

Political Context for Healthcare Reform in Andhra Pradesh, India

A Senior Honors Thesis

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by

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Abstract

In 2008, the South Indian state of Andhra Pradesh underwent significant reforms of the health care system. Among the reforms, the most significant reform program was the “Rajiv Aarogyasri Health Care Trust,” which was initiated to provide high quality and accessible health care for the poor in private, public, and non-profit tertiary care hospitals in Andhra Pradesh. This research project is both descriptive and analytic. After a description of normative and instrumental goals of reform for the health system, the health system of India and Andhra Pradesh is described. The thesis also provides historical, economic, and political context for the reforms in Andhra Pradesh.

Through in-person interviews with key actors in the policy formation and implementation of health care reform, including party officials, members of the executive branch, hospital administrators, and physicians in the field, the political explanations for why health care reform occurred when and how it did can be gleaned. After exploring potential exogenous (non-political) explanations for reform, political determinants such as party and electoral politics, interest groups, institutional factors, and state executive leadership are analyzed. The insights gleaned from this project can be generalized to health care policy in developing countries more broadly to inform the reform process and extricate common conditions and obstacles.

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Undertaking any academic venture makes one self-aware of their interdependent status as a person. The very act of citation is recognition of dependence on another being, a profound understanding that this work is dependent in nature on the sweat and toil of someone else. Beyond citations, I have felt the reverberations of interdependence in my own life. I am grateful to have support from innumerable individuals, many of whom I will not have the opportunity to thank in the insufficient space provided. If I could do so, it would undoubtedly require a length longer than the thesis itself.

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Above all, I am reminded of a quote of philosopher Michel de Montaigne: "I have gathered a garland of other men's flowers, and nothing but the thread that binds them is mine own." This work is the product of many, not one, and I thank each and every one of them.

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Preface: Health Disparities on the Ground: A Vision for Development

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Explaining the Case of Srikirin Institute of Ophthalmology: Context

In December of 2008, I traveled to the rapidly developing coastal city of Kakinada, Andhra Pradesh, India. There, I had the opportunity to have a detailed look at the health delivery in South Asia through the medium of a nonprofit organization providing critical eye care to hundreds of thousands. Along the lines of health delivery, I would also see the interacting issues of medical education, outreach in rural areas, and coordination nationally and locally with hospitals and non-governmental organizations. The non-profit organization was the Srikirin Institute of Ophthalmology. Researching and being embedded within the Srikirin Institute allowed me to focus on a number of central issues within the health delivery at the district, state, and national level in India.

I should also mention the fairly extreme political circumstances that struck Andhra Pradesh during my stay. There were frequent agitations and some violent protests in efforts to partition the existing state of Andhra Pradesh. The political climate had been simmering between the various regions within Andhra Pradesh for decades, and it finally came to a boil at the exact time of my visit. Fortunately, my research was mostly unaffected by the agitations. However, everyday *bandhs* (a complete halt of economic activity) permeated daily life with uncertainty of being able to travel and work normally.

The time in Srikirin gave me insight into the development process in the field: the burgeoning hospital led by a charismatic leader was a fascinating case study for international nonprofit health work. Srikirin focused in on the plague of blindness in India, a state of illness that plagues the poorest individuals to a disproportionate degree when simple preventative and curative methods would alleviate it. In order to contextualize the

degree of suffering inflicted by the condition, I have provided a brief background about the epidemiology of eye conditions in India. Additionally, I've told the story of Srikirin and its founder, Dr. Chandrasekhar Sankurathri, since they are fundamentally intertwined, as the narratives of many nonprofit organizations are.

Background of Eye Health Conditions in India

Worldwide, there are 45 million blind individuals, and one-third of those people are located in the Indian subcontinent. India has a number of factors that contribute to this huge number: poor diet, high ultraviolet radiation, lifestyle factors, and high genetic tendencies for diabetes, which can often lead to blindness due to problems with blood supply. The subcontinent is the blind capital of the world, and blindness is rampant in the state of Andhra Pradesh. In India, an enormous 62.4% of the cases of blindness are as a result of cataracts. Cataracts are essentially clouding of the lens that refracts light to neurological tissue to allow sight. Many mature cataracts are identifiable by the deeply unsettling mucosal whites that block the central pupil of the eye. Due to the early curative (and preventive) nature of cataracts, they are much more common in developing countries like India due to low awareness and lackluster infrastructure to tackle such a problem on a nationwide scale. Other than cataracts, common eye problems and causes of blindness include ptosis (“drooping eyelid”), diabetic retinopathy, vitamin A deficiency, and glaucoma.

The Srikirin Institute: Foundation and Current Operations

Dr. Chandrasekhar Sankurathri (hereafter Dr. Chandra) is one of the founders and current manager of the Srikirin Institute of Ophthalmology. Learning the history and

development of the Srikirin Institute, which is inherently tied to Dr. Chandra's own past, was essential for me to understand the mandate and direction of the organization: the engine that motivated the organization to continue its progress. We communicated at length on a day-to-day basis. Dr. Chandra, at times bluntly and unreservedly, recounted his commentary on this history piece by piece in several conversations to me. However, I have detailed it here in chronological order, with my own emphasis at important junctions.

In 1985, Dr. Chandra lost his wife, son, age six, and daughter, three, in a terrorist attack on an Air India Flight. Dr. Chandra had been working in Ottawa as a biologist for the Canadian government. Driven by the grief of his tremendous loss, five years after the attack, Dr. Chandra was compelled to devote his life to serving others. He decided to return to India, where he grew up and had been educated. He began to build a house in Kakinada, Andhra Pradesh, a rural town at the time, where his brother-in-law lived. Dr. Chandra hoped to build an orphanage where he could shepherd twenty or thirty parentless children to a better future. After travelling to the area though, he had observed and spoken to many extremely low-income children who were working in the field during the day, at their parent's behest. Since they could not attend school during normal school hours, they were losing the opportunity to be educated. Dr. Chandra saw the chance to help them, and began night classes in the newly constructed building to explain basic arithmetic and language skills. Soon, the children that attended government schools, who were still not proficient in even these basic categories, began attending the classes as well. With the government schoolchildren, the ranks swelled to forty-five. By 1992, it had become a full time school, named for his daughter, Sarada Vidyalayam.

When I asked Dr. Chandra what motivated him to even begin such an endeavor, he replied emphatically, “You know, nearly 70% of children do not even have access to primary education. This is the country’s future, and it is being squandered. This generation’s education will have an effect on generations to come.” In terms of his own motivations, I could see Dr. Chandra had a great deal of patriotism for the country that had raised him. However, he also spoke of “building a more compassionate world,” a statement that struck me as more universal.

From the beginning, Dr. Chandra utilized his personal network from his time living in Canada to fundraise. He had attained nonprofit status for the “Manjuri Sankurathri Memorial Foundation” in Canada, allowing him to accept donations. In 1996, the Sankurathri Foundation leaped an evolutionary bound and began their first project in eye care specifically. Dr. Chandra was approached by a Canadian non-profit organization, the Help the Aged Canada (HTAC). HTAC wanted assistance with field support on a proposal on elderly sight improvement in the area, with the funding provided by the Canadian International Development Agency (CIDA). CIDA is the body within the Canadian government that administers foreign aid and often, as in this case, it partners with non-government entities and international bodies.

Suddenly, the organization had found itself deeply involved with eye care in the region. Dr. Chandra himself had been aware of the magnitude of the problem for a few years now. His childhood friend, Dr. VK Raju, was an ophthalmologist in West Virginia. Dr. Raju had told Dr. Chandra about the real need in Andhra Pradesh for *sustainable* eye care. Although he had come to India every year and set up shop to perform his own tests and

procedures, the real impact on blindness rates in the area was miniscule due to the lack of any infrastructure, especially in the more rural areas where health infrastructure and accessibility is even lower.

The HTAC elderly sight project was continuously approved for funding, and as a result MSMF initiated another proposal with CIDA. This time, MSMF initiated a pediatric eye health project, which would include school screenings. Eventually, the pediatric eye health project would continue for three years with CIDA partnership, but with partnerships with other international non-profits it would continue and expand along with the Srikirin Institute.

At first, as the hospital began, it was mostly for paid patients and consisted of only one floor. Each week, on Thursday, patients who could not afford to pay could receive free treatment. However, word spread quickly, and soon the volume of patients on Thursdays was too much for too handle in one day. The hospital began to expand, and separate facilities for paid and nonpaid patients were built. However, the surgeons and operating rooms were the same for patients, regardless of whether they had the capacity to pay or not. This is how the hospital is run to this day, although both facilities have expanded greatly.

It was clear to me that the organization's mandate formation and Dr. Chandra's own history and decision making were inherently linked. Even the smallest interactions spoke volumes about the structure and organizational capacity of the Srikirin Institute of Ophthalmology. Dr. Chandra was involved in every aspect of the nonprofit organization intimately, ranging from broad goal creation and fundraising to signing off on a free pair of

eyeglasses for a poor farmer. However, a key issue I saw was that the organization relied on him so heavily that without him, I couldn't see it even functioning at this moment. Fundraising was directly linked to his friends and personal connections that he had made over the last two decades, and even in day-to-day organization, I did not see anyone that could step into Dr. Chandra's shoes and run the organization as efficiently. Sustainability of the progress that had been made was, at least currently, correlated directly with Dr. Chandra's level of involvement. When I asked him about it directly, he replied that he recognized the issue, and was looking for someone (or a group of people) he could train over a period of time to take his place. However, that person would have to have a cultural understanding of India as well as be able to fundraise in Canada and the United States.

MSMF has a Canadian Board of Directors, with five members. Each of these members comes from a diverse professional background. Dr. Chandra described the process of choosing board members, as one without considerations to "North or South Indian, White or Brown, regardless of caste, creed, or social status." The Board includes a French Canadian and North Indian, and there is a conscious variety in perspectives by including nurses and non-doctors. The Board of Directors works without an actual office, and has extremely low functioning costs (a point of pride for the organization). They teleconference with Dr. Chandra, and he lets them know what the highest priority needs for the hospital are, while they in turn respond with how financially feasible each of those goals is.

Current Hospital Facilities

The central hospital is located on the site that Dr. Chandra first bought in 1990, and is located right next to the school that Dr. Chandra also runs. It has grown to be four floors, along with a cafeteria, optical shop, glass manufacturing factory, and a pharmacy. The Srikirin Institute performs about 15,000 surgeries a year with their staff of 160 total hospital staff and 4, usually 5¹, ophthalmological surgeons. They perform the second most eye surgeries of any hospital in the state of Andhra Pradesh.

For a comparison, the juggernaut eye hospital L.V. Prasad Eye Institute is the largest in Andhra Pradesh. It is located in the one of the largest cities in India (and capital of Andhra Pradesh), Hyderabad, and has 80 ophthalmologists on site and performs 22,000 surgeries a year. They also largely operate on a for-profit basis. A key tool that Srikirin uses to maintain such a high volume of surgeries without compromising at all on cost is the assembly line procedure. The surgeons are, admittedly, underpaid for their skill level, about 50,000-60,000 rupees per month.

The actual setup is modeled after the famous Aravind Eye Care System, in Tamil Nadu, which has been the subject of a Harvard Business School study. In the setup, the smaller percentage of paid surgeries allows the hospital to be sustainable, while performing essential surgeries for patients that are unable to pay. However, the Aravind Eye Care System is 30-40% paid, while the Srikirin Institute is only 10% are paying patients.

¹ One surgeon is currently on a exchange program fellowship in Canada to become a retinal specialist and will return in January 2010

In terms of costs, MSMF fundraising mostly funds the Srikirin Institute. Ten percent of the total volume of surgeries is paid, but these surgeries contribute relatively little to offset the total budget for nonpaid surgeries as well. Those crucial fundraising efforts are generated through an annual public engagement seminar series that Dr. Chandra presents in Canada. There are also partnerships with other international NGOs and development agencies for specific proposals. All foreign donations must be specific, and have to be deposited into a special bank account with special government imposed regulations (due to fears of terrorist financing). There is a district investigator that checks financial records about every six months.

When I asked about his fundraising strategy, Dr. Chandra stated plainly, “I never ask for money directly. I only try to make people aware of the work we are doing. If they want to be a part of it, then the money will come by itself. I wouldn’t give my money if someone just asked me, so why should I expect them to?” It is a viewpoint that is borne of empirical experience. In Canada, the number of donations exploded when the public television channel CBC ran a documentary special detailing Dr. Chandra’s mission in 2002. There were barely any donations coming from within India until *Eenadu*, one of the largest Andhra newspapers, ran a long article about the Srikirin Institute. It is a “if you build it, they will come” philosophy. There is little awareness or coordination in the United States currently though. Any donations there are coordinated through a nonprofit run by a friend of Dr. Chandra’s. Dr. Chandra was also recently nominated for CNN Heroes, which boosted his American profile considerably.

The Srikirin Institute uses some of the best surgical equipment in India, and has quality standards equivalent to the best eye hospitals in the country and world (mostly due to their ability to fundraise). Along with this, Dr. Chandra emphasized the organization's focus on providing choice to the customers, with paying packages ranging from 2,000 rupees (40 USD) to 20,000 (400 USD), prices that are still lower than other hospitals around the country with equivalent equipment and quality. Consistently, they have been setting the standard for eye-care quality in the district and region for both public hospitals and private hospitals, simply on the basis of competition. A very basic cataract procedure, the implantation of a replacement intraocular lens (IOL) after removal of the calcified lens, was not even available in Kakinada until the Srikirin Institute began using it. Soon after, every hospital in the area was forced to raise their standards to use the IOL.

In October, there was a visit from a consulting service from Bangalore in order to focus on improving the efficacy of the organization. They gave Dr. Chandra several key suggestions from improving the organization. First, because the Srikirin Institute is a non-profit, charitable entity, many potential paying customers associate it, misguidedly, with lower quality care. They often travel to Hyderabad or Mumbai to receive the same level of care that they could find very close in Kakinada, usually for a lower price. These customers could help to offset the 90% nonpaid surgeries that are conducted, and bring the Institute closer to full self-sustainability. In addition, they found that actual awareness of the Institute and its goals and mission might be high in Toronto and Vancouver (where the fundraising comes from), but within Kakinada, many did not have a working knowledge about the level of eye care it provided. This basic awareness within the local community (from which the paying customers are drawn) is essential, and during my time there we

tried to tackle it with some initial steps. This meant advertising heavily, with a focus on increasing awareness of the high quality of its eye care services, along with the charitable focus.

Another aspect that Dr. Chandra hoped to focus on more was partnering with private organizations. In the “Wild West” healthcare system in India with government spending being extremely limited, private partnerships are even more important. Dr. Chandra talked of partnering with companies that had employee-healthcare plans, since it brought in a large group of paying patients at once. Also, Dr. Chandra wanted to take advantage of corporations that had corporate social responsibility clauses, where it is stipulated that a certain percentage of profits annually are to be given to charitable causes. This often stems from a moral responsibility that the corporation feels, but it can also serve as good advertising and PR for the corporation. The challenge, on the non-profit’s side, is convincing the corporation that their cause is the most worthwhile causes to give to. For the charitable organization, this involves having an already well-known profile, and personally appealing and lobbying the corporation. For example, after nearly three years of persistent calling and communication from Dr. Chandra, the Srikirin Institute received a 45,000 USD donation from the technology company Infosys.

Another key point of expansion in recent years has been the construction and self-sustainability of four “vision centers,” which are compounds staffed only by technicians. They are spread around the city of Kakinada, and exist as fully functional appendages of the main hospital in the rural areas where this level of infrastructure is rare. The vision centers charge a nominal fee for checkups, and serve as awareness outposts. To date, there have

been over along 50,000 outpatients, nearly 13,000 children screened, and 20,000 pairs of glasses prescribed. Because of the low cost of maintaining a vision center, the operating costs are completely paid for with the fee charged for consultations.

Eye Camps and Community Outreach Program

The eye camps are easily the most complex part of the Srikirin Institute's organization, and are the source of the most needy patients that come through the doors of the Institute. All patients that participate in the camps are treated for absolutely no fee, so this is the largest charitable operation as well. The camps serve 4 major districts of Andhra Pradesh, and serve a population of ten million people. Each camp is meant to cover about 10,000 people, usually about 20 villages.

The initial step of the camps coming to fruition could come in two forms: either a local sponsor would come to Srikirin and ask to set up a camp, or Srikirin, through their Outreach staff, would identify an area of need themselves. The latter is much more common than the former. In that case, a member of the Outreach team would visit the area searching for a local partner who could co-sponsor the camp with the Srikirin Institute. This local co-sponsor could come in the form of an NGO, a government hospital, or anyone prominent locally. This step, I realized, requires an immense amount of cultural awareness and acuity. The outreach team initially just asks around a village or locality, or goes through connections that Srikirin already has in the areas. Finding sponsors in rural areas, where more of the need is, since doctors are less willing to work there, is much more difficult compared to urban areas.

The local sponsors usually put in about 15,000 rupees (330 USD) of financial help, and pay for lunch for everyone at the camp. But along with the financial assistance, they serve just as important of a role logistically, by picking out a suitable location (usually a school or hospital), setting up tents and seating, and making the local population more aware. “When it comes time to give credit and advertising,” Dr. Chandra told me, “We always put their name at the top and embolden it. This is not an ego-battle for us, and it is probably better for local awareness since they know them better than us. It is some level of local involvement.”

The camp location choice and partnering with the local sponsor are both completed at least a month before the date of the eye camp, along with printing and distribution of brochures and posters. The camps begin at 8:00am, and the first step is to inaugurate the camp as a partnership by cutting the ribbon together. The Srikirin Institute sends only primary technicians, most of whom are high-school educated, to the camps. “Sending our doctors is not an efficient use of resources,” Dr Chandra told me. For the next five hours, full registration of each camp attendee is conducted. In addition, the technician would complete all essential tests, including testing intraocular pressure (an indicator of glaucoma), blood pressure, and vision testing, as well as looking for signs of cataract development with a flashlight. Usually, about 150 to 300 people are tested throughout the day. After lunch, which the local partner provides, the bussing of all patients who need further treatment at the main campus begins. The Srikirin Institute has 2 large buses and 3 smaller buses that are used to transport all the camp attendees from where they are to the hospital. In some cases, the distance could be up to 250 km, which could take several hours on the poor roads. Donkorai, a tribal region where three camps have taken place recently,

is 210 km away. The patients are served dinner and they stay overnight in the ward of the main hospital. The next day, patients are scanned for corneal size (to determine the size of the replacement lens that needs to be implanted if cataract surgery is necessary), and readied for surgery. They rest for the day, and the next morning, at 5:30 AM, the technicians and doctors begin the marathon process of running all post-surgery diagnostic tests, showing safety videos, distributing eyewear, and bussing all the patients back to their hometowns.

The whole process takes three days, but all the patients are consulted to return to the main hospital ten days and forty days after surgery, in order to run diagnostic tests and prevent any complications. Unlike many other hospitals, the Srikirin Institute has an extremely high rate of patient's returning for follow-ups, over 90%, versus around 70% for most eye hospitals that provide free surgeries, because of the free bussing and services. When the patients return, they pay a fee (40 rupees or about one U.S. dollar) for the consultations and also pay for any medicines. There are some other providers in the districts for free surgeries, but none with the quality of the Srikirin Institute.

Programs with International NGOs

Dr. Chandra has participated in a number of partnerships with International NGOs, which have been essential to the growth of the Srikirin Institute. It is a symbiotic relationship; the organizations often provide financial support for a specific project and Srikirin fulfils their mission with the resources that they have at hand. Rotary International is a partner that has sponsored many eye camps, through their local members in villages across Andhra Pradesh. ORBIS International is another organization that Srikirin has

partnered with in the past. ORBIS focuses on building capacity by partnering with local partners (NGOs, government health departments, and eye banks) on three-year projects, in addition to its celebrated “flying eye hospital,” a DC-10 jet aircraft that houses a full hospital. ORBIS International partnered with the Srikirin Institute on developing a pediatric center, especially with infrastructure and training.

The Christoffel-Blindenmission (CBM), of Germany, has also worked with the Srikirin Institute. They are a global organization focused on people in developing countries afflicted with disabilities. In 1997, representatives from CBM, including their scientific advisor and G.N. Rao, the Chairman of L.V. Prasad (mentioned earlier), came to visit Dr. Chandra and were immediately impressed by the school and facilities. They started funding Srikirin, with the condition of thorough annual financial reports. Over the years, Srikirin has been one of the best performing organizations that CBM provides support to in India. However, Dr. Chandra recounted that, when he had last met with them, many more financial resources were being shifted to Africa from India. The reasons for the shift were varied. In India, CBM had been cheated by many non-profit organizations that were corrupt. CBM had relied on these organizations heavily, due to the importance of cultural integration to be effective.

However, the widest reaching program is the Vision 2020 Right to Sight program. In 1999, the World Health Organization and the International Agency for the Prevention of Blindness (IAPB), an umbrella organization consisting of multiple blindness prevention NGOs, came together with the goal of eliminating the main causes of avoidable blindness by 2020. Vision 2020 is a global program, and tries to bring together NGOs, Ministries of

Health, corporations, and eye hospitals. Each country that they work in has a national coordinating committee, which develops technical plans to raise national capacities and mobilize resources. Dr. Chandra told me that the Srikirin Institute pays about 20,000 rupees (440 USD) a month to attain membership of Vision 2020 and attend the meetings. There is also significant government representation at the meetings, including the head of the National Programme for Control of Blindness (NPCB) and members of the Ministry of Health. Truly, this is one of the key points of interaction between the government and nonprofits on a national scale. The President of the Indian chapter of Vision 2020 is Thulasiraj Ravilla, who also happens to serve as an administrator at the aforementioned Aravind Eye Care System.

Public, Private, and Non-profit Interaction in Delivering Eye Care

In 1976, the Indian government began NPCB to tackle the rampant blindness nationwide, the first program of its scope. In terms of administration, the central government provides funding and broad guidelines that are tied to the money for the district level. The responsibility for the DBCS at the district level falls to the District Collector, civil servants who are the most powerful government officials of the district. Among their responsibilities are revenue collection, law and order, and emergency response. Currently, the focus of the NPCB is on cataracts (as the primary cause of avoidable blindness in India), but recently they have initiated programs for diabetic retinopathy and pairs of spectacles. Theoretically, the DBCS should be leading the coordination of all the eye care providers in the district, efficiently refunding all cataract surgeries performed by any eye hospital for needy patients, and working to increase

awareness district-wide. In reality, administration is much more convoluted and complex, at least in the East Godavari district that I observed.

There are a number of issues with the implementation of the NPCB at the district level, among them the lack of constant coordination (both at the district and national level), accountability, and transparency. Although it may be making a dent in the incidence rate of cataracts, it is not nearly as effective a program as it could be. First, the backlog of the DBCS in paying back hospitals for performing cataract surgeries for low-income surgeries is enormous. In order to receive the funding, a printout of the exact patient details has to be submitted to the district controller's office

Without accountability, corruption is a major obstacle for efficient distribution. First, the responsibility of the DBCS falls to the District Collector, the most powerful government official of the district. The District Collector has many other responsibilities in the district and has little time to coordinate health issues in their district alone. At this moment, the district owes the Srikirin Institute tens of thousands of dollars in refunds for cataract surgeries. If Srikirin were not so able in terms of fundraising, they literally would not be able to survive. The outlook is extremely bleak for smaller NGOs and hospitals that are looking to start up in the district, if they hope to receive the refunds. Often, the collector will ask for a 3-4% bribe in order to release the monies at a faster pace, and the first hospitals in the district to receive the funding when it comes from the central government are the ones that have paid the bribe. On purely ethical standards, Dr. Chandra refuses to pay the bribe, and because of his size, he is able to take that stand.

As mentioned, preventing blindness is not the highest priority task for the district collector. When I asked Dr. Chandra when the last district wide meeting of the DBCS had been, he recalled the last one had taken place four or five years ago. At the meeting, the District Collector, who had decided to take some action on the issue of blindness, had called together all the major providers of eye care services for a meeting. In the East Godavari District, populated by 4.9 million people, there are fifty-four ophthalmologists total. Among the major providers were seven NGOs (including Srikirin), one teaching hospital, and one specialty hospital. At the time, out of the 22,000 annual cataract surgeries in the district, Srikirin performed a sizeable 17,000, or 65%, of them.

At the meeting, the District Collector had asked each of the hospital to put forth an estimate of about how many cataract surgeries they could perform daily. Dr. Chandra estimated, extremely conservatively, that the Srikirin Institute could perform about 50 surgeries a day with a staff of four ophthalmologists. The government teaching hospital though, with its staff of nearly 20 surgeons, estimated about 5 per day. When the Collector asked if they could perform at least ten a day, they replied that it was an impossible task. The District Collector could do little but request each hospital to perform slightly more surgeries, and even those requests could be shot down. Rather than the district wing of the NPCB giving vision and mission to all the eye health providers in the area, little was being accomplished. The DBCS served as little more than an unsatisfactory middleman for refunding the basic cataract surgeries.

Communication is insufficient, and often the hospitals are left in the dark as to which procedures are refundable and on new programs from the Centre Government. For

example, it was not until Dr. Chandra attended the annual Vision 2020 meeting, which Srikirin pays a monthly fee to for membership, that he discovered that the NPCB program now refunded both diabetic retinopathy and spectacles. Unlike the Srikirin Institute, the vast majority of eye care providers in India do not have the opportunity to participate directly in national Vision 2020 meetings, and are not privilege to this crucial health information. Somewhere, the important information is not being delivered fully.

On top of the inefficiency and corruption, the actual refund itself is insubstantial. The lowest cost cataract surgery at Srikirin, at the minimum quality standards, costs the hospital 1500 rupees (about 30 USD), without accounting for transportation of the patient. However, the government refund gives only half of that amount, about 750 rupees (15 USD). This lower payment encourages a lower standard of surgical care, especially for average teaching hospitals or private hospitals that cannot afford to subsidize the difference as Srikirin can.

Ration Card System and Relation to Health Outcomes

Andhra Pradesh has a system of ration cards, in which citizens at different income levels receive color-coded cards. The lowest income bracket receives white cards, which are important for receiving rice and oil rations. These white cards also serve to identify the below poverty line (BPL) citizens (less than an annual income of 11,000 rupees), and these identifications play out in many other government programs. It is also interesting to note that there are separate annual income limits for urban and rural areas.

In practice, the NPCB program should only be serving patients that are below poverty line, and the only standard indicator in Andhra Pradesh is whether the patient is a white cardholder. There are several problems with hospitals using the white card as the only indicator of poverty status. For one, fraudulence and counterfeit cards are rampant, and even fairly middle class citizens can get a hold of a counterfeit white card for a few hundred rupees. Dr. Chandra told me that the Srikirin Institute hesitated to mention the white card system at all in association with their free cataract surgeries, because it was so rampant with fake cards. There had been some cases where he had refused to treat a patient in possession of the white card because it was so obvious by looking at their jewelry and clothing that they were wealthier than the poverty line. While the white card is the primary indicator of poverty status, the Srikirin Institute treats many patients without white cards that are simply unable to pay. This highlights another problem: many of the actual impoverished do not receive the white card and therefore are not able to get full health benefits.

In addition, the process for distributing the white cards and then verifying the actual income status of the recipient is flawed. The Mandal Revenue Officer is the chief presiding officer for the rationing system, and oversees the “mandal” or an Andhra Pradesh administrative term for a grouping of villages that lies within a district. The mandal serves as a form of local government, and a number of mandals lie within each district. Administratively below the mandal is each village, termed the “Gram Panchayat.” The Mandal Revenue Officer issues all new cards, after conducting a detailed interview of each applicant, including details on occupation, dependents, and annual income. One could see all the opportunities for inefficiency, and the significant logistical issues in determining

honestly who actually lives below the poverty line. There are many cases of cards being issued to dead persons, and even to the extremely affluent.

An Introduction to the Health Reform movement: Aarogyasri and Eye Care

In 2008, Andhra Pradesh, under the leadership of Chief Minister (Governor) Y.S. Rajashekhara Reddy, initiated a health program called the Rajiv Aarogyasri Health Care Trust to provide health care for the poor. I visited an Aarogyasri health camp in a rural area; with a number of physicians, including some from Srikirin, from a variety of specialists, the camps were able to provide accessible care to citizens.

I interviewed the Aarogyasri Medical Camp Coordinator (AMCCO) at Srikirin, and he explained to me the role of the Aarogyasri Health Care Trust, and its impact on day-to-day operations at Srikirin. Essentially, the AMCCO serves to communicate with the government program, and each hospital that participates in Aarogyasri has its own AMCCO. The Aarogyasri program was created in 2007. The goal was to help all below poverty line (BPL) citizens of Andhra Pradesh by having government funds pay the co-payments on health bills of several essential procedures. The earliest program was termed “Phase I,” and was limited to a few districts and procedures for heart, brain, and kidney ailments.

In order for a person to show that they were eligible for the benefits of Aarogyasri, they had to be in possession of an Aarogyasri Health Card. The distribution of the Aarogyasri Health Card was not dissimilar to the white card system, and really highlighted the intersections between the various levels of government in India. First, the elected official in each village, the “Panchayat Sarpanch” or chairperson, goes door to door and

determines the financial status of every member of the village or town. From these door-to-door surveys, the aforementioned Mandal Revenue Officer compiles a list. There are 1128 Mandals in the state, and each Mandal is apportioned with 30,000-50,000 people. The MRO reports the financial listings to a sub district level administrator called the Revenue Divisional Officer, whose responsibility it is to issue the cards. The card will have an image of the BPL family and dependents on it.

When the Aarogyasri program began, it was limited in scope and the free treatment was only given at primary health centers, community health centers, or government general hospitals. However, many of these health centers did not have the full capacity to treat many ailments, and the program was extended to private hospitals and corporate hospitals. Determining which hospitals are registered with the Aarogyasri health trust is a process unto itself. First, the hospital requests involvement with the program. Then representatives from the Board of Aarogyasri, which resides in Hyderabad and is made up of members of the Health Ministry, goes to each hospital and oversees proficient instruments, doctors, specialists, and bed strength. If a hospital becomes an Aarogyasri partner, 1/3 of their beds must be allotted to patients with the Aarogyasri program. If all specifications are met, the hospital signs an enormously complicated legal document and is endowed with the title of “network hospital.” There are 727 total network hospitals in the state of Andhra Pradesh.

Under the Aarogyasri program, five eye procedures, and specifically does not include adult cataract surgeries (since these are already covered under the NPCB). The process for having a patient qualify for Aarogyasri begins by mailing a photo and

preauthorization form. Then, the clinical notes must satisfy the panel of doctors in Hyderabad. The whole process is a cashless transaction for the patient. This is possible with the involvement of a private insurer, the Star Health and Allied Insurance Co. Ltd. In 2007, Star Health went through a competitive bidding process to be chosen for the Aarogyasri program. In that year, the government paid 66 crores rupees (14.5 million USD) to Star Health to cover 2.3 million people. The Aarogyasri Health Care Trust is under the chairmanship of the Chief Minister, and they consult with the insurance specialists and medical professionals, and pay the premium to the private insurer, who in turn covers the hospital bills of the poor.

Another facet of the Aarogyasri program is the mandated camp program they run each month with every network hospital. Four to six camps are required of each hospital per month. The camps seek to reach out to more rural inaccessible areas. Usually, there will be three or four specialties at each camp, in order to maximize resources. First, the AMCCO of each network hospital and the Regional Coordinator of Aarogyasri agree on several dates for camps.

My research trip to Srikirin to study the eye care networks in South India provided me a “day in the life” perspective of a health provider, with the myriad of interactions that the nongovernmental hospital underwent everyday with the private and public sector. It was also a shining example of an unadulterated success story. The Indian health landscape is riddled with failures from every angle; what I sought in my experience was an example success in the midst of ruin, and I tried to gleam what specific and generalizable lessons I could from Srikirin. It was the trip that would ignite my interest in this massive

governmental program: Aarogyasri. I knew little then of the details of the Aarogyasri program. Visiting the Aarogyasri health camps gave me some perspective from the field, but I resolved to return to India to study this health reform program from a keener, academic lens.

Ch. 1: Introduction

1.1: Public Health Systems and Motivations for Health Reform

1.2. The Indian Public Health Infrastructure

1.3 Preview of Thesis

1.1. Public Health Systems as a Whole and Motivations for Reform

Reform within the health sector is a central issue for nations across the globe of all income-levels and a fundamentally political process. Many health systems do not perform their central task to provide for the health status of their population to a maximal level. Health policy reform processes take on various forms and seek to improve diverse aspects of a complex health sector. These differences can be traced to the ultimate *ends* of the health sector reform process: the expectations of what a health system should ultimately deliver, and how it should be structured.² Defining “health” along with the goals and jurisdiction of the health sector in providing for the health of a population is essential before tackling the complexity inherent in the health reform process. These definitions and ends are ultimately politically determined, and shape the health reform process.

The ways in which health and the health sector are defined as goals within the development framework has transformed at least the language of the health policy debate in many developing nations, including India. This language has in turn affected the shape that health reform movements have taken; within the larger context of developing individual Indian states, the question arises as to what the end goal of the development process itself is. Along with investment in education and technological advancement, investment in health is one of the major inputs through which a state can impact its development. The form of the investment, the role of governments and markets, and the institutional arrangements reform should take are still up for debate.

² Hammer JS, Berman PA. Ends and means in public health policy in developing countries. In: Berman PA, editor. Health sector reform in developing countries: making health development sustainable. Cambridge, MA: Harvard University Press, 1995.

Reform of the health sector is also an essential part of the development project. Health is clearly a central aspect to any development effort. It is inextricably linked to poverty and economic deprivation. The definition of development itself is in contention, but it can largely be characterized as an effort towards improvement of the existing status of individuals and the human condition. Modernization of the economic and increased economic growth is often one essential aspect of development. Per capita income has been used as an indicator of the level of development of a nation and has come to define broad categories of developed and developing nations. India, clearly, falls into the latter group of low and middle-income nations.

In terms of economic growth, numerous studies have confirmed the notion that good health outcomes would translate to positive economic growth. Poor health directly causes reduced work productivity, preventing an individual from contributing to the larger economy. In addition, poor health can cripple whole families and communities and leave them further embedded in the “cycle of poverty.”

Disease has both direct and indirect economic costs to stricken impoverished households. Direct costs include the costs of seeking direct treatment, like transport, while indirect costs are characterized by loss of productive labor time.³ With greater vulnerability to the high relative costs of healthcare, the result can be devastating. Studies in India on the impacts of tuberculosis, a chronic disease, showed that the average period of loss of wages was 3 months, and a 20% of educational activities were prematurely

³ Russell S, 2004. The economic burden of illness for households in developing countries: catastrophic or manageable? A review of studies focusing on malaria, tuberculosis, and human immuno-deficiency virus/acquired immunodeficiency syndrome. *Am J Trop Med Hyg* 71(Suppl 2): 147–155.

discontinued due to the disease.⁴ These expenditures are a larger portion of total expenditures, and the costs are debilitating for families that have already low household incomes. If certain diseases are left untreated due to high cost of treatment for impoverished families, they can compound the distress they cause, impeding educational and therefore economic progress. Health infrastructure is also lacking for the impoverished, in terms of sanitation, water systems, sufficient nutrition, and access to primary and secondary health care. These factors increase the burden of disease on those in the lowest income brackets.

Well-being is an essential precursor, as well as a dividend, of economic growth. Health serves an instrumental role in providing economic growth and increasing GDP per capita. Historical studies on developed nations have showcased this instrumental role that health plays in economic development.⁵ One WHO study correlated low infant mortality rates with higher rates of economic growth, where nations with an IMR of between 50 and 100/1000 live births had 3.7% growth, while nations with an IMR of over 150 had only 0.1% growth per year, on average.⁶

While high capacity health systems are correlated with economically productive citizens, some schools of thought have come to question this central notion of economic productivity as the end goal of development in and of itself. Notably, the “capability approach,” spearheaded by Amartya Sen and Martha Nussbaum, questioned the use of per

⁴ Rajeswari R, Balasubramanian R, Muniyandi M, Geetharamani S, Thresa X, Venkatesan P, 1999. Socio-economic impact of tuberculosis on patients and family in India. *Int J Tuberc Lung Dis* 3: 869–877.

⁵ Sachs, J. et al. Commission on Macroeconomics and Health. *Macroeconomics and health: investing in health for economic development*. Geneva: WHO, 2001

⁶ Lustig, N., Gonzalez, E. Mexican Commission on Macroeconomics and Health. *Investing in health for economic development: Executive Summary*. Puebla, Mexico: Universidad de las Americas, 2004.

capita GDP as a marker for economic development. Without consideration of distribution of the benefits or integrality of the human being, per capita GDP becomes the end. Instead, the capability approach views poverty not solely through a financial lens, but also sees it as deprivation of the capabilities of man and those means that allow freedom, like sanitation, access to physicians, and education. ⁷

In the Aristotle's theory of functioning, political arrangements should be directed towards a structure that maximizes a "good life," beyond attainment of wealth as its own end.⁸ Health is an essential portion of the human good that Aristotle circles as the end for political action. Aristotle's theory of functioning rests on the fundamental obligation between the state and society to provide and empower its citizens towards the goal of "human flourishing."⁹ Health care, as the focal determinant of health and a main line of intervention by the state, holds weight in allowing the human flourishing to be enabled. This line of thought has influenced Amartya Sen's capabilities approach to development. He argues that poverty is not only defined by lack of material resources, but also by ill health. Here, health is an end and not only a means to the end of economic growth. Poverty, then, is not only a cause and result of ill health. In this paradigm, ill health itself is a characteristic of poverty.

Rights-based approaches, whether to development as a collective right or to health as an individual right, have had normative consequences for global and national health law. The UN declared a right to health as early as 1966, where the International Covenant on

⁷ Sen A. *Development as Freedom*. Oxford: Oxford University Press, 1999.

⁸ Ruger , J.P., *Health and Social Justice*. Oxford: Oxford University Press, 2010.

⁹ Ruger JP. Health and social justice. *Lancet* 2004;364(9439):1075–1080.

Economic, Social, and Cultural Rights (ICESCR) enshrined “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.¹⁰ Still, this individual right to health has faced criticism as both not matching up to state beliefs in their own obligations to citizens as well as having little explanatory power for the true determinants of health. An alternative has been the ‘right to development’ that focuses on social justice. The various interdependent rights contribute to an all-encompassing ‘right to development’ that are all equally important. In the case study for Andhra, we will see how this interdependence of financial security and health status towards an emergent ‘right to development’ informed the reform movement, even though the reforms were focused on solely providing healthcare.

Developing the nature of health as a goal in development is a process that has informed and transformed at least the language of the health policy debate in many developing nations, including India. This language has in turn affected the shape that health reform movements have taken; within the larger context of developing individual Indian states, the question arises as to what the end goal of the development process itself is. Along with investment in education and technological advancement, investment in health is one of the major inputs through which a state can impact its development. The form of the investment, the role of governments and markets, and the institutional arrangements reform should take are still up for debate.

What is the health sector? The health sector differs widely across nations, and across individual states within India. It encompasses all institutions that enable citizenry to

¹⁰ A. M. Fox and B. M. Meier, “Health as freedom: Addressing social determinants of global health inequities through the human right to development,” *Bioethics* 23/2 (2009), pp. 112-122.

have improved health outcomes. The World Health Organization states that a well functioning health system improves the health status of individuals, families, and communities, defends against threats to the population's health, protects individuals against financial consequences of disease, and provides equitable access.¹¹ These institutions can be governmental or nongovernmental, and include preventative, primary, and secondary health services. In sum, the health sector can refer to the "totality of policies, programs, institutions, and actors that provide health care - organized efforts to treat and prevent disease."¹²

The health system can be viewed in either an "inventory" approach, in which the elements are associated by the common function of providing healthcare, or a "relational" approach, in which the relations between the various units are also taken into account.¹³ The second approach will be utilized within this paper; in seeking to understand causes and consequences of reform, the individual elements driving the system towards providing health care must be understood within a network of bidirectional interactions. The political and economic changes in a health system come from various actors' actions, the effects of the actions on other units within the health system, and the institutional backdrop that allows or prevents certain actions from being possible. Different actors have different modes of participation within the system: the state, for example, can participate non-exclusively through regulation, financing, and service provision, and studies of OECD

¹¹ World Health Organization (2010). "Key Components of a Well Functioning Health System."

¹² Berman, P. (1995) Health sector reform: making health development sustainable. In *Health Sector Reform in Developing Countries: Making Health Development Sustainable*, ed. P. Berman, pp. 13±36. Harvard School of Public Health, Boston.

¹³ Frenk, J.(1994).Dimensions of health system reform. *Health Policy*, 27, 19–34.

nations have shown an increasing trend towards a mixed approach for governments.¹⁴ Complexity is also a fundamental feature of the health system, and one that requires a corresponding deftness in political analysis.

The health sector serves as a central means to the end of beneficial health outcomes and positive health status and well being for the citizenry of a state. With ethical clarity on the ultimate end-goal of providing for the health of the people, the debate over the procedural shape that the health system should take in moving towards this end goal can take place. Reform is ultimately centered on transformation of the existing system into one that aligns more sharply with the capability to provide better health outcomes *effectively, efficiently, and equitably*. Financial sustainability and distributive justice concerns are often the driving force of reform efforts.^{15;16} In both categories, there are negotiations around concerns of quality, access, and cost. These three characteristics of a health care system compose the “iron triangle” of health care, with which any single corner of the triangle cannot be improved without compromising the other two.¹⁷ Reform of the health sector is occurring in many nations across the world, and various methods of reform are being experimented with at different scales.

¹⁴ Rothgang, H., Cacace, M., Grimmeisen, S. and Wendt, C. (2005) ‘The Changing Role of the State in Health Care Systems’, *European Review* 13 (1): 187–212.

¹⁵ Norman Daniels, "Justice, Health, and Healthcare," *American Journal of Bioethics* 1 (2001):3.

¹⁶ Thomson S, Foubister T, Figueras J, Kutzin J, Permanand G, Bryndová L. Addressing financial sustainability in health systems. Colombia: World Health Organization, European Observatory on Health Systems and Policies; 2009.

¹⁷ William L. Kissick, *Medicine's Dilemmas: Infinite Needs Versus Finite Resources* (1994).

The health care system has three types of inputs that reform can affect: health care law, financing, and organization.¹⁸ Policies include actions like regulation of the private sector and legal codifications of a “right to health care.” Level of expenditure and salaries of health care providers fall under financing, and the actual organization of the health system can include the proportion of public and private providers along with the geographical distribution of health facilities. Health systems can be evaluated on their outcomes in the population served: satisfaction of participants within the system, improvement in health status, maximization of value of resources, fair distribution, and accessibility to disadvantaged groups.

Equity is often the stated goal of health reform movements, including the health reform movement in Andhra Pradesh. Whitehead defines health inequity as “differences in health that are unnecessary, avoidable, unfair, and unjust.”¹⁹ As confronted in the Whitehead document, there is a clear distinction between inequities in the provision and distribution of health services and the level and quality of health. However, the provision of health services is causally linked to the eventual output of health outcomes, while biological and environmental determinants do play a role. The goal of health equity is not to reduce the differences in quality of health, but provide “fair opportunity to attain full health potential.” Amartya Sen highlights this distinction between achievement of health

¹⁸ Kruk ME, Freedman LP. Assessing health system performance in developing countries: a review of the literature. *Health Policy* 2008;85:263-76

¹⁹ Whitehead M. *The concepts and principles of equity and health*. Copenhagen: World Health Organization, 1990.

and *capability* to achieve good health, and further distinguishes the fairness and nondiscrimination of the processes of health.²⁰

Equity is related to the social justice tenet of reform movements. It relies on the just distribution of resources that are communal in nature. Health equity can also be defined as the “absence of systematic disparities in health (or its social determinants) between more and less advantaged social groups.”²¹ Fundamentally, equity in health is a normative concept that drives reform to drive health resources to be broadly accessible. The late 1970s and early 1980s saw worldwide health equity reform movements, including the “health for all” movement’s emergence out of the WHO-UNICEF 1978 Alma-Ata Conference that pushed for expansion of primary and preventative care to the poor.²² These movements focused on the substantial gap between health outcomes along geographical, gender, and racial lines. In addition there was, and continues to be, a substantial focus on the socioeconomic “gradient,” in which a lower socioeconomic status is tied to worse health. This phenomenon has been shown globally in nations of all income levels.²³

According to the WHO, responsiveness of a health system is a key criteria for measuring performance, and is composed of respect for patient dignity, autonomy, confidentiality, prompt attention, quality of amenities, and choice of care providers.²⁴ Often in low and middle-income nations, public health services benefit the wealthiest rather than

²⁰ Sen A. Why health equity? *Health Econ* 2002; 11: 659–66.

²¹ Braveman P, Gruskin S. Defining equity in health. *Journal of Epidemiology and Community Health* 2003; 57:254-8.

²² Gwatkin, D.R. 2001. The Need for Equity-Oriented Health Sector Reforms. *International Journal of Epidemiology* 30: 720-23.

²³ Marmot, M. Achieving health equity: from root causes to fair outcomes. *Lancet* 2007; 370: 1153–63.

²⁴ Blendon R, Kim M, Benson J. The public versus the World Health Organization on health system performance. *Health Aff (Millwood)*. 2001;20(3): 10–20.

the poor.²⁵ Lack of responsiveness to the socioeconomically disadvantaged and the regressive status of health systems has inspired “pro-poor” reforms, rather than reforms that emphasize cumulative gains.²⁶ The two main mechanisms of transforming a health system to be more equitable are service delivery and financing.²⁷ Free or low-cost procedures for poor citizens can often make up the framework for a “pro-poor” reform process. Financing is undoubtedly a major source of inequity; even in the public sector, health costs can leave the vulnerable poor in financial ruin. In some Indian states, the poor are even more likely to borrow in public sector hospitals than the private sector.²⁸ Additionally, expansion of available health facilities to geographies previously lacking them can transform access to service delivery.

In assessing the performance and quality of a health system to evaluate its potential for reform, two other key pillars remain: efficiency and effectiveness. These two characteristics of health systems highlight the economic forces that often drive political and ideological pushes for health reform. Effectiveness relies on the processes of healthcare resulting in an improvement in health and quality of life, while efficiency is concerned primarily with maximization of the value of the health resources.²⁹ Through either process indicators or health outcomes, the two can be measured and evaluated.

²⁵ Gwatkin DR, Bhuiya A, Victora CG. Making health systems more equitable. *Lancet* 2004; 364: 1273–80.

²⁶ Carr D: Improving the health of the world's poorest people. *Health Bulletin* 2004, 1:1-34.

²⁷ Kruk ME, Freedman LP. Assessing health system performance in developing countries: a review of the literature. *Health Policy* 2008;85:263-76

²⁸ Peters DH, Yazbeck A, Sharma R, et al. Better health systems for India's poor: findings, analysis and options. Washington, DC: World Bank; 2002

²⁹ Aday LA, Begley CE, Lairson DR, Balkrishnan R. *Evaluating the Healthcare System: Effectiveness, Efficiency and Equity*. 3rd ed. Chicago, Ill: Health Administration Press; 2004.

Effectiveness, for example, can be evaluated through the framework of patient satisfaction or the quality of procedures, both ways of determining social benefits and comparing to the social costs and unique challenges. Efficiency can be defined in various ways: technical (maximizing improvement from a single intervention), productive (comparatively efficient versus the alternative), or efficiency of allocation (from a global perspective). In evaluating efficiency, health care is often seen as the intermediary between health resources allocated and health outcomes produced. These “resource inputs” can take the form of costs (including health expenditures as a portion of GDP).³⁰

Reform, once these goals are clarified, occurs on varying levels within the health care system and to various degrees. Frenk isolates four potential policy levels for reform within the system: systemic, programmatic, organizational, and instrumental.³¹ Among these “levels,” differences arise in goals, mechanism and difficulty of institution of reform, and central issues. For systemic reform, for example, eligibility and institutional arrangements themselves may be altered with the goal of seeing an improvement in equitability of the system. On the other hand, a lower “level” such as the organizational one may be primarily concerned with technical efficiency through either an increase in productivity or quality of care.

One can imagine the significant difficulties inherent in a transformational reform. Reforms that call for larger-scale, institutional change are also beholden to political resistance from actors with vested interests within the system. If, however, the

³⁰ Palmer S, Torgerson DJ. 1999. Economic notes: definitions of efficiency. *Br Med J* 318:1136.

³¹ Frenk J. Dimensions of health system reform. *Health Policy* 1994; 27: 19–34.

simultaneous push for reform is pursued in a politically feasible atmosphere with the support of the right interest groups in the right institutional context, systemic reform can occur. Additionally, systemic reform within a nation is most often directly related to the role of the state within the system. In calls for equity and changes of interrelations of the many aforementioned components within the health care system, only governmental bodies have the authority and jurisdiction to institute systemic change through policy formation. This holds true even if the governmental bodies have vested interest in the outcome of the reform, for good or for ill.

Hsiao defines “control knobs” as the main centers of adjustment for health reform efforts: financing, payment, organization, regulation, and consumer behavior.³² In doing so, one can differentiate substantial, “big R” reform, in which multiple knobs are effected, from “small R” reforms. Examples of “small R” reforms include the introduction of user charges in public clinics.³³ The topic of study of this paper is a “big R” reform in the state of Andhra Pradesh, India. A multitude of political factors led to the adoption of the encompassing reform movement, culminating in the creation of the Rajiv Aarogyasri Health Community Health Care Trust among other significant policy changes. Fundamentally, how did a substantial health care reform program arise in a political context? Additionally, how did the political backdrop for the reform movement within the state impact its ultimate shape and breadth?

³² Hsiao, W. C. (2003). *What Is A Health System? Why Should We Care?* Cambridge, Massachusetts: Harvard School of Public Health.

³³ Peter A Berman and Thomas J Bossert, “A Decade of Health Sector Reform in Developing Countries: What Have We Learned” (Boston, MA: Data for Decision Making Project, Harvard School of Public Health, 2000)

1.2. Indian Public Health Infrastructure

The health care system in India is in a perilous state. Viable options for care are few for the hundreds of millions that live in abject poverty. In addition, the preventative public health infrastructure, consisting of community health and primary health care centers, along with larger scale interventions like water sanitation and healthcare worker availability, are woefully inadequate. In spite of the situation, state spending in India remains low, even for developing nations; less than 1% of GDP is spent on health.³⁴ This is troubling in both the public health and medical spending, where health needs are vastly overshadowing the health systems that seek to address them.

A still-rapidly expanding population, modernization with rapid urbanization, the nutrition transitions, and the looming threat of pandemics in infectious disease bring new health issues to the forefront, and emphasize old ones as well. Building a sustainable and universal health system that can address multiple health targets will be essential, especially for developing nations like India. In India, less than 15% of the population is currently covered under a health plan.³⁵ The out-of-pocket payments to private providers that make up most health transactions in the nation disproportionately impact the poor, who have little to no savings. The result is enormous amounts of crippling indebtedness that pushes the inescapable cycle of poverty forward. According to the Lancet medical journal, costs of health care, including the high reliance on out-of-pocket payments, brings about 37 million

³⁴ Berman P, Ahuja R. Government health spending in India. *Economic and Political Weekly* 2008; 46:26-7

³⁵ World Health Organization. India tries to break cycle of health-care debt. *Bulletin of the World Health Organization* 2010; 88:7.

people into poverty in India annually.³⁶ The health system leaves much of the population vulnerable to the whims of illness and disease. One study showcased the efficacy of the inverse care law, in which those with the greatest need have the greatest difficulty in accessing health care, in relation to maternal and child services in India.³⁷

While this state of affairs may be shocking, equally shocking is the level of inconsistencies among states in terms of nearly every health marker. In terms of vaccination coverage, for example, the rates range from above 70% in Tamil Nadu all the way to ranging from 10-20% in Nagaland.³⁸ State to state differences in prominent development markers, including health ones, showcase the importance of the state level of governance in the nation. India is a federation, first and foremost, and most reforms and programs occur at the state jurisdiction. States in India are the main actor of public good distribution, and political accountability by the citizenry does not buck the trend.³⁹

State borders are not the limit of vast disparities and enormous variation in health outcomes. As Bajpai noted, “health status in India varies systematically between rural-urban location, membership of scheduled caste and tribe, and by age and gender.”⁴⁰ Questions of distributive justice are embedded in India’s health structure. It is a prime example of “structural violence” that leads to a great deal of preventable illness. Paul

³⁶ Van Doorslaer E, O’Donnell O, Ranna-Eliya RP, et al. Effect of payments for health care on poverty estimates in 11 countries in Asia: an analysis of household survey data. *Lancet* 2006; 368: 1357–64.

³⁷ Balarajan Y, Selvaraj S, Subramanian SV. Health care and equity in India. *Lancet* 2011; published online Jan 12.

³⁸ Sharma S. Immunization coverage in India. Working Paper Series No. E/283/2007. Delhi: Institute of Economic Growth University Enclave. Available at: www.iegindia.org/workpap/wp283.pdf. Accessed 2011.

³⁹ Chhibber, P, & Nooruddin, I. (2004). Do party systems count? The number of parties and government performance in the Indian states. *COMPARATIVE POLITICAL STUDIES*, 37(2), 152-187.

⁴⁰ Bajpai N, and Goyal S. (2004). Primary Health Care in India: Coverage and Quality Issues.” Working Paper Number 15. Globalization and Sustainable Development.

Farmer, et al, describe structural violence as “structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people (typically, not those responsible for perpetuating such inequalities).”⁴¹ It is the subject of this research paper to look at an example of a movement to conduct structural interventions to improve the social machinery that drives health outcomes.

The path of liberalization that India began in 1991 has transformed the health care industry. Eighty percent of the healthcare economy is made up of private providers- a total valued of more than \$34 billion.⁴² Rising rates of chronic conditions and a growing middle-class with disposable income have enabled this growth. The quality of care at many of these institutions, almost all urban, is extremely high. World-class care at the rapidly-growth corporate sector has led to an increase in medical tourism. Even preceding liberalization though, the private sector remained the haven for higher quality medical care despite higher cost. India’s health system lacked sufficient funding initially for the public sector, and even further reductions in spending resulted from recession in the 1970s and restructuring of international loans. This led to a lackluster public sector and a growth of technical expertise and innovation limited to the private sector for decades. Private health care accounts for 80-85% of all physicians and 93% of hospitals.⁴³ Additionally, the overall share of private sector within health is upwards of 70%.⁴⁴

⁴¹ Farmer PE, Nizye B, Stulac S, Keshavjee S. Structural violence and clinical medicine. *PLoS Med* 2006; 3: e449.

⁴² Price Waterhouse Cooper. *Emerging market report: Healthcare in India*. 2007.

⁴³ Peters DH, Muraleedharan VR. Regulating India's health services: To what end? What future? *Social Science & Medicine*. 2008;66(10):2133–2144.

⁴⁴ Mudur G. 2003. India plans to expand private sector in healthcare review. *British Medical Journal* 326: 520.

The result has been a two-tiered system: the efficient and high quality care that constitutes the rapidly proliferating private industry and the lackluster and disintegrating public sector. This health care system, stemming from the wave of neo-liberal policies initiated in the early 1990s, serves two distinct populations bifurcated along socioeconomic lines. Between 8-12% of the second lowest quintile socioeconomically falls below the poverty line due to health expenditures. ⁴⁵ Curative care can devastate a family at an inopportune time, driving them into further debt. Households in the bottom twenty percent of the income brackets receive 10.10% of public subsidies, while the top 20% receive 30%.⁴⁶

Government dollars consist of most public health and primary health care spending in India, while the opposite is true for curative care. Still, the public health and primary health care system is insufficient for the need of the population it seeks to serve. In terms of infrastructure, personnel, and patient satisfaction, the public sector is sorely lacking.

The dilemma, for Indian state governments as well as the federal government, has been translating the economic success to the larger populace in terms of human development. This issue has been recognized as the centerpiece of the twelfth five-year plan (2007-2012), which highlighted “inclusive growth” as a primary objective. ⁴⁷ Yet, only one-tenth of the populace has health insurance access.⁴⁸ On both a national and state level,

⁴⁵ Berman, P. (1998) “Rethinking Health Care Systems: Private Health Care Provision in India” *World Development*, 26 (8): 1463-1479.

⁴⁶ Mahal A. et al. *Who Benefits from Public Sector Health Spending in India?* New Delhi: National Council for Applied Economic Research, 2002.

⁴⁷ Planning Commission. Government of India. Ministry of Health and Family Welfare. “12th Five Year Plan 2012-2017.” Available at: <http://planningcommission.nic.in/plans/comments/inter.htm>.

⁴⁸ Balabanova D, Oliveira-Cruz V and Hanson K. (2008), *Health Sector Governance and Implications for the Private Sector*. Discussion paper prepared for the

building an equitable health care system that is affordable, accessible, and high quality is a policy priority. The state of Kerala shows the highest Human Development Index score at 0.625.⁴⁹

Historically, Kerala has been a unique experiment in social spending and public sector involvement in the health sector. Education and health compose the highest portion of public spending.⁵⁰ The majority of this public sector growth, especially in the health sector, was between 1961 and 1986, during which the number of government hospital beds nearly tripled. Since then, fiscal problems in the state government caused significant cutbacks in the public sector and the private healthcare industry grew.

There is broad consensus among political actors that reform is needed in the health sector of India. However, the meaning of “health reform,” what change it actually requires and which form it comes in is hotly debated. Various health reform programs have been undertaken across the nation, most implemented and experimented at the level of the state. State governments are chiefly responsible for financing and organizing the health sector. The promise of universality of the health care within the Indian constitution, too, is also primarily a task left to the state level of governance. This accounts for the distinct paths that reform processes, and policy processes more generally, have taken in individual states.

In India and other developing nations, it is clear that health reform can be instrumentally good in providing for higher economic gains and more efficient use of

Rockefeller Foundation, November 2008.

⁴⁹ Suryanarayana, M.H., Agrawal, A., Prabhu, K.S. Inequality-adjusted HDI for India’s States. United Nations Development Programme in India. 2011.

⁵⁰ Kutty VR. Historical analysis of the development of health care facilities in Kerala State, India. Health Policy and Planning 2000;15:103-9.

resources. Reform, however, can also be normatively good. In terms of tackling fairness, justice, and capability to achieve good health, it is clear that health reform can contribute positively to these issues as well. Why, then does reform occur so rarely? Problems of accessibility, cost, equitability, and effectiveness plague health care systems the world over, yet few are addressed in the policy realm in a competent, methodical manner.

Understanding why certain health care systems' problems are addressed, and how these problems are addressed, is essential in health policy to exporting the reform process and creating the conditions to proliferate reform. There is a broadly converging consensus on how health systems should be conceptualized and performance measured; however, approaches to strengthen health systems are lacking.⁵¹

Ultimately, health reform occurs in a political context, yet political explanations for why reform occurs are sorely lacking within the health reform literature. What political factors contribute or detract from an initiation of health reform and how this health reform looks in terms of its reach and shape? Electoral politics, party linkages, associational life, elite political actors, and institutional structures all mediate the formation of a policy and its outcomes, whether measured in financial or human terms. How much each of these factors played into the development of a "big R" reform in the state of Andhra Pradesh, in the Hsaio's lexicon, in which regulation, financing, and overall organization of the healthcare system was impacted, is the question that will be contemplated through a descriptive analysis.

⁵¹ Shakarishvili, G., et al., 2010. Converging health systems frameworks: towards a concepts-to-actions roadmap for health systems strengthening in low and middle income countries. *Global Health Governance*, III (2).

Scholars have often pointed to vague factors for explanatory power on why some health reform movements work while others flounder and fail. As Reich and others have stated, World Bank reports on health reform have attributed these successes and failures to “political will” and the existence of “capable planners and managers,” both nebulous terms that do not serve any informative capacity.⁵² “Political will” is an insufficient variable for explaining how and when political agendas are set.

There are theoretical frameworks which hold enormous analytical power in this case, however. Stakeholder analysis has increasingly become used in policy analysis, an import from business management.⁵³ Understanding various stakeholders and their roles in the policy formation process, along with their perspectives, relative power levels, and ultimate goals for the policy process, allows fuller characterization of the health reform process.⁵⁴ Additionally, describing social, cultural, historical, and economic context is essential to providing generalizable facets of a policy process, and also understanding the constraints under which stakeholders work.

The “multiple streams” approach remains a prominent conceptualization of policy formation. John Kingdon first enunciated the theory in 1984 in opposition to purely rational and linear models of policy formation. It states that when multiple sets of activities, “streams,” coincide in the public realm, a window of opportunity opens up for

⁵² Reich, Michael R. 1997. “Review of World Development Report: Investing in Health (New York: Oxford University Press, 1993).” *Economic Development and Cultural Change* 45: 899- 903.

⁵³

⁵⁴ Brugha R, Varvasovszky Z. 2000. Stakeholder analysis: a review. *Health Policy and Planning* 15: 239-46.

policymakers.⁵⁵ These streams are composed of problems (perception by the general public), politics (electoral pressures and other political events), and policy solutions (generated by mid-level bureaucrats). The multiple streams approach can provide description that stakeholder analysis can often miss: why certain policies emerge when they do in an anarchic and irrational policy environment.

Finally, the “method” of historical institutionalism also serves as an important contextualizing force in understanding the creation of health reform programs. While previous theories assume institutions are static loci in which policies are coordinated and negotiated, historical institutionalism seeks to provide the shared cultural meanings and norms that are socially constructed within institutions.⁵⁶ It has often been used to address direct empirical problems of change.

1.3. Preview of Thesis

In the following pages, the Andhra Pradesh reform movement will be described fully. Impact on a health system level, along with impact on a micro scale on the accessibility and cost-burden for an individual citizen will be described. The reform process was transformative systemically, and its effects trickled down to the health, opportunities, and lives of individuals. Semi- and unstructured interviews with central actors in the health policy formation process will contribute heavily to the descriptive analysis, along with primary media sources and communication materials.

⁵⁵ Walt G, Shiffman J, Schneider H, et al. ‘Doing’ health policy analysis: methodological and conceptual reflections and challenges. *Health Policy and Planning* 2008;23.

⁵⁶ Thelen, Kathleen. 1999. “Historical Institutionalism in Comparative Politics.” *Annual Review of Political Science* 2: 369-404.

After a complete description of Andhra Pradesh's health care system and its economic and political contexts, tracking roughly two decades, Chapter 3 will seek to extract non-political factors for why the health reform movement occurred. Chapter 4 will seek to explicate the political factors, and which political factors contributed most heavily, seeking both prospective and retrospective analysis before and after the implementation of the health policy. This will include analysis using a broad spectrum of theories in political analysis in order to flesh out the policy formation and subsequent implementation in the fullest possible sense.

It was a thornier process to study implementation than policy formation; finding out exactly how the health policy played out on the field is difficult to assess completely and without bias. However, attempts using the publicly available metrics of the health programs (a central facet of the reform movement being public information) and other more qualitative observations serve to inform. Objectives and actual implementation processes are often divided by a large gap, even larger so in developing countries. Corruption, lack of stated funding, poor institutional capacity, and bureaucratic malaise all afflict the implementation of a health policy and serve to widen this gap.

This project uses the case study of Andhra Pradesh's health reform programs, including Aarogyasri, to inform public policy investigations of health sector reform as a whole. The research will also generate generalizable policy prescriptions for low and middle-income nations in instigating the creation of and implementing health sector reform effectively, efficiently, and equitably. The generalizability of the case here will be extricated from historical and contextual influences that are specific to the case. It is

retrospective in this sense: a history of the health system's development, as well as the political context surrounding welfare and reform, is necessary in order to fully extricate causal factors for the health reform movement's emergence. Largely, though, the study is prospective, with the relevant policy cycles being within the decade. Through description, empiricism, and theory, a well-rounded study of the phenomenon can be elicited. It will also be an institutional study, through which the institutional structures that impact and allow health reform is analyzed. In this way, both the ontology (the state of the reformed health system) as well as the epistemology (how the reform itself came about) can be addressed.

Primarily, how was Andhra an example of "big R" reforms in Hsiao's framework by affecting the control knobs of financing, payment, organization, regulation, and consumer behavior? What political factors led to such an expansive program being implemented and shaped the way it was? These questions will be the focus of this work. We are primarily looking at the impact on the constitution of the existing health system- something the MDG's recognize as essential to the achievement of multiple health targets simultaneously. The health system is primarily designated as a public activity: governments, in developing nations, are usually both the source of financing and delivery of care. This reform created new rules for the private and public health sectors to follow.

The research methodology included collecting scholarly accounts of the political situation in Andhra Pradesh. Additionally thorough, unstructured interviews with key actors in the government and health sectors were an essential part of the research methods. Understanding their perspective in formulating and implementing the health reform

program, as well as obtaining information about the health programs themselves were the central goals of the interviews. The interviewees were chosen based on proximity to the health reform process and implementation, and the “chain sample” method was used for attaining recommended interviews.

Ch. 2 Health Reform of Andhra Pradesh

2.1: Introduction

2.2: Andhra Pradesh within India

2.3 Andhra's Post-Independence Political History

2.4 Andhra after Liberalization: Chandrababu Naidu and YSR

2.5 Content of Health Reform

2.1. Introduction

In Chapter 1, normative and instrumental reasons why any nation would undertake the health reform project were provided, followed by a description of types and levels of health sector reform, methods of analysis in health policy, and a brief overview of the existing health infrastructure across the Indian nation. In the following chapter, an understanding of Andhra Pradesh's health reform movement will be described in complete context: historical, political, and geographical. For the meta-policy approach undertaken, there are a number of factors that must be considered to fully discern both the process, how and within which limitations the policy comes to be, as well as power, who is influential and why these individuals hold power. Complexity abounds, and a full understanding can only be attained with descriptive analysis that seeks to provide context for the health reform movement.

An understanding of where the state of Andhra Pradesh fits within the Indian context, its history, recent political transmutations, and economic and social structures, are essential to understand the overarching environment for policy transformation. Deep institutional histories are the limiting factors; they set the fences for what is and is not possible within the "arena" of government. These institutional histories, borne of overarching historical and political factors, help gain wisdom into why the events unfolded the way they did, rather than in an alternative way.

As stated in Gill Walt's fundamental text of health policy, "By focusing on the political system it is possible to build up a picture of the complexities of how societies allow people within them to express demands and wishes and how these are translated into

policy by their governments...Processes do not have a life of their own, but are dependent on actors to give them expression, analysis of the policy process is interwoven with an exploration of which actors are involved, and how far each may be exerting influence on policy.”⁵⁷

In demonstrating the policy process, there is much debate about whether group models and mass appeal models are even relevant in a developing world context. They are relevant, along with the elite model, in understanding why and how these policies come to be. While not perfect, the general robustness of liberal democratic structures within India provide for this allowance. Even within India, there are varying depths of democracy, and the “substantive-ness” of Andhra Pradesh’s democracy is up for debate. The lack of clientelism and corruption, civil society, the relative power of associations: these are among the factors that promote democracies beyond the procedural dimension. ⁵⁸

The political system is a byproduct of geographical, economic, and social forces. Only through understanding the specific conditions of Andhra Pradesh’s political system can the generalizable prescription for health reform elsewhere, in either developing or developed nations, be realized.

2.2. Andhra Pradesh within India

“The Indian state, then, for historical reasons associated with the experience of colonialism, the international geopolitical situation, the ideological orientation of its policy

⁵⁷ Walt G: *Health Policy: An Introduction to Process and Power*. London, Zed Books 1994, (6).

⁵⁸ Heller, Patrick. 2000. “Degrees of Democracy: Some Comparative Lessons from India.” *World Politics* 52 (July): 484-519.

makers, and the economic realities of India, was seen as *the* agent of social and economic transformation.”-Pradeep Chhibber, *Democracy without Associations*⁵⁹

India uses a federal political system, in which states are afforded relative freedom fiscally and politically to organize social, agricultural, and industrial policy. This fact of Indian politics accounts for the vast interstate disparities described in every socioeconomic indicator in Chapter One. To understand the political process, there are undoubtedly macro-level national factors at play, but the policy arena exists primarily at a state level. Divided along linguistic and cultural, lines, the states have sharply diverged over the last half-century of Indian independence from colonial rule.

The federal system in India allows management of rich diversity in a country that, when it gained independence, had 15 languages with over 20 million speakers each. The 1950 Indian Constitution was constructed with the creation of a unity among such diversity in mind; devolution of power from the center (the federal government) would be necessary to preserve the nation as a whole.⁶⁰ The orator, social reformer of the caste system, and economist B.R. Ambedkar, who served as Chairman of the Constitution Drafting Committee, attributed the demise of both the Austrian and Turkish empire to multi-lingual states, and stated, “India cannot escape this fate if it continues to be a conger of mixed [multi-lingual] States.”⁶¹

⁵⁹ Chhibber, P. K. (1999). *Democracy without associations: Transformation of the party system and social cleavages in India*. Ann Arbor: University of Michigan Press. 28.

⁶⁰ Alfred Stepan, “Federalism and Democracy: Beyond the U.S. Model.” *Journal of Democracy* 10: 19-33.

⁶¹ Ambedkar, B.R. (1955). *Thoughts on Linguistic States*. Aurangabad.

The focus of this work is on specifically changes occurring in the state of Andhra Pradesh. The state is an interesting case study, both for its unique characteristics, some cultural, political, and economic, as well as more generalizable conclusions, due to its status as a rapidly developing region.

By either geographic mass or population, Andhra Pradesh is among India's top five largest states. It was linguistically constructed with the language of Telugu as its unifying factor, only after a fast to the death, rioting, and subsequent police firings forced the hand of the Indian national government. Lying along the southeast coast, limited by the Bay of Bengal to the east, Andhra is a fertile land mass overall with vast differences in climate, ranging from delta regions along the rich Godavari and Krishna rivers to tropical regions.

These geographic conditions translate into cultural and economic realities, impacting inequalities in resource availability and affecting political representations, discourses, and narratives. With over 77% of the crop output being rice, Andhra has been known as the "Rice Bowl of India." Historically, Hyderabad, the capital city of almost 8 million in the metropolitan area, had been ruled as a separate State under independent, monarchic Muslim rule, first under various Sultanates, and then under the Nizams, beginning in the early 18th century. Under both later Mughal and British rule, Hyderabad remained a political sovereign of the Nizams.⁶²

The result of the rule of the Nizams was enormous wealth for the Hyderabad State: palaces, jewels, and other luxuries became a mainstay over seven generations. Along with

⁶² Karen Leonard, 'The Hyderabad Political System and its Participants', *Journal of Asian Studies*, 30(3), 1971, pp. 569-582.

the palatial atmosphere, though, was a mixed record in the social dimension. The autocratic Nizams institutionalized a patron-client system, and Nobles held steep control over grants and positions in the bureaucracy. Literacy rates were low and public health responses to malaria epidemics were weak at best.⁶³ At the same time though, economic industrialization, the creation of hospitals and universities, and the foundation of a civil service all fomented under the Nizam rule.⁶⁴ An additional effect was cultural (the major language being Urdu) and political isolation from the rest of what would become Andhra Pradesh: a fact that continues to trigger divisions in modern Andhra Politics today, especially as the spoils of economic development schemes and agricultural riches are disputed.

The united Andhra Pradesh was formed from three separate regions, with distinctive histories and polities, the unifying bind being the language of Telugu. Coastal Andhra borders the Bay of Bengal, and was originally part of the Madras state to the south. A prolific agricultural base, from the basins of multiple rivers, allowed the growth of a “productive and commercialized agrarian economy in the 19th century,” with the fishing industry along the coastal lines.⁶⁵ This commercialization led to greater development of the region than the other two in Andhra Pradesh. The second of the three major regions that unified to form Andhra Pradesh was Rayalaseema, bordering Karnataka and Tamil Nadu to the South. Under British Rule and preceding unification of Andhra Pradesh, both Coastal Andhra and Rayalaseema were a part of the Madras Presidency to the south. English

⁶³ Reddy, R. 1987. Economic history of Hyderabad State. Delhi: Gian Publishing House.

⁶⁴ Lucien D. Benichou. 2000. From Autocracy to Integration: Political Developments in Hyderabad State, 1938-1948, Hyderabad: OrientLongman, 2000.

⁶⁵ Upadhyaya C.,(1988), “The Farmer-Capitalists of Coastal Andhra Pradesh”, Economic and Political Weekly, July 2.

(rather than Urdu) was the *de jure* language throughout the Madras Presidency, a signifier of the differing trajectories these regions took, and the fault lines those trajectories create.

The third region, Telangana, was under the jurisdiction of the Nizams historically. While Urdu was the official language of Hyderabad, Telugu was spoken widely, both in the Hyderabad State as well as more widely across the Telangana districts. The splendor and prosperity of the Nizams in Hyderabad was not spread equally across the Telangana State. D.B. Forrester states, "For two hundred years Telangana was separate from the rest of the Telugu country, maintained in a rather backward feudal condition by the Nizams of the Asaf Jahi dynasty. The *jagirdar* system of landholding seems to have stood in the way of agricultural development...the Telangana backwardness has essentially political roots: with better administration the considerable water resources could have been more fully tapped for irrigation."⁶⁶

Economic and social development had proceeded with significant disparities in the Telangana region, creating fault lines of some permanence in the politics of Andhra Pradesh. Unification was not an entirely smooth process. The November 1956 mandate for political unification from the national government also included attempts at safeguards, including reservations of jobs for citizens of each region.⁶⁷ These various regions have seen distinct patterns of mobilization, an expression of their differing political processes and cultural development. Agricultural areas in the Telangana region were the wellspring of the

⁶⁶ Forrester, D.B. 1970. Subregionalism in India: The case of Telengana. *Pacific Affairs* 43(1): 5-21.

⁶⁷ Gray, H. (1971) 'Demand for a Separate Telangana State in India', *Asian Survey* 11 (4), May.

Communist (Marxist/Leninist) Party's growth, growth that would lead to the emergence of the violence of the Naxal militant groups.⁶⁸

The economy in Andhra today is driven by two streams: agriculture (formed from the irrigation made possible by the Godavari and Krishna rivers) and technological (exports of which are in the billions of USD). Growth of the Information Technology (IT) and computer software sectors have been enormous in Andhra Pradesh over the past two decades; in the twelve year period between 1993 and 2005, the average growth of the industry was 75%.⁶⁹ Hyderabad, especially, has been at the forefront of this "high-tech" explosion, and numerous multinational corporations have built their Indian or Asian headquarters there. Still, questions about the inequitable nature of this development have been raised, with literacy rates, wealth concentration, water supply, and health care access as a focus.⁷⁰

How developed is Andhra Pradesh, both absolutely and relative to other states in India? How equitable has development in Andhra Pradesh been? In terms of the key indicators, Andhra has a mixed record. Andhra Pradesh's GDP was \$85.7 billion in 2009. According to the Economist, its nearest the equivalent was Slovakia for total GDP, but Nicaragua for GDP per person.⁷¹

⁶⁸ Srinivasulu, K. (2002) 'Caste, Class and Social Articulation in Andhra Pradesh, India: Mapping Differential Regional Trajectories', Working Paper 179, London: Overseas Development Institute.

⁶⁹ Kumar, R. 2009. The Development of the Software Industry in Postreform India: Comparative Regional Experiences in Tamil Nadu, Andhra Pradesh, and Kerala. Cambridge Press. New York.

⁷⁰ Ramachandraiah, C. and Bawa, WK (2000). Hyderabad in the Changing Political Economy. *Journal of Contemporary Asia*, 30(40):562-74.

⁷¹ <http://www.economist.com/content/indian-summary>

With a life expectancy of 64.4 years, Andhra Pradesh's measurements are slightly higher than the all-India life expectancy of 63.5, far exceeding the 58.0 years of Madhya Pradesh, but far below the gold standard of Kerala: 74.0 years.⁷² According to the UNDP 2011 Human Development Index study, Andhra loses rank when inequality is adjusted for using the Inequality-Adjusted Human Development Index (IHDI). Globally, it is important to note that India falls short of the world average, 0.504 to a global average of 0.624, categorizing it as a nation with "Medium Human Development." Andhra Pradesh, however, falls in the "Low Human Development" category based on its HDI of 0.485. Nations closest to AP's human development level are Pakistan, the Congo, and Bangladesh.

Health indicators are stark too. The infant mortality rate decreased from 2001 to 2005 from 66 to 53. Still, according to the state government document Andhra Pradesh Human Development Report 2007, "It is a level that is unacceptably high. Moreover, the earlier sharp decline in IMR has not continued in the recent past."⁷³ Health facilities are also meager: there are four hospitals for every million people. Even for primary healthcare centers (PHCs), there are only 1570 for the rural population of 60 million. This number falls far under the standard of 1 PHC for 30,000 individuals. The rural-urban divide is deep: 79 percent of the physicians are in urban areas, and absenteeism is rampant in the public hospitals and health institutions common in rural areas.

2.3 Political History of Andhra Pradesh (After 1956)

⁷² Suryanarayana M.H. et al. Inequality-adjusted Human Development Index for India's States 2011. UNDP India. New Delhi.

⁷³ Andhra Pradesh Human Development Report 2007

On November 1, 1956, Andhra Pradesh was unified as a single state under the States Reorganisation Act. The political developments that have occurred, in both policy process and electoral cycles, have left profound indents and fault lines in the government of AP. Examining this political history will provide an underlying structure for what individuals, factions and interest groups hold sway, how power is held, accumulated, and used by central actors, and the construction of the existing social and political environment that the health reform movement moved into. To understand Indian politics, and Andhra politics especially, parties, castes, identities, and personalities must be fleshed out. Indian political life consists of weak associational ties, leaving political parties to bridge state and society.⁷⁴

Andhra Pradesh's political system was dominated by the Congress Party for a quarter decade period directly after the state's creation. Although the Congress Party had significant struggles with finding a central "ruling" figure, they were consistently able to find the center between the party of the right, Swatantra, and the left-leaning Communist Party.⁷⁵ This fact, combined with the lack of any alternatives and the deft use and abuse of caste divisions to drum up votes during election time, led to the consistency of the Congress Party's successes. Even throughout the violence of the separatist movement, during which students were incited to form *bandhs* (stopping of all economic activity and public protesting), the Congress Party sputtered on. In fact, Channa Reddy, who led the separatist Telangana movement, would eventually become Chief Minister. Power, and the

⁷⁴ Chhibber, P. K. (1999). Democracy without associations: Transformation of the party system and social cleavages in India. Ann Arbor: University of Michigan Press. 28.

⁷⁵ Suri, K.C. (2002) Democratic Process and Electoral Politics in Andhra Pradesh, India', Working Paper 180, London: Overseas Development Institute.

holding of power, depended on one's closeness to the national government and Indira Gandhi, the Prime Minister.

During the 1983 elections however, N.T. Rama Rao (NTR), a charismatic star in the Telugu film industry, led a new party, the Telugu Desam Party (TDP), one that would become a force in the Andhra political scene. As K.C. Suri describes, NTR was able to unify both anti-Congress and non-Congress factions, taking on players from far-opposing ends of the spectrum. Demeaning the corrupt and kleptocratic nature of the Congress Party rule in Andhra, and doubly painting the TDP as the populist party through a promise of no agricultural taxes, NTR and his party coasted to a landslide victory. The ensuing years where politically hostile ones between the TDP and Congress, and would set the formative network for a bipolar party distribution in Andhra Pradesh for decades to come. Pingle notes the workings of caste politics here too: the TDP movement was led by the Kamma caste of coastal Andhra, which suppressed the issue of a separate Telangana state that would simmer under the surface of Andhra politics.⁷⁶ As Suri commented:

“TDP–Congress relations showed that in the evolution of a democratic polity in a developing society with too many social cleavages and mutually conflicting economic interests, political parties, especially the main opposition, seem to give less importance to parliamentary conventions and fair means.”

NTR controlled Andhra Politics handily for a half-decade. NTR projected himself as an *Anna* (older brother) who would give benefits to the public from his schemes, a “donative

⁷⁶ Pingle, G. (2011). Reddys, Kammas and Telangana. *Economic and Political Weekly*. September 3. XLVI: 36.

discourse.”⁷⁷ After losing in 1989, the TDP won once more with NTR at the perennial helm. His reign, however, was short-lived. Within months, his own son-in-law, Chandrababu Naidu, would lead a revolt against him, pushing back with a claim for a mandate of pragmatism and economic reform. Naidu had the support of the elites in Andhra; as he had served as Finance Minister, he presented a new vision of neo-liberal development, and those that became rich through his reforms in turn aided in his subsequent construction of the party structures. Even without the charisma and political clout of NTR (he would die within months of the political betrayal by Naidu), the TDP had somehow survived. It was clear that the two-party system was here to stay in Andhra:

“The characteristic feature of this much hankered after political grace [referring to the two-party system] is that there are two hardly distinguishable political formation each with its own constituency of loyal voters, while the non loyal voters shift from one to the other in sufficient measure from one election to the next...Critics lacking in the blessed spirit of charity will call it a Tweedledum-Tweedledee political system.”⁷⁸

2.4 Andhra after Liberalization: Chandrababu Naidu and YSR

Chandrababu Naidu, too, proved to be an able negotiator of the careful balance between liberalization and welfare schemes that successful South Indian politicians need. Within weeks of taking office, his administration had constructed a White Paper, one that

⁷⁷ Mooij, J. (2003) 'Smart Governance? Politics in the Policy Process in Andhra Pradesh, India', ODI Working Paper No. 28 London: Overseas Development Institute

⁷⁸ Balagopal, K. (1995). Andhra Elections: What Happened and What Did Not Happen. Economic and Political Weekly. January 21. Mumbai, India.

mirrored an independent World Bank undertaking, that called for fiscal prudence, curtailing subsidies, and cutting government programs that were deep in the red.⁷⁹ Governance, economic, and agricultural reforms ensued. In the health sector, primary reforms included a much larger role for the private sector and the implementation of user charges to aid cost recovery efforts. The results of such reforms, though, were mixed. Communication and construction grew quickly, but failures were also large: the irrigation project was universally criticized. They were also mixed in their equitability: an urban middle class grew, but rural farmers were hit hard, leading to an epidemic of farmer's suicides.⁸⁰ Debt, too, as a percentage of GSDP, increased ten percent. All his economic World Bank-backed reforms were a double-edged sword: the ancillary effects included "the accentuation of poverty, growing income inequalities, unemployment, and unabated farmers' suicides."⁸¹

Naidu, though, would feel the pain that comes from holding central power. The TDP started to fracture at the local level as party leaders began to feel their influence was underappreciated, and that Naidu solely listened to the bureaucratic machine in Hyderabad. After 10 years of consecutive rule, Naidu and the TDP lost the next election to the Congress Party.

Telugu Desam Party's loss, however, had a number of causal factors, not least among them the dramatic rise of a dominant personality. One Congress Party parliamentarian, Y.S.

⁷⁹ J. E., Mooij. (2005) Hype, skill and class : a comparative analysis of the politics of reforms in Andhra Pradesh, India. In: ISS Working Papers - General Series.

⁸⁰ Vakulabharanam, V. (2005) "Agricultural Growth and Peasant Immiserization Under Globalisation in South India." Journal of Development Studies.

⁸¹ Suri, K.C. (2004). Fall of the CEO in Arena of Democracy. Economic and Political Weekly. 5493-5497.

Rajasekhara Reddy (YSR) had undertaken a *padayatra*, literally pilgrimage of the foot, which saw him cross Andhra Pradesh walking for three months and rallying rural troops. The publicity move, one that harked back to the Salt march of Gandhi, was a brilliant maneuver, not only presenting a populist counter-image to Naidu, but also consolidating leadership in the Congress Party. “Dressed in a white shirt, dhoti, and a turban...YSR could easily establish rapport with the simple and poor rural folk.”⁸²

It was a smart political move, and showed the keen political instinct of a budding Andhra icon. A physician by training from the water-scarce districts of Rayalaseema, his wealth came from a mining operation that passed into his hands from his father, and allowed his rise as a politician. His father, Raja Reddy, was local mason, politician and strongman who had not been unopposed to using violence and murder to justify his ends in the anarchic Rayalaseema districts.⁸³

Political discourses played a large role in TDP’s loss, as Srinivasulu points out. After an attempted assassination attempt on Naidu’s life by a Naxalite, the election took on a personal turn to be a referendum on Naidu’s rule. Congress, in turn, took this as an opportunity to tie farmer’s suicides and other failures of the liberalization process to Chandrababu Naidu and TDP by extension, promising free power for farmers. Despite Naidu’s laments about the impracticality of the proposal, and the fact that previous attempts to use the same “free power” election gambit had failed, Congress continued to promote the promise, and did so with greater credibility. Smaller parties were

⁸² Srinivasulu, K. (2004) Political Articulation and Policy Discourse in Elections Andhra Pradesh, 2004. Economic and Political Weekly. August 21. 3845.

⁸³ Balagopal, K. (2004) Beyond Media Images. Economic and Political Weekly. June 12. 2425-2429.

marginalized in the process, and the election became a great battle between TDP and Congress.

Caste alliances have been important for intraparty construction. In recent years, there was a renewed call for a separate state for Telangana, harking back to the debate bubbling under the surface since Andhra's inception. In Telangana, dominant castes, including the Reddys and Velmas, fell into the separatist movement too, lending it political clout. As a result, YSR provided a promise of a separate Telangana state, a common tactic to delay any action on the issue.⁸⁴ Congress also built a coalition with a minor but key player in the Communist Party of India (Maoist), a marriage of convenience for both parties.

YSR would rule with a powerful hand, one of mass popular appeal that had not been seen since the days of NTR.⁸⁵ Still, at times he showed a capacity for deftness: in dealing with the extreme communist Naxalites, he brought legitimate actors to the table, and launched welfare schemes and irrigation to tackle the root socioeconomic causes of their distress.⁸⁶ YSR's *padayatra* had set the stage for his direct interaction with the people, enabling a direct, participatory link that had not existed in Chandrababu Naidu's administration. The result was greater success of his schemes that required so, and more shaping of policy by the people directly, as would be seen in the *Janmabhoomi* (an effort to facilitate grassroots involvement in development and make the administrative machinery accessible) and health reform schemes. He also built on TDP schemes that had already been

⁸⁴ Pingle, G. (2011). Reddys, Kammas and Telangana. *Economic and Political Weekly*. September 3. XLVI: 36.

⁸⁵ Sainath, P. The Congressman with a mass following and appeal. *The Hindu*. September 4, 2011.

<http://www.thehindu.com/opinion/op-ed/article14812.ece>

⁸⁶ *The Hindu*. YSR: From aggressive politician to mass leader.

<http://www.thehindu.com/news/national/article14323.ece>

set up. TDP's *Deepam* (light) scheme aided the formation of self-help committees directly by the people, including the Development of Women and Children in Rural Areas (DWCRA). YSR expanded on this foundation, providing the organization with cooking stoves and gas cylinders.

With rare examples, both Naidu and YSR showed a proclivity for reforms and schemes that were strategically targeted at certain voter groups, showcasing the consciousness that both felt under electoral pressure. The *Deepam* scheme was targeted directly at the women's vote, while a *Rosini* scheme, one that allowed the renovation of old mosques and construction of marriage halls, was targeted at the Muslim vote.⁸⁷

YSR's rule was unprecedented in Andhra politics, perhaps only equaled in stature by the film star-turned-CM N.T. Rama Rao. Until his dramatic death in 2009 of a helicopter crash, he wielded a Machiavellian hand over Andhra politics, simultaneously corrupt (his son Jagan Mohan Reddy is under investigation by the Central Bureau of Investigation for amassing mass amounts of wealth under YSR's tenure) and populist (described in a BBC News obituary as a "champion of social welfare schemes").^{88,89} After a ten year period in the opposition to Chandrababu Naidu's TDP, YSR's Congress Party was finally in power after a landslide victory in 2004, his Congress coalition having 226 seats to the BJP/TDP coalition's 49.⁹⁰ The "Cuddapah Tiger" had found his place of power, and stated upon

⁸⁷ Srinivasulu, K. (2004) Political Articulation and Policy Discourse in Elections Andhra Pradesh, 2004. Economic and Political Weekly. August 21. 3845.

⁸⁸ Prasad, B Krishna. "CBI launches countrywide raids on Jagan Reddy's properties." The Times of India. Aug 18, 2011

⁸⁹ BBC News. "Obituary: YS Rajasekhara Reddy." Sept 3, 2009.

⁹⁰ Election Commission of India, Andhra Pradesh Assembly Elections 2004 Results

inauguration, “I will not blindly remove all measures of my predecessor but I will ensure that all his anti-common man policies will not find a place in the administration.”⁹¹

2.5 Development of the Health Reform Policies

The political stage had been set in Andhra Pradesh for further reforms, with a significant amount of centralized power in the state. Unlike other states, like Karnataka, the Andhra Pradesh government had resisted decentralization of power in governance reform.⁹² Even within the aforementioned DWRCA program, Naidu presided over all reforms, including water, and did so with significant funds from the World Bank. Once YSR came into power though, how did the health reform programs emerge in the governmental arena? What shape did they take, and how did institutional, cultural, and political legacies mold the reform process and ultimate policy?

In 2007, the state of Andhra Pradesh implemented the largest insurance scheme in the world with coverage of over fifty million below-poverty line individuals, the Aarogyasri Community Health Insurance Scheme, with Star Health as the chosen insurance company. The unveiling of the initial stages of the health coverage scheme, in which the financing itself was finalized, occurred on the two-year anniversary of the Congress Party coming into power from 2004.⁹³

⁹¹ The Telegraph. “Farmers flavor of YSR season: Cuddapah Tiger set for Friday roar.” May 13, 2004.

⁹² Manor, James. 2007. Successful Governance Reforms in Two Indian States: Karnataka and Andhra Pradesh. *Commonwealth & Comparative Politics* 45 (4):425-451.

⁹³ The Hindu. “YSR Unveils health cover scheme.” May 15, 2006.

How Aarogyasri Health Care Trust works for the patient on the ground:

How does the Aarogyasri Health Care Trust work for below-poverty line patients on the ground? An interview with Initially, the Aarogyasri Card itself must be in the possession of BPL individual. Per family, it affords two-lakh INR (\$3,600) of health financing for treatment. The cards are distributed in much the same way as the “White Card” rationing cards are, through district and local officers, and in some Aarogyasri camps the two are used interchangeably.

The BPL patient has two options: either referral through the health outreach camps, or directly entering the tertiary care center. At the camps, if an individual is below the poverty line, but does not possess a card, the designated “CM Camp Officer” can draw directly from the Chief Minister’s Relief Fund.

In tertiary care centers, the “Aarogya Mithra,” a government non-medical bureaucrat, and the Rajiv Aarogyasri Medical Coordinator (RAMCO), a medical officer, directly greet the patient, and take photographic evidence. Throughout the entire process, there is no cash exchanged at all. After verification by the RAMCO, the patient is admitted into the hospital if there malady matches a list of preapproved diseases.

The medical attendant fills out an authorization form ,with history, symptoms, and expected treatment, which is then electronically uploaded with the card and photograph. Each hospital has a dedicated staff for this, with shared officers of both the government and the hospital. After approval by a medical officer at the Trust, electronically sent, the treatment begins. In emergency cases, the treating doctor can call the medical officer at the Trust directly for verification to AS1 and AS2.

The patient is discharged after treatment, and provided food and transportation. Additionally, pharmaceutical drugs are provided for up to eleven days by the hospital, without charge to the patient. After eleven days, the Credit Collection Unit of the Aarogyasri Trust, consisting of three officers, raises the claim. The Trust medical officer inspects the case and the treating doctor gives any clarification if necessary.

Interview with RAMCO at Nizam’s Institute of Medical Sciences (NIMS), Dr. Nagendara Prasad

YSR's *padayatra* had initiated a trend in his own rapport with the citizenry of Andhra Pradesh. As Dr. Kiran Kumar Reddy, the Private Secretary to the Chief Minister (a position analogous to a Chief of Staff) described, YSR made a point of meeting with hundreds of individuals daily at times.⁹⁴ These citizens would often come in with concerns of financial solvency, health bills, agricultural problems, and other woes. YSR, in turn, would aid many of them through a program called the Chief Minister Relief Fund (CMRF) a specific account with a set amount of funding set aside for the CM to use at will. It relied on donations and legislative allotment, and discretion of the fund's use was completely up to the discretion of the executive branch. In its official mission statement, it cites addressing "health problems which require expensive medicare, loss of life of kin and kith, and loss of properties and sources of livelihood due to unforeseen incidents" as its central cause. The CMRF had existed since 1990, preceding even liberalization.⁹⁵

The financial insolvency of citizens due to health costs was a central driving force for the initiation of change. Financial protection from the high costs of healthcare, for which 65% of Andhra citizens had to borrow, motivated those at the highest level.⁹⁶ Indebtedness was a central political; the spate of farmer suicides, which the Congress Party had highlighted in the last election, had resulted from the debt trap that had befallen so many farmers in Andhra's rural areas.

What role could the public sector play in this, beyond the CMRF aid in hospitalization bills? Government played a majority role in primary and secondary care,

⁹⁴ Interview with Dr. Kiran Kumar Reddy, Private Secretary to the Chief Minister

⁹⁵ Rockefeller Foundation. *Catalyzing Change: The System Reform Costs of Universal Healthcare*. 2010.

⁹⁶ Rockefeller Foundation. *Andhra Pradesh Health Reform: A narrative case study*. 2009

but tertiary care centers in the public sector were ill equipped to deal the large volume of patients, and quality was far exceeded by hospitals in the private sector. Congenital heart diseases, for example, were not treated at all in many government hospitals.⁹⁷ Vision 2020, the plan for Andhra Pradesh's reform system, specifically stated the governmental desire to be the first state to use the private sector and partner with public systems to achieve health objectives.⁹⁸

The first step was using the existing system to its fullest but limited capacity. Claims in the CM Relief Fund were slow and laborious, and could take up to three to six months. Members of YSR's executive office worked to reduce this time as more and more citizens began to utilize it. CMRF recipients came through either members of the legislative assembly (MLAs) or directly through the CM's office. In a typical CMRF case, according to the fund was able to aid with 40% of the cost of the bill. The structure of the program was bureaucratic though; forms detailing the cost of the procedures from the hospital had to be mailed directly to the CM's office, and once sanctioned, the order returned to the hospital after being paid.

Gradually, the system was sped up through the addition of checks and balances and IT: administrative staff in the executive branch pushed for the creation of a website for direct downloading of the order, and utilized cell phones and an SMS system to speed up the system further. Soon, the CMRF's sanction process was down to within days. MLA referrals were also made electronically. Statistics were prepared to see the utilization of

⁹⁷ Interview with G. Suresh Gurumani, Officer of the Indian Medical Association, Andhra Pradesh Chapter

⁹⁸ Bandhyopadhyaya, D. (2001). Andhra Pradesh: Looking beyond Vision 2020. Economic and Political Weekly, March 17, 2001.

the CMRF, and the results were stark. Despite the increased efficiency of the process, 40% of the recipients still could not afford to pay the bills. Dr. Kiran Kumar, Private Secretary to the CM, informed the Chief Minister, and he describes the CM responding with a suggestion for an “insurance scheme” to be put in place.

The staff responded with detailed study of potential insurance schemes to draw on, including ones in Bangalore and Assam. Each alternative had its problems, though, and any insurance scheme for below poverty line (BPL) individuals in Andhra would be larger than any previous insurance scheme, with a target population of over 50 million people.

However, in studies looking at the distribution of BPL Cards, the method through which many different social welfare schemes are administered, findings have pointed towards at least two of every five cardholders not being from impoverished households.⁹⁹

Administrators within the executive branch initiated the program, with consultations with “physicians, hospital representatives, and local politicians”.¹⁰⁰

Dr. Kiran Kumar prepared a presentation for YSR, indicating target populations for the CMRF to expand to, and the major procedures and specialties to be covered. As he states, since the risk was defined, program’s coverage by the insurance company would be less than it would be otherwise. At this time, large corporate hospitals in the region were consulted as well by members of the inner circle of the executive. Dr. Bhaskar Rao, CEO of the Krishna Institute of Medical Sciences (KIMS) met with the Principal Secretary to the

⁹⁹ Ram, F. Mohanty, SK. Ram, U. “Understanding the Distribution of BPL Cards: All-India and selected states.” *Economic and Political Weekly*: 44,7 : 66.

¹⁰⁰ Rockefeller Foundation: Catalyzing Change: The System Reform Costs of Universal Healthcare

Department of Health Medical & Family Welfare (DoHMFW) and discussed the government's need for 6,000 to 7,000 beds for the program.¹⁰¹

The structure for the first wave of the program was an expansion of insurance coverage. Based on the relief fund, the patient would be referred from a public primary health center, where a Aarogya Mithra (government official) and a paired medical officer would refer the patient to the tertiary care center, with travel, tests, food, treatment, and medicines covered. On a trial basis, 120 procedures were gradually phased in in 3 primer districts. They began expanding this first wave Aarogya Sri 1(AS1), gradually expanding the coverage 5 districts at a time to 23 districts. Using epidemiological data, the incidence of disease could be clearly seen.

The Star Health and Allied Insurance Company won the rights to insure the program, and the government paid the premium directly to them in 2007. The company was Chennai-based, and collected 130 million INR to provide a one-year accident coverage to 78.7 million people, and an additional 330 million INR premium for surgical procedures.¹⁰² Subsequently, two other separate health programs were introduced or expanded on, a centralized emergency service, EMRI, funded by the later bankrupted Satyam Corporation and the GVK charity fund, and the Health Management and Research Institute (HMRI), a call center to handle over 50,000 non-emergency medical cases.

Information technology, data retrieval, and relative transparency were focused on from the initiation of the Aarogya Sri program. According to members of YSR's executive

¹⁰¹ Interview with Dr. Bhaskar Rao, CEO of KIMS

¹⁰² The Hindu. "Star Health cover for BPL families in Andhra Pradesh." Oct 14, 2007.

staff, their initial goal was not to bolster corporate hospitals either; instead they wanted to gradually improve the tertiary care centers in the government while providing below poverty line individuals a steady and high-quality source of healthcare. Tata Consultancy Services, from the massive Tata Corporation, aided in maintaining the website throughout, and promoting rapid referrals to hospitals.¹⁰³

Information technology would be essential to the rapid turnaround time possible for urgent cases. With one of the largest medical databases in the world, the turnaround time after evaluation by a physician at Aarogyasri headquarters could be as short as six hours for oncology, and twelve hours for other cases.¹⁰⁴

Eventually spawning into its own program, AS1 was chiefly based through a separate insurance company, with government as an intermediary. AS2 would take hold from the CMRF's expansion, and would be based on a government trust.¹⁰⁵ Tens of millions of rupees were spent on the Aarogyasri program's offices and staff in hospitals, and initially, the Aarogya Mithras (being politically-appointed positions) had numerous allegations of corruption. Each hospital required a Rajiv Aarogyasri Medical Coordinator (RAMCO) as well to verify every claim.

These "network" hospitals had specific requirements in order to join the Trust. First, they needed to undergo an empanelment process by the government, with a government team sent to inspect the hospital for a variety of metrics. Among these were sufficient post-operative care facilities and the requirement of at least fifty beds devoted to the Aarogyasri

¹⁰³ The Hindu Business Line. "Arogyasri to be streamlined further." Oct 22, 2009.

¹⁰⁴ Interview with Smt. V. Anuradha, Deputy Executive Officer of Aarogyasri at NIMS

¹⁰⁵ Interview with Dr. Prasad of NIMS Hospital

program.¹⁰⁶ Aarogyasri officers on the ground saw the goals as a larger part of a health movement; tertiary care from the private sector was needed, according to ground officers, because the public sector was ill-equipped.¹⁰⁷ In interviews with the Aarogyasri Joint Executive Officer at NIMS government hospital, he stated that the trust would be part of a larger movement that would also devote funding to secondary and primary care.

AS1 would eventually expand to cover 942 interventions with a maximal coverage of 2 lakh INR. This limit, however, was flexible and interventions that required further financial coverage could be requested through the CMRF directly.¹⁰⁸ Here, the government began to form a network of private, corporate hospitals that were included in the Aarogyasri 1 program to provide service to below poverty line patients (defined as 60,000 INR in rural and 75,000 INR in urban areas).¹⁰⁹ The Star Health Insurance Company, in turn, provided risk coverage and administrative aid.

Health camps also became an ancillary expenditure for the Aarogyasri Health Care Trust (funded for by directly by the state government), in which multi-specialty camps would be set up in rural areas without access to care. These camps, while they provided many referrals to the hospitals, were controversial with physicians, especially specialized ones who came into camps without the needed infrastructure to practice.¹¹⁰ By 2008, Aarogyasri was rapidly expanding to new districts, and was launched in the Karimnagar district, totaling 56 “network” hospitals, with 5000 to 6000 million INR annually spent on

¹⁰⁶ Interview with Joint Executive Officer at NIMS

¹⁰⁷ *ibid.*

¹⁰⁸ <http://www.hindu.com/2010/01/04/stories/2010010452600300.htm>

¹⁰⁹ *ibid.*

¹¹⁰ *ibid.* Interview- Gurumani.

the program. Aarogyasri I and II were implemented concurrently; Aarogyasri listed 681 specific procedures, the treatment for which it covered without any financial treatment at all.¹¹¹

2008 also saw the expansion of the Rajiv Aarogyasri Awareness Camps to reach rural areas and an expansion to include 344 hospitals in the “network”. By the end of 2008, 863 disease were covered in both Aarogyasri I and II, and 50,000 surgeries had been conducted.¹¹² By the following year, the Chief Minister was attempting to secure further funding from the federal government (on a 70:30 cost-sharing basis) in order to pay for the program while also not crossing his promise of not raising taxes.¹¹³

All in all, the coverage would increase from 10 to 15 percent in 2006 to 85 percent in 2010. One study, conducted on 80,000 patient claims, saw significant out-of-pocket payment reductions in impoverished households.¹¹⁴ In 2010, the opposition first began to speak out in criticism of the program.

Chandrababu Naidu, leader of the TDP, started a walkout in a legislature session based on health funding for the prominent National Rural Health Mission, and the Lok Satta President, N Jayaprakash Narayan criticized the sitting government: “The government is unable to spend Rs 100 crore per annum on health care delivery but is giving Rs 1500 crore to corporate hospitals in the name of health insurance,” he alleged and registered his

¹¹¹ The Hindu Business Line. “Aarogyasri-I to be launched in 5 more districts” June 18, 2008

¹¹² The Hindu. “Rajiv Arogyasri Awareness camp organized.” Aug 8, 2008.

¹¹³ The Times of India. “CM Seeks Central Funds for Aarogyasri.” Jun 15, 2009.

¹¹⁴ Rao M, Ramachandra SS, *et al.* Addressing the healthcare needs of people living below the poverty line: A rapid assessment of the Andhra Pradesh Health Insurance Scheme. *Natl Med J India* 2012;24:000–0.

protest.”¹¹⁵The result, and questions of sustainability and vested interest, resulted in an increased taxation on corporate hospitals (with 25 beds or more and with centralized AC) by the Union finance minister.¹¹⁶

¹¹⁵ The Hindu. “Andhra government under fire for neglecting health care services.” Jul 9, 2010.

¹¹⁶ The Deccan Chronicle. “Health Budget Burdens Aarogyasri Trust, state” Mar 1, 2011.

Ch. 3 Extra-Political Causal Factors for Health Reform: Structural, Economic, and External

3.1 Exogenous Factors for Policy

3.2 Liberalization and its Response

3.3 External pressures: International Agencies and National Business Interests

3.4 The Role of History, Civil Society, and the Policy Window Opportunity

3.1 Exogenous Factors for Policy

Andhra Pradesh had seen the structure of its health system fundamentally altered with the reform movement of 2007. On every level, this was a “big R” reform: the Rajiv Aarogyasri Health Care Trust was a flagship program of the sitting government that the Congress Party used across India in promotion, and one that impacted every “control knob” of the health care system in Andhra Pradesh. The insurance program altered health financing significantly, allowing patients to access the “networked” corporate hospitals via cashless transactions through a third party insurance agency. Organization, patient supply, and consumer behavior too, were transformed, as new below poverty line (BPL) patients flooded corporate hospitals. The actual organization of the corporate hospitals was changed, as the novel officers required of the program integrated within the hospital’s bureaucratic structure. Chapter 2 detailed the substantial impact of the reform on the healthcare system.

What factors, however, actually account for such transformative change? What explains why such an alteration in the healthcare system was possible in Andhra Pradesh, while similar movements have not occurred in other states in India or in Low and Middle Income Countries more generally? Furthermore, there are specific reasons why the reform occurred the way it did, rather than in a different way.

There are, undoubtedly, explicitly political factors for the transformation. That, however, is not the focus of this chapter. In this factor, there will be an effort to extricate factors existing outside of the political system that impacted the possibility and probability of the health reform movement unfolding in the manner in which it did. Gill Walt terms

these factors “exogenous factors,” the range of factors outside of the political system that impact policy formulation and implementation.¹¹⁷ Using Leichter’s model, Walt characterizes these extra-political factors into four categories: situational, structural, cultural, and environmental. The insinuation is not, however, that these factors impact policy independent from political processes. They interact dynamically with the political factors that impact policy formulation, and work either in conjunction or counter to one another. To varying degrees, the exogenous factors impacted the shape of the Andhra health reform movement.

Each of these categories will be explored in the following chapter. Of the four, cultural factors hold the weakest explanatory power for the rise of the health care reform movement. The caste politics that predominate electoral politics and underlie political coalitions across Andhra did little to impact the formulation of the health reform process. For the purposes of this study, the focus on culture will be primarily the *political* culture, and the resulting dialogues and discourses that were generated as a result of that political culture. Still, full studies on the “language, religion, and traditional social values” in the emergence of the health reform are undoubtedly important, but not within the scope of the study here.

The culture value of health itself has been contested in politics since India’s inception. In a description of the Congress Planning Committee, the schizophrenic view of health was showcased: “The need for public health stemmed from an egalitarian commitment to welfare, and from a far-from- egalitarian fear of the rising numbers of the

¹¹⁷ Walt G: Health Policy: An Introduction to Process and Power. *London, Zed Books* 1994. p. 30

lower castes.”¹¹⁸ Fluctuating in importance within the public debate, health began to emerge again in a rights-based context in the past decade, a perspective expressed through civil society groups like the Jan Swasthya Abhiyan, whose slogan is “the right to Health For All, Now!” While the constitution of India guarantees universal healthcare, the pragmatic reality on the ground is far from the ideals.

Of the four categories of exogenous factors, situational, structural, and environmental factors pose the most vexing questions and the most powerful explanatory power, and all three are interlinked. The external actors that influenced health policy aided in forming the structure of the policy realm through financial aid, and in turn affected large-scale economic policies.

Situational factors are largely short-term factors in the policy realm; war, crisis, natural disaster. In affecting policy, the farmer-suicide crisis was undoubtedly a major factor. From the beginning of the policy formation process, stemming from the Chief Minister himself, was a desire to resolve the issue of financial insolvency and debt that was affecting the poor citizens. This was an issue that had reared its head during the elections, and had hurt Chandrababu Naidu considerably. The first citizens to meet YS Rajasekhara Reddy in his daily meetings were requesting financial aid for their health costs.¹¹⁹ Reports during this time of over 150,000 farmers committing suicides shined a spotlight on the heavy load of debt and financial insecurity that inflicted suffering on the poorest citizens of

¹¹⁸ Amrith, Sunil (2007), “Political Culture of Health in India: A Historical Perspective”, *Economic and Political Weekly*, 13 January.

¹¹⁹ Interview with Dr. Bhaskar Rao, CEO and Director of KIMS Hospital

the state.¹²⁰ Although not directly correlated with the reform of the health system, the rising tide of farmer suicides provided a mandate for YSR to continue with a host of economic reform programs, free electricity, irrigation reform, and health reform.

The structural and environmental factors in the case of Andhra are intertwined. Economic regime, political regime type (procedural democracy) and technologies all played important roles in impacting how the Andhra health system could be changed. Structural factors are constant facets of the society, while environmental factors are ones that "exist outside the boundaries of a political system but which influence decisions within it."¹²¹

These externalized environmental factors are primarily the strong presence of international actors, the World Bank and the Department for International Development (DFID) of the United Kingdom. The World Bank, in particular, has had a constant presence in Andhra Pradesh that has transformed policy options over the last decade, and therefore has become a structural factor. Additionally, looking to the interests of private business and larger neoliberal dialogues of promoting private industry are helpful for understanding the structural forces that shaped Andhra's health reform. Liberalization, since 1991, has held sway in Indian national economic policy and affected the state's options in terms of methods through which the health care system could be reformed. The Aarogyasri Health Care Trust went through the existing tertiary care structures of private, corporate hospitals. The reasons for this type of insurance expansion are multivariable, but the legacy of liberalization and the growth of the private sector in Andhra played a large role.

¹²⁰ Rediff news. "1.5 lakh farmers committed suicide between 1997 and 2005." Nov 22, 2007.

¹²¹ Ibid. Walt 30

The health reform movement, too, was focused centrally on the proliferation of information technology and networking information rapidly from the care centers to the Aarogyasri offices for quick referrals. Hyderabad, the capital city of Andhra Pradesh, was second only to Bangalore for technological progress and sophistication. This fact aided in the technological nature of the reform: each network hospital had computer kiosks and had high-speed Internet.¹²² Additionally, Tata Consultancy Services was brought on board to build the website and maintain the complex web structures that would transfer patient information in a confidential manner from network hospital to central administration of the Aarogyasri Trust and back again to the hospital. Without the existing technological infrastructure at disposal in Hyderabad and in Andhra Pradesh, the reform movement could not have integrated information technology to the degree that it did in the final reform movement. Even in the beginnings of the reform efforts, changes to make the Chief Minister Relief Fund (CMRF) more efficient were centered around the use of technology, through the creation of a website to directly download forms for the sanction process and integrating cell phone and information technology capability.¹²³

Still, while technology capacity undoubtedly factored into the capacity of the reform process, the larger shape the reform took, as one that changed financing while funneling patients into the existing private tertiary care system had much deeper economic roots.

3.2 Liberalization and its Response

¹²² *ibid.* Rockefeller Foundation: Catalyzing Change: The System Reform Costs of Universal Healthcare

¹²³ Interview with Dr. Kiran Kumar Reddy, Private Secretary to the CM

“Government initiatives since 1991 to restructure the basis of the Indian economy ‘ended four decades of planning and have initiated a quiet economic revolution’”

-Rob Jenkins, *Democratic Politics and Economic Reform in India*¹²⁴

The economic revolution of 1999 is not quiet any longer however. Transforming a near half-century of economic policy, the debt crisis of 1991 forced Prime Minister P.V. Narasimha Rao and Finance Minister Manmohan Singh (soon to become the Prime Minister) to initiate neoliberal reforms, at the behest of the International Monetary Fund. During that time, India sought between 5 and 7 billion USD from the IMF.¹²⁵ In return, the IMF would seek a radical restructuring of India’s economy that would have ripples in every sector and adjust India’s society drastically.

With Manmohan Singh at the helm of the financial ship, India would undertake the Adjustment Program. The structural reforms took three forms: industrial liberalization, trade liberalization and finance sector liberalization, and sought to remove regulations across the board. One study of the macroeconomic effects on health access stated, “In the output market, the pricing, sale, and moving of output, which had been severely regulated are being made to imbibe market principles...For a highly regulated economy such as that of India MAPs has brought about a sea change.”¹²⁶

¹²⁴ Jenkins, Rob. 1999. *Democratic Politics and Economic Reform in India*. Cambridge UK: Cambridge University Press.

¹²⁵ Weinraub, B. “Economic Crisis Forcing Once Self-Reliant India to Seek Aid.” *The New York Times*. June 19, 1991.

¹²⁶ Narayana D. *Macroeconomic adjustment policies, health sector reform and access to health care in India*. Draft. Thiruvananthapuram, India: Center for Development Studies, 2001.

Since 1991, then, the economic reforms have been a fundamental fact of the Indian landscape, and liberalization transformed the economy across sectors, including the health sector. Andhra Pradesh, within this fabric, held a special role in liberalization. It was the first state in India to directly invite the World bank to implement Structural Adjustment Programs, what would later be termed the AP Economic Restructuring Program. The AP Economic Restructuring Program would initiate a relationship between the World Bank and Andhra Pradesh that would change policy options and the economic outlook for the state.

Global forces were the primary initiator in spurring change in Andhra Pradesh and India. It was a trickle-down policy environment: pressures from the global financial organizations affected the policies at the central federal government, which in turn pressed on state governments to enact and implement the reforms themselves. The changes occurred to various degrees, but by most accounts, AP was a model state for the World Bank. These longstanding fiscal pressures would change the reform movement.

The result for healthcare in Andhra Pradesh, as overlaid in Chapter 1, was a privatization of health delivery, with a predominantly corporate sector. In Andhra Pradesh, the percentage of private hospitals grew from 58.3 to 70.5% of all hospitals, while public hospitals fell from 41.7 to 25.1% from 1992 to 1998.¹²⁷ Without any government, AP's health industry, especially at the tertiary level, has operated on a near pure free-market basis with heavy out-of-pocket expenditures. Additionally, the state government has

¹²⁷ Narayana, K. (2007) 'The Role of the State in the privatisation and corporatisation of medical care in Andhra Pradesh, India' in Sen, K. (ed.) *Restructuring Health Services: Changing Contexts and Comparative Perspectives*, London: Zed Books

encouraged the growth of the private market, with reductions of tariffs on imports, subsidies, lending from the World Bank loans, and land at reduced price or for free.¹²⁸ World Bank loans and projects encouraged marketization of the health care system, and sought user charges and referrals from government hospitals to private care centers, beginning in 1996.

The result of increased corporatization can be seen through the example of the explosion of Apollo Hospitals. The subject of a case study at Harvard Business School, Apollo Hospitals tracked a rapid rise from its founding in 1983 as the first for-profit hospital. By 2003, it would include over 33 hospitals, and maintain 14% of the total tertiary care market.¹²⁹ Apollo Hospitals Ltd. was worth 311 million USD in 2004. It was based entirely on a fee-for-service model, with the average cardiac surgeon making a salary of 300,000 USD, a pay cut from the average salary of an American cardiac surgeon, but an enormous sum for the average Indian one. Apollo provided care that rivaled the best care in the developed world, including the United States and Europe, and as a result was a major site of medical tourism.

Apollo Hospitals' rise was enabled by the spate of deregulation and the opening of markets, and an environment that eschewed a government role in providing health for the populace. The result is an astounding inequity in the distribution of benefits. Narayana states in looking at health access across India, "The differential impact of structural reforms may be seen in clear terms in Chennai. The workers in the informal sectors and lower level

¹²⁸ *ibid.*

¹²⁹ Oberholzer-Gee F, Khanna T, Knoop CI: Apollo-hospitals--first-world health care at emerging-market prices. *Harv Bus Sch* 2005.

industrial labourers are the ‘losers’ and the higher income groups are the ‘winners’ of liberalization.”¹³⁰ Liberalization enabled multinational corporations to take over the distribution of health; Apollo Hospitals, for example, operates today across the globe, including Qatar, Nigeria, and Bangladesh. Oligopolies have developed within the health industry, focusing on high-tech specialty hospitals.¹³¹

The ones who are left out were the poorest, most vulnerable groups. “Poorly regulated privatization may have a negative impact on access and affordability for the poor or for other groups that are socially disadvantaged or discriminated against.”¹³² The health sector was left unprotected by the public sector post-liberalization, leaving a radically transformed space in which a bifurcation of health care services resulted. Public health spending overall decreased, and other than one increase in capital spending, the Andhra Pradesh Reconstruction Project that allocated 66.7 million USD for primary health centers, spending on public health or healthcare overall has been scant.¹³³ The policies of liberalization have created deep structural features of the health care system that played a large role in the policy development of the Aarogyasri Health Care Trust.

3.3 External pressures: International Agencies and National Business Interests

How significant is external pressure in determining any changes to the health care system of Andhra Pradesh? Numerous international financing agencies had long seen

¹³⁰ Ibid. Narayana 144

¹³¹ Baru, Rama V. *Private Health Care in India- Social Characteristics and Trends.*: Sage Publications, 1999.

¹³² Sen G, Iyer A, George A. Class, gender, and health equity: lessons from liberalizing India. In: Sen G, George A, Ostlin P, eds. *Engendering international health. The challenge of equity.* Cambridge: MIT Press, 2002. 281–311.

¹³³ Narayana D. Adjustment and health sector reforms: the solution to low public spending on health care in India? In: Haddad S, Baris E, Narayana D, editors. *Safeguarding the health sector in times of macroeconomic instability.* New Jersey and Ottawa: Africa World Press and International Development Research Center; 2008.

Andhra Pradesh as a foothold for health development within India, and a model state for the policies they sought to be introduced. According to Srivatsan et al., “It is clear that the impetus to set up universal healthcare in India comes from big business and the state’s agenda for growth...the Planning Commission constituted the [High Level Expert Group] (HLEG) and gave it the responsibility to come up with a way to spend 2.5% of the GDP in the healthcare sector. This figure was presumably predetermined and this is likely the reason the *report starts with the subject of finance (instead of ground-level considerations such as disease burden, health goals and system weaknesses)*”¹³⁴, emphasis mine. Clearly the predominant position of the World Bank, IMF, and other international donor agencies, like the DFID of the United Kingdom and the Rockefeller Foundation, affected agenda setting in the health care realm.

The World Bank has a long and profound history in Andhra Pradesh. From the beginning, Andhra was centered on as a “focus state,” which would “enjoy the widest and most lenient access to World Bank assistance, despite a ground reality of reform performance that fell short of its government’s often grandiose rhetoric.”¹³⁵ Kirk subsequently identifies two reasons for the status as a focus state: its leaders’ commitment to reform, primarily through the “CEO” CM of Chandrababu Naidu, and the closeness of the state leaders to national leaders.

¹³⁴ Srivatsan, R., Shatrugna, V. Political Challenges to Universal Access to Healthcare. *Economic and Political Weekly*. Feb 25, 2012: XLVII:8. 61-63.

¹³⁵ Kirk, J (2005) Banking on India’s States: the politics of World Bank reform programs in Andhra Pradesh and Karnataka. *India Review* 4(3-4), 287-325.

Lending began in 1998 after Chandrababu Naidu pushed for an appointment he had not received to meet with World Bank President James Wolfensohn.¹³⁶ Subsequent World Bank programs imposed restructuring in the electricity board, increasing investments in infrastructure, education, and health, and levying user charges on public services. Officially, June 1998 saw the 543.2 million USD loan project, termed the Andhra Pradesh Economic Restructuring Project, followed by a 210 million USD loan in the next year.¹³⁷ By 2004, a total of 1.6 billion USD would be loaned from the World Bank to the state of Andhra Pradesh. Throughout this time, Naidu delicately balanced the sacrifices required of the structural programs, including slashing food subsidies, while simultaneously providing welfare schemes. Naidu implemented welfare and development projects, liberalized for the business interest, and was also highly corrupt. K.C. Suri, a political science scholar at the Central University of Hyderabad, stated that his successful handling of the mix of the three led to his popularity.¹³⁸

Naidu's combination of welfare schemes and implementation of liberalization policies afforded him political survival and a good relationship with the World Bank at the same time. Naidu himself had admired Mahathir Mohamad's reform policies in Southeast Asia, and modeled his own Vision 2020 plan after Mohamad's.¹³⁹ An enthusiastic proponent of the World Bank policies, he justified the Bank's emphasis on Andhra Pradesh as a "focus state." His electoral loss in 2004, however, created ruffles for the World Bank's

¹³⁶ Dugger, Celia. "Indian Courts World's Riches and Poor's Vote." *The New York Times*. Sept 10, 1999. Retrieved May 3, 2012: (<http://www.nytimes.com/1999/09/10/world/indian-courts-world-s-riches-and-poor-s-vote.html?pagewanted=all&src=pm>).

¹³⁷ Ibid. Kirk

¹³⁸ Interview with KC Suri

¹³⁹ HBL Bureau. "Naidu seeks Mahathir's help to draw Malaysian Investors." *Hindu Business Line*. Oct 16, 2002.

intentions in the state. YSR, as a candidate, pledged to give free power and create an irrigation network, bucking the World Bank trend of liberalization. His words provoked a bank response, threatening a cut off of loans to states that initiated free power schemes and the like.^{140,141} YSR subsequently had a turnaround, meeting with Michael Carter, the World Bank country director for India, and requesting financing for a urban development project, irrigation projects, and structural adjustments.¹⁴² The Bank's influencing power was once again firmly in place, but not as firmly as before. A 225 million USD adjustment loan went through in 2007.¹⁴³

The DFID, similarly, provided limited grants for many of the health reform projects, including the emergency services, and the initial Aarogyasri program. From 2007 to 2010, the British development agency provided 64.8 million USD to Andhra Pradesh for various projects. The political impact of the DFID, however, is much more limited in scope and intention. Specific grants were allotted for partial aid with credible partners, and after the grant period is over the control of the program returned to the state government in order to build capacity.

How do these environmental factors contribute to the political discourse and the policy process? In terms of discourse, the World Bank's influence and maintaining Andhra Pradesh's autonomy was a prime point of contention in the 2004 election. Despite this fear, Naidu constantly painted himself as a populist to the electorate while simultaneously

¹⁴⁰ World Bank, *Unlocking Andhra Pradesh's Growth Potential: An Agenda to Achieve the Vision 2020 Growth Targets*, August 2004. Accessible via <http://www.worldbank.org>.

¹⁴¹ SubhomoyBhattacharjee, "WorldBankMayCutOffStateLoans," Rediff.com, August 9, 2004.

¹⁴² "Heels Over Head: YSR turn pro-World Bank," *The Economic Times*, May 18, 2005.

¹⁴³ Kirk, James. *India and the World Bank: The Politics of Aid and Influence*. Anthem Press, Apr 1, 2010. 74.

conferring user fees on public services and meeting with top global businessmen to build a top business school in Hyderabad.

In terms of policy, however, it is clear the World Bank's relationship has left a lasting imprint. By limiting the channels of possible policies to those that build on top of the already liberalized structure, the World Bank and other international monetary and aid agencies had a significant role to play in shaping policy on the state level. The health reform movement had to build on top of a significantly liberalized and deregulated health sector, much as a result of macroeconomic policies passed down from the center and from the pressures of loans from international agencies.

3.4 The Role of History, Civil Society, and the Policy Window Opportunity

The health reform may also come at an opportune moment in the political cycles of Andhra Pradesh politics, and built on top of a history that was leading to a reform movement of some kind. In the case of Tamil Nadu, for example, some scholars have attributed the success of its health care in terms of equity to "struggles over the last century with the problems of political representation, self-respect, and Brahmin domination."¹⁴⁴ It is difficult to say that the same factor played a role in the Andhra Pradesh health movement. Far from moving from a ground up way in the policy formation, the policy was a brainchild of the chief executive's close team, and proceeded to be formulated downwards, interacting with hospital associations, medical associations, and insurance companies first.

¹⁴⁴ Srivatsan, R., Shatrugna, V. Political Challenges to Universal Access to Healthcare. *Economic and Political Weekly*. Feb 25, 2012: XLVII:8. 61-63.

What may have aided YSR in his reform movement was a temporary weakness in an issue that had been bubbling under Andhra Pradesh's surface since its inception: a separate state for the Telangana people. During the period from 2004 to 2009, the Telangana issue remained in the backdrop as farmer suicides, starvation, and economic development stayed at the forefront. The Telangana separatist party that had traditionally held sway, the Telangana Rashtra Samithi (TRS), was weakened even further during the 2004 elections. When both Congress and TRS members formed a coalition, they were criticized universally, including by the BJP.¹⁴⁵ The result was a window of opportunity for YSR to push through reforms without the distraction of the Telangana separatist issue on his plate.

Finally, it is difficult to ascertain the presence of a civil society on the formation of the health reform policy, but it is undoubtedly limited. In defining a civil society, Hoerber defines it as the "the idea of a non-state autonomous sphere; empowerment of citizens; trust-building associational life; interaction with rather than subordination to the state."¹⁴⁶ In Andhra Pradesh, and across India, NGOs, social movements, and civic associations (including employment based associations) would fall under this purview. However, they played little role in the actual shaping of the policy.

In describing the health sector reforms of Latin America, Fleury et al. described two modes of civil society-state interaction:

¹⁴⁵ "BJP slams Congress, TRS on Telangana." The Hindu.
<http://www.hindu.com/2004/10/08/stories/2004100808570400.htm>

¹⁴⁶ Hoerber Rudolph, Susanne (2000) 'Civil Society and the Realm of Freedom', Economic and Political Weekly, May 13, pp. 1762-1769.

“The emergence of a new vision to reshape the relationship between the state and different groups of civil society may come either from organized civil society groups, as in Brazil, or from government authorities, as in Argentina and Mexico”¹⁴⁷

In Andhra Pradesh’s case, the narrative of the policy formulation gives credence to the latter, one which was executive directed, while it may have been inspired by interactions with the populace. After initial foundations of the policy were set up, however, civil society played an enlarged role: non-profit hospitals, like Srikirin Institute, are also networked and trade associations are necessary signatories for the policy’s Memorandum of Understanding.

The media’s role in Andhra Pradesh’s health policy transformation, too, was probably limited. In describing the role of the media at-large, Aggarwal says, “Serious journalism has become a high risk area which only the brave can tread. Dissent, by and large, is not tolerated in most of the Indian States...”¹⁴⁸ This can be seen in the vested interest present in the state’s media apparatus. There is little independence among newspapers; Sakshi, the large media group that owns the second largest newspaper and a major TV channel, is seen as an organ of the Congress Party. The firm that owns the paper, Jagathi Publications, is partially owned by Y.S. Jaganmohan Reddy, YSR’s son, who would later make an ill-fated run for the position of Chief Minister himself. Controversially, major

¹⁴⁷ Fleury S, Belmartino S, Baris E, eds. *Reshaping health care in Latin America: a comparative analysis of health care reform in Argentina, Brazil, and Mexico*. Ottawa: International Development Research Centre; 2000.

¹⁴⁸ Aggarwal, S.K. *Media Credibility*. Mittal Publications. Jan 1, 1989. 213.

cement companies, pharmaceutical groups, and other Andhra corporations made investments in Sakshi, a favor returned with prime government contracts and land deals.¹⁴⁹

In conclusion, the largest forces that impacted the health reform policy were structural and external in nature: the reform movement had to come to terms with the existing neoliberal structures and pressures in providing universal care. More than civil society (through the media, mass separatist movements, and NGOs), the World Bank and international donor agencies exerted their influence on the policymaking process.

¹⁴⁹ The Times of India. "FIR details investments in Jagathi Publications, Sandur." Aug 20, 2011. Accessed: May 3, 2012 (http://articles.timesofindia.indiatimes.com/2011-08-20/hyderabad/29908739_1_total-investment-jagathi-publications-sez)

Ch. 4 Political Analysis of the Health Care Reform Movement

4.1 Introduction and Policy Analysis Frameworks

4.2 Political Hypotheses and Explanations for Large-Scale Reform

4.3 Stakeholder Analysis

4.4 The Importance of Political Factors in the case of Andhra Pradesh

4.1 Introduction and Policy Analysis Frameworks

In the past three chapters, the various reasons, both instrumental and intrinsic, that nations undergo the health reform process have been elucidated. After exploring the reasons for health reform, the case study of reform in Andhra Pradesh was contextualized historically, the actual process of health reform described, and the “exogenous” factors, that lie outside of the political system, were characterized and evaluated for impact on the creation of the Rajiv Aarogyasri Health Care Trust.

The titular political context will be described and analyzed in the following chapter. A number of theoretical explanations for why such massive reform occurred the way it did, rather than in another way, will be compared for their empirical usefulness in explaining the case of Andhra Pradesh. Doing so will require drawing heavily on Chapter 2, further interviews with high-level officials within the Andhra government and network hospitals, and secondary sources.

Policy analysis has largely moved beyond seeing the creation of public policy in a simplistic, linear model: a rational, sequential process in which the issue is recognized and subsequently makes it onto the agenda for key actors to make policy decision on. In Indian and developing world policymaking, the motives and processes are not so cut and dry; a clearer and more powerful model need to take into account networks and narratives, of

individuals and organizations, and the relative power within institutional frameworks, as Sutton notes.¹⁵⁰

In order to do so, specific and unique facets of the health reform movement need to be highlighted. Aarogyasri targeted below-poverty-line (BPL) individuals, using the existing BPL evaluation system. In addition, the trust was paid for with general taxes, in which the payments of the patient to the healthcare provider were removed altogether (a cashless transaction). Perhaps the most important and impactful feature of the health reform program was that it was one of the largest and most meaningful examples across Indian sectors of the much-discussed “public-private partnership” (PPP).

It has been seen in other health schemes in India, but why did the state of Andhra Pradesh take the lead in realizing the 2002 National Health Policy guideline of “partnering with private sector for service delivery with public financing as one of the most feasible approaches to universal coverage”?¹⁵¹ Aarogyasri combined the forces of high-quality tertiary care hospitals, a newly created government bureaucracy as a part of the executive branch, a private health insurance company, and public and nonprofit hospitals to compose a fully-formed example of a public private partnership in constant evolution.

In order to understand the political role in initiating transformative change, the “policy triangle” has been employed.¹⁵² The three points of Walt and Gilson’s policy triangle

¹⁵⁰ Sutton, R. (1999) *The Policy Process: an Overview*. Working Paper 118. Overseas Development Institute, London

¹⁵¹ Maurya, D. “Politics of Adoption of Public Private Partnership: Healthcare Sector 1950-2010” Lee Kuan Yew School of Public Policy at the National University of Singapore. Presented at the Political Science Association Conference in Belfast. April 3-5 2012.

¹⁵² Buse K, Mays N, Walt G (2005). Making Health Policy. Understanding Public Health Series Open University Press.

are content, context, and process, and to a certain extent each of the following points has been probed throughout. The content itself of the health reform has been described, as has the non-political context. Political context and its influence on policy, as well as the role of the political actors that make up the central policy formulators and implementers, will be described in this chapter.

In Andhra Pradesh, for the analysis of health reform at least, the view will be primarily “top-down” rather than “bottom-up.” The policies reflect the role of the governing elite, presenting greater value in interviews with elite actors. As Dye argues, policy development reflects the values, interests, and preferences of the governing elite.¹⁵³ This may not be true in all nations and for all policy proposals, but it largely was true for the Andhra health reform movement. This same governing elite, however, is under electoral pressures and institutional pressures. To get a full picture of a policy’s implementation and formulation, bureaucrats and civil service staff that act at the front lines of the health reform movement need to be consulted as well.

4.2 Political Hypotheses and Explanations for Large-Scale Reform

How is large-scale reform possible in any sector? What political theories exist to explain the ways in which transformative public redistribution projects are imported into public policy? Looking at analyses of various sector reforms, including the past economic reforms in India, the political frameworks that were used to explain, and provide context

153 Dye T. *Top down policy making*. New York & London: Chatham House; 2001.

for, enormous policy changes can be used and evaluated for empirical justification in the case study of Aarogyasri.

Although a powerful explanation for understanding HIV/AIDS policy in comparative perspective, Lieberman's "boundary institutions" theory, which states "boundary institutions are those sets of rules that regulate racial and ethnic group categories and intergroup behavior," plays only a minor role in understanding health reform. Caste politics and group-membership did not factor directly into the minds of the reform team as they sought to change the health system of Andhra Pradesh. Additionally, the final shape of the reform was different than many reforms undertaken in the past by Chief Ministers of Andhra Pradesh, including the sitting one, Y.S. Rajasekhara Reddy (YSR). Efforts like the *Deepam* light scheme and the *Rosini* scheme for Muslim marriage halls and mosques were explicitly targeted at voting blocs and played directly at identity politics. Unlike these efforts, Aarogyasri covered a broad swath of below poverty line (BPL) citizens, giving near universal, while limited, tertiary care coverage to those citizens.

Many of the theories surrounding the political reasons behind the economic reforms of 1991 in India serve a useful comparison point in understanding the health reform program's inception as policy. Political explanations for the radical economic reform ranged, from attributing it to the micro-scale of individual reformers' skill to the societal explanations that sought the roots of the changes in a transformed class structure. In the following pages, explanations that seek their causality in the intentions and motivations of the reformers will be explored for veracity in the case of AP: the role of reform in building the political image of the reformers, the possibility that reform was cloaked from the

electorate, and an attribution of the success of the reform to the political management and skills of the reformers themselves. Mass societal and institutional structures will be studied as well: national policy, electoral politics, political party dynamics, and the structures of the sitting government. In doing so, the question of *cui bono*, who profits, from the new arrangement of the health care system's structure is informative.

Did a liberalizing India creation of a new middle class enable the reform movement? The emergence of a middle class, with new discourses and desires, is economic fact: in a ten year period after 1998, the number of IT companies grew rapidly, especially in Hyderabad, increasing employment twenty times.¹⁵⁴ With this new class have come new sociocultural and political concerns: consumerism, employment in a global marketplace, and concerns tied with a geography that is primarily urban. This new middle class has fundamentally restructured the labor market, not only in Andhra, but also across India.¹⁵⁵

However, how much political influence does this middle class actually hold? In Hyderabad, *The Times of India* reported on the "Hamletian dilemma" of the new middle class, with central issues of "footpaths, street lights, green patches among others" lacking from party platforms.¹⁵⁶ Despite its vast economic strength, in Andhra Pradesh at least, the middle class has not been able to translate this strength to political influence.

Such a class movement would have not suggested the creation of the health reform program. Growth of a middle class's sway in the political processes would not have led to a

¹⁵⁴ Ghani, Ejaz ed. *The Service Revolution in South Asia*. Oxford University Press, (2010). p. 1-10.

¹⁵⁵ FERNANDES, L. (2000b) Restructuring the new middle class in liberalizing India, *Comparative Studies of South Asia, Africa and the Middle East*, 20, pp. 88-104.

¹⁵⁶ The Times of India. "Middle Class in a Hamletian Dilemma." Nov 14, 2009.

social welfare scheme that would only serve patients of the lowest income quintile. While undoubtedly there was an enormous growth of a middle class in Andhra Pradesh due to rapid proliferation of a service sector and multinational corporation involvement in the economic activity of the state, their impact on health policy, especially the creation of a health reform program that would serve another segment of the population, was little. This society-centered explanation, while intriguing, does not align with the expected outcome. A rising middle class would not have been electorally enticed by a large-scale health program, the beneficiaries of the program being outside the middle class largely. Arguments that a strong and rising middle class affected reform movements have been made in South Korea, Taiwan, China, and Chile. Stemming from Barrington Moore's *Social Origins of Dictatorship and Democracy*, sociologists and political scientists have sometimes sought factors of class relations behind political facts of history; in this case, however, it does not hold true.

Did federal policy, stemming from the Indian National Congress (Congress Party)'s rule at the center in Delhi, affect state-wide concerns in Andhra Pradesh and did concerns about national political views weigh heavily on the minds of reformers and those interest groups at play? In the Eleventh Five Year Plan, highlighting policies from 2007 to 2012, explicit recommendations for contracting in and out, subsidies, and further privatization were made, along with an overall encouragement of public-private partnerships.¹⁵⁷ In addition, the Working Group on Health Care recommended a reduction in out-of-pocket financing of healthcare through "a combination of public finance and private contribution

¹⁵⁷ Planning Commission, Government of India. Ministry of Health and Family Welfare. "11th Five Year Plan 2007-2012." Available at: <http://planningcommission.nic.in/plans/planrel/11thf.htm>.

by establishing various collective financing options....pool together the various sources of financing and manages it for ensuring all the members access to comprehensive healthcare.”

Still, despite such concordant statements from the annals of national policy, did these words trickle down to the reformers at the state level? Interviews with political and health sector actors involved, including the Private Secretary to the Chief Minister, suggest that the policy was conceived and formulated on a mostly state level: the dominance of corporate hospitals, the desire to expand the Chief Minister Relief Fund, and prevent indebtedness.^{158, 159} While potential models for the health reform program were evaluated in Bangalore, Assam, and across the nation, it is clear that national directives from the ruling federal government, as well as national platforms of the Congress Party were not consulted heavily in the policy formation process.

Still, national pressures can be seen in the financial bearings of the final project, as well as the public statements of the CM YSR. In the official unveiling of the program, YSR stated, “Andhra Pradesh should play a major role in strengthening the hands of Ms. Sonia Gandhi,” referring to the reigning All India Congress Committee President (the “decision-making assembly” of the Indian National Congress) and wife of former Congress Party Prime Minister, the slain Rajiv Gandhi.

The 2004 election manifesto of the Indian National Congress stated, “some state governments administered by the Congress have introduced innovative health insurance programmes. A national scheme of health insurance for families living below the poverty

¹⁵⁸ Interview with Kiran Kumar Reddy, former Private Secretary to the Chief Minister

¹⁵⁹ Interview with G Krishnamurthy, Financial Advisor to the Department of Health, Medical and Family Welfare (DoHMFV)

line will be proposed.”¹⁶⁰ Even preceding the creation of Aarogyasri, the national government, led by INC, were seeking state experimentation before taking political leadership on the issue. In Aarogyasri, they realized these hopes of state experimentation.

In reality, the causal arrow was flipped; far from national policy influencing state policy, the federal system and other states’ health policies were subsequently changed by the implementation of Aarogyasri in Andhra Pradesh. The initiation of the Aarogyasri Health Care Trust spurred the creation of a federal program, the Rashtriya Swasthya Bima Yojna (RSBY) a year after in 2008 and the Tamil Nadu state government program, Kalaingar’s Insurance Scheme.¹⁶¹ Both mimicked aspects of Aarogyasri; for RSBY, for example, utilized a maximum amount of coverage for tertiary coverage. Congress Party, in addition, utilized the scheme’s political advantages in its succeeding platform, promising health insurance for all BPL families for three years.¹⁶²

Two of the following theories use similar structures to explain why politicians could push through reform: either by skillful political cloaking by the elite, or through a distracted mass politics.¹⁶³ In describing a “fooled” electorate, Varshney’s theory of a distracted mass politics was used to explain the economic reforms of 1991, and succeeding reforms. “Reforms that touch, directly or primarily, elite politics have gone farthest: a large devaluation of the currency, a restructuring of capital markets, a liberalization of the

¹⁶⁰ Indian National Congress. “Manifesto of the Indian National Congress: Lok Sabha Elections 2004.” Attained at: http://www.qbtpl.net/congress/congress_manifesto.htm#Education%20and%20Health

¹⁶¹ Selvaraj, S. and Karan, AK. Why Publicly-Financed Health Insurance Schemes Are Ineffective in Providing Financial Risk Protection. *Economic and Political Weekly*/ XLVII: 2. March 17, 2012. P 60

¹⁶² Nilesh, CT. “Congress Party issues campaign platform. *Asia News IT*. March 26, 2009.

¹⁶³ Mooji, Jos. *The Politics of Economic Reform in India*.

trade regime, and a simplification of investment rules.”¹⁶⁴ Here, reform is not a central campaign issue for reformers, and is instead benefiting the vested interest in an underhanded way. Political coalitions and alliances are not formed on the basis of the reform; instead caste and religion play a larger role in mass politics for Varshney, and mask the creation of reform.

Like Varshney, Jenkins’s theory of skillful political cloaking as an explanation for reform movement’s success relies on the fundamental aspect of stealth, in which the reform movement is formed within the state, with the political knowledge of lack of support from the citizenry. Jenkins explains the liberalization efforts by stating, ““The reformers tried- successfully- to cloak change in the disguise of continuity. By claiming one thing but doing another, and by introducing *de facto* reforms when official policy statements stress continuity, reforms could be introduced without much opposition.”¹⁶⁵ The argument presupposes a broader argument, one that divides the public officials that form policy from the electorate, and especially so in developing countries. Stemming from the ideas of Grindle and Thomas, the argument goes that developing nations “tend to be more insulated, and they play a more central and intrusive role in managing the economy...relevant policy information and expertise tends to be contained within governmental circles.”¹⁶⁶ It is essential to parse out the assumptions of each espoused theory before evaluating it on its relative merits to the political record of the development of the health reform movement in Andhra Pradesh.

¹⁶⁴ Ibid. Mooji.

¹⁶⁵ Ibid. Bates

¹⁶⁶ Porter, R. and Hicks, R. Knowledge Utilization and the Process of Policy Formation: Toward a Framework for Africa. SARA Project- HRAA Project of USAID. Retrieved from:
http://sara.aed.org/publications/cross_cutting/knowledge_utilization/html/utilization.htm

The policy process in Andhra Pradesh, as stated before, should be viewed from a “top-down” perspective; the policy was designed and adjusted completely at an elite level. The initial events that motivated the policy, however, came from daily meetings with below poverty line individuals. Additionally, there is significant evidence that the reform movement was not enacted in an underhanded manner. A reform effort that seeks to provide health camps, even in far-reaching rural areas, is not intended to be one that slips the collective mind of the electorate. Instead this reform was of the opposite way: balancing the interests of the elite stakeholders while also providing a large-scale social welfare scheme in the form of health insurance for tertiary care. YSR himself publicized the unfolding of the Aarogyasri at the level of campaign events, even bringing Sonia Gandhi to launch the second phase of the program, Aarogyasri-II.¹⁶⁷

Instead of being an underhanded reform process, the Aarogyasri scheme was used as an image-building program for the political actors to bolster their credentials as reformers. The INC candidates for re-election in 2009 pointed to the Aarogyasri health program as a prime example of their accomplishments in office over the last five years, even bristling at suggestions that the health reform program might be flawed. During election season, the Finance Minister, K. Rosaiah, criticized the opposition party, TDP, for petitioning the Election Commission against issuing Aarogyasri cards.¹⁶⁸ The Aarogyasi Health Care Trust was explicitly used for electoral purposes; in the same statement, Rosaiah defended the use of card issuance during the election season. The ambitiousness of

¹⁶⁷ The Hindu. “Sonia Launches Rajiv Arogyasri scheme” Jul 18, 2008.

¹⁶⁸ The Hindu. “TDP slammed for petitioning against Arogyasri.” Mar 13, 2009.

the ultimate scope of Aarogyasri and publicity with which its development was paired serves to discredit “stealth” in the reform process.

The reformers at the top of the policy process were undoubtedly important in pressing the creation of the policy. To what extent were their own political skills, personality, and expertise in navigating within the political system attributable for the ultimate reform and shape of the reform? In the health reform literature, much of the analysis has focused on the specific attributes and “political will” bridled by a small group of technocratic change makers.¹⁶⁹ These “change teams” are central to the ultimate feasibility of the health reform occurring at all. “Change teams have been described as technocratic because their leverage relies on the mix of skills their members bring to them – partly technical, partly political – which allows them to operate effectively both in policy formulation, as well as in political manoeuvring [sic].”¹⁷⁰

Undoubtedly, the role of the executive in Andhra Pradesh, stemming from the Chief Minister to his executive team, was essential to forming the health reform movement. Coming from a landslide victory in 2004, with broad electoral mandate and an electoral promise to initiate sweeping reform in a number of sectors, the CM and his team felt limitless in power. Sainath described, in an obituary, “YSR was dynamic and effective, ruthless and authoritarian. An idea he liked would translate into an order shortly after he heard it...The suggestion that the Land Development Work under the NREGS in the State be prioritised to first benefit Dalit, Adivasi and women-headed households was such an

¹⁶⁹ Rossetti, AG. Mogollon, O. “Enhancing the Political Feasibility of Health Reform: The Mexico Case.” Harvard School of Public Health. Health Sector Reform Initiative. June 2000.

¹⁷⁰ Ibid. Rossetti et al.

idea.”¹⁷¹ The idea to expand the Chief Minister Relief Fund into a broader welfare scheme that would be revolutionary in nature was quickly implemented by the executive team of the Chief Minister.

An additional reason for the success and shape of the health reform movement was that it largely did not affect vested interest. In this cynical theory, the Aarogyasri reform did not truly disadvantage the political position of the Congress politicians in charge of policy formulation, and could therefore be transformative while still preserving the interests of the politicians while also satisfying the needs of the various interest groups that would be otherwise incensed: private hospitals, public hospitals, medical associations, and other stakeholders. Jenkins ascribes the economic reform movement’s success to “survivor” politicians “‘Actually existing’ democratic governments are often more ‘accountable’ to the powerful than to the powerless, a fact which affects their operation in times of reform no less than it does in times of stasis”¹⁷²

The health reform movement worked through the existing channels of power, offending no single stakeholder and thereby enabling its success. Using general taxes, votes were gained, hospitals pulled a larger patient influx at no cost to them, and BPL citizens were afforded the use of the best quality tertiary care centers. Financing was detached from the actual supply of care, and the winner-take all bidding system that was used allowed the sole insurance company, Star Health and Allied Insurance, to rake in massive profits.

¹⁷¹ Sainath, P. “The Congressman with a mass following and appeal.” *The Hindu*. Op-Ed. September 4, 2009.

¹⁷² Jenkins, Rob. 1999. *Democratic Politics and Economic Reform in India*. Cambridge UK: Cambridge University Press.

But there were also institutional dynamics at work: parties, electoral processes, and the distribution of power within the branches of the government allowed for the health reform movement to be created and implemented with relative ease. The concentration of executive power, the form of the party coalition that the Congress Party formed in the legislative assembly, a high degree of cohesion within the parties, and federalism all impacted the agenda-setting process. All of these institutional factors help to explain why Aarogyasri itself was formed without contention in the legislative body itself, with many of the complaints coming much after the unloading of the policy during the 2009 election. It also helps explain the dominance of YSR and the Indian National Congress in the legislature and public policy during this time.

In Lijphart's *Patterns of Democracy*, he seeks to explain how party's can dominate government and have complete control over policy. In Andhra Pradesh's case of health policy, this was clearly true of the Indian National Congress with YSR at the helm. A number of structural features of the political institutions themselves lent YSR more control once in power to push forward his health reform agenda and make the idea of an insurance-based scheme covering fifty million in AP a reality. Lijphart lays out two dimensions of democracy, executive-parties and federal-unitary, and accordingly identifies characteristics of cabinets and legislatures that lend itself to party control.¹⁷³ "Minimally winning coalitions," for example, he identifies as a cabinet large enough to control a parliamentary majority, which leads to a "consensus" democracy rather than a majoritarian one. Additionally, the cabinets themselves were at the behest of YSR rather than the other way around: they trumpeted policy that came from the close confidants of YSR, including his executive team, rather than

¹⁷³ Lijphart. 1999. *Patterns of democracy*. New Haven: Yale University Press.

generating wide-reaching policy transformations themselves. YSR and his chief executive team generated not by the ministries, but all the free electricity scheme, irrigation proposals, and health reform schemes.

To clarify the political situation in AP, the power was explicitly concentrated in the executive branch by the INC. Every single member of 24 members of the YSR cabinet in 2004 was a Congress Party member, while he struck a balance of castes and geographies.¹⁷⁴ This situation would yield YSR even more power to form his own agenda without opposition. In Andhra Pradesh, the party in power had relative political leeway to accomplish their agenda as they saw fit, characterizing it as a majoritarian democracy. While a multi-party system, the Andhra legislative assembly was dominated by two parties: the INC and the TDP and largely functioned as a two-party system with hangers-on parties that had little chance of taking power, such as the Left Party, TRS (a separatist Telangana Party), and BJP (a small force within Andhra but larger nationally), but could influence policy on a minor level. Other part The cabinet size of 24 was a small portion of the 294 total seats in the assembly. The personality driven electoral politics, in addition, pitting YSR an his *padayatra* against the sitting Chandrababu Naidu, also shaped the governing style once the Chief Minister was sworn in. The personalization of politics within the party contributed heavily to the cohesive aspects of Congress.

During the 2004 election, YSR and INC pulled a landslide victory, taking 185 electoral seats, while TDP and Chandrababu Naidu fell from power to attain only 47 seats. It was a drastic and overwhelming victory, with 62.9% of the vote before any coalition

¹⁷⁴ Kumar, S Nagesh. "24 Ministers inducted into YSR Cabinet." The Hindu. May 22, 2004.

forming.¹⁷⁵ This gave the Congress Party relative free will once in power to choose cabinet ministers and gave the opposition party little voice to protest on the initiation of large social programs. This was no “minimally winning coalition,” or a grand coalition. The Congress Party’s utter dominance over the electorate, one that would decrease in the 2009 election with the loss of twenty-nine seats, afforded it complete control over the policy process over the next five years.

Additionally, the party cohesion within the Congress Party was extremely high, with little dissention of voices of opposition. This allowed the policy to be implemented relatively quickly without any criticism intraparty. What factors led to the high levels of party discipline? YSR’s personal charisma and role in bringing Congress back to power in Andhra Pradesh did play a large role, and the temporary fractioning within the party after his death in 2009 supports this hypothesis. However, there are larger political forces at work to contribute to the strong party cohesion within the INC that allowed Aarogyasri’s formulation and implementation. Congress Party in AP had ideological cohesion over the juxtaposition to a pro-World Bank agenda of pure liberalization, as the previous government’s agenda was characterized. Cohesion around the message of populism and representation for the poorest citizen provided enough party unity to allow the expansion of the Aarogyasri program from the initial stages of a larger CM Relief Fund. This ideology was expressed during the election, when the pro-poor inclinations of YSR’s Congress Party were expressed through his dramatic walk across the state.

¹⁷⁵ Roy, Ramashray. Wallace, Paul. *India’s 2004 Elections: Grass-Roots and National Perspectives*. SAGE Publications, 2007. 64.

How did YSR deal with dissension within the Congress Party? Looking to YSR's handling of the often-decisive issue of Telangana, as well as the re-emergence of the separatist political party TRS, is insightful. An issue for decades in Andhra Pradesh politics, its re-emergence worried Telangana-area politicians within the Congress Party. YSR skillfully manipulated and satisfied the TRS, providing them two minor ministerial positions, preventing the larger Telangana movement while simultaneously silencing Telangana politicians within the Congress Party.¹⁷⁶

Studies on cohesion and coalition formation in parliamentary democracies have poked through the assumption that parties are unitary actors. Theorists have stated that party leaders in general seek party cohesion due to their leadership position being at risk, and also that high leadership control over decisions increases likelihood of a party being in government.¹⁷⁷ This was a factor in YSR's Congress, with YSR's interest in remaining leader, and his dictatorial rule over the party, enabling the party's success in 2004 and subsequent initiation of the Aarogyasri reform program. Democratic decision-making processes were not a feature of the Congress Party under YSR.

What other electoral constraints push party cohesion in Andhra Pradesh? In studies on Portuguese parliamentary elections, factors such as party headquarters selecting candidates, parties being seen as the only election agent, and an emphasis on national parliamentary mandate are all important.¹⁷⁸ However, unlike the Portuguese case, Andhra

¹⁷⁶ Times of India. "TRS may join YSR Cabinet." May 25, 2004.

¹⁷⁷ Back, H. "Intra Party Politics and Coalition Formation." SAGE Publications: Party Politics. 14(1). 72.

¹⁷⁸ Leston-Bandeira, C. "Dissent in a Party-Based Parliament: The Portuguese Case." Sage Publications: Party Politics. 15(6). 695-705.

Congress Party politicians did not express dissension in voting behavior, being even further constrained. All of the above factors are true in the case of Andhra Pradesh as well.

In the debate between executive and bureaucratic control over the policy process, in the case study of Andhra Pradesh clearly shows the power dynamic being swayed towards the former. In the policy process, the executive dominated and set jurisdiction over competing branches of government as well as the massive bureaucratic structures within Andhra Pradesh. In discussions with bureaucrats from the Ministry of Health and Family Welfare, the directive of the bureaucracy was seen as one of implementing the policy desires passed on from the policy formulators in the executive branch.¹⁷⁹ While there was some back and forth, especially regarding the public sector's role in delivering tertiary care, it was clear this issue was brought up far along the policy process. The bureaucracy itself was left to discussing the administrative details of the plan once its general shape took place, with "proactive discussions of the financial requirements with the Finance department regarding the budget cap;" ones that would lead to a final indicative figure to be included in the budget to be voted on for the state legislature. As Walt states, "In those countries of the Third World where political leadership is personal and unaccountable- where constitutional rule is the exception rather than the norm- most major policy decisions will be left in the hands of the chief executive."¹⁸⁰

4.3 Stakeholder Analysis

¹⁷⁹ Interview with G. Krishnamurthy from the Ministry of Health and Family Welfare

¹⁸⁰ *ibid.* Walt- Introduction to Process and Power

How useful is a retrospective stakeholder analysis? Despite the policy stemming from a small advisory circle of the Chief Minister, other interest groups were still affected, and the actual policy formulation involved consulting with the various parties that would be affected and anticipating the political impact on these various interest groups. Varvasovszky and Brugha detail the approach of stakeholder analysis as, “a tool or set of tools for generating knowledge about actors- individuals and organizations- so as to understand their behavior, intentions, interrelations and interests; and for assessing the influence and resources they bring to bear on decision-making or implementation process.” A long-term, reflective look at all of the stakeholders and the ways they were impacted by the transformation in health delivery and financing as well as patient behavior is informative. Evaluation of the groups’ political power will come from both tangible and intangible resources, ranging from money and people to visibility, legitimacy, and access to legislators.¹⁸¹ Seeing these interest groups in their context of electoral and financial relevance to the policymaker is also important, along with evaluating their public statements along with private interests.

In Roberts et al.’s *Getting Health Reform Right*, they list groupings of potential stakeholders in the health reform process, some of which are applicable to the case study of Andhra Pradesh, and others that are not.

“Stakeholders:

- *Producer groups*: doctors, dentists, nurses, pharmacists, other health sector employees and their unions, domestic and international

¹⁸¹ *ibid.* Roberts et al. *Getting Health Reform Right*. 83

- pharmaceutical companies, and equipment manufacturers;
- *Consumer groups*: disease-based organizations, local and regional consumer groups, women's organizations, unions representing insured workers, retirees, and military groups;
 - *Economic groups*: businesses with health insurance schemes, industries affected by health policies (e.g., tobacco farmers, drug sellers), and workers who gain or lose jobs;
 - *Ideological groups*: political parties, reform organizations, single-issue advocates (e.g., environmentalists, anti-abortion activists);
 - *Health development groups*: multilateral development banks, bilateral aid agencies, international health organizations, non-governmental development organizations."¹⁸²

In the Andhra context, economic groups (insurance companies, health workers, hospitals), ideological groups (political parties), and producer groups (physicians associations) held the most immediate political power. Along with groups within this category, the mass resources of the consumer groups also factoring into the decision making process of the CM's executive team, mostly through individual citizens holding the power of the vote and counsel with the CM on a daily basis. With the added pressure of presenting themselves as a populist juxtaposition to the TDP from the previous election, the Congress Party and the CM had this interest group and serving politically tenable benefits to the BPL patient population.

¹⁸² *ibid* Roberts et al. 81

4.4 The Importance of Political Factors in the case of Andhra Pradesh

International pressure from the Bretton-Woods institutions and other donor agencies undoubtedly played a large role in influencing Andhra politics. These larger cultural and economic forces, however, influence the intuitional limitations and discourses within the political sphere. A liberalized health sector was the playing field with which the political actors, primarily the Chief Minister YSR and his executive team, had to work within, and also some international pressure to reinforce private distribution of tertiary care. Additionally, economic facets of Andhra Pradesh's economy, like the growth of the information technology sector, also impacted the way in which reform took place and the possibility of certain aspects of the health reform movement. Rapid transfer and confirmation of patient records from hospital to the state government offices and enormous record-keeping and best practices evaluation would not have been possible without the significant IT infrastructure already present in Hyderabad. The crisis situation of the farmer suicides highlighted indebtedness as an issue for the 2004 electoral cycle, and was on the top of the newly initiated government leaders' minds as they took office, including the Chief Minister, YSR.

Essential in enabling the reform, too, were the macroeconomic factors. "These measures became possible, partly because of the increase in the revenue of the state government due to expansion in economic activity during the growth years after 2005 and

the increase in tax revenue as percentage of gross state domestic product (GSDP) from 5.2% in 1995-96 to 10.1% in 2007-08.”¹⁸³

However, the specific facets of the proposal, both its limitations and wide-reaching scope, are due to the political forces: domination of the executive over the legislature, Congress Party’s vast electoral mandate in 2004, the role of the individual “change team,” and the capacity to use the health reform movement as a prominent publicity scheme. Beyond targeting specific portions of the population and subgroups, the program was ambitious in scope and sought to reach all below-poverty-line individuals, numbering over 50 million in AP, and subsequently tie the program to the Congress Party’s success in power. Instead of being influenced by federal policy that might have called, somewhat vaguely, for programs of Aarogyasri’s type to be tried and tested on a state level, Aarogyasri ended up influencing federal policy as well as the health policy of neighboring states, from Karnataka to Tamil Nadu. Rather than having a distracted and fooled electorate, Congress relied on an electorate that would utilize the newly created social welfare reform program, and tie the use of this program, even in far-reaching rural health camps, to the Congress Party and YSR. Through intra-governmental dominance and appeasing vested interests, the Aarogyasri Health Care Trust was created and passed without much opposition, either from the Telugu Desam Party or from the various interest groups in the health sector.

¹⁸³ Srinivasulu, K. “Y S Rajasekhara Reddy: A Political Appraisal.” *Economic and Political Weekly*. Sept 19, 2009. 8-11.

Ch. 5 Conclusion

5.1 Synthesis of Project and Summary

5.2 Overall Impact: From Procedural to Substantive Democracy?

5.3 Closing Remarks

5.1 Synthesis and Summary

This appraisal of the health reform program of Andhra Pradesh, borne of studies at the Sri Kirin Institute of Ophthalmology, was undertaken with an eye for the political factors behind the structure and policy process behind it. The initial exploration of what the ends usually are in health reform served to inform the health reform experience in Andhra Pradesh, and seek an answer for what the motivations and desires, or at least stated desires, were for reformers. Borne of the issue of indebtedness and financial insolvency, a major issue in the 2004 election, the health reform program took on a gradually expanding role due to a multitude of factors. Limitations, institutional and structural, within India and Andhra Pradesh, expressed themselves through this process. Fundamentally equity focused and a “pro-poor” reform, the Aarogyasri Health Care reform trust transformed Andhra’s health care system by opening up the doors of private and public tertiary care hospitals to below poverty line patients.

Andhra Pradesh’s political history gives insight into the possible ways the reform could have been structured, and the policy process itself. A description of the ways in which Aarogyasri, as the major part of the reform process, transformed AP’s health care delivery, financing, patient behavior, and infrastructure, provided the necessary facts to provide backing for the political analysis.

In Chapter 3, “exogenous” factors for health policy change were explored, structural, situational, external, and economic. The dismissal of the importance of caste politics, and cultural factors, along with the importance of the farmer suicide crisis and the strong legacy of liberalization stemming from a “focus state” relationship with the World Bank were showcased. These factors, combined with an opportune political time, allowed and

limited the scope of the reform. Aarogyasri benefitted private tertiary hospitals with a new patient pool. These hospitals were created from a deep trend in AP's health sector and across sectors: an inclination towards privatization of health services.

Chapter 5 saw the crux of the political analysis and an application of various theories of reform to the case study of health reform in Andhra Pradesh. Public policy was not cut and dry in Andhra Pradesh; there were a number of influences that flowed through the halls of the state government. Explaining the private-public partnership, of unheard of scope, of the Aarogyasri Health care Trust required digging into an analysis of the central interest groups and actors involved in policy. The executive team of the Chief Minister were the primary formulators and initiators of policy change, and therefore a "top-down" policy analysis was undertaken. Class structures, boundary institutions, the influence of federal policy, and cloaking of the policy are dismissed as plausible explanations for the massive reforms of the health care system. Instead, the reforms served as publicity for the electoral campaigns of the Congress Party, and were so successful since they did not impact the vested interest at hand. Finally institutional explanations were explored, ranging from party cohesion to concentration of power in the executive branch.

5.2 Overall Impact: From Procedural to Substantive Democracy?

The idea that the program is part of a shift from a procedural democracy, in which the electoral process is undertaken but the influence of the citizenry is little, to a substantive democracy, one of true representation of the will of the people, may have been too ambitious and was not vilified by the ultimate outcome of the program or succeeding elections.

Still, such massive redistributive efforts in the health sector could be one portion of a larger movement of democratization. Indian states have a sizable gap to overcome between procedural and substantive programs, and large-scale health and education programs can allow more states to achieve Kerala-like social mobilization and development indicators.

More likely than a movement towards greater and more substantial democratization is a shift from “clientelist politics toward a welfare regime,” as outlined by Carolyn Elliot when studying the Andhra 2009 elections:

“The historical practice of clientelism has lost its capacity to bring victories, either because there are too many claimants or the rewards demanded by claimants have risen too high. Therefore incumbent governments have regularly been ousted from power by dissatisfied voters, the so-called anti-incumbency wave (Nooruddin & Chhibber, 2008). In what one observer (Manor, 2010) has called the ‘post-clientelist’ regimes, politicians have had to seek other ways of attracting votes...This shift to provision of welfare without revenue caps has been enabled by a dramatic rise in government revenues (Centre for Economic and Social Studies, 2007: 43).”¹⁸⁴

The patronage links and voter perception of the health reform movement requires further study. These study focused on political factors of the central actors involved in the movement; voter identification and electoral perception studies could shed more light on how the health reform movement was perceived on the ground and in the ballot box.

¹⁸⁴ Elliot, C. “Moving from clientelist politics toward a welfare regime: evidence from the 2009 assembly election in Andhra Pradesh.” *Commonwealth and Comparative Politics*. Feb 2011. 49:1: 48-79.

5.3 Closing Remarks

The health transformation that occurred in Andhra Pradesh has impacted many individual lives. Individual health costs that would have been incurred have been avoided with the implementation of a large-scale health reform program in the Aarogyasri Health Care Trust, and other health programs that emerged during the same period. In this project, the political context behind the health reform movement was explored, a context that is lacking in exploration in the literature. While means and ends have been researched fully, understanding why certain regions undergo this policy process, while others do not, is an essential task, not an incidental one.

What aspects of this study are generalizable for practitioners and researchers of the health reform process, and reform policy more broadly? There are undoubtedly many factors, situational, cultural, historical, and political, that allowed for a scheme of such massive proportion to take place in Andhra Pradesh. However, there are also important lessons to take away for other health reform movements, and for studying health reform policies internationally.

First, exogenous factors are enormously influential in affecting the shape of reform. In Andhra's case, World Bank legacies of liberalization created a health system within which only certain kinds of reform were politically tenable. Crisis, and one that tied indebtedness to the issue of health reform, was also important for the policy opportunity window, and was shown to be an essential precursor to massive reform. Lack of crisis, in the ethnic and regional tensions that had been existent in the region for decades, was also a central factor to preventing loss of policy focus on health reform.

Politically, the differences in causal factors between the economic reform of the early 1990s and the succeeding, reactive social-service expansion that included Aarogyasri are important to distinguish. Obviously, some of the explanatory theories fit better than others. Class, cultural, and institutional divisions can be overcome in the reform process, as long as the vested interests (in this case, private hospitals, insurance companies, and the below-poverty line patients) are provided benefits as a result of the reform process.

Only from understanding both the specific and generalizable factors of policies such as Andhra Pradesh's health reform program can other health reform movements be impacted and initiated. Additionally, further research on the impact of the policy itself is necessary. Did Aarogyasri impact financial risk protection as intended? How widespread is its use, and is it being actually utilized by below-poverty-line patients? In comparative perspective, is this the best way in which to deliver universal healthcare, or are there better health insurance models? These questions, and more, require answers if whole societies and individual lives are undergoing paradigmatic change in terms of the impact of the healthcare system.

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