

- a) Food
- b) Education
- c) Dragged your family into vicious circle of debts
- d) Dress
- e) Religious Expenditure
- f) If others specify

VIII. Surgery in Network Hospital:

69. Do you know of network hospital connected with RACHI?

- a) Yes
- b) No

70. Name of the hospital that was provided you treatment?

71. How many times, did you go for check-ups or treatment for your disease in network hospital prior admitted into the hospital?

- a) Only one time
- b) 2 to 3 times
- c) 4 to 5 times
- d) if more than five, specify its number_____

72. What type of hospital is it?

- a) Super Specialty Hospital
- b) Specialty Hospital
- c) Government General Hospital
- d) Government Area Hospital
- e) Other Specify

73. With whose help, did you approach this hospital?

- a) Family doctor/RMP/ANM
- b) Suggested in Health Camp
- c) ANM
- d) RMP
- e) Local Clinics
- f) Relatives or Family Members
- g) He or she directly approached the hospital

74. When did they start treatment for you?

- a) Within the same day
- b) Next day
- c) Two days later
- d) Three days later

75. How many days later, did you undergo surgery since your admission into the hospital?

Ans_____

76. How many days overall, did you have hospitalisation for treatment of your disease?

Ans_____

77. Did you pay for service of hospital when you being inpatient?

- a) Yes
- b) No

78. if yes,

S.N	Items	Amount (Rs)
1	Transpiration	
2	Outpatient	
3	Doctor Consolation	
4	Diagnostic Tests	
	ECG	
	X-ray	
	BP	
	Blood test	
	Scanning	
5	Bribe	
	Doctors	
	Nurse	
	Ward Boys	
	Gate men	
6	Medicine	
	Total amount per year	

79. Where did you get the medicine as inpatient?

- a) Hospital sponsored it free of cost
- b) Took it from medical shop outside by paying from out of pocket
- c) Got some medicine within the hospital by paying on my own
- d) Some medicine you got from hospital on free of cost and for costly medicine you went for outside medical shops by paying from own pockets
- e) Others Specify

80. Did you pay any amount of money to doctor for extra care when you were inpatient in hospital?

- a) Yes
- b) No

81. If yes, how much do you paid?

82. Has any money asked from you by the hospital/doctor/ any other during the course of surgery when you were in network hospital as inpatient?

- a) Yes
- b) No

83. If yes, how much has been asked for?

Rs. _____

84. Did you pay?

- a) Yes
- b) No

85. If no, do you find any change in their treatment or behaviour?

- a) Yes
- b) No

a) Yes b) No

87. Have you ever referred to any diagnostic center or any hospital for diagnosis by the network hospital?

a) Yes b) No

88. For what service you have been referred to?

Ans, _____

89. If yes, have you paid there?

a) Yes b) No

90/. If yes, how much it was _____

91. Did you get medicine which provide by hospital for free of cost?

a) Yes b) No

100. If yes, how many days the medicine would be?

a) days_____

b) Months_____

101. If no, did you pay money for it?

a) Yes b) No

102. How much it is?

Ans, _____

103. Did they suggest any further check-up?

a) Yes b) No

104. If yes, what is it?

Ans. _____

105. Are you still continuing medicine prescribed by doctor at the time of discharge?

a) Yes b) No c) Yes, but that period was completed

106. If yes, how much money are you spending on medicine every month?

Ans. _____

107. How do you get financial support to buy medicine every month?

a) My own
b) Family supports for it
c) Friends and relatives support me financially
d) Donor Supports

108. How many days of wage or working days are you losing due to this treatment even now also?

a) Days _____
b) Months _____

109. How this money is affecting on your family ?

- a) Saving in your family
- b) Basic needs of your family
- c) Your children education
- d) If other, specify_____

110. Did you suffer from any other disease after the surgery?

Range:

- a) Name_____
- b)Time period_____

111. During this post-surgery period, how are you taking treatment for this disease (if it is other disease)

S.N	Treatment	An average money he/she spent on the disease per 3each time	How many times you went for it
1	Doctor's consultation fee		
2	Doctors' name and qualification		
	A		
	B		
	C		
3	Medicine		
4	Test		
	A		
	B		
	C		
5	An average total money that you spent for it		
6	Others specify		

IX. Impact of Treatment of Family's Financial Status:

112. Do you save money?

- a) Yes
- b) No

113. If yes, how much_____

114. If no, why?_____

115. If no, are you saving after hospitalisation?

- a) Yes
- b) No

116. If yes, How much_____

117. If no, why_____

118. If yes, is there any difference between pre and post hospitalised saving?

119. If yes, How much Rs._____

120. Why there has been declining in saving?

Reasons:

