Additional Expenditures of Insured Patients during Hospitalization: A Case Study of Aarogyasri Scheme in Two Network Hospitals in Hyderabad City, Telangana

RAVI KIRAN RUNJALA[†]

Centre for the Study of Social Exclusion and Inclusive Policy, University of Hyderabad, Hyderabad 500046, Telangana
E-mail: runjalahcu@gmail.com

KEYWORDS: Hospitalization. Health expenditure. Private hospitals. Public hospitals. Insurance. Hyderabad. Aarogyasri scheme.

ABSTRACT: Insurance provided by the government is considered an alternative solution to reduce the burden of health expenditures among the poorer sections of the society. However, a comparative study between two network hospitals in Hyderabad of Telangana State – one a private hospital and the other a public hospital – shows that the purpose of insurance has not been fulfilled as insured patients continue to incur huge expenditures of their own in both the types of hospitals related to travel, food, tipping and fruits. The minimum requirement of the hospitals to be a network hospital – proper diagnostic and free medicines – are also not present leading to patients and care providers incurring huge expenses. The purpose of insurance coverage launched by the government to provide free medical care is not met. The paper calls for a relook at the way insurance is provided to solve these lacunas.

INTRODUCTION

Good health is a necessary component for a good life. A healthy population, among other things, leads to an increase in a country's economic performance apart from the better quality of life the population enjoys (Mukherji and Hema, 2013). It is for these reasons that agreements on health for resource and knowledge sharing and cooperation among nations have been in the international scene, showing the importance given to health by almost all the countries (Backman *et al*., 2008). However, even a cursory look at the available data shows a sizeable gap between developed and developing countries not only in terms of health outcome measured in different ways such as life expectancy, child mortality, infant mortality, immunization, etc. but also in input measures such as the doctor-to-population ratio, number of beds in hospitals-to-population ratio, or the proportion of income spent on health by the government. Developing countries suffer from insufficient allocation of resources towards health not only in absolute terms but also in relative terms (Dasgupta and Ray,'87; Strauss and Thomas,'98, Mukherji and Hema, 2013).

Coupled with illiteracy and superstition (along with poor allocation of resources), the developing countries are at a double disadvantage in achieving health outcomes. Many developing countries have not been able to meet healthcare needs of their people, particularly of poor people, and are in constant struggles with shrinking budgetary allocation, inefficient service delivery, and user charges (World Bank,'93; Jutting, 2004). India, as a developing country, has not been free from ill-health and measures to tackle it. In fact, South Asia (including India, Pakistan, Nepal, Bangladesh, Myanmar and to an

[†] Research scholar

extent China though China has made rapid progress in recent decades) has often been clubbed with Sub-Saharan African countries in terms of very poor health outcomes. While some countries make rapid strides in health and other social indicators as their economies grow[1], the same has not been true about India. While often labeled as a welfare state, India's spending on health as well as the achievements made have been left with much to be desired[2]. This is not for lack of political rhetoric as in its seven decades of independence, different policies, aims, schemes and resolutions on health have been launched, with aims to increase government spending on health to be increased to 3.1 per cent of national income from the present level of around 1 per cent (Acharya and Kent, 2005).

Issues related to healthcare system have turned out to be of vital dialogue in recent years among academicians, practitioners, civil society organizations and public administrators in the country. It has been in the forefront of public debates and academic scholarship ever since the healthcare delivery system turned into a profitable industry especially for corporate. Recent scholarly works have clearly demonstrated ((Chakravarthi *et al*., 2017; De Costa and Diwan, 2007; Parker and Harper, 2006; Reddy *et al*., 2011) an apparent failure of the public healthcare delivery system in the country and a simultaneous increase in the private healthcare delivery system, the constituents of which are not necessarily more efficient though costlier than those provided by the public healthcare delivery system with inadequate regulations put in place by the government. As a result, a large number of Indians are kept out of efficient and quality healthcare delivery systems in this country, and are relying on unqualified medical practitioners and inefficient public healthcare delivery which are jeopardizing their lives. For instance, according to Berman ('98) the poorest people forego treatment for 2.6 times higher when compared to rich people during their illnesses. According to the World Health Organization, about 80 per cent of total expenditure on health in India comes from private sector. In addition, most studies of healthcare spending have found that out-of-pocket spending in India is actually progressive, or static as a proportion of non-food expenditure (Devadasan, *et al*., 2004). Constant acceleration of treatment costs immensely impacts the households' earning and standard of living.

Medical expenditure not only increases the economic burden of poor people but for people marginally above the below poverty line, medical expenditure many times imply falling into debt trap. As a result of medical expenditure resulting from hospitalization, about 3.3 per cent of Indians get impoverished every year (Kalyani, 2015). Although the government has implemented various policies and schemes, and enacted acts for the welfare of people's health, such efforts have failed to achieve comprehensive health expenditure coverage as well as failed in delivering comprehensive healthcare services.

The government's strategy on health has changed several times since independence. A strategy on health which is rather recent is that of providing health to the people through an insurance-based mode. Under this, instead of providing healthcare services directly to the people which is fraught with challenges such as doctors preferring urban areas over rural areas, non-functional hospitals and rural dispensaries, poor equipments, lack of medicines, etc., the government has taken on a partnership mode by providing resources to the people through insurance while the healthcare services is to be provided by a third entity – either a public hospital or a private one. This paper is an attempt to make a microscopic study of an insurance scheme launched by the government in the erstwhile undivided Andhra Pradesh and continued in the new carved-out state of Telangana – the Aarogyasri scheme. The paper seeks to understand the functioning of the insurance scheme from the perspective of the actors – the patients and the care providers. The study stems from an aim of the scheme – that the government seeks to provide healthcare services at zero cost to the patients and the patients' families. Any cost incurred by the patients and the care providers i.e. patients' families is an instance of the scheme failing to meet all the aims set forth. The paper explores whether the scheme has been able to meet its lofty standards.

The next section introduces the readers to the Aarogyasri scheme followed by a brief introduction to the study area. The section following, that looks at the different expenditure components viz. medical and non medical, and how patients and their care providers

or family members meet those expenses. This constitutes the core section of the study. This section also constitutes the findings by its very nature. The next section analyses the findings and concludes.

Rajiv Aarogyasri Community Health Insurance

Rajiv Aarogyasri Community Health Insurance (RACHI) or in short the Aarogyasri scheme was launched by former Chief Minister of the united Andhra Pradesh, Dr. Rajashekar Reddy in 2007 to meet the medical expenses of people below poverty line. It is a scheme funded completely by the state government. The scheme was launched initially as a pilot project in three districts represented equally in the three regions in the state that included coastal area, Telangana and Rayalaseema (Reddy and Mary, 2013; Purendra and Raghavendra, 2012). It was however later extended to all districts of the state by the year 2008. Presently, it covers 949 procedures that require hospitalization and surgery or therapy. Its healthcare providers comprise both public and private network hospitals that deliver the service after which the reimbursement is made by the Aarogyasri Trust. Each qualified family can get coverage of ₹ 2 lakhs per year implying that a member or all members in a family can utilize this amount. Of this amount, ₹ 1.5 lakhs is allocated as basic coverage of the package but the rest ₹ 50,000/- is considered as a buffer amount to meet medical expenditures of an enrolled family each year. In addition, the Trust also provides ₹ 6.5 lakhs as a package for each case for treatment of Cochlear Implant Surgery with Auditory Verbal Therapy (*aarogyasri scheme website/ www.aarogyasri.org.in*).

The scheme is been rolled out with the aid of its four pillars – Aarogyasri Trust, Insurance, Network Hospitals, and Mithras. It operates under public-private partnership mode ((Bhat and Jain, 2006). These four pillars have to work together to achieve the objectives set by the government under this scheme. Among all these pillars, Aarogyasri Trust is considered as possessing superior administration under which the rest of the three pillars have to deliver their services. Insurance, however, has been delisted from this four pillars' list as Trust has taken over Insurance's responsibilities completely. In case of network hospitals, every network hospital has to deliver appropriate service to insured patients. Mithra who is posted in the hospital has to assist insured patients coming from the whole nooks and corners of the state. The Trust oversees the entire process of this service and makes reimbursement to the concerned network hospital. Currently, this insurance scheme has many critics in connection to its administration, delivery of network hospitals, increase of premium rate etc. Clearly, the premium amount for each BPL family set only at ₹ 279 in 2008 has gradually been escalated to ₹ 330 by March 2009 and later, to ₹ 439 since 5th April 2009 (*cf.* Reddy and Mary, 2013).

Network Hospitals

Usually all network hospitals have to be selected by the Trust. For enrolment, each of such hospitals require maintaining certain standards set by the Trust that includes, among others, at least 50 beds, medical and surgical facilities i.e. pathological test, X-ray, E.C.G, etc., fully equipped operation theatres, and qualified nursing staffs and doctors working round the clock. In addition, such hospitals have to maintain complete records as required on day to day basis, be able to provide necessary records of the insured patient to the insurances or his representation as and when required. It also has to maintain or use defibrillator (ICD) code for drugs, diagnosis, surgical procedures, etc. And it also has certain responsibilities in terms of providing free-out patient consultation as well as substantial discount on diagnostic tests and medical treatment required for beneficiaries. It has to provide minimum 10 to 12 health-camps per year. Every network hospital also has to provide comprehensive healthcare service from the stage of outpatients being admitted up to the post-hospitalization stage. In the first stage of pre-hospitalization, the network hospital has to start delivering its service to insured patients three days prior to their admission into the hospital. In case of post-hospitalized stage, its coverage is only for ten days but one year for 125 diseases which require long term medication and are under observation by the doctors concerned (*http://www.aarogyasri.telangana.gov.in/*).

Study Area

The paper attempts to comprehend the burden of out of pocket expenditure (OOPE) among insured

patients being hospitalized in two hospitals, representing both the sectors *viz.* private and public. The sample drawn for the survey includes 100 patients in total who have been distributed equally in these two network hospitals – Care Banjara Hospital and the Gandhi Hospital – which are private and public hospitals respectively. The survey aimed to find out which hospital causes more out of pocket expenditure burden among the insured patients. The patients are residents of both rural and urban areas but have approached the hospitals located in Hyderabad city. This study has concentrated on transportation during the time of admission, and both medical and non-medical expenditure during the hospitalization. Again, medical expenditure embraces expenses of diagnostic tests and medicines whereas non-medical expenditure includes expenses of food, fruits, and tips. Such expenditures do not come under insurance coverage but can be burdensome for the poor patients.

MEDICAL EXPENDITURE

The scheme warrants that the entire medical expenditure should be met by the insurance company. However, even a casual enquiry reveals that this is not the case and patients have to bear medical expenditures. In fact, a network hospital even compelled them to spend from their pocket as that network hospital does not have proper equipments and sufficient quantity of medicines. The medical expenditure includes both diagnostic expenditure and expenditures on medicine that the insured patients incurred during their hospitalization.

Out of Pocket Expenditure (OOPE) Over Medicine

Table 1 shows that a considerable number of patients from the public network hospital incurred a large sum of OOPE when compared to such patients from the private hospital. My sample size is 100, initially, I contacted with them over mobile phone based on the list that I obtained from the Aarogyasri Trust, and noted down their current addresses. Finally, I selected them for the interview through convenience non random sampling. It was a comparative study between two network hospitals from sectors, public and private. The public network hospital which was studied as a part of this study is Gandhi Hospital and in case of private network hospital, it is Care Banjara Hospital. One fifth of the insured patients of the public hospital have borne quite a huge amount of money on diagnostic tests and medicines as this hospital failed to provide them. For example, Shak Babu (30 years) was admitted in the Gandhi Hospital for treatment of his fractured right leg. He slept on the ground as no bed was vacant. He was asked to purchase medicines from the shop located in the premise of hospital as medicine was not available in the hospital pharmacy. On the contrary, the private hospital provided free and needed services to the insured patients.

TABLE 1

Out of pocket expenditure (OOPE) over medicine

Amount (in ₹)	Private (Care Banjara Hospital)	Public (Gandhi Hospital)
₹ 1000 - ₹ 2000	2	12
₹ 2001- ₹ 5000	–	3
Haven't spent	48	35
Total (c+d)	50	50

In a few cases, assistants of patients had gone back to their homes to get some money by borrowing from relatives or friends or money lenders in order to meet such medical expenses. This despite the fact that this public network hospital is recognized as a network hospital of the insurance company; it has also not been able to provide medicines to patients. For example, Nagamani an aged (65 years) woman was relying on her family members for both her basic needs and medical needs. She was initially treated at Gandhi hospital without the coverage of this insurance and she met all medical expenditures. For the second time, she was admitted into the same hospital with insurance coverage but again had to meet all expenditures on medicine. According to her, this expenditure increased the financial burdens to a high extent on the family members. The high medical expenditure is due to prolonged hospitalization.

In another instance, Shrawanthi (22 years) a housewife, stated that she was in the hospital for a month. She complained that she did not receive proper care from the hospital staffs and doctors. She wanted to get discharged as early as possible because she had

to take care of her children but was not able. Such situations rarely occurred among the insured patients in private hospital. Almost all patients in the private hospital had received medicines without purchasing outside. It is confirmed from the field visit that public network hospital has been handicapped due to the dearth of medicines unlike the private hospital.

Expenditure on Diagnostic Tests

During the hospitalization, a few insured patients had incurred out-of-pocket expenditure on their diagnostic tests because such diagnostic equipments in the network hospitals were unavailable and dysfunctional. The number of such patients were equally distributed (six each) between these two network hospitals but the amount they spent varied greatly. Patients of the private hospital incurred more expenses when compared to those in the public network hospital. Such patients had to spend before they came under insurance coverage and during the time of their admission in the private hospital (they had come under insurance in the hospital). However, though the amount spent in the public hospital was less, the patients who spent were all under insurance coverage. Generally, it happens for every patient to incur medical expenditure out of his/her pocket, prior to the insurance coverage. Once they come under the insurance coverage, they need not have to incur such expenditure any more. For example, Rama Devi (34 years) had incurred OOPE of ¹ 3000/- approximately over her diagnostic tests prior to insurance coverage during her admission into the hospital. After coming under this insurance coverage, she did not made any payment but obtained this service further from the hospital free of cost.

TABLE 2

Expenditure on diagnostic tests (delete cells)

Amount (in ₹)	Private (Care Banjara Hospital)	Public (Gandhi Hospital)	Total
₹ 1000 - ₹ 2500	–	6	6
₹ 7000 - ₹ 8000	6	–	6
Haven't spent	44	44	88
Total	50	50	100

On the contrary, a few insured patients in the public hospital had to incur this OOPE expense as the equipments of the diagnostic of this hospital were not working as they were defunct. As mentioned above, such patients who required diagnostic tests had to incur expenditure even after insurance coverage. The amount that they incurred on this need also varied. During the hospitalization, six insured patients in the private hospital had borne more money, the mount ranging between ¹ 7000/- to ¹ 8000/-. In comparison, the six patients in the public hospital had spent an OOPE ranging from ¹ 1000/- to ¹ 2000/-. It shows that the cost of diagnostic expenses was much higher in the private hospital compared to the public hospital. Such cost of expenses in this hospital would be controlled through proper monitoring mechanisms of the government.

Non-Medical Expenditure

One of the drawbacks of the insurance service is that it does not care for the complete coverage of non-medical expenditure, which many times increases the financial burden of the vulnerable patients. These patients depend entirely on the government in order to meet their needs. Other than medical, the important non-medical expenditures include transportation expenditure during the admission, expenditure on food and tips to the staffs of the hospitals.

Transportation

In case of transportation during the admission, they rarely rely on 108 services provided by the government for free of cost – only three patients from public hospital availed this service. They mainly rely on the private transportation which increases their financial burden. For transportation, the severity of health condition of the patients compelled them to rush to the hospital without waiting for the 108. The private transportation facilities are always at the doorstep of the people unlike public transportation implying that this transportation expenses turned out to be unavoidable expenses for the insured patients. They used various transportation facilities such as bus, private ambulance, car, auto, and train, based on the distance, seriousness of the diseases, timely availability of such service, and finally their financial condition. Among them, about a half of them had reached these hospitals by public buses, which are followed by private ambulance, car, auto, and train.

Nearly two-third of patients from the private hospital and three-fourth of patients from the public hospital relied exclusively on bus and private ambulance. It shows that buses and private ambulances have played significant role in bringing insured patients to the network hospitals in Hyderabad city. Though the remaining transportation facilities have also played a prominent role, their services were restricted only to a few patients. Hence, patients of both the hospitals relied mainly on bus and private ambulance but free-transportation provided by the government was only availed by few patients to reach the public network hospital. Table-3 shows the mode of transportation facilities used by the insured patients.

TABLE 3

Mode of transportation

Mode of transportation	Private	Public	Total
Bus	23	19	42
Private ambulance	11	10	21
Car	7	7	14
Auto	3	8	11
Train	6	3	9
Public ambulance (108)	–	3	3
Total	50	50	100

In case of incurring OOPE, the patients who depended on private ambulance and car incurred relatively higher amount of money out of pocket but they did not receive that money back. Such patients were mostly admitted into the private hospital for the treatment of their diseases. In addition, a few patients who depended on the service of train travelled for a long distance to reach these hospitals. Such patients mostly spent nominal amount on this service. Patients who used the services of both auto and bus to reach the hospitals also incurred only a small amount of money as compared to those who relied on cars and private ambulances. Table 4 shows OOPE of the insured patients on their transportation during the time of admission.

TABLE 4

OOPE on transportation during the time of admission

Mode of transportation (Amount in ₹)	Private	Public	Total
Below ₹ 500/-	22	22	44
₹ 501 - ₹ 2000	24	18	42
₹ 2001 - ₹ 5000	2	6	8
₹ 5,001 - ₹ 6500	2	1	3
Not spent	–	3	3
Total	50	50	100

Expenditure on Food

Insured patients also have to bear other non-medical expenditure burden during their hospitalization due to failure of the hospital administration. These include patients spending OOPE on their food, fruits and tips. For food, almost all the patients bought food out of their pocket although these network hospitals provided the food to patients whose health expenditures were assured under this insurance scheme. Almost all the patients in the public hospitals, and about one-third of the total patients in private hospital spent money on food. They mostly bought the food for their relatives for whom the government decided not to provide food during the hospitalization. The reason of a few patients who haven't purchased it is that the patient and assistant shared the food provided by hospitals. It is because the food provided by the private hospital is sufficient for both patient and assistant. Such patients are more in number in the private hospital than those in the public hospital. In this regard, one more reason is that the food available outside of the private hospital is quite expensive. Each meal costs between ₹ 100/- and ₹ 150/- approximately in hotels. In the public hospital, almost all patients bought the food from hotels and roadside vendors outside the hospital. The cost outside of this hospital could be anywhere between ₹ 20/- and ₹ 100/-, but most of the patients had spent less than ₹ 100/- over each meal.

About the taste of the food in the public hospital, the patients had complained that the food was not tasty and was thus unsatisfactory. The quantity of the food was also not sufficient if the food was shared between the patient and his/her assistant. This constant purchasing of food increased OOPE burden on the insured patients. In addition, more than one assistant stayed in the hospitals as more numbers of relatives visited the patients in the public hospital which also impacted heavily on the financial ability of the patients. In the private hospital, only one assistant is allowed to stay with the patient and the hospital has not encouraged the visitors to see the patient. Table-

5 shows the OOPE burden on food incurred by the insured patients during the hospitalization.

TABLE 5

Expenditure on food by the insured patients

Expenditure on food (in ₹)	Private	Public	Total
₹ 20 - ₹ 100	1	13	14
₹ 101 - ₹ 200	17	25	42
₹ 201 - ₹ 300	–	8	8
Not spent	32	4	36
Total	50	50	100

Expenditure on Fruits

During the hospitalization, a few patients have spent OOP money on purchase of fruits on their own and on the advice of the doctor. The private hospital has less of such patients when compared to those in the public hospital because it provided the fruit-juice every day at around 4 p.m. The public hospital does not have such provision, but it wanted the patients indirectly to rely on fruit vendors located outside the hospital. Such patients purchased fruits from small vendors every day. This expense also increased the OOPE burden on the insured patients. Around 13 per cent of patients in the public hospital spent from ₹ 100 - ₹ 200 every day on fruits (Table 6). Not only that, more than two-third of the total patients in the public hospital purchased fruits every day whereas such patients are only less than one-fifth of the total patients in the private hospital. Hence, the private hospital reduced OOPE burden on the insured patients by proving fruit-juice daily to the patients. Table 6 shows OOPE of insured patients on fruits.

TABLE 6

Out of pocket expenditure of insured patients on fruits

Expenditure (in ₹)	Private	Public	Total
₹ 20 - ₹ 100	0	22	22
₹ 101 - ₹ 150	9	10	19
₹ 151 - ₹ 200	–	3	3
Not spent	41	15	56
Total	50	50	100

Expenditure on Tipping

Hospital administration plays a prominent role in delivering health care service properly and monitoring administrative activities of various departments in the hospital. Apparently, the hospital administration failed in monitoring the service of their lower staff who demanded tips from patients. Sometimes, patients offered tips on their own. Such culture is very prominent in the public network hospital because the patients are entirely dependent on the public hospital. If the patients deny it such employees do not extend their services on time, which is likely to increase the number of hospitalized days for the insured patients. Such culture is completely absent in the private hospital – shown in the table where the number of patients who tipped the staffs in the private hospital is nil.

TABLE 7

Out of pocket expenditure for tipping

Expenditure (in ₹)	Private	Public	Total
₹ 20 - ₹ 100	–	13	13
₹ 101 - ₹ 200	–	4	4
₹ 201 - ₹ 300	–	2	2
Not spent	50	31	31
Total	50	50	100

In stark contrast, 38 per cent of the patients in the public hospital tipped though it was not daily. About 13 per cent of insured patients tipped between ₹ 20 and ₹ 100 while 4 per cent and 2 per cent of the patients tipped to the employees between ₹ 101 and ₹ 200 and ₹ 201 to ₹ 300 respectively. This amount is relatively high for those patients who spent more number of days and underwent surgery. The lower staff often demanded the patients for tips during the diagnostic tests and surgery during activities such as bringing the patients from the patients' room to the room for diagnostic tests and the operation theatre.

CONCLUSION

When the issue of health expenditure and insurance coverage is discussed, the focus is mostly on medical expenditure – diagnosis, medicines, availability of medicines and equipments and so on. However, the paper highlights that such an approach is very narrow. Firstly, there are costs of transportation which many times insurance do not cover. A patient also rarely comes alone to the hospital – he brings with him friends or relatives to look after him apart

from the medical help providers in the hospital. Such care providers not only need a place to stay but also incur expenditures by way of food expenses. Food and lodging expenses for the care provider can become burdensome for a poor patient. Tipping is also a culture in public hospitals which cannot be overlooked. The bulk of the focus, however, is on the minimal infrastructure and diagnostic tools which have to be in place for a hospital to be a network hospital. It is disappointing that such hospitals have been declared a network hospital even when they do not meet the required criteria burdening the poor patients even further.

The very nature of the scheme is for the poor, for the illiterate and the lower section of the society in the socio-economic ladder. Providing care to them not only requires proper equipments and man power on the ground but also requires sensitivity to their needs which present insurance coverage do not provide. Provisions have to be made not to only to make the acceptance of network hospitals more stringent so that not only OOPE on the poor patients and their families will be lessened but quality care can also be provided to them. There is also a need for provisions where a minimum amount of money is disbursed to the patients and the care providers so that expenses not covered in the insurance can be taken care of. This will go a long way in lessening the financial burden of the poor due to bad health. One has to understand that the costs incurred due to spending time in hospital are multilayered – the patients and care providers in the family or friends incur cost; at the same time, there is an opportunity cost lost because time is spent in the hospital. Even while the patients spend time in the hospital, family members have to be fed, school fees have to be paid and debts repaid. Incurring more costs due to poor health burdens the patient even further. A comprehensive and sensitive health insurance should take cognizance of these multilayered costs incurred by a poor patient.

ACKNOWLEDGEMENT

I would like to thank Prof. N. Sudhakar Rao and Dr. Vasantha Srinivas for their immense support and guidance for the completion of this paper.

NOTES

1. There is a debate as to whether investment in health and other social categories such as education leads to growth or whether growth leads to increase in investment in social sectors such as education and health. The Bhagwati-Sen debate in India is a prime example.
2. Scandivinian countries spend a whole lot more on health. It is not surprising that their countries also have much better health and quality of life outcome indicators

REFERENCES CITED

Acharya, Akash and M. Ranson Kent 2005. Health care financing for the poor: Community based health insurance schemes in Gujarat. *Economic Political Weekly*, 40 (38): 4141-4150.

Backman A. Gunilla, Paul Hunt, Rajat Khosla, Camila Jaramillo-Strouss, Belachew Mekuria Fikre, Caroline Rumble, David Pevalin, David Acurio Paez, Monica Armijos Pineda, Ariel Frisancho, Duniska Tarco, Mitra Motiagh, Dana Farcasanu, Cristian Viadescu 2008. Health systems and the right to health: An assessment of 194 countries. *Lancet,* 372: 2047-2085.

Berman, A. Peter 1998. Rethinking healthcare systems: Private healthcare provision in India. *World Development*, 26(8):1463-1479.

Bhat, Ramesh and Nishant Jain 2006. Analysis of public and private health expenditure. *Economic and Political Weekly,* 41(1): 57-68.

Chakravarthi, Indira, Bijoya Roy, Indranil Mukhopadhyay and Susana Barria 2017. Investing in health: Healthcare industry in India. *Economic Political Weekly,* 52 (45): 50-60.

Dasgupta. P, and D. Ray 1987. Inequality as a determinant of malnutrition and unemployment: Theory. *Economic Journal,* 97:177-188.

De Costa, Ayesha and Vinod Diwan 2007. Where is the public health sector? Public and private sector healthcare provision in Madhya Pradesh, India. *Health Policy,* 84: 269-276.

Devadasan, N., Kent Ranson, Wim Van Damme and Bart Criel 2004. Community health insurance in India: An overview. *Economic and Political Weekly,* 39 (28):3179-3183.

Jutting, P. Johannes 2004. Do community-based health insurance schemes improve poor people's access to health care? Evidence from rural Senegal. *World Development*, 32 (2):273-288.

Kalyani, P. 2015. A study on implementation of community health insurance scheme in the cardiology department of a tertiary care government hospital. *Evaluation of Medical Dental Sciences,* 4(18): 3124-3133.

Mukherji, Arnab and Hema Swaminathan 2013. The role of right to health in healthcare management and delivery in India: In conversation with Dr. Devi Prasad Shetty, Chairman, Narayana Hrudayalaya. *IIMB Management Review,* 25:28-35.

Parker, Melissa and Ian Harper 2006. The anthropology of public health. *Journal of Biosocial Science,* 38:1-5.

Purendra, Prasad. N and P. Raghavendra 2012. Healthcare models in the era of medical neo-liberalism: A study of Aarogyasri in Andhra Pradesh. *Economic and Political Economy*, 47(43): 118-126.

Reddy, Sunita and Mary Immaculate 2013. Rajiv Aarogyasri Community Health Insurance Scheme in Andhra Pradesh, India: A comprehensive analytic view of private public partnership model. *Indian Journal of Public Health,* 57(4): 254-259.

Reddy, K. Srinath, Vikram Patel, Prabhat Jha, Vinod K. Paul, A. K Shiva Kumar and Lalit Dandona 2011. Towards achieving of universal healthcare in India by 2020: A call to action. *The Lancet Indian Group,* 377(9767): 760-768.

Strauss, J. and D. Thomas 1998. Health, nutrition and economic development. *Journal of Economic Literature,* 36: 766-817.

World Bank 1993. *World Development Report*. Oxford University Press: New York.