

Expanding health care services for poor populations in developing countries

*Exploring India's RSBY national health
insurance programme for low-income groups*

Amrit Kaur Virk
St. Catherine's College
Hilary Term, 2013



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EXPANDING HEALTH CARE SERVICES FOR POOR POPULATIONS IN DEVELOPING COUNTRIES

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ABSTRACT

Health is deemed central to a nation's development. Accordingly, health care reform and expansion are key policy priorities in developing countries. Many such nations are now testing various methods of funding and delivering health care to local disadvantaged populations. Similarly, India launched the Rashtriya Swasthya Bima Yojana (RSBY) national health insurance programme for low-income groups in 2008. The RSBY intends preventing catastrophic health-related expenditure by improving recipients' access to hospital-based care.

This thesis is an in-depth qualitative evaluation of the RSBY in Delhi state. It examines the RSBY's effectiveness in fulfilling its goals and meeting local health care needs. Walt and Gilson's (1994) actors-content-process-context model informs the research design and an actor-centred "responsive" (Stake 1975) or "constructivist" approach guides data analysis.

Three research questions are examined: (i). Why was a health insurance programme launched and why now? Why was this model favoured over alternate methods of service expansion? (ii). Is the RSBY delivered as intended? If not, why? (iii) How does the RSBY affect patients' access to services?

The findings are based on documentary sources, observation of implementation sites and activities and 164 semi-structured interviews with RSBY policymakers, insurers, NGOs, doctors, and patients.

The results show improved access to curative and surgical care for RSBY patients. However, RSBY's focus on hospitalisation and omission of primary and outpatient services had undesired negative effects. The lack of ambulatory facilities led RSBY patients to self-medicate or use dubious quality informal providers. By only allowing inpatient care, the RSBY also seemingly encouraged the substitution of outpatient care with costlier hospitalisations. In effect, the RSBY's design contributed to cost increases and poor patient outcomes.

While more funds and human resources were needed to improve RSBY implementation, the performance of frontline agencies could potentially improve through more stable, longer-term contracts. Similarly, modifying RSBY's monetary incentives for doctors may lead to better service delivery by them.

By evaluating the RSBY's strong points and shortcomings, this thesis provides key lessons on strengthening policy design and health service delivery in developing countries. Thereby, it makes a broader contribution to understanding the determinants of successful policymaking.

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LIST OF ABBREVIATIONS

APL	Above Poverty Line
BPL	Below Poverty Line
CGHS	Central Government Health Scheme
CT SCAN	Computed Tomography (CT) scan, a medical imaging procedure
ESIS	Employees' State Insurance Scheme
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit, German Technical Cooperation
HLEG	High-Level Expert Group for Universal Health Coverage
ICU	Intensive Care Unit
IEC	Information, Education, and Communication
ILO	International Labour Organization
INR	Indian National Rupee
JSY	Janani Suraksha Yojana
LMIC	Low-and Middle-Income Countries
MoHFW	Ministry of Health and Family Welfare
MoLE	Ministry of Labour and Employment
NCEUS	National Commission for Enterprises in the Unorganized Sector
NCMH	National Commission on Macroeconomics and Health
NGO	Nongovernmental Organisation
NRHM	National Rural Health Mission
NSSO	National Sample Survey Organization
OECD	Organization for Economic Co-Operation and Development
OOP	Out-of-pocket expenditure
OPD	Out Patient Department
PHC	Primary Health Centre
RSBY	Rashtriya Swasthya Bima Yojana
SHI	Social Health Insurance
TPA	Third Party Administrator
UHC	Universal Health Coverage
UHS	Universal Health Insurance Scheme
UPA	United Progressive Alliance
US\$/ \$	U.S. Dollar; Conversion rate used for data in Indian Rupees: US\$1 = INR 50 (all \$ in the text refer to the U.S. Dollar)
WHO	World Health Organization

Chapter 1: Introduction

HEALTH IN A DEVELOPMENT CONTEXT

In recent years, health and health care reforms have come to occupy a high profile on the policy agendas of governments in developing countries as well as the international development community (African Development Bank 2012; PMA Conference 2012; WHO 2012b). Addressing the World Health Assembly of all member states of the World Health Organization (WHO) in 2012, the organisation's Director-General, Margaret Chan, observed that the past decade was a "golden age for health development" with governments coming to realise that health was not a "drain on resources...(but) a driver of socioeconomic progress"(Chan 2012). Earlier, influential publications by the World Bank and the WHO Commission on Macroeconomics and Health, establishing the importance of health for the long-term economic development of nations, were important in paving the way for the emergence of health as a top policy priority world-wide (Commission on Macroeconomics and Health. 2001; World Bank 1993).

The need for global intervention in health is further established in the context of growing evidence on the vast health inequities that exist between rich and poor nations and among populations within these countries. To cite just a few examples: a shocking 99% of all maternal deaths are reported to occur in developing countries (WHO 2012a); well over 80% of all children dying before their fifth birthday are likely to belong to Sub-Saharan Africa and South Asia (UNICEF 2012). Furthermore, about one billion people globally are estimated to

lack access to health care and 100 million are apparently pushed below the poverty line each year by paying directly for medical services (PMA Conference 2012). There are also numerous statistics that reveal striking disparities within regions, underlining the fact that the poorest in all countries are often the worst affected in terms of their access to services and physical and mental well-being (Reid 2011; Waldron 2007). The data shows, for instance, that globally the wealthiest 20% of women are up to 20 times more likely than the bottom quintile to have skilled birth attendance. Moreover, belonging to the poorest 20% of the population, doubles the risk of a child dying before the age of 5 as compared to one from among the richest households (WHO 2012a). Well-known problems such as their lack of resources, limited knowledge and distance from health facilities are often core contributing factors which prevent the poorest groups from accessing health care when they need it most (Bhattacharyya et al. 2010).

In this context, expanding health care for the poor and instituting a universal health system is increasingly favoured by the global health community. Of late, universal health coverage (UHC) features as a particularly prominent topic in global dialogues and declarations by key health policy figures (Chan 2012; Ministers of the East African Community 2012; UNGA 2012). Defined as all individuals having access to good quality health care without impoverishing medical costs (WHO 2005; WHO 2010), universal health coverage is, therefore, being pushed forward as a vehicle for “sustainable growth, social cohesion and population well-being” (WHO 2012b).

Given its positive association with economic progress and productivity, the idea of UHC has both pragmatic and moral appeal for developing countries with

high levels of socio-economic deprivation. However, a central concern for many governments in the global South is about how they can address existing gaps in health care provisioning and extend services for historically underserved populations. On its part, the global health community recognises that “effective health systems delivering comprehensive health services” and “based on equitable and sustainable financing” are an important means for advancing towards UHC (UNGA 2011). Led by the WHO, global advocates are increasingly calling upon governments in developing countries to create health systems where people can access services that are mostly free at the point-of-delivery and to devise mechanisms for advance payments for health care and risk pooling in order to prevent catastrophic¹ personal spending on health (UNGA 2012; World Bank 2013b; WHO 2010). This also marks an important shift in health financing debates from earlier in the 1980s and 1990s when powerful organisations like the World Bank and the International Monetary Fund (IMF) recommended cost recovery plans and user fees for public facilities in low-and middle-income countries (Akin et al. 1987).

Against this background, a variety of government-sponsored health programmes for the poor have emerged across large parts of the developing world. In fact, some middle-income countries like Brazil, Mexico, and Thailand have achieved or are close to reaching near total population coverage through various State-led initiatives (Joint Learning Network 2013c; Lagomarsino et al. 2012). According to some analysts, however, the labelling of many such schemes under the rubric of “health insurance” can be misleading when programmes for

¹ After basic needs have been met, spending more than 40% of household income directly on health care (WHO 2010, p.5).

the poor are largely funded through public taxation and may also conceal local innovations that can inform reforms elsewhere (Kutzin 2012; McIntyre et al. 2010). Most developing countries are indeed experimenting with novel ways of financing and delivering health services alongside more common and conventional methods such as funding through general taxation, user fees, and insurance contributions or delivering services through traditional State-run public providers. For example, in conjunction with general revenue transfers and payroll taxes, 75% of funding for Ghana's National Health Insurance Scheme (NHIS) comes from a new VAT² levy it introduced for the purpose (P4H 2013). Similarly, Gabon generated \$25 million in 2009 to fund health care for its non-insured population through a levy on mobile phone companies (Stenberg et al. 2010). Nations are also experimenting with decentralised institutional arrangements to manage new programmes, moving away from the traditional reliance on national Health Ministries to run all health initiatives. For example, some governments like those in Kenya and Cambodia have set up independent funds managed by public primary health facilities and nongovernmental organisations (NGOs) to run health care programmes for their poorest and most vulnerable individuals (Gandham et al. 2013; Giedion et al. 2013). Countries are also trying out new methods of demand side financing of health services, essentially directing funds to health care providers based on the individual preferences of patients rather than through traditional budgeted transfers to public facilities. Hence, individual country programmes provide a rich array of different approaches and programme designs. Yet common to many such initiatives is their inventive use of mixed sources of

² Value-Added Taxes.

financing (general State revenues and payroll taxes) (World Bank 2013b). This is further explored in Chapter 2.

THE SCHEME: RASHTRIYA SWASTHYA BIMA

YOJANA (RSBY)

One such “hybrid” government-sponsored health programmes to emerge recently is the Rashtriya Swasthya Bima Yojana (RSBY) or National Health Insurance Programme for people below the poverty line (BPL) in India.

India is a lower-middle income country in South Asia with one of the highest levels of out-of-pocket (OOP) health spending by patients worldwide (Van Doorslaer et al. 2007). Such direct payments by users at the point-of-use account for nearly 70% of total health expenditure in the country (NHA 2009). Each year, treatment costs push an estimated 60 million Indians into poverty (Berman et al. 2010). Besides finances, there are other huge barriers to accessing good quality care including the availability and responsiveness of medical suppliers in the country (MoHFW 2012). To address such challenges, the central government in India introduced the RSBY, which as mentioned, is a publicly funded national health insurance scheme for the poor. Launched in 2008, the main goal of the RSBY is to prevent catastrophic health spending by enabling better access to hospital-based treatments for recipients of the programme (MoLE 2013). The RSBY was part of wider efforts by the national government to provide social protection to over 300 million Indians in informal employment (Government of India 2008b) and through them offer health coverage to dependent family members.

The RSBY is a unique initiative in public financing for health in India, where governments have traditionally funded a State-run health service through fixed budgets. Instead, by routing public funds through patients onto multiple public and private medical providers, essentially creating a demand-led financing model, the RSBY correspondingly brings about some changes in existing health care arrangements. Furthermore, given that only about a tenth of the country's population was covered by some form of organised health insurance in 2007 (Planning Commission 2008b), a programme like the RSBY is an unprecedented effort to mainstream health insurance nation-wide to 60 million poor households in India (MoLE 2013). In this context, it becomes important to evaluate the RSBY and assess its role in improving health care provisioning in India.

However, as a relatively new programme, there is generally limited empirical evidence on the RSBY's performance both in terms of formal evaluations (for e.g. Amicus Advisory Private Limited 2010; Mott McDonald 2011; The Research Institute 2012; Westat India Social Sciences 2010) and independent research (for e.g. Nandi et al. 2012; Rajasekhar et al. 2011; Seshadri et al. 2012). Furthermore, many of these are quantitative evaluations to test users' awareness about the RSBY, their enrolment and utilisation patterns or assessments of service quality through facility-based surveys. There are comparatively few qualitative assessments of implementation and health care delivery and even fewer of users' experiences in the programme. Moreover, even studies with a qualitative component sometimes do not make these results explicit, focussing instead on the numerical measures of patients' access or satisfaction with services. While producing important information on the programme's functioning, few studies provide a holistic lens on the RSBY. The paucity of research on the programme

thus makes it important to qualitatively and comprehensively evaluate the RSBY. Furthermore, given the variety of approaches for expanding health care to the poor in developing countries, investigating the RSBY provides an opportunity to learn about the distinctive features of this new initiative and consider its applicability to other low-income contexts.

Goals and intentions of the RSBY

The RSBY is a federal health insurance programme for informal workers and their families in India who are officially below the poverty line (BPL). The national Planning Commission estimates the total number of BPL people in a state based on a national socio-economic survey of households, which also takes into account annual inflation rates³ (Planning Commission 2013a). Meanwhile, the central Ministry of Rural Development conducts periodic surveys in each state to identify BPL individuals to target for specific welfare benefits⁴ (MoRD 2013). However, the identification of the poor is often done in a way as to not exceed the total BPL population in a state as determined by the Planning Commission. The primary objective of the RSBY is to “provide protection to BPL households from financial liabilities arising out of health shocks that involve hospitalization” (MoLE 2013). According to the RSBY website, “a health insurance which shares the risk of a major health shock across many households by pooling them together...may both

³ Not surprisingly, there are passionate debates on BPL numbers in India considering the fact that large gaps in provision may be occurring as a result of such methodology (Alkire & Seth 2013; Drèze & Khera 2010; Mahamallik & Sahu 2011; Ram et al. 2009; Roy 2011).

⁴ Currently, there are no equivalent criteria for estimating the poor in urban India (Planning Commission 2012). As a result, states normally have their own parameters for identifying the urban poor. In Delhi, for example, the state administration in 2001 had rather arbitrarily decided to give slum-dwellers with self-declared incomes below INR 24,200 (\$504) BPL status (Government of Delhi 2002). Moreover, as in the case of Delhi, there are infrequent estimations of the poor in the state. Therefore, old BPL lists are often the basis for targeting welfare benefits to local underserved populations. This background is particularly pertinent to this thesis because it was conducted in primarily urban Delhi.

increase access to health care and...improve its quality over time” (ibid.). The RSBY, therefore, mainly intends preventing health-related impoverishment by offering its members secondary level curative care at hospitals.

The Congress Party-led United Progressive Alliance (UPA) that launched the RSBY in April 2008 initially planned for it to run for five years. By 2013, the programme aimed to cover an estimated 300 million BPL individuals or about 60 million families. However, the RSBY’s tenure was recently extended until 2017 (Planning Commission 2013b). Furthermore, the central government has also gradually extended the RSBY to other non-poor workers in low-paid jobs including building and construction workers, street vendors and domestic workers; with fresh plans to cover additional occupational groups such as taxi drivers, sanitation workers, rag pickers and mine workers (PIB 2013b). Various declarations by key government Ministers highlight the RSBY’s “success” (PIB 2008), “immense popularity” (PMO 2012a) and its emergence as an “effective instrument for providing a basic health cover to poor and marginal workers” (PIB 2011b) as the basis for opening out the scheme to other unorganised workers. Official documents also indicate that the Labour Ministry managing the RSBY always intended to “extend the social security measures to all segments of the society” and “the gradual stabilization of RSBY and (its) technology” had allowed the government to expand it to other poor and marginal workers (PIB 2008). Revealing the RSBY’s revised coverage targets, the country’s (now former) President in her address to Parliament in 2012 noted that the RSBY’s term was being extended (beyond its original run until 2013) with an expectation that it would reach 70 million households by the end of 2017 (PMO 2012a, p.6).

Key features of the RSBY: funding, service delivery and coverage

Per capita insurance contributions are publicly funded from the general revenues of the State⁵: the national government pays 75% of the premium and state governments contribute the remaining quarter. While sharing RSBY expenditure with local states, the central administration is obliged to pay premiums only up to a maximum limit of INR 565 (about \$11) per family. Therefore, state governments will need to cover any extra charges were insurance premiums to rise beyond this amount. RSBY recipients are exempted from paying insurance contributions. However, they must pay an annual enrolment fee of INR 30 (about 60 cents) to cover administrative costs of registration. Except this enrolment charge, all other payments whether to the insurer or to RSBY hospitals are retrospectively paid based on the actual number of enrolments or treatments.

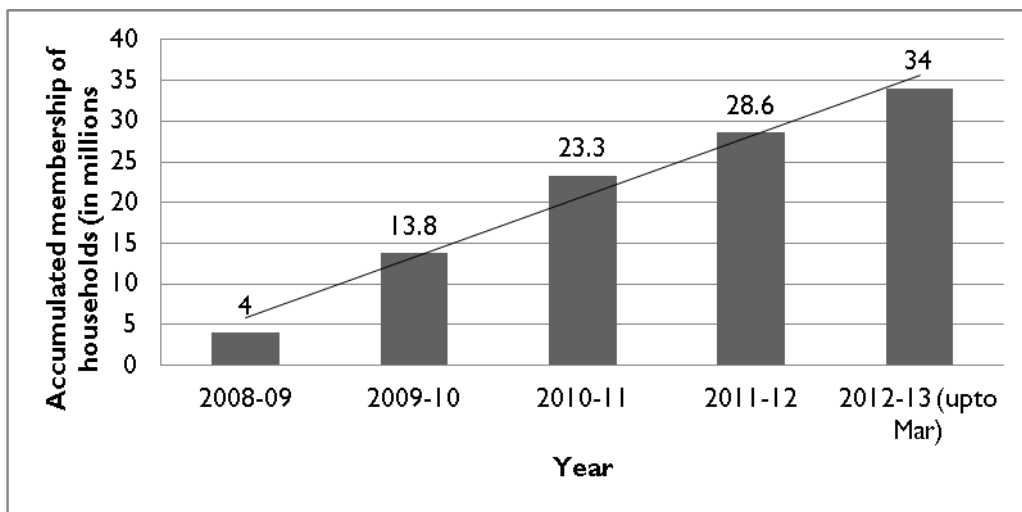
In addition to the main benefit recipient, up to (but no more than) four other family members can join the RSBY. Age or pre-existing illnesses are not taken into account for RSBY membership. In terms of what the RSBY offers, enrolled families are entitled to hospital-based treatments worth a maximum of INR 30,000 (about \$600) per year at all participating hospitals; unspent balances cannot be carried onto the next year. It is important to note that RSBY coverage runs out each year unless a household renews its membership. The programme currently lists over a thousand inpatient and surgical procedures that members can be treated for in any participating hospital (further details in Appendix D). At present, there are nearly 12,000 hospitals that are part of the RSBY; over two-thirds of them are private-sector facilities (MoLE 2013). Primary and outpatient

⁵ In the text, “State” refers to the national government, while provincial governments are denoted by lower case letters as “state”.

services are currently not offered to RSBY patients, although pilot programmes to provide outpatient care are ongoing in a handful of districts (RSBY 2011a).

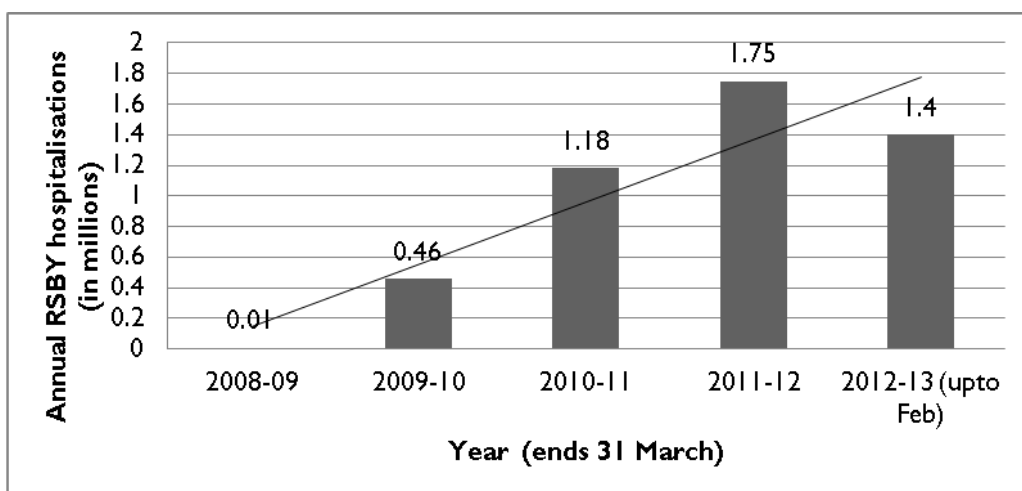
According to recent data, about 34 million families were part of the programme until March 2013 (Figure 1) and nearly 5 million hospitalisations have taken place since the RSBY began in 2008 (Figure 2) (MoLE 2013).

Figure 1: RSBY enrolment, 2008-13



Source: Ministry of Labour and Employment (MoLE, 2013)

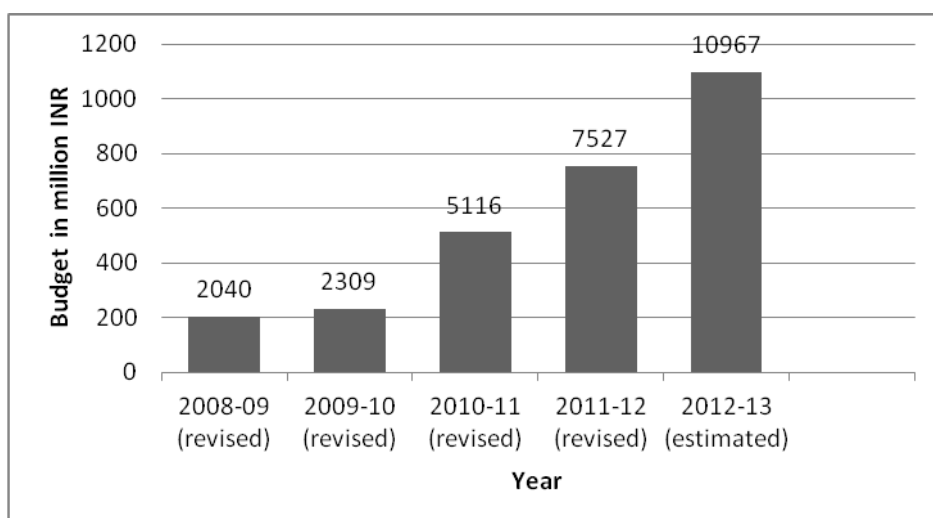
Figure 2: Annual RSBY hospital utilisation, 2008-13



Source: Ministry of Labour and Employment (MoLE, 2013)

As Figure 3 below shows, the federal government's funds for the RSBY (three-quarters of the programme's total financing) have consistently risen, year on year. Yet, most times the Labour Ministry has overspent the annual funds allocated to it and, therefore, has had to ask for additional top-ups from central finances (MoLE 2012a). In 2012, having exhausted its resources just halfway through implementing the RSBY, the Ministry apparently had to delay payments to insurance companies as it awaited contingency funds from the centre (The Economic Times 2012). Labour Ministry documents indicate that this was partly to do with the RSBY's expansion to additional groups of workers (MoLE 2012a). However, based on the total BPL population in the country and average RSBY premium rates, a recent study estimates that central government allocations to the programme are likely to be insufficient to cover all those individuals below the poverty line (Dror & Vellakkal 2012; Ministry of Finance 2012). There are also serious financial implications for the RSBY now that the programme has been extended to many more low-income earners who may not be BPL. Available policy documents show that except building and construction workers (and more recently railway workers) for whom RSBY contributions will be funded by worker welfare funds, existing RSBY budgets will need to cover the premiums for many of these additional target groups (PIB 2011a; RSBY 2011b).

Figure 3: RSBY central allocations (2008-2013)



Data source: Ministry of Labour & Employment/Press Information Bureau

How is the RSBY run?

The central Ministry of Labour and Employment (MoLE) receives an annual budget from general government revenues to manage the RSBY nationally. Although a federal government programme, RSBY administration is decentralised to local state governments. Through a periodic competitive tendering process mainly judged on price, state governments will normally contract the insurance company with the lowest bid to run the RSBY locally. There are currently 15 public and private sector insurance companies working on the RSBY across 28 of India's 35 states and union territories and encompassing 486 districts (of the country's 629) (PIB 2013a).

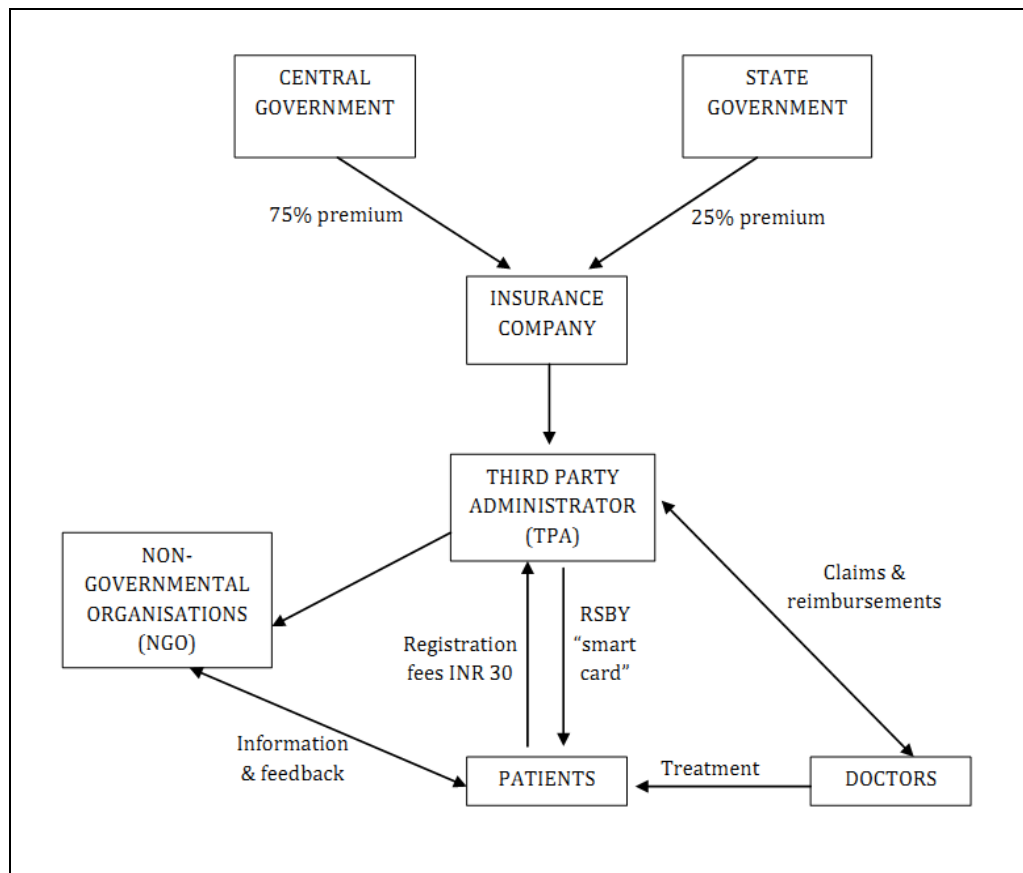
RSBY insurance premiums are determined at the state or district level and are based on some form of community rating. Premiums often vary significantly between states and across districts, normally ranging from INR 224 (approx. \$4.5)

to INR 745 (approx. \$14.5) (PIB 2013a). RSBY policy, however, does stipulate that the charge per family should not exceed INR 750 (\$15).

RSBY policy also urges private companies to engage local non-governmental organisations (NGOs) and community organisations to help liaison with poor families and mobilise them to join the programme (MoLE 2012d). In some states like Delhi, the insurance company hires an intermediary agency or third party administrator (TPA) to run the RSBY: enrol families, set up a network of hospitals, manage transaction records, and settle financial claims.

The RSBY is structured as a classic money-follows-patient model where individual patients are (in principle) free to attend any RSBY hospital of their choice. Policy documents assert that RSBY's demand-led financing will stimulate medical providers to deliver better quality care in their bid for more clients (MoLE 2013). Participating hospitals will have agreed to treat RSBY patients at fixed rates set by state-level authorities for which they are paid retrospectively by the insurer (RSBY 2012b). Normally, doctors are paid a per-diem allowance of INR 500 (\$10) for non-surgical treatments, with the rate going up to INR 1000 (\$20) for intensive care treatments and different package rates for individual surgeries. Figure 4 below presents a graphical representation of the main actors and their roles in the RSBY.

Figure 4: Key actors and processes in the RSBY



In order to enrol people, insurance companies/TPAs normally set up temporary stations at key locations like local schools and NGO offices. The Labour Ministry supplies them the lists of eligible individuals within each district. In principle, a state-appointed agent needs to be available through the course of enrolment to verify through documentary evidence that applicants belong to RSBY lists. Once their details are verified, each family is issued an ATM-like, RSBY “smartcard” which contains their biometric details. This makes the RSBY a cashless operation from patients’ point of view, meaning that technically they only need to swipe their card at a participating hospital in order to get treatment.

AIM AND CONTRIBUTION OF THESIS

This thesis evaluates the RSBY in India with the aim of developing better understanding about both, the scheme itself as well as State-sponsored health programmes for the poor in developing countries more generally. It adopts a holistic approach to assess the RSBY and accordingly there are two aspects to the study. First, it assesses the RSBY's initial performance against its stated goals of providing greater financial protection and better access to hospital treatments for its members; focussing particularly on the latter. Secondly, this thesis examines the role of the RSBY more broadly, in terms of whether the programme delivers good quality health care to its recipients based on their essential needs and if it generally results in more effective service delivery. It does this in order to consider how well the programme's objectives relate to wider health system outcomes and goals including equity, quality, efficiency, effectiveness, and consumer satisfaction (Atun & Menabde 2008; Hsiao 2003; McPake & Kutzin 1997). This information is likely to be useful for assessing the transferability of the RSBY to other developing country contexts.

A holistic view of evaluation also guides the qualitative and pluralistic methods of this research. It is designed accordingly as a case study of the RSBY in Delhi state in India and uses in depth interviews with its various stakeholders in order to explore the programme from its conception through to its implementation and delivery of treatments to patients.

Through this research, the thesis intends contributing to existing health policy research and theory in three important ways. First, it seeks to develop an

evidence base on the RSBY to improve the programme and its practice. To my knowledge, no published research so far has systematically documented the antecedents and early history of the RSBY. In tracing the programme's origins, this study paves the way for more robust evaluation of its goals and intentions. Moreover, as mentioned earlier, most current assessments of the RSBY focus on a limited number of measurable outcomes to gather numerical information on service quality and patient satisfaction. This thesis, therefore, hopes to provide a more comprehensive evaluation of the RSBY in terms of the range of issues it explores with multiple stakeholders in the programme. These include RSBY policymakers, administrators, medical professionals, and patients. Secondly, this thesis will add to emerging research on government efforts in developing countries to expand health care to their poor and under-served populations (The Lancet 2011; The Lancet 2012; Joint Learning Network 2013c; UNGA 2012; World Bank 2013b). In this respect, this study intends identifying elements of good policy design that can improve patients' access to services. It will also generate evidence on the challenges and barriers to effective implementation and service delivery. Thirdly and finally, through its examination of the structures and dynamics of RSBY policymaking and implementation, this study will add to the wider policy analysis literature by bringing to it the unique perspective from a developing country (Gough & Wood 2004; Horowitz 1989; Mooij 2003; Rudra 2007; Thomas & Grindle 1990; Walt & Gilson 1994).

Key terms and definitions

Social health insurance

It is important to reflect on the meaning of the term “health insurance” as the RSBY is a publicly sponsored programme of health insurance as are several other initiatives for the poor in developing countries. The health economics literature generally refers to health insurance as a system of advance payments for health care where funds are pooled together and used to underwrite treatment costs for contributors (Culyer 2008; Black et al. 2009). Outside the United States, most developed countries are believed to provide health insurance universally to their populations although using different methods of raising funds and delivering services (Cutler & Zeckhauser 2000). Health care systems in a European context are commonly classified as either tax-funded national health services (NHS) or as social health insurance (SHI) systems funded through payroll taxes (Freeman 1998; OECD 1994).

In this thesis, health insurance refers specifically to SHI, regarding it as a distinct mechanism of public financing of health care. The term is thus distinguished from a tax-financed health system. A distinction is drawn because extensive research shows that organising health systems as either tax-based NHS or as contributory SHI is likely to have different implications for the equity, efficiency and quality of service delivery (Freeman 1998; Mossialos et al. 2002; Oliver & Mossialos 2005; Van der Zee & Kroneman 2007). While Chapter 2 explores these differences in detail, it may be helpful to briefly outline here the connotations of SHI as a method of financing health care. SHI systems are normally funded through compulsory, wage-linked contributions into a common pool with

State revenues providing top-up coverage for those outside employment or less-affluent groups (Normand & Busse 2002). In other words, coverage under SHI is mostly tied to employment status although the State redistributes funds for the uninsured, thereby ensuring universal access to an explicit package of health benefits (Saltman et al. 2004). Delivery arrangements are often pluralistic involving multiple public and private providers (Hsiao & Shaw 2007). NHS systems also provide universal coverage but are normally funded by government tax revenues, although these may be general income taxes, sales tax, local taxes, VAT, or another form of taxation.

In order to assess the RSBY, this thesis uses standard dimensions for evaluating health systems including access, health care needs, equity, efficiency, quality and effectiveness of services (Atun & Menabde 2008; Frenk 1994; Hsiao 2003; McPake & Kutzin 1997). At the outset, it is also important to point out that this thesis explores these aspects from a social policy perspective. It is not an analysis of the above dimensions from a health economics perspective. The latter normally lends itself to a very different kind of assessment focussing for example, on numerically modelling the effects of insurance on households' health expenditures or on health care utilisation behaviours in order to study issues of access, equity, quality, and efficiency.

Access

Access is defined in many ways in the literature with researchers often emphasising different dimensions of access in terms of the physical availability of services (Mooney 1983), the actual use of services (Penchansky & Thomas 1981) or the outcomes of health care (Millman 1993). Along with multiple definitions,

there are various parameters for evaluating access to health care services including their availability, accessibility, accommodation, affordability, and acceptability (Penchansky & Thomas 1981).

In this thesis, access refers to the “timely use of health care services (by RSBY members) when needed” (Campbell et al. 2000; Peters et al. 2008). It focuses particularly on the geographical proximity of facilities, their affordability (extra charges, travel and opportunity costs), and responsiveness of medical providers (waiting time, treatment delays).

Need

The ambiguous and subjective nature of health care need often makes it a complex task to render it into a workable measure for evaluating policy (Bradshaw 1994). In defining the parameters of need in this thesis, it is firstly important to distinguish that the primary concern here is to examine “health care needs” which is a demand expressed in relation to individual ill health. It is thus distinct from a population’s “health needs” which relate to the social environments in which people live and the behavioural and material factors that impact on their health (Wilkinson & Marmot 1998). Hence, an assessment of existing public health measures and their role in improving the health of communities is beyond the purview of this thesis. Secondly, as a subjective measure, need may be determined by experts, politicians or patients themselves. Essentially, therefore, this thesis seeks to examine the nature of RSBY services and benefits in relation to local articulations of health care need. This is also referred to as the “relevance” of a health service to patients (Maxwell 1992, p.171).

Equity

In order to fully grasp the meaning of equity in health care, it may be useful to look at what its converse “inequity” implies. Hence, inequity refers to “unnecessary and avoidable” differences among individuals or groups that are perceived to be “unfair and unjust” because they are unrelated to health care need and often systematically affect lower socio-economic groups (Whitehead 1990, p.5). In this context, differences resulting from biological factors like age are not inequities and neither are situations where individuals knowingly opt to not use a benefit (LeGrand 1987). