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The price of obfuscation

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“Demand Side” Health Insurance in India: The Price of Obfuscation

Stefan Ecks

Social Anthropology, University of Edinburgh

ABSTRACT

In India, most healthcare expenses are patients’ out-of-pocket payments to private sector providers. Catastrophic health expenditures drive millions of families deeper into poverty. To save poorer households, hundreds of government-funded health insurance schemes have been introduced since the 2000s. These “demand side” schemes suggest that treatments in the private sector will be fully reimbursed. Fieldwork in one of India’s largest hospitals shows that GFHIs overpromise. GFHIs are designed to turn patients into co-creators of healthcare value, but instead they deepen individuals’ lack of market transparency. Poor patients pay the price for the state’s lack of trust in them.

KEYWORDS

Health insurance; India; poverty; neoliberalism; healthcare financing; value

Baseer was upset. He had just been told that their government-funded health insurance (GFHI) would only cover Rs. 2,000 ($27) of his brother Ali’s tumor surgery. Baseer and Ali were members of a GFHI scheme called Yeshasvini, which promised to pay for up to Rs.150,000 ($2000) of hospital expenses. The brothers had expected that the scheme would cover most, if not all, of Ali’s surgery costs, which were estimated at Rs. 25,000 ($334). Baseer could not understand how the hospital’s insurance office had arrived at this calculation: “We just did the insurance approval. The office person said that we would only get Rs. 2000 ($27). What is the point of getting Rs. 2000 from Yeshasvini? We are poor people! They should cover at least half the cost.”

The brothers were both in their 40s, Baseer a few years older than Ali. They came from a poor rural family, surviving on Rs. 70,000 ($945) per year. They named their occupation as *kuli karmika*, day laborers. They lived in a village 35 km away from Mysore, the second largest city in the Indian state of Karnataka. Baseer said the family only owned one hectare of land and could not afford to sell any of it to cover high medical bills. The news that their government-funded health insurance would only cover a fraction of the cost was distressing. Baseer underlined that they had been paying their annual membership fees for several years and that they had never made a claim before. They had hoped treating Ali’s liposarcoma would be made affordable by Yeshasvini. The tumor – a rare kind of cancer that becomes life-threatening if left untreated – formed a visible lump on Ali’s neck. They had anticipated that the treatment would not be entirely free: no one could ever go to hospital without any expenses, he said. Even before deciding if they wanted to go through with the surgery at JSS Hospital, they had already spent Rs. 6000 ($80) on an MRI scan, Rs. 2000 ($27) on blood tests, Rs. 500 ($6.70) for X-rays, and around Rs. 3500 ($47) for miscellaneous expenses. Baseer said the family could spend another Rs. 10,000 ($133) from their own money. But that they should only receive Rs. 2000 out of a promised maximum of Rs. 150,000 was bad news. It further worried them that Rs. 25,000 ($334) was just a quote, and that the final bill might still be much higher. The doctor in the hospital warned them that the procedure could cost up to Rs. 50,000 ($668), so it was hard to predict what kind of additional charges for medications or further procedures might arise.

CONTACT Stefan Ecks stefan.ecks@ed.ac.uk Social Anthropology, School of Social & Political Science, George Square 15a, University of Edinburgh, Edinburgh EH8 9LD, UK.

Media teaser: In India, the cost of private healthcare drives millions of people into poverty. Government-funded health insurance schemes that prioritize private market competition and individual decision-making fails to help.

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Baseer wanted to return to JSS Hospital's insurance counter to see if more could be done, but the brothers were already weighing their options on what to do next. A shift to Mysore's government hospital was a possibility. The government hospital would probably take less money for the surgery, but they would have to wait longer to be seen and be treated. They also viewed the government hospital with suspicion because, they said, doctors there were not as good as at JSS. Baseer said it could always happen that government doctors would send them back to be treated at JSS because the public hospital did not have enough time or enough staff.

The family had no enrollments in other GFHIs from where additional cover might come. Whether there were any other sources of funding, the brothers were unaware. They knew of another GFHI for cancer treatments for poor people, the Vajpayee Arogya Shree (VAS). JSS Hospital also participated in the VAS scheme. They had checked if VAS would reimburse the treatment, but for unclear reasons, liposarcomas were not covered.

India's healthcare schemes force poorer people to perform complicated valuations of health, wealth, and well-being. How much extra money was it worth spending on Ali's surgery? The answer hinged on many variables: the cost of the surgery, the family's total assets, Ali's earning potential, other household expenses on health, food, education, and maintenance of their land. They had to evaluate if membership in the health scheme was worth it. Yeshasvini's annual membership fee for each family member was Rs. 200 ($2.70). Ali and Baseer together had already paid more than Rs. 2000 (US27) for membership before going for the liposarcoma surgery. If the insurance only covered Rs. 2000, was it even worth being part of this scheme? Was it worth doing the procedure in JSS Hospital instead of the government hospital, where costs were lower but quality was lower as well?

The answer to whether Ali's family should pay an additional Rs. 23,000–48,000 for his life-saving surgery depends on a series of "biocommensurations": contextual decisions about whether an action will make life better or not (Ecks 2022). Biocommensurations compare two or more entities for which is better at enhancing life, drawing health, disease, and medicine into comparisons with living and non-living entities. In the case of Ali's liposarcoma, these value comparisons included human lives (Ali's life relative to other family members), nonhuman assets (the relative value of money, insurance, land), and actions (the treatment).

What is valuable and what is not depends on many criteria. Whether it is worth spending money on health insurance is compared to other costs, including education and food. The criteria for comparisons vary by social, cultural, and economic contexts (Espeland and Stevens 1998). In Ali's case, whether an additional expenditure of Rs. 23,000 was "worth it" depended on how much cash the family could spend; how much money they had already spent; and how much they were set to lose when the tumor progressed. Ultimately, it depended on how much Ali's life was worth. Amy Dao (2020), in her work on private health insurance in Vietnam, calls these cost comparisons "anticipatory activities." The decision of whether to go through with the surgery exemplifies what health economists call "expected utility" (Doherty and Eeckhoudt 1995). What preferences for action do people reveal when they face highly uncertain outcomes, and how do these preferences change depending on the relative value of different variables? Because of the family's relative poverty in the case I have described, they were extremely sensitive even to small variations in the price of the surgery and the relative value of the insurance reimbursement.

Valuing health and therapy is directed toward deciding between different transactions. For example, should the family make an out-of-pocket payment for a medical treatment even though it presents a catastrophic household expenditure? Transactions can be direct exchanges, such as A gives money, B gives service. Out-of-pocket (OOP) healthcare expenses are an example of direct exchanges: a patient gives money to a healthcare provider in return for treatment. Transactions can also be indirect or involve more than two exchange partners. For example, in reimbursements, C can give money to B for services rendered to A, or C can give money to A for services received from B. Insurance schemes always involve several transactants. Each transactant makes their own value calculation, and what seems "worth it" to one transactant may not look worth it to another.

As social processes negotiated among different transactants, biocommensurations rest on several factors: recognition, transparency, routinization, institutionalization, expertise, and technological elaboration. Recognition can vary between A and B, what A sees as a fair exchange may differ or agree with what B recognizes as fair. Further, there are degrees of transparency about what is being valued and who is doing the valuing. Each dimension differs by how routinized commensurations are (making valuations frictionless usually increases value). This includes degrees of institutionalization. Each differs by levels of expertise required to perform a convincing valuation. Levels of expertise, routinization, and institutionalization are tied to varying forms of technological elaboration. When health is valued, the work of experts in institutions, and of the accounting technologies used, can vary considerably.

All these dimensions mattered in Ali's case. In terms of recognition, Ali and Baseer saw the insurance calculations as illegitimate. There was a huge gap in routinization: JSS Hospital did valuations professionally and regularly, whereas claimants have next to no experience. The institutionalization of the insurance and of the hospital costing was so high that the brothers had nothing to match it. The expertise and the technological elaboration also lay entirely with these institutions. Most serious was the lack in transparency: the brothers had no idea why only Rs.2000 would be reimbursed, or what parts of the surgery were on Yeshasvini's approved list and which were not. They did not know if going to another hospital might be cheaper or not, nor did they know if the treatment at a cheaper hospital would have the same quality of care. They also struggled to value insurance and hospital fees against what they were set to lose or gain if they did not go through with the surgery. Crucially, this is not merely a "lag" in public understanding of how insurance works that will eventually disappear when people are more accustomed to insurance schemes (Ahlin et al. 2016:9–11). Nor is claimants' lack of market transparency produced by a willful cost obfuscation by providers (Mulligan 2016). Instead, this lack of transparency is a systematic fault in the design of India's government-funded health insurance. The way the Indian schemes work will never put patients in a position where they have as much market transparency as, by the schemes' own criteria, they are supposed to have. The stated intention behind India's GFHIs is to help poorer people avoid catastrophic health expenditures. But in practice, they exacerbate upsetting situations where people are forced to calculate the value their families' lives under conditions of duress. In India, the poor pay the price for this lack of transparency.

Demand side insurance: patients as co-creators of private market value

Yeshasvini, the scheme that Ali claimed for, was one of many new health financing schemes for poor people that were introduced in India in the past decade. In the 2020s, India has five key forms of healthcare financing: household out-of-pocket (OOP) payments, government health facilities, non-state charities, private health insurance, and government-funded insurance. Yeshasvini is one of these GFHI schemes. Until the 1990s, only three of these forms existed: the government institutions, the charitable sector, and OOP spending. Public insurance included a handful of schemes for formal sector employees, such as the Employees' State Insurance. Faith-based charitable institutions have long been of great importance: various Hindu, Christian, and Muslim hospitals have been active since the nineteenth century. But OOP spending has been the chief source of financing throughout the post-Independence era. Even during the three decades of Indian National Congress governments after Independence (1947–1977), when the private market was curtailed and public infrastructures prioritized, private households had to shoulder the majority of healthcare costs (Jeffery 1988).

Overall health spending in richer countries is around 9% of GDP. In Brazil, 8.9% of GDP is spent on health; in China, 5.2%. In India, only 3.9% of GDP is spent on health. Almost no other comparable country spends less on health than India (OECD 2015:156). This is overall spending: the share of the government has been around 1% of GDP since the 1990s (Government of India 2019; Rao and Choudhury 2012). Today around 70% of all health care expenses continue to be paid by people out of pocket.

Government hospitals are meant to cover all citizens' healthcare needs, but in reality the public sector facilities supply only 30% of health services. Even compared to other lower and middle-income countries, budgets allocated to health are extremely low in India (Khetrapal et al. 2019). In the 2010s, central and state governments' shares of health spending further declined, from around 40% to 30%. In 2014, a new BJP-led government under Prime Minister Modi enacted a budget cut to health of 20%.

The state of public sector health facilities is of varying quality and availability. There are a few elite institutions (such as the All India Institute of Medical Sciences at Delhi) and a number of decent large hospitals across the country, but the general story of India's public health sector is one of chronic underfunding. Healthcare in the private sector, meanwhile – always much larger than the public sector – has been growing.

In the late 1990s, the Indian government liberalized the market for private health insurance. Since then, private insurance companies, both Indian and multinational, are allowed to operate. The private insurance market splits into schemes for employers and schemes for private households. Employer schemes give cover to workers for the time of employment. Most large private corporations offer their staff some form of private health insurance.

The individual private health insurance market remains insignificant: only around 2% of Indian households had private insurance in the 2010s (Statista 2020). Private insurance is only affordable to richer households. For example, to cover up to Rs. 300,000 of annual medical expenses for a family of four with Bajaj Allianz, the annual premium was around Rs. 10,000 in 2020. This is expensive for a middle-class household and completely unaffordable for a household living on less than Rs. 100,000 per year.

Since the mid-2000s, a fifth type of health financing emerged: government-funded health insurance, which offers publicly-funded means-tested reimbursements. In 2018, 33 such schemes existed in India (Hooda 2020). These forms of insurance are meant to help individual households prevent catastrophic OOP expenditures for health. The best-known programme of this kind is the Rasthriya Bima Yojna (RSBY), launched in 2008. In its prime, RSBY was the world's largest health insurance scheme by number of enrolled beneficiaries. Government support for RSBY petered out after the BJP-led government under Modi came into power in 2014, partly because RSBY was too closely associated with the previous Congress-led government. Since 2018, a new scheme called Pradhan Mantri Jan Arogya Yojana (PM-JAY) began to supersede RSBY.

Disastrous OOP spending on private healthcare has long been known about but was only acted upon by the state since the 2000s. In its *National Health Policy* of 2017, the Indian Ministry of Health and Family Welfare recognized "catastrophic expenditure due to health care costs" as one of the four most pressing problems in the country's healthcare system (Government of India 2017:2). In an earlier draft of the National Health Plan (Government of India 2014), these insights were more clearly expressed than in the final draft. The 2014 draft diagnosed a "failure of public investment in health to cover the entire spectrum of health care needs" (2014:8) and a "worsening situation in terms of costs of care and impoverishment due to health care costs" (2014:8). People's OOP expenditures were said to be "more impoverishing than ever" and that treatment in government hospitals could not protect against catastrophic health expenditures. "Catastrophic" here means that the cost of medical treatment is so high that families have to cut back on essential other items, such as food or their children's education, or that families have to take loans at high interest rates, or sell vital assets such as land. The Ministry estimates that 63 million people in India fall deeper into poverty every year because of OOP health costs (see Peters et al. 2002; Shahrawat and Rao 2012). In 2011–12, 18% of all Indian households experienced catastrophic health expenditures, up from 15% in 2004–2005.

All GFHIs share the idea that catastrophic expenditures are bad for both individual households and for the economy at large (Kasirajan 2012; Kien et al. 2016; Reshmi et al. 2012). All these schemes assume that existing public sector health facilities cannot supply sufficient affordable healthcare. All sections of Indian society, including poor people in rural and urban areas, consult private practitioners more than government practitioners (Bhatia and Cleland 2001; Devadasan et al. 2006; Madhukumar et al. 2012). GFHIs are meant to allow poorer people to access costly private health care without having to pay out of pocket. So-called supply side financing, in the sense of putting money into government infrastructures, was unable to

reduce household OOP expenditures. Hence Indian policy makers designed GFHIs as a new type of demand side financing that is meant to place the "freedom of choice" about health expenditures into the hands of the people. This, policy makers thought, would lead to new levels of transparency about healthcare costs and new levels of competition between suppliers for higher quality and lower prices.

What is called "demand side" can include a wide range of health financing strategies (Gupta et al. 2010). It can mean giving vouchers for health services to private households that can be used in private-sector clinics (e.g., Ahmed and Khan 2011). It can mean cash transfers to beneficiary households for the purpose of health expenditures. It can mean giving smartcards that are linked to a central database to private households, which they can then be used similarly to a prepaid debit card (Ahlin et al. 2016). All the major GFHIs in India are demand side schemes where beneficiaries enroll in a scheme and receive a card that they can use to claim for expenses to be paid from a central agency. For the beneficiaries, these look like "cashless" transactions. These cards give private individuals a choice between healthcare suppliers but they are not given a choice over other aspects. Notably, patients cannot negotiate the price and form of healthcare services with suppliers. They can take the card to a supplier but they cannot bargain with suppliers.

Demand side schemes can be seen as "neoliberal" because they favor self-reliance, individual choice, and market competition over state-provided welfare (Abadía-Barrero and Bugbee 2019; Cerón and Jerome 2019). Citizens are meant to change from passive recipients of government handouts to proactive consumers. In India as elsewhere, demand side financing is based on the ideology that free markets produce optimal decision-making and resource allocation. Once citizens were empowered as consumers, private providers would compete for their business. Through more market competition, healthcare costs would fall and quality would improve. Citizens-as-consumers would become co-creators of healthcare value.

Yet these healthcare schemes fail in "making citizens responsible for their own self-management" (Anjaria and Rao 2014:424–5). Their design assumes that the citizen, conceived as a rationally choosing *homo economicus*, operates in a transparent market and has all the necessary knowledge to make optimal decisions. It assumes that insurance cards would confer the same bargaining power to citizens as cash in their pockets would. But as Ali's case and many others I encountered show, the new schemes cannot override citizens' profound lack of healthcare transparency, and citizens are not given the same range of demand side powers that direct money payments would.

The influence of neoliberal economic thought on public health policies has been extensively analyzed (e.g., Ayo 2012: Pfeiffer and Chapman 2010). Neoliberalism is particularly evident in the US insurance market, where "the fundamental right is not to health but rather a (deeply stratified) consumer freedom" (Horton et al. 2014:3). Neoliberal insurance schemes arguably favor corporate profits over medical benefits to private citizens (Mulligan 2016). My ethnography of government-funded health insurance in India contributes to this debate by showing the blind spots of neoliberal health policy design. The idea behind GFHIs is that giving citizens discretionary spending powers will turn them into savvy, rationally choosing subjects whose demand brings down prices and enhances quality by private healthcare providers. The reality is that individuals cannot and do not play this role of co-creators of healthcare value. It is well known that neoliberalism shifts responsibility onto individuals, but how these supposedly responsibilized citizens are coping with the decision-making powers put upon them is much less explored.

The GFHIs I look at are markedly different from the types of "insurance" others have studied. One important difference is that India's GFHIs are predicated on citizens being able to compare value for money in different health services, as if they were comparing different consumer products. Even in the US, insurance claimants are not asked to compare value for money by specific procedure and by different providers, yet this is what India's GFHIs ask people to do. In practice, GFHI claimants are simply not in a position to compare providers in this way. The lack of transparency about healthcare is too deep and the costing of services is too complex. The poorest patients pay the highest price for being confronted with an obscure healthcare market.

Fragmentation and convergence in the GFHI market

Baseer and Ali were speaking to me in a seating area next to the health insurance office counters in Mysore's JSS Hospital. My fieldwork in Mysore and the rural areas around the city was part of an international research collaboration called Indian Health Insurance Experiments, which evaluated the uptake of new insurance schemes among poorer people in India (e.g., Nandi et al. 2015; Ecks 2018). This included participant observation and semi-structured interviews with 125 insurance claimants conducted in 2015. The interviews were translated and transcribed by a Kannada-speaking research assistant. All personal names have been anonymized.

More than 100 of these interviews were taken at JSS Hospital because it receives far more insurance claimants than any other hospital in the region. JSS Hospital is one of the largest hospitals in India and by far the largest in Mysore district. Up to 1,000 patients are treated every day in JSS's outpatient departments. The hospital has 1,800 beds. Across its 27 operation theaters, 3000 surgeries are performed every month. More than 20,000 inpatients and more than 16,000 outpatients are treated per month. The motto of the hospital is "to uphold the value of human life" (JSS 2020). It welcomes poorer people and those from the rural districts by being "dedicated to serving the poor and downtrodden with affordable and quality healthcare" (JSS [Jagadguru Sri Shivarathri] 2020). For poorer people, JSS Hospital was the first point of call for all serious health problems because of the low registration fee. For just Rs. 50, JSS allowed patients to be seen by one of the hospital's doctors. With a diagnosis in hand, patients could get a better sense of what the treatment costs might be. Charges for surgeries, medications and other services are also lower than at most other private hospitals in the region. The typical bed charge for staying in a private hospital ward was around Rs. 1,000 per day, but at JSS, it was only Rs. 200.

JSS Hospital is run by the Jagadguru Sri Shivarathreeswara Trust, a Hindu charitable organization with a strong presence in health and education in the south of Karnataka. JSS University comprises a medical college, a college of pharmacy, and several other medical disciplines. JSS also oversees a wide range of educational institutions, from nurseries to universities. The new hospital complex was opened in 2013. The building resembles an Indo-Saracenic palace on the outside, and a giant hotel on the inside. The hospital's open-plan arrival hall echoes loudly with the voices of hundreds of people waiting or walking through. The payment offices on the ground floor includes counters for different insurance providers. At the insurance counter where Ali's claim was processed, a range of other government-funded schemes are also administered. JSS accepted claims from 11 public schemes and 45 private schemes. The GFHIs included Vajpayee Arogya Shree (VAS), which covered costly cancer and cardiology treatments for people living below the poverty line; Employee State Insurance; Arogya Bhagya Yojana (ABY); Anyuta; and Sarva Sikshana Abhiyana. Each scheme had a different target group, enrollment criteria, ways of being administered, and limits of cover.

India's largest and best-known program was the Rasthriya Bima Yojna (RSBY), first launched by the Central Government's Ministry of Labor and Employment in 2008 (Ahlin et al. 2016). RSBY promised "below poverty line" (BPL) families up to Rs.30,000 for hospital expenses. The RSBY smartcard was meant to make claiming and reimbursing benefits "safe and foolproof" for all participants. The enrollment process was run by private insurance companies, which targeted high enrollment numbers and low claimant numbers. The government incentivized them to enroll as many people as possible because they got a premium for each person joining. In turn, private insurers did not benefit from anyone making claims. Most costs that came with hospitalization were not covered. RSBY reimbursed many hospital expenses, but neither out-patient treatments nor medications, the two principal sources of household health expenditures (Garg and Karan 2009; Shahrawat and Rao 2012). RSBY was unevenly available in different states of India. Some states provided continuous support for RSBY, whereas others never participated fully in RSBY, only participated for a limited time, or never committed sufficient resources to it.

In 2018, RSBY was superseded by a new scheme called Pradhan Mantri Jan Arogya Yojana (PM-JAY). PM-JAY covers up to Rs. 500,000 per year per family, much higher than RSBY's mere Rs. 30,000.

The scheme has a longer list of procedures and services covered. In particular, drugs and diagnostics are now better covered. Another difference is that PM-JAY smartcards can be obtained more easily than RSBY cards. Entitlement is based on data from the Socioeconomic and Caste Census (SECC), which establishes if a household is "BPL." These data are held on a smartcard called Aaadhar. Organized by the Unique Identification Authority of India (UIDAI), Aaadhar cards are the world's largest biometric ID system, capturing nearly 100% of the adult population. Aadhar's mission is to "de-duplicate" the entire nation so that no one is able to make fake benefit claims (Chaudhuri 2020; Cohen 2016). Eligible Aadhar card holders can go to a PM-JAY kiosk to obtain a card. Making it slightly easier to get enrolled might well be PM-JAY's main advantage over RSBY. One of the failures of RSBY was its haphazard enrollment process (Ecks 2018). Otherwise PM-JAY is similar to RSBY: beneficiaries are enrolled with a smart card, the card can be used in RSBY-empaneled hospitals across state boundaries, and the card reimburses hospitals. Similar to RSBY, PM-JAY continues to be focused on hospital expenses. PM-JAY also continues the politicization of health coverage in India (Hooda 2020): as noted earlier, the BJP government wanted to replace RSBY because it was too closely associated with the previous government. Since *Jai Hind* is the victory cry of the Independence fight, the new scheme's name might be read as "Prime Minister's triumph." Several states, including West Bengal, Telangana, and Odisha, did not join PM-JAY precisely because of their political opposition to the BJP-led central government.

By 2020, 124 million PM-JAY smartcards had been issued and 10 million claims had been reimbursed. One of the scheme's goals is to reduce the bewildering fragmentation of health insurance schemes in India. The government body overseeing the implementation of PM-JAY stated in its 2019 Report that "the funding and reach is very large in absolute terms as compared to any scheme in the world", but even PM-JAY is "still modest as per the overall health financing landscape in the country, especially when compared to the enormous out-of-pocket funding and the needs of the poor population" (Government of India 2019:17). On 31 May 2020, Prime Minister Modi (2020) issued a statement celebrating the first 10 million reimbursements under PM-JAY: "Crores of poor in our country have been living with a big worry since decades. Their worry is, what will happen if they fall sick: get themselves treated or earn bread?" (Modi 2020). PM-JAY solved their problem: they can go to hospital *and* eat. "You can imagine how relieved they must feel." Modi assured all Indian citizens who were not eligible for the scheme that their sacrifice was not in vain: "I want to tell the honest taxpayers of our country that you also deserve real credit for the happiness of the poor who has been treated free of cost. Our honest taxpayer is also real worthy of this good deed."

Meanwhile different states in India continued to introduce other coverage schemes. In 2018, the Karnataka state government started to roll out Arogya Karnataka, which is yet another form of health coverage of poorer people. Like PM-JAY, Arogya Karnataka also tries to reduce the extreme fragmentation of the health schemes. Hence the state government decreed that many other existing schemes, including Vajpayee, Yeshasvini, and RSBY, were going to "converge" with the new scheme. Like PM-JAY, Arogya Karnataka also bases eligibility and membership on the Aadhar smartcard. One difference of RSBY is that the new scheme is also open for families "above poverty line" (APL). The maximum annual coverage is also larger than that offered previously, at up to Rs. 500,000 for a BPL household and Rs. 150,000 for an APL household.

"The government should not cheat the people like this"

The Yeshasvini health scheme that Ali wanted to claim from was introduced in 2003 by a collaboration of farmers' cooperative societies and the Karnataka state government. Yeshasvini was one of about a hundred "community-based" GFHIs (Aggarwal 2010; Michielsen et al. 2011; Devadasan et al. 2006; Dao and Nichter 2016:26), and drew on existing infrastructures of rural cooperative societies. This eased the enrollment process: membership applications were accepted in tens of thousands of co-operative society offices dotted around Karnataka (Aggarwal 2010). The Yeshasvini card was not a biometric smartcard but a simple photo ID, which lowered the technological demands. Eligibility for

Yeshasvini was based on cooperative membership rather than BPL status. Membership was open to rural cooperative members as well as to informal sector workers in urban areas. The fee for enrollment per individual member was Rs. 200 per person. Yeshasvini reimbursed for both in-patient and outpatient procedures.

In a study that compared Yeshasvini members to BPL households without insurance, Aggarwal (2010:24) found that members were far more likely to go to private hospitals than the uninsured. Yeshasvini members borrowed around 30% less money to pay for expenses than nonmembers, and members had to take 74% less money from their existing savings than nonmembers: "there is strong evidence of financial protection offered by the program in cases of surgical treatment where the program has a significant direct price reduction effect" (2010:25). On the downside, the fixed package prices were "inadequate and irrational" (2010:26). The patients had to foot the bill for all costs not covered by Yeshasvini out of pocket. This explains why Yeshasvini members had 20% higher health care expenses than nonmembers: whoever had Yeshasvini was more likely to go to a private hospital than to a public hospital, yet the scheme left them with substantial out-of-pocket expenses. The fact that Yeshasvini members spent more on health care than nonmembers suggests that health cover had the unintended effect of making people spend more rather than less. The paradox that people "covered" by GFHIs end up with much *higher* OOP expenses than people without them has been consistently documented (Prinja et al. 2017; Hooda 2017; Ahlin et al. 2016:11).

Ali and Baseer's disappointing experience with having the costs of surgery covered by Yeshasvini was at odds with how health scheme administrators portrayed it. One of the scheme's district coordinators told me in an interview that "Yeshasvini is the most beautiful scheme." Members could be assured of extensive financial protection: "Once the approval is done, the patient will get free treatment, everything free." When I asked him why so many scheme members did not, in reality, get "everything for free," he conceded that, yes, not "everything" was covered. When medicines were unavailable in the hospital, patients needed to buy them from an outside medicine shop. When a procedure was not part of an approved package, patients needed to pay. When patients wanted procedures beyond the scheme's approved list, they had to pay. When a patient needed further procedures or needed to stay in hospital longer than pre-approved, they had to pay. When an operation had to be performed repeatedly, patients needed to pay. Bed charges and most non-surgery charges were outside coverage. Furthermore, the price list for the procedures was set by the Trust's central office in the 2000s. It had only been updated once. During the same era, hospital charges had hugely increased, so the maximum cover was not as great as it once was. On the whole, however, all these caveats were insubstantial: Yeshasvini absorbed the bulk of all treatment costs, and in most cases, no extra charges to patients were necessary.

In interviews with insurance claimants, we asked how people had become members of the scheme, whether they knew of other schemes, and, if they did, whether they were enrolled in any of them. In the majority of cases at JSS, Yeshasvini was the only kind of health insurance that people had or had even heard of. Awareness of other schemes was very limited. This included RSBY, even though the campaign to enroll people was under way during this time and most of the Yeshasvini members would have also been eligible for RSBY. In the 71 interviews we conducted with Yeshasvini claimants, only seven people said that they had even heard of RSBY. A 35-year-old man said he had enrolled in RSBY a week earlier: the panchayat (village council) had handed out tokens to BPL households and told them to bring all family members to the enrollment station. They went with the family of five and waited for two hours for their turn. When we asked him what the benefits of RSBY were, he said that he did not know: "I didn't get what is the use of that card. Someone just said we should go for enrollment. What is the benefit? I don't know." When asked why he had spent two hours in a queue, he responded: "Because panchayat (local council) people said we should go for enrollment."

Not one of the people we talked to at JSS had a clear understanding of how the health schemes actually worked. Most of them knew that with Yeshasvini they could go a hospital and that up to Rs. 150,000 ($2000) would be covered. People expected that, if the treatment costs were below Rs. 150,000, the scheme would cover all healthcare expenses. People only realized when they tried to make a claim

at the hospital that this was a false belief. When claimants learned about how much money would be covered, they were disappointed: almost all patients expected to receive more from Yeshasvini. If the costs were too high, they could ask to be discharged before the procedure was done. But in urgent cases, there was no time to reflect and choose. Whatever calculation the hospital arrived at was usually accepted.

What made claimants' informed choice of treatments even harder was that the JSS office never told them how they calculated the costs and what criteria they used. Claimants only received an estimate without details of how the insurance share was calculated. Some patients went to another hospital to check if they might give them a better price. Such shopping around was time-consuming and costly because hospitals did not accept each other's diagnostics, so to obtain a quote from another hospital meant that one had to pay for diagnosis again.

Take the case of Manjunath, a man in his 50s who suffered from a ruptured hernia. We talked to him and to his 30-year-old son after they had shifted to JSS from another private hospital. The other hospital quoted Rs. 30,000 ($400) for the procedure: Yeshasvini would cover Rs. 7000 ($93), the remaining Rs. 23,000 ($307) would have to be paid OOP. Manjunath was upset that Yeshasvini would cover only Rs. 7,000 and decided to try JSS Hospital instead. There they had to go through diagnostics again, costing another Rs. 2,500 ($33.30). Manjunath complained about how obscure the costing was. The government made big promises that they did not keep. Instead of only telling people the theoretical maximum reimbursement, the government should "make clear what is going to be paid, everything should be displayed on a board right during enrollment." He went on to say that the government got so many people to enroll because they had given them these promises, but then failed to deliver: "The government should not cheat the people like this."

Many claimants complained that the reimbursements were not high enough. The problem was not the maximum cover but that so many items were excluded. No one even got to exhaust the maximum amount because of the countless exclusions. In all the cases we recorded, no one got all expenses covered; a small number got up to 70% back; the majority were reimbursed for 50% or less of their actual expenses. This tallies with survey data on GFHI from across India showing that fewer than 4% of all claimants are actually fully covered (Hooda 2020). People signed up to the promise of being given "up to Rs.150,000" ($2,000), but when they claimed their expenses, they found they are not fully covered, and then felt let down. The promise of reimbursement is what brought so many poor people to private providers, but once they passed through the process they found themselves saddled with lots of unexpected out-of-pocket expenses. This was by far the most common concern expressed in our interviews.

The disappointment about not having their costs covered loops back to the concern that people do not understand how the schemes work. This lack of transparency can be partly blamed on the agents who sign up people. According to Mrs. Kapli, an administrator in the JSS insurance office, the people who enroll members in the healthcare schemes are to blame for telling people that "all" costs are reimbursed. This was not how they were designed. People should be given better information: "The problem is that patients get told that '100 percent' is covered, but that's not true. They should make sure that they give accurate information." Mrs. Kapli talked me through a stash of JSS Hospital bills. These bills only listed items that patients still needed to pay. They neither showed all the services billed nor how much money was reimbursed by GFHIs. Claimants ended up with bills that told them nothing about the value of insurance. The billing process precludes rational decision-making or fine-grained individual allocations of funds. In turn, the insurers only receive claims for what is to be reimbursed and not the full list of services billed. There is no feedback from hospital to insurers about patients' actual out-of-pocket expenses.

The obscurity of the hospital bills made many suspicious of what was going on behind the scenes. Some blamed the hospital, saying that the government wanted to reimburse all the costs but that the hospitals siphoned off most of it. For example, a married couple had come from 50 km away for the birth of their second baby, which had to be done by Cesarean section. They had been enrolled in Yeshasvini for four years and had not made any claims. An insurance

administrator had told them to go to JSS because they would be "100%" reimbursed. When they got the estimate, this turned out to be wrong. They knew from other villagers that a Cesarean at JSS costs Rs. 20,000 ($267) without insurance. JSS told them they had to pay Rs. 12,500 ($167), so they figured that the insurance only covered Rs. 7,500 ($100). The husband alleged that Yeshasvini had in fact paid Rs. 20,000 to the hospital, but that the hospital pocketed all the money and billed them Rs. 12,500 on top of that: "Yeshasvini is very good. The government gives one hundred percent. But the hospital doesn't give that money, they keep a big chunk for themselves." He phoned the Yeshasvini district administrator to complain that the hospital asked them pay most of the costs from their own funds.

Despite the widely-held view that insurance did not cover enough of the actual costs, and despite the opacity of the billing process, the majority of people said there was no alternative to going to JSS Hospital. So whatever the government provided in extra funding, they were happy with that. Even if most had expected full coverage, they were glad that they did not have to pay everything themselves. Hospitals cost a lot of money – everyone knew that – so if there was *any* reduction of the cost, one should be content with that.

The price of obfuscation

All the demand side GFHI schemes introduced in India in the last decade are based on a (neo)liberal theory of value. This value theory is also called "subjective theory of value" because all value is determined by transactants. Nothing has an inherent value or value outside of market exchanges. The value of a good is what someone is willing to pay for it (Applbaum 2004:52). Value is synonymous with market value, and this value is expressed in price. Anything can be given a price, and anything can be drawn into market transactions. Subjective value theory assumes that relative scarcity and subjective preferences determine price. Economics becomes the study of how resources are allocated under constraints of scarcity (Glimcher and Fehr 2014:5). Neoliberal economics apply the same principles to health. Life stops being "priceless" once its market value is made calculable and financialized (Baehre 2020; Hausman 2015; Mulligan 2016). Health economics makes life, death, and health measurable by criteria such as future earning capacity. Once the criteria are established, health and life can be treated like another type of personal property (Zelizer 2011).

Since the 1990s, health policy in India has increasingly shifted toward neoliberal health policy. The state is ever less invested in building up its public infrastructure and instead encourages the private health sector to grow. Instead of aiming at supplying healthcare to all citizens, the state fosters the expansion of nonstate health providers. The introduction of demand side insurance for the poor is emblematic of this shift. Instead of smoothing out social inequalities through direct government investments, this neoliberal governmentality wants to work with self-maximizing individuals. Every citizen should "take the initiative and use the market to help themselves rather than rely on government assistance and handouts" (Gupta 2012:241–2). But the burden of decision-making about health has always been on people in India, even before the 1990s. India has never had a comprehensive healthcare system that could have been dismantled (Gupta 2012). Healthcare in India has always been "demand side" because it has never truly been "supply side."

GFHIs for the poor are products of state-driven market liberalizations. The design of GFHIs is guided by the idea that market competition is much better able to meet demand than public provisions. The change of government in 2014, from the center-left Indian National Congress to the Hindu right-wing Bharatiya Janata Party (BJP) accelerated this trend. However, the question is how these policies play out on the ground (Horton et al. 2014). Neoliberal policies may aim to make citizens responsible for their own health and wealth, but how far these reconfigured citizens actually become self-maximizing individuals is an open question. Many scholars see a gap between policy theory and consequences in practice. Anjaria and Rao (2014), for example, think that this gap is deep: "The embrace of neoliberal doctrine at the highest levels of state does not correspond with a thorough transformation of society" (2014:424–5).

My findings on people's experiences with government-funded healthcare schemes in India confirm this conclusion. Like Anjaria and Rao, I also argue that the new healthcare schemes are part of a neoliberalization move toward "demand side" healthcare. In the Indian context, GFHIs did not introduce demand side resource allocation, rather these schemes shifted even more decision-making responsibilities onto individuals. At the same time, there is such a profound lack of transparency about how the various GFHIs work that the policy ideas of creating market-savvy individuals is illusory. Patients who draw on reimbursement schemes do not understand what different services cost and why some costs are covered and others are not. GFHIs task individuals to "co-create" healthcare value by their decision-making in the market, but the lack of transparency makes this impossible. Instead, all the decision-making is in the hands of private market healthcare providers. They set the prices and they administer the payment process.

If GFHIs intend to give poor people life-saving treatments without forcing them into catastrophic out-of-pocket expenditures, why not design schemes that provide free treatment for those in need? Ali's liposarcoma surgery is clearly worthy of being fully covered. But instead Ali was only offered a pittance because, for obscure reasons, this particular surgery was excluded by Yeshasvini. The reason why GFHIs work with excessively detailed lists of what is covered and what is excluded is because the state remains deeply suspicious of the private sector (Gupta 2012). GFHIs strain to make transactions incorruptible (e.g., no cash changes hands, stringent ID card requirements) because it fears that private market actants make bogus claims and fleece the system. GFHI policies are built on the assumption that wherever there is a public handout, someone in the private market will find a way of abusing it. It may be the hospital, it may be the patient, it may be the insurance administrator, but someone will look for ways of claiming for services that were not provided. GFHIs only pay for select services in a highly complicated way *because* the government thinks of private market participants – both individual and corporate – as opaque and untrustworthy. With these schemes, the state transacts money to private healthcare providers for services given to private healthcare consumers. The state is not directly involved in the service transaction between providers and consumers. For the state, the only way to ensure that neither private consumers nor private providers take more than their fair share is to create hyperspecific lists of legitimate transactions. By being excessively specific about what services are legitimate, the state effectively excludes a huge range of medical goods and services from reimbursement. The state asks patients and providers to make their own decisions but at the same time distrusts these patients and providers to be honest. Neoliberal health policy expects people to exercise "freedom of choice" where there is a fundamental lack of transparency about the relative value of these choices. In India, the poor pay the highest price for the state's lack of trust in them.

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Notes on contributor

Stefan Ecks is Senior Lecturer in Social Anthropology at the University of Edinburgh. His most recent book, *Living Worth: Value and Values in Global Pharmaceutical Markets*, is forthcoming from Duke University Press (2022). Address for correspondence: School of Social & Political Science, University of Edinburgh, George Square, Edinburgh EH8 9LD, UK. E-Mail: stefan.ecks@ed.ac.uk.

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