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AROGYASREE AND PUBLIC HOSPITALS: A CASE STUDY OF POST-HOSPITALIZED AAROGYASRI PATIENTS IN HYDERABAD CITY

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Abstract: Arogyasree is a public sector Insurance Scheme that the government of Andhra Pradesh had set up originally in 2007 to cater for the health needs of families below the poverty line. A study has revealed some dissatisfaction among those beneficiaries who received service in public network hospitals for high out-of-pocket costs and not covering the minor ailments that surfaced mostly in the post-hospitalized stage. Patients generally feel that they received relatively better service from private hospitals in comparison to the public sector hospitals due to less financial burden, fewer post-hospitalized related difficulties and a quick recovery rate. On the other hand, the public network hospitals are able to provide quick post-hospitalized check-ups and allow multiple visits and consultations in the post-hospitalized stage but did not provide quality service. The study has further shown that achieving goals of the insurance through public health care is an impossible task because these hospitals have joined the insurance network without developing on par with private hospitals. In general, the welfare scheme Arogyasree has achieved its goals to a limited extent by including poor and marginalized sections of the society by extending health care services, but ultimately relying on public network hospitals. Therefore, unless the services of public network hospitals improve their delivery of health care, it would be very difficult to deliver qualitative service to insured patients and such hospitals also would fail to deal with a deadly virus like Covid-19 properly. So, the development of public hospitals would play a significant role in delivering quality service to poor people.

Introduction

Health is so precious asset of people in the present era and also be considered a wealth of the nation. The illness usually attaches the family-financial stability and pulls it down below

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the poverty line category because of augmented healthcare prices at private hospitals, which are branded as efficient healthcare providers. In India, the constitution reveals that health is a state subject, and its responsibilities are distributed unequally between the centre and states governments. The centre holds the responsibilities of policy-making, planning, guiding, evaluating and coordinating the different provincial health authorities and also providing funding to implement national programmes. At the same time, every state set up its own objectives and frames specific policies to attain the goals of reaching out to all the sections of society with quality and efficient healthcare services, alongside cooperating with policies and schemes curved and implemented by the central government. For instance, one of the state-initiated schemes in Andhra Pradesh is Aarogyasri Scheme. In the country, since 1961 onwards, special attention has been given to the hospitals' development, especially public hospitals' development, with increased bed-occupancy, organizing outpatient departments, encouraging the establishment of convalescent homes and *Dharamshalas* (guest houses) near hospitals to reduce the additional pressure on hospitalized patients (Duran *et al*, 2015).

The government aims to provide effective health care facilities with the motto 'Health for All' to the general public and especially to those living below the poverty line, regardless of socio-economic, religious, regional and other differences (Waddington and Claudia 2015). It is part of the Global Health Care Service for All People in Low- and Middle-income Countries (MIR), under Million Development Goals (Rao and Chaudhary, 2012). In India, the health care system has been in a state of disrepair for decades. Many policies and programs that seek to improve healthcare have ultimately failed to produce the desired results. In addition, rising health care costs, changing diseases, government medical services in dire straits, and inaccessible advanced medicine to the poor are challenging the contemporary medical field. Currently, a large number of patients are also getting services from private hospitals. At the same time, the number of those relying on insurance for health care is also on the increase. India differs from China in terms of out-pocket expenditure equal to population growth (Yip and Mohal 2008). India outperforms some developed and developing countries in this out-pocket expenditure (Kalyani, 2015: 3124).

Health care expenditure in India is divided into several categories, 75% out of pocket, 15.2% out of state-government allocation, 5.2% from central government, 3.3% from third party insurance and employers, and finally 1.3% from domestic and foreign donors (Bank 1995; Bhatt and Jain 2006). Government funding has been very low for some years and the bulk of the funding for healthcare comes from private companies. In addition, most of this government funding is allocated to urban areas (Sengupta 2013). From the public healthcare budget, most of the funding is towards the salaries of the healthcare workers, so the lower percentage of the fund is spent on significant health areas, for

example, spending on medicine (Bhatt and Jain 2006). In specific, the Indian health sector is being challenged not only due to the continued dominance of out-of-pocket spending but also the overall low level of financial support from the government and lack of accountability on the part of the public delivery system (Nagpal, 2013: V). Owing to the above, the demand for private healthcare has increased. Actually, such an increase has been exponential from the mid-1990s to the early 2000s due to the low performance of public healthcare institutions. And streams of medicine have also increased since 2002 (Ghosh 2011). Sometimes, the government launched several programmes that worked out in favour of the rapid growth of private hospitals. All these have contributed to a heavy financial burden on families. Therefore, some households are spending a large percentage of their family income on healthcare especially if they are below the poverty line. For example, in Andhra Pradesh people spend 6% of the total income of their family on their health (Prasad and Raghavendra 2012).

In view of that health insurance in the country emerged as a social security measure to handle the increased health care costs due to the quality service that private hospitals have been able to provide compared to the public hospitals that are suffering from certain inherent problems. Insurance means that a group of people together pay medical bills of a person otherwise an individual patient alone has to pay from his/her pocket if not covered by insurance. Currently, in developing countries like India, this health insurance is divided into four categories, namely, (1) Social Health Insurance Scheme (SHIS), (2) Private Health Insurance Scheme (PHIS), (3) Community Health Insurance Scheme (CHIS) and (4) Government Health Insurance Scheme (GHIS). These schemes differ grossly from one another in terms of methods of payment and coverage. For example, there is a pay-roll exemption in SHIS, but it is a voluntary exemption in the case of CHIS and PHIS and tax-based policy in the case of GHIS (Subba Lakshmi and Dukhabandhu 2013). Despite the existence of all these schemes, many people are unaware of insurance and even get involved with an insurance service with unethical values. In a survey conducted in five villages in Pune district, Maharashtra, it is revealed that most respondents do not know about insurance (Pandve and Chandrakant 2013). Vimo-service is found to be an organization providing unethical service of insurance (Desai 2009). In view of that some of the health insurance schemes launched by different state governments for the poor, such as (i) Vajpayee Aarogyasri (VAS) in Karnataka: particularly the state of Karnataka has launched free health services for all families below the poverty line in the state through this health insurance scheme for the recovery of patients suffering from certain ailments. In fact, private hospitals charge huge amounts of money for treating patients with certain identified diseases. A person residing in the State of Karnataka is covered under the Vajpayee Aarogyasri Health Insurance Scheme if he/she belonged to the "eligible household" as

defined by the National Food Security Act, 2013 and the government issued a card to all the eligible families. Otherwise, one is considered a general patient who has to bear the entire cost of treatment on his or her own. (ii) Chief Minister's Comprehensive Health Insurance Scheme (Amma Health Insurance)-CMCHIS: This scheme is a positive step towards providing world-class health care to millions of people in the southern Indian state of Tamil Nadu. The scheme has successfully covered more than 65% of the state's poor families with low annual incomes. With "Amma Maruthuva Kapitu Thittam", the patients do not have to fight financially during a medical emergency. This insurance plan covers the whole family with cashless services. In addition to hospitalization and diagnostic service, follow-up service is also very important. Generally, there is no follow-up under a commercial health insurance plan. This further reduces the financial burden of medical treatments (*https://www.acko.com/health-insurance/chief-ministers-comprehensive-health-insurance-scheme/*Retrieved 4th April 2021, 10.15 AM). (iii) Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PM-JAY) The AB-PM-JAY is launched in 2018 as the flagship of the government of Bharatiya Janata Party. This healthcare insurance scheme states its commitment as to "Never Leave Anyone". More than 10 crore people are guaranteed healthcare cover up to Rs.5 lakhs. It covers largely those admitted to private healthcare institutions (*https://pmjay.gov.in/ Retrieved 2nd April 2021 and 3 PM*). (iv) Rajiv Aarogyasri Community Health Insurance Scheme (RACHI): Arogyasri is the flagship scheme of all health programs of the State Government of Andhra Pradesh to provide quality health care to the poor i.e., families below the poverty line. The state government has set up the Arogyasri Healthcare Trust with the aim of achieving "health for all" to effectively implement the scheme. Under the scheme, the facilities include free food, transport, free follow-up service and cashless treatment for the targeted families. In short, Rs. 2 lakhs have been given to each targeted family and 949 diseases are included in this insurance (*https://aarogyasri.telangana.gov.in/ASRI2.0/ Retrieved 5th April 2021*). In addition to this, an organ transplant facility is also provided. So far 70 lakh people have been benefited under this scheme and this works for more than 80% of the individuals in the state. Despite its benefits, it has been confronted with several criticisms. Although many are sceptical of its sustainability (Reddy and Mary 2013); it excludes street residents and migrant workers. Further, it has been pointed out that more than the Scheduled Caste and Scheduled Tribe families the insurance scheme has been made use of by the socially dominated castes (Rao 2011). Some poor families do not know anything about this scheme (Kalyani 2015). While in-network hospitals, patients still spend more on the things which are not covered under the insurance (Michelle, Ajay and Thomas 2011).

As a whole, the government has been able to address the motto of health for all through its inclusive policy. It realized that the current health system excludes the poor

and marginalized sections. From the theoretical academic debate and discussion, the question of health can be conceptualized from the framework of social exclusion and inclusion. Social Exclusion has been in use in the academic literature and policy documents since the 1970s, as it is being adopted by the National and International agencies like World Health Origination, the European Union and the World Bank that finger out the process of social exclusion among the lower-income groups in almost all countries in the world. Such people need to be included in mainstream society or the common resources through certain welfare schemes. Under this inclusive policy, governments have initiated several schemes, policies and programmes for the welfare of such excluded people who are being neglected over several decades. In the Indian context among them, Aarogyasri scheme is one, which tried to include those excluded some families, but they failed to be included into the group of people who usually avail efficient and quality healthcare service, due to inefficient service of healthcare provider, which can be called 'passive-exclusion'. Another set of people, who are deliberately excluded from this insurance service because of their ineligibility to be members or beneficiaries of the scheme. This process is called 'active exclusion'. These concepts of active and passive exclusions are proposed by Amartya Sen (2000). The present study focuses on why only set of patients has obtained a better healthcare service under the insurance coverage and why not all the patients?

Methodology

The study was undertaken among the patients who received free healthcare benefits through Arogyasri. It covered the beneficiaries both from private and public network hospitals in Hyderabad. By the time of the survey, they had completed hospitalization and were in a post-hospitalized state. Some of them were also using prescribed medication. A total of 132 patients were covered in the study, and they are divided equally between the two-sector network hospitals by 66 patients and all of them were from the slums of Hyderabad. They received healthcare from 6 public network hospitals and 28 private network hospitals. The patients were selected based on patient's information collected from the Arogyasri Trust for this purpose, and through a non-random sample method by obtaining their consent over the phone for interviewing them at their residences.

Results and Discussion

At the beginning of the post-hospitalized stage, the patients had the opportunity to receive free services from network hospitals where they were treated for a short while; it is termed as the recovery stage of the patient. At this stage, they are on medication and also under the supervision of doctors though not directly. Through this survey, we will examine which sector network hospitals are providing better and more efficient health services,

and also how much the financial burden on patients has been reduced. The following is an overview of how patients recovered after being hospitalized and how they progressed in this order. Generally, after hospitalization, every patient must have a certain period of time to recover from his or her disease. At this stage, the patient has the opportunity to receive free post-hospitalized check-ups from the respective network hospitals. By the time of the interviews, it was noticed that many of them had completed these check-ups and obtained the assistance of free medicine from the network hospitals concerned, so the hospitals stopped supply of medicines to them. In addition, 6.1% of patients were not instructed on this check-up and were advised to continue using the medication given at the time of discharge, as shown in Table 1. Of the 6.1% of patients, most of them (4.6%) are from private hospitals. This is due to some non-cooperation of the private hospitals.

Table 1: Post-Hospitalized Check-ups

	Private	*Public*	*Total*
Received post-hospitalized check-ups	57(43.2%)	59(44.7%)	116(87.9%)
Not availed though they obtained the reference	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%)

It is important to note that some patients did not go for post-hospitalization check-ups. It is because they were not satisfied with the treatment offered to them during the hospitalization even though there was the provision for post-hospitalization check-ups and in some cases, the distance from their homes is too long to cover. But there are also some patients from private hospitals who said they were completely satisfied with the service provided in the hospital and therefore did not feel like attending these check-ups to avoid the cost of transportation. Some patients who were treated in public network hospitals turned down this post-hospitalization service due to the unavailability of diagnostic equipment and medicines. Apart from that some of them also said that they have lost faith in these hospitals because of the inefficient service being provided in the public hospitals. They accounted for 5(3.8%) of patients from government hospitals and 3(2.2%) of patients from private hospitals. They are outnumbered by public hospitals in comparison. Network hospitals offered patients specific time schedules as part of the first post-hospitalization check-ups at the time of their discharge from the hospitals. These first-post-hospital visits are divided into three types. These are: visit within a month, after two to three months, and finally for some it is after six months.

The patients who made post-hospitalization visits account for 46.2% from public network hospitals and 37.1% from private network hospitals. Some persons started making visits for these check-ups immediately after discharge from the hospitals i.e., within a month, Table 2 shows the frequency of these visits. Among those who visited the hospitals for these check-ups two to three months later, from the private hospitals are approximately three times higher than those from the public hospitals. The last category of patients is all from the private network hospitals only. Hence, it is understandable that public network hospitals provide these post-hospitalization check-ups to patients more quickly than private hospitals. Overall public hospitals offer these services at a faster pace but it makes sense that private hospitals are not showing any interest in this matter.

Table 2: Referring First Post-Hospitalization Check-Ups After Discharge

	Private	*Public*	*Total*
Within a month	49(37.1%)	61(46.2%)	110(83.3%)
Two to three months	9(6.8%)	3(2.3%)	12(9.1%)
Six months	2(1.5%)	-	2(1.5%)
Not referred	6(4.6%)	2(1.5%)	8(6.1%)
Total	66(50.00%)	66(50.00%)	132(100.00%)

Many patients have used these hospital services several times as public network hospitals are ready to provide their services to patients at all times at this stage. Although these hospitals provided this service to patients many times, but a question arises here that why did they need this service several times. Whether this has really helped patients to recover faster and start their financial activities, as usual, is clearly discussed below. In stark contrast to this type of service, private hospitals offered this service up to 15 times to some patients, it was much less often than in public hospitals. The frequency of most of the public hospitals was approximately 21 - 30. The two-sector network hospitals are similar to each other in providing this service to patients five or fewer times. These two types of hospitals differ from each other in providing this service more than five times, shown in Table 3. Patients visited public network hospitals frequently as they were easily accessible. But in some cases, they did not visit because these hospitals did not provide them with any effective service and there was no rapid recovery. For example, a 23-year-old patient named Khan received treatment for an ear infection from a public network hospital in King-Koti. He visited about 25 times for check-ups as part of the post-hospitalized service but there was no relief. The doctors finally advised him to register afresh with the insurance scheme for getting this hospital service again.

Table 3: The total number of Post-Hospitalized Check-Ups of the Patients

The total number of check-ups	*Private*	*Public*	*Total*
1-5 times	45(34%)	45(34%)	90(68%)
6-15 times	12(9.2%)	10(7.6%)	22(16.8%)
21-30 times	0	4(3.1%)	4(3.1%)
Not availed (due to dissatisfaction and distance)	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%)

Loss of Working Days: Generally, patients take some rest after getting discharged from the hospital, during which time they have no income, so they depend on family members and other financial resources for meeting their basic needs and buying medicines. Of 50(38.1%) total such patients, 22(16.8%) are from the public network hospitals and 28(21.3%) from private network hospitals, as shown in Table 4. While some patients used to earn before admission into the hospital, it is observed that some were able to resume their daily activities and engaged in earning also after recovery from the diseases and after taking some rest at home. Hence, some patients recovered quickly and were able to earn meet their basic and health needs. Such of them are more from the private network hospitals.

The long-term rest sometimes depends on the type of the service or the type of network hospitals they relied upon, and the severity of the disease they are suffering from. For example, a 63-year-old woman has gone through surgery for a cardiovascular problem, under the insurance plan, and she still uses her medicine a year after the surgery. She depends upon her family members for medical expenses. It is a financial burden on her and her family as well. She says she will have heart pain if she does not take the medicine daily, so she needs a lot of rest for the rest of her life. Also, as these medicines are not supplied by the hospital, she has to buy them or the family member buy them for her from their meagre earnings.

Table 4: Loss of income for the inability to work in the first few days after discharge from the hospital

	Private	*Public*	*Total*
A month and below	20(15.2%)	18(13.7%)	38(28.9%)
Two to three months	6(4.6%)	1(0.8%)	7(5.4%)
One-year	2(1.5%)	3(2.3%)	5(3.8%)
Not effected	38(28.7%)	44(33.2%)	82(61.9%)
Total	66(50%)	66(50%)	132(100%)

***Medication*:** After hospitalization, patients are required to be on medication as prescribed by the doctor. In several cases, the impairment caused by the disease is so substantial that full recovery or coming back to normalcy is not possible even if they are using medicines. Some continue to take medicine for a short duration but some have to take it for a long time. It would have been nice if network hospitals had taken major responsibility of providing medications to insured patients until the complete recovery from illnesses but that is not the case. So, there is an unavoidable burden of buying medicines in the market for a longer period, which causes their families to get into financial crisis time and again which often make them debt-ridden continuously. The following discussion describes who supported them financially and how many resorted to seeking lenders. By the time the interviews were held, 85(64.3%) had completed post-hospitalized medication. According to the category of hospitals, they are divided into 33.3% from private hospitals and 31% from public hospitals respectively. The remaining 35.7% of patients purchased the medicines on their own or with family support, and borrowings, at this post-hospitalized stage.

Table 5: Various financial aids for their medications in the post-hospitalized stage

	Private	*Public*	*Total*
Family support	10(7.6%)	19(14.4%)	29(22%)
Self-dependent	7(5.3%)	3(2.3%)	10(7.6%)
Borrowed / lenders support	4(3%)	1(0.8%)	5(3.8%)
Network Hospital	1(0.8%)	2(1.5%)	3(2.3%)
Completed medication	44(33.3%)	41(31%)	85(64.3%)
Total	66(50%)	66(50%)	132(100%)

As table 5 shows, a significant number of the patients that accounted for 29(22%) have the support of their families for their medication because they are not earning at this stage. Of them, 19(14.4%) are from public hospitals and 10 (7.6%) patients are from private hospitals. As mentioned earlier, some of them borrowed money from others to meet the hospital expenses because there are no earners in their families and also, they themselves are unable to work. And, most of them are from private hospitals, and their number is nearly four times those who received treatment in public hospitals. Although the total number of patients who depend on lenders is relatively small in this stage, most of them are from private hospitals, which is the result of a shortage of earners in their families. According to this table 5, most of the patients in private hospitals have completed

their medication. Compared to patients in public hospitals, fewer patients in these private hospitals have obtained the families which means that they failed to obtain such financial support from their family members because there was absent of more number earners in those families and also the money that their family members earn would only be enough to meet their families basic needs and none couldn't be leftover to meet their medical needs. Moreover, more patients of the private hospitals are self-dependent as they restarted earnings immediately after their resting period is over, and eventually, support themselves financially for purchasing their medicine.

Borrowing in the Hospitalized Stage: The ultimate goal of the insurance scheme is to provide comprehensive guaranteed and cashless health services to the patients enrolled in the scheme, but on the contrary as empirical evidence unfolds it is not the case in practical terms. Specifically, the patients are required to spend on medical and non-medical needs after their admission into the hospital on their own savings or money borrowed from others, but the main hospital expenses are paid through the draft or check or transferred directly by the insurance to the hospital. They are more numbers in the stage of hospitalization compared to the post-hospitalized stage. They are 41(31%) hospitalized patients as shown in table 6 and just 5(3.8%) post-hospitalized patients as shown in table 5. At the hospitalized stage they depended on different resources to meet their needs, namely creditors, friends, relatives and siblings as table 6 clearly explains. Among all of them, lenders stand out in the first place.

Table: 6 Money that they borrowed in Hospitalized stage

Finance in hospitalized Stage	*Private*	*Public*	*Total*
Money-lenders	2(1.5%)	17(12.8%)	19(14.3%)
Relatives	5(3.8%)	1(0.8%)	6(4.6%)
Friends	6(4.5%)	8(6.1%)	14(10.6%)
Siblings	0	2(1.5%)	2(1.5%)
Not borrowed	53(40.2%)	38(28.8%)	91(69%)
Total	66(50%)	66(50%)	132(100%)

In this stage, as mentioned in table 6, the insurance beneficiaries relied heavily upon lenders and borrowed money on interest. Such patients in public hospitals have eight rates higher than those in private hospitals so far as the borrowing is concerned. In the post-hospitalization phase, there are only fewer cases of borrowing, but for the hospitalized stage, most of them belong to private hospitals as shown in table 5. In the opinion of some patients, they spent their own money on diagnostic tests and medicine in the same

private network hospitals, before they were admitted to the same hospitals. But in public hospitals, however, they spent after they were admitted in the hospital as some of their tests were also done in the private diagnostic centres and for other needs. In this regard, the non-medical needs of the patients in those public hospitals include food expenses, transportation costs, and giving tips to fourth-grade employees. Medical requirements include spending on diagnostic tests and medicine. Due to the shortage of diagnostic equipment, government hospitals have asked the patients to go to private hospitals or diagnostic clinics for tests where they spent money out of pocket with an assurance that money would be reimbursed to them later by the respective network hospitals but it did not happen. While some patients borrowed, some others turned to friends, siblings and relatives for money, which is a comparatively equal proportion to these private and public network hospitals. The vast majority of people from public hospitals relied heavily on creditors at the time of hospitalization and they are continued in debt even in the post-hospitalized stage. In this regard, some of the patients in private hospitals are in a safe position comparatively.

Side-effects and Sufferings: After being admitted to the hospital, they fell ill due to some side-effects for reasons and these include pericardial headache, ear swelling, sore throat, abdominal pain, etc. They make up 10.1% of the total in both categories of the hospitals, while 7.7% in the case of public network hospitals and 2.4% in private network hospitals, as shown in table 7. Compared to private network hospitals, such side-effects are five times more in government hospitals/public hospitals. These diseases are not covered under the insurance. Consequently, they had to spend money out of their pocket for treatment. So, they depend on the local private healthcare providers for the treatment of these side effects. It can be observed that a very small number of such patients is from

Table 7: Minor diseases encountered in the post-hospitalized stage

	Private	*Public*	*Total*
Headache	1(0.8%)	5(3.8%)	6(4.6%)
Swelling of ear	0	1(0.8%)	1(0.8%)
Throat pain	0	1(0.8%)	1(0.8%)
Stomach pain	1(0.8%)	0	1(0.8%)
Suffering with same diseases	1(0.8%)	0	1(0.8%)
Enlarging body-size	0	2(1.5%)	2(1.5%)
Leg pain	0	1(0.8%)	1(0.8%)
Not affected	63(47.6%)	56(42.3%)	119(89.9%)
Total	66(50%)	66(50%)	132(100%)

private hospitals. The patients of public network hospitals, as a result of out-of-pocket expenditure, became poorer and the families continue to face financial problems as there is no insurance coverage for these diseases as mentioned earlier. In this regard, it would be best to treat such diseases also under insurance as well. The public network hospitals, i.e., the government will have to pay special attention to these health issues and equip themselves with expertise and technology for making their services effective and helping the poor patients reduce out of pocket expenses.

Conclusion

Although the Arogyasree insurance scheme in Andhra Pradesh was initiated with the noble aim of catering to the health needs of the poor, the present study reveals that the efficiency of the government network hospitals needs to be improved. They are in a position to provide prompt and repeated service, but the quality service delivery required to be enhanced to bring it at par with the private hospitals. It is to say, there must be more budg*et al*location of the government on healthcare in the state or country. Patients are spending large sums out of pocket during hospitalization in public hospitals. Further, there is a need for additional expenditure in the post-hospitalized stage for getting treatment for the side-effects, and such cases are relatively more among the patients of the public than from those of the private hospitals. The private hospitals also required strict supervision of the government so that these hospitals optimize their efficiency and also can accommodate a larger number of insured patients. In general, welfare scheme such as Arogyasree has not been able to achieve their goals to a hundred per cent though to a large extent it helped the inclusion of poor and marginalized families in quality healthcare. For total satisfaction of the BPL beneficiaries, it is needless to state that cashless healthcare services require up-gradation of public network hospitals. Therefore, if the services of public network hospitals continue to remain in the same state of affairs, it will be very difficult to deal with a virus-like Covid-19 properly if there is going to be a third wave or if there will be a similar pandemic situation in future.

The scheme excludes certain individuals from its coverage which can be termed as the active exemption. It is because it provides some relief but it is inadequate health service through its network hospitals. As a result, few patients still suffer from the burden of persistent illness even after hospitalization, as they had to incur unexpected expenditure during hospitalization and also during post-hospitalization, which comes under the category of passive exclusion because these patients are not excluded deliberately but being excluded passively by inadequate and poor service delivery of its network hospitals, among them, public network hospitals stand at the first position in this regard.

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References

Bhat Ramesh and Jain Nishant. (2006). Analysis of Public and Private Health Expenditure. *Economic and Political Weekly* 41(1): 57-68.

Duran, Antonio, Kamal Gulati, Arunachalam Gunasekar, Shakti Kumar Gupta, Parmeshwar Kumar, Chandrakant Lahariya and Angel Rajan Singh. (2015). Public Hospital Governance in India. *World Health Organization,* 222-255.

Ghosh, Soumitra. (2011). Catastrophic Payments and Impoverishment due to Out-of-Pocket Health Spending. *Economic and Political Weekly* 46(47): 63-70.

Kalyani, P. (2015). A Study on Implementation of Community Health Insurance Scheme in Cardiology Department of a Tertiary Care Government Hospital. *Evaluation of Medical Dental Sciences* 4(18): 3124-3133.

Nagpal, Somil. (2013). Expanding Health Coverage for Vulnerable Groups in India. *The World Bank,*1-40.

Rao, M. *et al.* (2011). Addressing Healthcare Needs of People Living Below the Poverty Line: A Rapid Assessment of the Andhra Pradesh Health Insurance Scheme. *The National Journal of India* 24 (6): 335-341.

Rao, M. Govinda and Choudhury Mita. (2012). *Healthcare Financing reforms in India*. National Institute of Public Finance and Policy 2012. Available at: *https://www.semanticscholar.org/paper/Health-Care-Financing-Reforms-in-India-Rao-Choudhury/3ca423b3e151ea4f63ce6aaec9d0f4c71b304cff?p2df. Retrieved 2nd April 2021.*

Reddy, Sunita and Mary Immaculate. (2018). 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.

Sen, Amartya. (2000). *Social Exclusion: Concept, Application and Scrutiny.* Asian Development Bank. Available at: *https://www.adb.org/sites/default/files/publication/29778/social-exclusion.pdf.* Retrieved 5th April 2021.

Sengupta, Amit. (2013). *Universal Healthcare in India: Making it public and making it a reality*. *MSP Occasional Paper.* Available at: https://www.municipalservicesproject.org/sites/municipalservicesproject.org/files/publications/Sengupta_Universal_Health_Care_in_India_Making_it_Public_May2013.pdf. Retrieved 16th March 2021.

Subba, Lakshmi T. and Dukhabandhu Sahoo. (2013). Healthcare Financing Mechanisms in India: An Examination of Health Insurance. *International Journal of Scientific Research* 2(1): 160-163.

Waddington, Catriona and Claudia Sambo. (2015). Financing healthcare for adolescents: A necessary part of universal health coverage. *Bulletin of the World Health Organization* 93(1): 57-59.

Yip, Winnie and Mohal Ajay. (2008). The healthcare system of China and India: Performance and Future Challenges. *Health Affair* 27: 921-932.