- a) Medical Expenditure
- b) Child Education
- c) Costly food grains
- d) Borrowed money for surgery
- e) Others_____

121. If no, Why?

122. Have you ever borrowed money?

- a) Yes
- b) No

123. If yes, in which year_____ (112 to 116 not to be asked if someone gave no-reply to Q111)

124. If yes, from whom?

- a) MPIS
- b) Local money lenders
- c) SHIP
- d) Others Specify_____

125. Have you paid back this borrowed money?

- a) Yes
- b) No

126. If the borrowed money near to the year of treatment, then I will ask, what is the reason for the borrowed money?

Reasons:

- a)
- b)

127. What are your daily needs?

128. Have you curtailed in your basic daily needs due to the disease and treatment subsequently?

- a) Yes
- b) No

129. If yes, what are they?

- a) Low Grade Rice
- b) Less Non-Veg
- c) Less Party
- d) Less Mobility to relatives
- e) Eating outside
- f) No smoking

- g) No drinking
- h) No movies watching in theater
- i) Excursion

X. Perception of Beneficiary:

130. Did you satisfy with complete service of hospital?

- a) Yes
- b) No

131. If no, what kind of problems did you face during your treatment?

- a) Administration problem
- b) Doctor did not respond to me quickly concerning treatment
- c) Problem with nurses
- d) Problem with other staff
- e) Lack of proper technology

132. What kind of perception do you have towards doctors?

- a) Bad
- b) Medium satisfaction
- c) Good satisfaction
- d) No comment

133. What kind of perception do you have towards administration of hospital?

- a) Bad
- b) Medium satisfaction
- c) Good satisfaction
- d) No comment

134. What kind of perception do you have towards Nurses?

- a) Bad
- b) Medium satisfaction
- c) Good satisfaction
- d) No comment

135. What kind of perception do you have towards Mithra?

- a) Bad
- b) Medium satisfaction
- c) Good satisfaction
- d) No comment

136. Have you ever felt discriminated by any of them as inpatient in hospital?

- a) Yes
- b) No

137. If yes, what kind of discrimination did you face indirectly or directly in hospital?

- a) Because of free of cost
- b) belonging to slum area
- c) Social discrimination
- d) If others, specify

138. What is your perception on state's government RACHI's health policy for BPL people?

- a) Good
- b) Bad
- c) require some more efficiency
- d) No comment
- e) if others, specify_____

139. Do you completely believe that government is delivering social security to BPL under this scheme?

a) Yes

b) No

140. Do you think that this service is initiated for attracting votes from BPL people?

a) Yes

b) No

c) No idea

d) Somehow it would help them to capture votes from BPL people

141. Can you tell me where you had struggled in availing health care service under insurance coverage?

142. Can you tell me, where this insurance require to improve more for delivering proper service?

143. Can you give some suggestion for improper healthcare service in future under this insurance?

-----&-----

Authoritative letter of the RACHI Trust

Photos:

Annexure-3

The following images are captured during the course of my fieldwork in CARE and Gandhi Hospitals in Hyderabad City.



(Patients admitted in the CARE Hospital under RACHI Coverage)



(Bed Quality in the CARE Hospital)



(Patient with his Assistant in the CARE Hospital)



(Sanitary Employee Cleans Wall and Floor of the CARE Hospital)



(Hi-Tech Facility in Bathroom in the CARE Hospital)



(Sanitary Employees Cleans Toilet for Nearly Six Times a day in the CARE Hospital)



(Nurse Provides Service to Insured Patient in the CARE Hospital)



(Doctor Provides Service to RACHI Patients in the CARE Hospital)



(Television Facility for Patients in the CARE Hospital)



(Ward-Boy Takes Patient to Diagnostic Lab in the CARE Hospital)



(Aarogyasri Waiting Room in the CARE Hospital)



(RACHI patients in Aarogyasri Waiting Room in the CARE Hospital)



(Bed Facilities for Patients in the Gandhi Hospital)



(No Space Between Beds in the Gandhi Hospital)



(Patient is Staying for Last Three Months approximately in the Gandhi Hospital)



(No Lighting in Patient's Room in the Gandhi Hospital)



(Patient Stays Outside of the Room in the Gandhi Hospital during Evenings)



(Interviewing Patient in the Gandhi Hospital)



(Total Bed-Occupancy in the Patients' Room in the Gandhi Hospital)



(No Air Conditioner Facility for Heart-Patients After their Surgery)