Health Insurance Schemes as Sites of Power Expression in India

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Introduction

In 1991 India's debt grew to over $70 Billion and the country almost defaulted on its loans. The Indian rupee lost much of its value and the country was in dire economic straits. Because of the economic crisis the government of India turned to the International Monetary Fund for a loan (Weinraub 1991). The bailout came conditionally and India was required to start putting their economy through liberalization.

Following the initial crisis, the government of India shifted under the new Prime Minister, Narasimha Rao. With this shift the Indian economy started a slow move from a mixed economy (the model of Jawaharlal Nehru) to a market driven one. The initial policy changes involved the dissolution of the former model. This included dropping government licensing of industries, reducing the limits on investment in firms, and establishing a stock market (Denoon 1998, 53). These initial changes fell short of a wholesale liberalization of the economy.

Over the next few terms of Prime Ministers the changes started by Rao continued with related additions. In 2004 Manmohan Singh (who had been Rao's Finance Minister) became Prime Minister; he encouraged the next set of reforms. These changes focused on increasing the output of the economy. Tariffs were lowered further, labor laws were reformed, and foreign direct investment was emphasized ("One More Push" 2011). The focus on increasing the output and exports of the economy reflects how India is approaching liberalization in its own unique approach.

Until recently the government of India has not emphasized liberalizing the inputs to the economy (infrastructure, education, etc). Not changing inputs at the federal level has changed the Indian economy. The best way to view the Indian economy is by

examining stratification among states, metropolitan clusters, and cities. Due to the different path through liberalization and the political makeup of India we can see great difference in governance between areas. This can be easily seen through the GDP per capita measure. Growth is centralized in certain states, metropolitan regions, and cities. (*Understanding India's Economic Geography*). The divergence between locations grows in part from from different governance of inputs. Infrastructure, labor, and health governance can be drastically different between urban and rural India and between different states. This divergence has led to a variety of very different economic and social landscapes across the nation. In the differing landscapes populations grew forms of behavior and norms of interaction with governance that might seem foreign to the other populations.

In 1999 market liberalization met the insurance industry in India, and the Insurance Regulatory and Development Act was passed. This created the IRDA, a commission focused on reforming the insurance industry by controlling regulation and pushing for more foreign direct investment (Banerjee 2003, 123). Since this time, government subsidized health insurance schemes (GSHIS) have been developed in India. Basically these are health insurance plans that are financed by the government to support the poor. In this paper I will be examining two specific schemes: the Yeshasvini Farmers Health Care Scheme and the Vajpayee Arogyashri Scheme.

The first plan, the Yeshasvini scheme (hereafter referred to as Y) was unique because it was created not by a government official; it was designed by Dr. Prasad Shetty, who is famous for founding and running the Narayana Hrudayalaya Heart Hospital. Dr. Shetty was looking for more ways to increase the poor's access to tertiary

care and more specifically heart procedures.[1] Dr. Shetty worked with the Department of Cooperatives in Karnataka to develop this health insurance scheme. The scheme was then proposed to the state government who decided to subsidize it financially. It is very important that this plan has been developed by private health care professionals, the government, and the department of cooperatives. This variety of stakeholders and ideas has allowed Y to be innovative and break through with new forms of operation.

The second plan, the Vajpayee Arogyashri (hereafter referred to as VA) can be seen as Karnataka's cookie cutter GSHIS. Most GSHIS created by state governments after Y was formed followed a similar structure to each other. VA is no exception as it is directly based on Andhra Pradesh's Rajiv Aarogyasri Community Health Insurance Scheme. VA was created and is overseen by the Department of Health and Family Welfare (DOHFW) which is part of the state's public health care system. Contrary to Y, the VA scheme innovates and operates in relation to trends already established in the Indian public health system.

I have chosen to examine these two plans specifically because of significant differences in plan design; even while both are financially sponsored by the state government, VA and Y operate with vastly different mindsets. Their shared geographic location in Karnataka only helps to highlight the differences between the two schemes by taking out certain background factors. In the end this paper does not seek to find which plan is more successful in regards to each's goals or to compare them in regards

[1] Health care can be divided up into different tiers. Primary care is the first level of interaction between patient and medical system like meeting for a yearly checkup. Secondary care includes basic procedures for problems that can usually be dealt with in the clinical setting. This can be anything from a dog bite to giving birth. Tertiary care signifies complex procedures that require a hospital setting. These would be most surgical procedures. In India the public health system provides free care for the secondary tier but does not usually have the capacity to operate tertiary level procedures.

to efficiency of efficacy, but to better discern how power relations are operating through these plan designs.

Specifically I am examining these plans as expressions of power. In the lecture series *Security, Territory, Population* and *The Birth of Biopolitics*, Michel Foucault examines the shift in the aim of governance from traditional sovereign notions to a newer form that he terms government. What makes government different from sovereignty is that governance is no longer focused on territory but on the population within a territory and on the relationships through which people interact with things (Foucault 2007, 96-97). Foucault notes that government can operate through the concept of population using the statistics which describe populations and their activities. The aim of government becomes continually improving the population by focusing on statistical elements that can be shifted through power and control. With the shift to population governance Foucault tracks the development of two forms of power. I will be examining VA and Y as reflections of these two powers operating in India.

The VA scheme predominately utilizes disciplinary power. Disciplinary power controls through relating subjects to norms and using other individuals as teachers to discipline a specific behavior in subjects. To do this institutional authorities create the truth of hierarchy. Subjects are labelled at a certain place in the hierarchy (Foucault 1995, 182-183). In order to motivate behavior change, a certain place on the hierarchy is developed as a goal. Figures of power then function as teachers disciplining subjects towards that norm (Foucault 1995, 179). Discipline uses these norms to both create productive individuals and to manage resistance and risk.

In contrast, the Y scheme utilizes governmentality. Here specific freedoms are created within which subjects are urged to make choices. Control occurs when the

frameworks of freedom are set up in ways that form incentives and dispositions for subjects to choose from certain actions (Foucault 2007, 99-100). In the field of governmentality, truth about how the subjects ought to act comes from the 'natural' movements of the market (Foucault 2008, 30-32). Because governmentality shapes behavior through the creation of freedoms, it also leaves open the space for risk. Foucault examines how vulnerabilities to risk are managed by governments with the creation of apparatuses of security.

I am arguing that by viewing VA and Y as reflections of different systems of power relation we can see, within the context of Karnataka, changing notions of truth, governance, and security. By highlighting these changes I predict that neither form of power directly matches Karnataka which will create burdens on the schemes.

Method and Data

The subject and method of this paper has been greatly modified by the kinds of data accessible. In India we can read two different forms of relation amongst different populations. Between discipline and governmentality it is unclear as to which form of relation will be dominant. This struggle constitutes a very complex situation which requires us to look close and ask many questions. Some questions we need to ask are as follows: In what ways do forms of power hybridize into the Indian context? How will forms of truth be produced, resisted, or maintained by different actors? How might different actors use of power change the ways in which the public interacts with the private? Will new forms of citizenship be created concurrently? Are these forms of power utilized intentionally? If so, by whom? All of these questions are important for a more holistic understanding, but all require forms of data that I do not have.

Instead I have accessed and formed research around available operational data. To be more specific, I am using a 2012 World Bank document: *Government-Sponsored Health Insurance in India, Are You Covered* (La Forgia 2012). This report compares all of the Indian GSHIS in regards to specific aspects of plan design and their effective operation. This document also includes appendices for each plan that includes history, utilization figures, network data, beneficiary data, and pricing methods. I will critically compare these figures for the Y and VA in six ways. First, to see who is in charge of plan governance. Second, to see how risk populations are created. Third, to see how beneficiaries are involved in the identification process. Fourth, to find the impacts of differences in treatment packages. Fifth, to compare how empanelment and claims processes interact with different providers. Finally, to examine how research is sponsored. In each of these areas I am looking for how each form of power is shaping in the Indian contexts and how this reflects on truth, governors, and security. From this interpretation I will conclude by predicting the status of each form of power as they continue to operate in the Indian context.

So where does this World Bank document come from, and what does that mean for the method of this paper? The massive over four hundred page document was co-authored by two men. Gerard La Forgia is a World Bank health specialist working out of Washington DC for the East Asia division, but who had previously been the lead specialist on India and Brazil. Somil Nagpal was previously a medical doctor who then went on to work for the IRDA overseeing developmental initiatives for health insurance in India. At the time of this document's publication he was working in New Delhi for the World Bank as a health specialist for the South Asia region. Both of these men work for the World Bank and are looking at health insurance in an institutional/developmental

frame. They examine GSHIS in regards to how they run from a global perspective and in regards to how Indian health insurance compares to insurance in other contexts. A developmentalist bias will come from this viewpoint and a specific conception of how insurance schemes ought to be run will be expressed and compared against. This ideal scheme would have specific population characteristics and institutions that might not exist yet in the Indian context. To guard against this bias I have actively worked only from the appendices describing the VA and Y plans. The appendices have historical descriptions of plan operation and tables of data from the schemes. I have tried to be aware of and work against bias in my interpretation of the data.

Awareness of this bias normally would be complemented by readings from the indigenous perspective on the topic. This paper strikingly lacks the Indian perspective. For an undergraduate thesis I mainly worked from the American databases available to my university. This came with a struggle in finding information, not just about neoliberal governmentality relations but also on the history of medicine and healthcare in India and Indian power relations as a whole. If I continue this research it must include readings in these subjects and also more data on the history of these specific schemes and ethnographic analysis of the subject in Karnataka. At the moment I don't have all this information or even the skill sets needed to evaluate it. My research is problematically devoid of Indic voices. Understanding that this analysis falls short, what can be learned about the topic through utilizing a western view?

What can be gained by using this method and perspective? By limiting our gaze to the operation of power, we can gain a more nuanced take on power relations and their interactions with other aspects of power relations. When we take such a close look at these specific relation of power going on we can see that they need other characteristics

to exist in the field of relations in order for them to operate. Foucault observed that for power to function there also needs to be created specific forms of knowledge/truth. He also claimed that for power to function there needs to be specific relationships between governing figures and those who can have the right govern (Foucault 1995, 27). Through strictly analyzing the operation of power we can see how context will force changes in knowledge, government, and the mechanism itself or face risks to the plan's security.

Plan Governance Structure, Staff, and Goals

The VA plan is governed by the Suvarna Arogya Suraksha Trust (SAST). This trust consists of twelve individuals who decide the direction and focus of the scheme. While technically an independent body, SAST's board is full of public health officials, mainly from the Department of Health and Family Welfare. For staffing the VA, SAST hires: a CEO, Executive Board, and workers whom they refer to as Arogyamithras. For every provider empaneled in the VA scheme there is an arogyamithra. The role of arogyamithras is to interact with beneficiaries and provider staff to smooth the transactions that take place. Other administrative tasks regarding the VA plan are completed by a TPA (third party administrator). Even though this is a health insurance scheme VA's goals are not strictly related to health, but to reduce the negative externality of illness. The cost of catastrophic health care procedures would be unmanageable by the poor in Karnataka. The goal of VA is to complement the free health care in the public health system. The public health system is supposed to provide free care to those in poverty up to the secondary level of care. The VA scheme was created to provide coverage for tertiary procedures that the public system does not

cover. The end goal is not specifically to increase health but to keep people from sliding further into poverty.

The Y scheme's governing body is the Yeshasvini Cooperative Farmers Health Care Trust. This group was created as a "tri-partite" agreement between the cooperatives, the Karnataka state government, and several private hospitals. The trust of around 10 people is made up of directors from the cooperatives, state government officials, Dr. Shetty, and 4 other doctors from private hospitals. Meeting monthly, this group makes the large decisions about the direction and solvency of the scheme. This trust also oversees at least two other benefit programs at their monthly meetings. Y only hires two full time paid positions. These are the CEO and the Computer Operator. These two manage the large functional issues and the electronic/internet databases. All other tasks required for the scheme to operate are outsourced to a TPA. The goal of the Y scheme and other programs run by the trust is to secure better health care outcomes for members of the cooperatives in Karnataka.

The differences in power being used by these schemes changes the ways in which their organizations are structured and how their goals are chosen.

The makeup of SAST shows how the VA operates through disciplinary power. The decisions of SAST reflect the views of the public health officials whom compose its board. This reinforces the notion that head institutional figures will have a better grasp on what the population needs. In effect they hold the truth of what is best. In this case SAST sees that the true role of government (in this instance of health insurance) is to decrease the poverty statistic. Only the voice of the public health officials is heard in SAST's goal setting and this is an example of the unilateral power in discipline.

Y's structure also shows its use of power, but of governmentality instead of discipline. One of the goals of governmentality is to control others by building a desire to take on certain roles/responsibilities. Y does this by having other actors (the cooperatives, the public health system, and the providers) become a part of the structure. The Y trust that makes goals and decisions about the plan is made up of the many actors. This is a stark difference from VA, because in order for Y to still have its work accomplished it needs to share power. This matters in determining what goal would truly be the best for government. When Dr. Shetty had the idea of starting Y he specifically wanted more heart procedures to be accomplished. In order to gain the support of the different stakeholders this goal had to change. Given the state officials rather want financial protection (as we can infer from VA's goal) we can interpret their influence as to why the amount of procedures covered by Y expanded beyond heart medicine to include other tertiary medicine like gastroenterology, neurology, and ophthalmology. While partnering with other stakeholders managed to reduce the cost burden on the creator, it also watered down his original intent and started to shift power by changing who can set goals. The diversity of control in Y's trust is an example of the power shifting that occurs in governmentality.

The shifting of power that is seen in governmentality brings up an important question about who can be powerful. In the shift from ruling territory to governing a population, all it takes for an actor to become a governor is the ability to use and decipher statistics describing the population. With the changing of who can govern so do the fields of power and knowledge change. As these fields change we can see these insurance schemes also shifting and expressing different forms of power operation. As these mechanisms operate they not only exist and arise from the field or relations, but

the way in which the schemes are shaped will make further shifts in regards to power and governance. One change we can immediately observe is the centrality of power. The VA scheme maintains a hold on all of the decision making which protects the existing centrality of power. Y instead negotiates in regards to goal setting in order to get other actors willing to bear cost/responsibility. This shifts the control of power. In governmentality based systems truth is derived less from the authoritarian institutions and more through the operations of the market. Markets require many participants and their movements can be interpreted in many ways. The truth of the market provides the opportunity for other actors besides the state to become powerful and perform as governors. The best example of this in our setting is that the creator of the Y scheme is not a member of the state, but in fact when looking at power traditionally he can be seen as a marginal figure coming from the private health sector. When government and governmentality entered the Indian context these previously marginal figures can utilize the statistics and powers available to them and become a significant power, and this freedom can be seen in Karnataka as it further shifting forms of power relations there.

While the schemes show us that power is shifting in interesting ways, it is too early to specifically label exactly how power is shifting. First, this shift cannot be described as a privatization of power because this is not a wholesale giving over (or contracting out) of power from state to private entity. There is a sharing and struggle that is going on. In fact, the VA scheme (formed x years after Y) can be interpreted as a reaction and resistance to the shared power of the Y scheme[2]. Second, this cannot be described as a democratization of power. Not all actors can access and express power in

[2] Different forms of power relation interacting is one reason for scheme creation. This exists alongside other factors pushing change, and to get a better understanding requires a closer look at the history of the schemes.

this system. The common individual does not have the size required to access the vast statistics now used for government. Even when the poor band together as in cooperatives we can see that they aren't acting as a power figure. They are figures of power in regards to how they can resist, but it is harder for their actions to shift the whole field of relations. The cooperatives in the Y scheme generally benefit from and listen to the Y scheme but in my interpretation of the data they do not effect substantive changes to the structure as a whole. While having the size to utilize statistics, they do not yet have the kinds of knowledge needed to correctly understand and use them (Foucault would call this novel field of knowledge political economy). Third, it is too premature to establish a specific power formation as the overall frame in the Indian context. Indian power relations exist and are theorized, but India is still slowly moving through economic liberalization and it is organizations like Y are still changing and utilizing forms of power like governmentality. It is likely that as India moves into the future these forms of power will become shift more and become something strikingly different from what we see in the west. Instead of trying to name exactly what is happening I am highlighting a shift of power in Karnataka to see how this modifies the other aspects of plan operation.

Population Creation

The completely new population targeting system was the jumping off point from which Dr. Shetty created Y (La Forgia 2012, 254) and it radically changes how a beneficiary interacts with the scheme.

The standard in the Indian insurance industry and the ESIS and CGHS schemes was just like in the United States where populations were groups of employees working for employers whose premium contributions were taken directly out of pay. While this

worked in some cases (the central government workers), this is not how the Indian market as a whole operates. Many workers of the Indian market are in the informal economy and do not have traditional employee-employer relationships. We can look at the informal state of population employment as an example of how fields of knowledge are different in Karnataka. Insurance schemes will need to shift their mechanism of relation in order to solve related contextual problems, in this instance how to create a population/risk pool for the poor in Karnataka.

To solve this problem, most GSHIS (including VA) turned towards the below poverty line (BPL) statistics that the central government uses to operate food and welfare programs. If a worker or individual earned below a specific rupee amount, the government then classified that person as BPL. In order to define beneficiary populations most GSHIS took the lists of these BPL individuals and reported to state governments that those individuals are enrolled and receiving plan benefits. From this point state governments give the premium to the schemes and these individuals are now considered part of the plan. Whether or not the individual knew anything about the specific scheme did not matter; they were enrolled along with their family (La Forgia 2012, 336).

Y sidesteps the problem of population definition by creating a voluntary scheme. This operates like traditional health insurance in that each member of the plan is required to pay their own premium. What was revolutionary about this was that Y switched the linkage of payments from an employer towards the linkage of payments to the local cooperative systems. While most farmers and informal workers do not have employers, many do work through cooperatives to sell products or receive lines of credit for loans. While making these everyday transactions, those in Karnataka could also now

choose to link extra funds as a premium payment. This is not a decision that has been imposed upon a population, but a group of individuals choosing to become a part of the scheme's framework.

This novel method of premium collection creates a demand side consumer driven population that should be involved in the identity of the scheme. By paying the premium, the at-risk population is now choosing to be part of the scheme. They are, in a way, agreeing that health and this method of healthcare is what they want. Theoretically, they now should be more invested in the healthcare process. Whether or not the Indian population will take on this mindset (and the responsibilities that follow) is another question which will be explored in the next section. Either way this is in direct contrast to the population of VA, where BPL status and membership are applied upon individuals by the government without their knowledge. In Y choice creates identity.

We can also look at the difference in beneficiary size. In the VA whole families are enrolled under the plan. In Y only individuals may be enrolled. Both plans want the most individuals enrolled because this spreads out the risk more. The difference is that VA just outright controls who is signed up for the plan, while Y creates a norm for individuals. Once a head of household is enrolled there can be an expectation that they will then sign up the rest of the family. Y can expand its risk pool by utilizing and further developing existing norms, like the notion that people ought to invest in their health. This use of a norm can be seen as an apparatus of security used to safeguard against the risk of people not joining the scheme.

Y is not just subject to the whims of popular choice and norms but also manages to add incentives to the plan that can induce people to enroll as beneficiaries. Y has added financial incentives towards plan enrollment. The plan gave a premium discount

when five or more members of a family enrolled. This still leaves individuals with a choice but now there are more reasons for enrolling. When this measure was put in place it increased enrollment (La Forgia 2012, 257). In a subtle way Y is controlling behavior through incentives while beneficiaries still have the freedom/power of choice. The choices given are not passive but are framed in ways that will create a disposition to a certain behavior. In a similar way Y has also given incentives to the cooperatives where individuals sign up. For every enrolled beneficiary Y now gives a Rs. 10 benefit to the cooperation. The cooperations now have a profit motive for better convincing people to enroll. This incentive/power relation now occurs at the social level where the idea/mentality of using insurance for health coverage can be spread. Again there was a jump in enrollment when Y put this method to practice (La Forgia 2012, 257).

This power exercised subtly over choice can lead to results but it also leaves the plan open to danger. All insurance runs the risk of adverse selection, but this is even more likely in voluntary schemes like Y. Every year beneficiaries have the choice of whether or not they want to remain in the plan. Some individuals can abuse this opportunity. They can jump on board the plan the year they know they will need surgery and then leave the very next year. In this case a multi-thousand dollar procedure could cost only a few dollars. Choosing to adversely select can be viewed as a form of resistance to the governmentality. Individuals in the population can be aware of the system being created and try to abuse the holes in the system. While VA might not have as much active involvement from the population, it also does not run this risk of abuse. In the context of these schemes this is an example where governmentality does not fit in the specific context of the poor in Karnataka, because we have seen indicators of adverse

selection (La Forgia 2012, 257 and 263) while no apparatus of security has been created to combat this.

The difference in power between the schemes is evident. VA is operating through a frame of biopolitics, where traditional forms of disciplinary power are exercised at the level of population. Y has interestingly created plan membership through a certain 'freedom' of choice. Y has also effectively shaped dispositions through their incentive system. A related contrast is the mechanisms through which the schemes meet their beneficiary populations. In VA there is a political linkage where the government names the population through the BPL statistic which can be considered as flowing from the truth of the authority. The Y scheme instead meets their population through the truth of the market. The conduct of choosing membership is here being shaped through an everyday economic interaction. In this way a population is being created in the style of governmentality through the truth of 'natural' market interaction. This market linkage also serves as a new place of resistance and questions whether or not the population will actually be engaged in the schemes goals.

Staffing, Identification, and Plan Awareness

Both schemes have different systems of identifying beneficiaries when they seek treatment at a hospital. The VA beneficiaries meet with an arogyamithra and produce some proof that they hold BPL status. In Y the beneficiary upon premium payment submits a form and photo to be put into the online "Unique Health Identification" system. Once at a provider the ordinary hospital workers can identify the beneficiaries. Ys method reduces administrative costs but also displays VA's emphasis on control in contrast. In the VA scheme individuals must hold a BPL card and interact with the representative of the plan. In Y the individuals submitted their own information and

have to interact with the providers themselves. Y beneficiaries need to know how to identify themselves in this fashion and want to do so. This shifts some responsibility from the plan to the individual.

We can see the change from VA's system of direct control to Y's mode of expectations. VA control is focused through the use of arogyamithras. Located in every hospital these individuals make sure that the process runs correctly. Control happens in a hands-on method at the human/disciplinary level. Contrasting this in Y, there is a system based on expectations. Y has created computer based systems and standards/regulations that ought to be followed. From that point it is up to beneficiaries and providers to correctly follow the process. The moment of identification in Y's process is another moment of risk/resistance. Beneficiaries can bankrupt the process if they are not taking part in the process correctly, whether by choice or by not knowing. Risk is even greater in the case of Y servicing the rural population who will not be as familiar with the norms of process at urban providers. Again we see the governmentality based mechanism changes the operator of work/responsibility while simultaneously opening the space of risk and resistance.

In order for GSHIS to operate effectively they need to notify members of the benefits they receive and teach the process of benefit reception. Both Y and VA do attempt to inform beneficiaries. They both require health camps to be run and also perform mass media activities through the use of radio and television. On top of this the VA scheme uses more common advertising methods like handbills, posters, and bus panels. The ways health camps operate and the institutions that these schemes are not utilizing say interesting things about each scheme.

The Y plan expects their providers to run health camps. At these camps there are discounted diagnostic tests and free outpatient consultation. The problem with this method is that Y does not provide instructions on how to run these camps. Once empanelled a provider receives a few guidelines but none relating to health camps. The scheme has no measures to make sure these camps happen and because of this it is likely they are not being held on a large scale (La Forgia 2012, 270). This can be seen as an example of how cooperatives can resist the governmentality relation because of the mechanism's lack of regulatory measures. On top of this Y's meager staff of two people is not enough to adequately respond to confusion from the beneficiaries. If the process cannot operate because of this confusion then the goal of health is not being reached.

VA carries out their health camps through the use of their arogyamithras. At these camps, plan information is given out and the arogyamithras perform free health checkups and free diagnostic tests. These camps have a calendar so that the plan is sure that these are happening at specific places at specific times. Also at the first health camp in each region opened senior state level political leaders attend and assist[3]. What is interesting though is that public hospitals don't cooperate with VA. The goal of the plan was to fill the gaps of procedures not performed by public hospitals. Because of this advertisements and information packets should be available at public hospitals. Instead there is a lack of cooperation due to increased competition. When beneficiaries join VA they tend to utilize private hospitals (La Forgia 2012, 337-338) for most of their care and not just those procedures left uncovered by public hospitals. The funds for both the plan

[3] We are not sure what the political figures say at these events or whether or not they take part in the health checkup process. Depending on their behavior it could express either form of power we are examining. If in speaking they are ordering around the behavior of the public than it is an example of discilplinary power. If they speak about the virtues of good health and about how health would improve the lives of citizens then it would be an example of governmentality.

and hospitals comes from the state government so there is a contradiction. There is a changing economic system at work; the power is shifting from supply side to demand side, from the public to the private; the public hospitals, in turn, are resisting.

Again in terms of interacting with the beneficiary population, we can see the VA relying on more disciplinary forms of power. VA has a large staff of arogyamithras dedicated to help identify beneficiaries in hospitals. Arogyamithras in a bodily interaction make sure that the process of identification and pre-authorization occurs correctly. Very much in line with how governmentality operates Y uses the population as its tool. The individual beneficiaries are expected to interact with the hospital staff on their own. While this form of conduct might be cheaper for the plan to utilize, it also comes with problems.

Here though we have also seen resistance to the VA scheme. The public health system has not helped communicate information about benefits. In this case discipline is not applied against the public health structure. This might relate back to its standing as a government institution. Disciplinary power manages to control other actors outside of itself but is facing struggle within its own bureaucratic apparatus.

The Y scheme has more problems surrounding denied pre-authorizations (La Forgia 2012, 269) which most likely links back to an un-informed beneficiary population. In regards to both health camps and identification interactions, Y has taken a hands off approach for beneficiaries to act on their own behalf. The problem is that these mentalities/methods need to actually be held by the beneficiaries or informed to them in some fashion. Because of the problems that we see with beneficiaries misunderstanding coverage, this transfer of how one ought to interact/behave most likely is not happening with Y. Many of the beneficiary population being the rural poor

means that they won't automatically understand the ways Y wants them to act. In this case Y's focus on individual responsibility needs to be balanced by some form of information dissemination. The risk here is not a direct resistance, but more of a misunderstanding. Here Y expects a certain kind of citizen steeped in the truth of a certain market and its rules/behaviors. In fact, within the Karnatakan BPL context this type of person does not exist. We can infer that the framing provided by the freedom in governmentality needs to have an apparatus of security not just for direct resistance, but also to help coopt individuals into the mentality who otherwise might not think in that manner. In order for a power relation based in a governmentality to function a certain form of beneficiary/individual needs to be produced/created in order for the governmentality to properly function.

Treatment Packages

The slight differences between plans in regards to coverage and rate setting can induce different behaviors. In regards to coverage the VA scheme provides a more holistic package. It covers inpatient charges, pre-hospitalization screenings, medicine for ten days, and a reimbursement for public transit. VA also has fifty follow up packages which cover post-hospitalization care, such as consultations, diagnostics, and drugs for a year. This lies in stark contrast to Y which only covers in-house drugs, procedure expense, and bed charges. These small differences lead to different behaviors:

First, the Y scheme induces balance billing. The plan does not cover in-house diagnostic tests or surgical consumables. Providers now can mark up these prices or give more diagnostic tests that might not be needed. These attempts to earn more money come by trying to work around the lax packages.

Second, the difference in post-procedure coverage puts the covered populations at risk for financial difficulty. In VA the beneficiary has the opportunity of taking follow up packages that cover most costs. In Y the beneficiary is financially liable for any consultations, drugs, or diagnostics after the procedure. These costs can be quite high and might force the beneficiary into poverty. We can interpret this difference as flowing from the goals of the schemes. The VA scheme's goal is to keep medical costs from sending beneficiaries further into poverty. The Y scheme's goal is to provide certain forms of tertiary care for beneficiaries.

Third, we can see a difference in regards to the value of providers in different geographic areas. In both schemes the majority of claims are made in large, prestigious hospitals in Bangalore (La Forgia 2012, 260 and 339) . The difference between these schemes is that VA encourages the travel to Bangalore through the reimbursement of public transit. On the other hand Y does not do this. The absence of travel reimbursement in Y can be seen as an attempt to encourage beneficiaries to use more local providers; we will further look at geographic difference in the next section.

Besides coverage characteristics there are also some differences in regards to rate setting that induce provider behavior. In the Y scheme package prices are generally set at specific rate below the market price (usually between 40 and 50%). This rate setting is based off of the 'natural' market price. Price based off of the truth of the market sets most procedures at a similar ratio from their normal price. In order to seek profit providers are induced to balance bill (La Forgia 2012, 258-259). This leads to unnecessary costs for beneficiaries.

In VA every package price is set by a separate committee. These committees are made up of medical professionals on that specific procedure. The committees consult

existing prices, packages made across the country, and the prices in other GSHIS. The results makes various rates for different procedures ranging across the spectrum of cost. While most are usually at the lower end of market price this varies depending on geographic location and the chosen provider (anywhere from 20-100% difference) (La Forgia 2012, 337). This rate setting is based on the opinion of institutional figures who hold spots in certain committees which relates to disciplinary power's emphasis on institutional figures as the creators of truth.

VA's differential rate setting can be seen as inducing providers to seek out certain kinds of beneficiaries more than others. As stated earlier, in the VA scheme arogyamithras run health camps. It is possible that when providers give the diagnostic tests at these events they seek out and try to better persuade those who require higher profit procedures. This helps to explain the drastically high amounts of cardiovascular surgeries (51% of claims and 72% of total expenditures) (La Forgia 2012, 339). Here with differential rate setting the VA could possibly control what procedures are being done. This effect is also problematic (even if it aligns with VA's main goal of financial protection) because it leads towards better health for specific beneficiaries and not the population as a whole.

At the same time, Y has been able to control what procedures are being done by making new procedures available. Due to political pressures, which I will return to in my conclusion, Y had to add common secondary procedures to their coverage. When added these procedures were utilized more than neighborhood need data had predicted (La Forgia 2012, 262). For instance when Y added a normal birth package the amount of women having their child born in a hospital setting jumped (La Forgia 2012, 261). Also by adding a lower package for cataract surgery Y managed to raise the claims in

ophthalmology procedures as a whole (La Forgia 2012, 263). While adding procedures can control by changing the frame of what choices are available, this governmentality style relation also creates the space for risk. With Y adding secondary procedures more beneficiaries had these conditions treated in hospitals rather than in a clinical setting. Built into GSHIS was the idea of freedom to choose where you want to be treated. The problem is that procedures cost more in hospitals than clinical settings so the overall cost of healthcare increases in a manner that isn't sustainable at the level of procedures that need to be done in India.

Provider Empanelment and Claims Processing

In order to become empanelled a hospital must meet certain requirements set out by the insurance scheme. In the VA plan each hospital needs to have fifty beds, a well-equipped operation theater, a post-op ventilation room, and lab/radiology departments available at a moment's notice. In the Y scheme the requirements are twenty-five beds, three ICU beds, and specialists for the specific procedures performed there. Empanelment is normally a method of quality control and at the time of the World Bank document's publication it was the only quality assurance method that either scheme used. Y publishes guidelines for hospitals but neither plan gives any explicit standards to follow. VA has issued aspirational statements around forming quality assurance methods, but nothing has been done up to this point. While looking at both plans we can see a different use of empanelment criteria.

In Y we see empanelment being used as a method to increase the capabilities of underdeveloped hospitals in rural areas. In Y there are many providers who are empanelled even though they do not meet the empanelment criteria. A less than adequate facility is forgiven so that the hospital may be included in network.

Compounded with the fact that Y only removes providers from the network for egregious offenses, empanelment is not being used as a strict quality audit system.

Y is empanelling these providers without even expecting them to perform procedures but instead are using empanelment to improve provider quality and capacity. Out of the 543 empanelled hospitals 141 haven't presented any claims (La Forgia 2012, 259). On top of this a provider survey showed that 75% of empaneled hospitals significantly expanded their facilities post-empanelment (La Forgia 2012, 259-260). It would be easy to assume that the quarter of hospitals not presenting claims are also the quarter not expanding but this ignores other factors. First, the major top twenty hospitals in the plan, especially those located in Bangalore, most likely had no need to expand once within network. Second, there are thirty public hospitals empaneled in the plan whose expansions are based upon government grants and would not have been effected by empanelment. With all these factors combined we can say that many underqualified hospitals expanded their facilities in reaction to empanelment even though they received no new patients/revenue. While there are no formal contracts around this, a hospital agreeing to be a part of Y's network changes their attitude towards quality. The assumption of network status brings along not just a document describing basic guidelines but also a reputation change. While the plan most likely could enforce its empanelment requirements instead it uses these standards as a way of encouraging hospitals to change. Here power is being expressed through network identification and not hard control measures.

VA shows us the opposite of this in its traditional use of empanelment criteria. The providers in VA's network must reach the quality criteria before being empanelled. This led to the spatial result of provider centralization. When first established, out of the

ninety-four providers empanelled only nineteen were in the original rollout region of the plan. The best hospitals are located in the urban centers and not in rural areas so this could be expected when covering the rural poor. The problem is that strict measures of control did not alleviate this spatial problem (La Forgia 2012, 337-338 and 341). On top of this the VA plan offers a transportation reimbursement which only encourages individuals to use the providers with the best reputation (and highest cost). This furthers the quality gap between providers in urban areas and providers in rural areas. We can note how the form of power being expressed also changes the setting where power operates.

Once procedures have been performed by a provider it goes into the claims process through which providers are reimbursed.

In the VA system claims processing is still done through paperwork originating in the hospital. The arogyamithras are mostly in the hospitals to help with the preauthorization process and to assist with final documentation. The responsibility for completeness of claims paperwork lies with the provider. Once completed the paperwork is sent to the TPA who checks it, then they finally head to SAST who approves or declines the submission. Due to the travel of the documents and questions surrounding completeness this process can take much longer than the 2-3 week period the trust expected (La Forgia 2012, 338). The involvement of arogyamithras is intended to reduce false claims but also extends the length of time processing claims takes.. Again the method of direct control provides more security but can make processes not work as quickly/efficiently.

In contrast to the focus on security, the Y scheme has introduced a new system relying on providers quick submissions through IT systems. In Y, once a provider is

empanelled they have the choice of connecting to an online claims submission system owned and operated by the TPA. It is very important that Y left the new technology open as a choice. 191 network hospitals chose to connect to the software (La Forgia 2012, 261) and this helped create a new definition of timely.

When providers decided to join the network it increased the speed in which they were able to process claims submissions. Because such a large number of individual providers improved their claim submissions speed, the average and the standard for all providers rose. The majority of providers had quick claims submission times and this became a new norm/expectation. When the utilization of this new software seen Y started to apply fees (a percentage of total claim amount) when providers were late in submitting claims. If the claim is submitted 30-59 days after performance there is a 10% reduction, from 60-90 it is 30%. Overall this method has been successful at speeding up submissions and 90% of claims are submitted in less than 45 days (La Forgia 2012, 262).

The key to this change is that the figures are based upon a definition of timeliness created from the majority of providers who are using the IT system. A problem arises with providers having the freedom to choose. Once providers choose to not participate they still must face the same fee structure as the majority who chose to utilize the software. Many empanelled public hospitals chose not to enter the IT system. Public hospitals traditionally rival the private sector so it is expected that they will work against the norm. It is important that they have behaved in resistance. On the other hand, many small providers in rural areas have no real choice to participate in the system because of a lack of consistent internet access. Now they will be punished because they can't submit claims as quick as the more wired hospitals. Developing fee structures and trends based

on the majority of providers contradicts the efforts we previously saw towards improving the quality of rural hospitals through the empanelment process.

In this section we can see the effects of changing dispositions can be capitalized upon or ignored. To see this let's look at the two examples: First, how enforcing empanelment criteria which changes quality. Second, how new technology changed the definition of timeliness and the related fee structure.

By not enforcing their empanelment criteria, Y leaves a space open for providers to take on the responsibility of monitoring their own quality standards in comparison to the expectations held of empanelled Y providers. This in effect is the plan transferring a mentality to the providers. It can be said that it has been effective at expanding the capacities rural hospitals using governmentality.

In contrast to VA monitoring processing in a disciplinary fashion, Y gives providers the freedom to process how they choose. Interestingly, many providers chose to take part and this started to become the norm. At that point Y added the fee which can be interpreted as an attempt toward security. Providers had the freedom to choose the slowest processing method if they wanted to, but now while there is the appearance of total freedom there is also a fee structure providing the scheme security from late processing. Many providers took on the mentality being offered in the new online system and then Y was able to capitalize on this new mentality of providers who took on the framework of Y's governmentality. There is a problem though. The application for security endangers the governmentality that had developed in regards to quality expansion. Providers that expanded facilities because they were a part of Y's network might be alienated by the new few structure. Some of these providers may not have the

adequate internet access for faster claims processing. Here security counteracts a productive disposition.

Impact Evaluations

In order for insurance schemes to be sure they are actually alleviating the burden of health problems on the poor they need to run impact evaluations. The VA plan has had plans since the original rollout to do a full run of different evaluations but as of 2012 (the date of the World Bank document's publication) it had not yet been able to do so. The Y plan on the other hand has no plans to run evaluations. Instead Y expects all research to be donor driven. When a study needs to be done they rely on a donor to finance/operate it. This is most likely not a passive process and the plan probably actively seeks to involve another actor into their overall scheme. Y relies on the idea of public private partnerships in order to accomplish research. Because of this only two evaluations have been done in the twelve years since the plan began. On the other hand, VA seeks to do research within their own capacities and has managed to do none so far (La Forgia 2012, 343). While VA is still a young scheme it will take time to build up the capacity to accomplish this research.

Impact evaluation funding can show us how these power systems work once plans have reached the edge of their capacities. Y relies upon an expectation that research will be done. VA claims that is will perform the research itself. In this case VA's direct approach fails them. Research like impact evaluations are not cheap or easy to run and so far it seems like VA lacks the ability to perform them. While two evaluations is not that many for the amount of time Y has been operating, it is still more than Y might have been able to accomplish if it had sought out research on its own. These tasks that go beyond daily operating expenses are important, but generally hard to finance.

With its use of expectations Y has managed to shift the responsibility of this work to other actors. Others have taken on the mentality that research is important and that it ought to be done. In this case governmentality in the Indian context has managed to expand what the scheme can accomplish.

Conclusion

Through these six aspects of the insurance mechanism, we have seen VA and Y operate as distinct forms of power. VA has related to its stakeholders through discipline; Y has related to its stakeholders through governmentality. By reading the two schemes this way, we can see new things about who can govern, where truth is produced, and how these specific forms of power are creating risk. By highlighting these changes we can also forecast the viability of these two power relations (and the insurance mechanisms that represent them) in the context of India.

In Karnataka the opportunity for governance is opening up and more actors are taking on this responsibility. We have seen that Y includes other actors into their framework in order to spread the cost of work. This has given others the place of governance both in goal setting and in deciding where research ought to be done. Even in the VA scheme, whose disciplinary relations work to centralize, there has been an expansion of governance. With differential rate setting of treatment packages providers in the VA network are open to choose whatever forms of procedure they wish to pursue, and this changes which parts of the population benefit. In this way the providers are also governing. In both schemes we can see the spread of who gets to make decisions expanding.

The site of knowledge production is also shifting. We saw a split between the schemes in regards to population creation. Y used the market to connect to their population by making their scheme an economic choice. The exchange of premium cost created a sort of market truth. VA instead linked through institutional truth by naming their population with the BPL statistic. Through pricing we also saw this same split. Y made prices as a percentage from the normal price, a supposed market truth. VA made prices through institutional committees naming prices. Also with VA's pricing we saw that the providers interacting with VA did not share the committee made valuation and operated more from a market frame. The providers chose the procedures that had the most economic benefit for themselves (which had negative implications for the scheme's operation). So while there are still different methods of truth production operating we can start to observe, through both schemes located in Karnataka, a shift towards the dominance of 'market truth'.

Finally we have also seen how each scheme is facing a sort of risk. We see risk associated with freedom. The relations of freedom through which Y operates open the space of risk. We saw this through the market created population failing to properly behave in the identification process. Also we saw that when Y created an apparatus of security to ensure quick claims processing, it put at risk a previous effort towards expanding rural providers. Where Y creates risk through the misapplication of freedoms, VA instead faces risk by not responding to a changing context. In regards to treatment package pricing the providers seem to be bankrupting the system by operating from a different mentality. We also saw the tight controls of VA furthering the problem of geographical provider centralization. Finally, through impact evaluations we

saw that VA does not have the capacity to run the necessary tests which they need to do in order to retain political support.

Governance, truth, and risk all are pressing change.[4] We can look at these changes as differences in the field of knowledge/power that exists in Karnataka. VA exemplifies a disciplinary mechanism that is now facing the pressure of change. The ability for others to govern is questioning disciplinary centralization, and the market-produced truth is shifting the behavior of those with which the VA must interact. Y exemplifies the entry of a new form of power relation, neoliberal governmentality relations, which are facing the challenge of context in Karnataka. Typical operations through freedom are questioned by the resistance of the population and the cost burden that follows. Neither form of power adequately fits the changing environment.

I predict that the pressures from the context of India will create a novel form of power relation. We currently can look at the VA and Y schemes as exemplary of western forms of power, discipline and governmentality. The insurance mechanism was developed in the West, but is now being applied in the Indian context. I have shown that these mechanisms and forms of power do not fit the current context. Instead, a new form of power that reflects both the truth and governance in Indian contexts will need to be created.

[4] I am examining governance, truth, and risk because they were evidenced differences within the two schemes structures. The context of India is changing in many other ways that will also press change, but these were the main differences evident between Y and VA.

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