

Karnataka has been considered a forerunner in involving the private sector for delivery of health services through a plethora of state-supported insurance schemes for the poor, each designed for different populations and conditions, with considerable overlap. The schemes engage the private sector by providing reimbursements to empanelled hospitals for services rendered. The objectives for these schemes have been to improve access to health care and to prevent catastrophic health expenses by providing 'cashless' care.

This paper presents an overview of the various ways in which the state has increased the involvement of the private sector in these state insurance schemes, as well as users' experiences with accessing them, and data on state reimbursements to private and public sector institutions. Issues and concerns arising from the insurance model in the context of universal access to health care (UAHC), and especially the lack of continuity of coverage and the lack of preventive and primary care and implications for equity in health care are discussed.

**Methods** This formative research used a variety of methods such as literature review, review of contracts between the government and private or non-for-profit entities, Right to Information (RTI) applications, key informant interviews (n=10) with agencies administering insurance schemes, a cross-sectional survey of insurance users (n=61), and group discussions with insurance policy holders.

**Findings** Various public-private arrangements exist with a range of entities (NGOs, corporate hospitals, private service agencies), such as contracting in, contracting out, empanelling of hospitals, and facility adoption. The majority of hospitals empanelled in insurance schemes are private, and most of the reimbursement is being paid to the private sector. In RSBY, 62% of the empanelled hospitals are private, and over 90% of the money reimbursed by the government in 2014 went to private hospitals. In the case of the *Vajpayee Arogyashree* Scheme, only 5% of the total reimbursement expenditure was made to government hospitals.

The majority of the schemes are for tertiary care. The schemes work in isolation from each other although households may hold more than one policy. There was no evidence in any of the interviews of the survey of a continuum of care provided for people with conditions that required on-going treatment and/or monitoring. Among the 61 users of the insurance schemes surveyed, 87% went to a private hospital, and only 8% received free treatment, with out-of-pocket expenses ranging from INR 4,000–120,000. Users had already experienced high out-of-pocket expenses even before they availed benefits from the scheme, and the schemes did not cover follow-up care or the on-going cost of treatment and medicines. In-depth case reports of healthcare access for patients with serious illnesses were gathered. In addition to not having on-going treatment and medication costs covered, patients had to travel long distances and stay in large urban areas, incurring huge incidental costs on food, housing and local travel.

In parallel, Level 2 and Level 3 public hospitals are converting to autonomous institution status and are expected to raise operating costs through fee-for-service methods. Senior officials in these hospitals reveal that user fees for diagnostics and procedures have increased dramatically.

**Conclusions** While the current plethora of state insurance schemes provides some access to care for poor populations, the problems are manifold. The data reveal out-of-pocket expenses for the poor, of which only a small percentage benefits from free care. Tendencies to channel care to certain geographic areas is apparent and obvious given the concentration of services in urban areas of the state, and over time this may move the state

# OP-27 USING THE PRIVATE SECTOR TO EXPAND HEALTH CARE FOR THE POOR IN KARNATAKA: A ROAD LEADING TOWARD OR AWAY FROM UNIVERSAL CARE?

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**Background** Karnataka is a mid-to-high performing state in India, with a high variability in its human development index. Karnataka's health services profile varies widely by geographic location, with a mix of public sector health services administered by different levels of government and different departments within a level, as well as extensive private-sector health services.

away from the public health goal of care nearer to the patient. Emphasis of the schemes on tertiary care to the detriment of primary and secondary care, fragmentation of services with no backward nor forward integration (from preventive and screening services through to on-going treatment and medication needs) and poor referral lead to high out-of-pocket expenses and unsatisfactory experiences by those who need higher level and on-going care.

The targeted nature of the population covered by insurance (below-poverty-line) moves it away from the goals of universal coverage. The insurance schemes are fragmented, rather than one integrated policy for all members of a household that includes preventive and screening services, as well as outpatient visits, hospitalisation, diagnostics, treatment, and on-going care for chronic and unresolved conditions. There does not appear to be any policy vision anticipating the impact on public sector hospitals and on cost of care due to (a) large amounts of government reimbursement flowing to the private sector; and (b) the shift to greater use of private-sector services. In addition, weak regulation of the private sector in general and specifically in the implementation of government insurance schemes, and of autonomous public hospitals, make fee-for-service mechanisms vulnerable to supplier-induced demand in the form of irrational and unethical procedures. Besides, continuity of care is not achieved. The observed policy direction is a move away from the stated goal of Health for All.

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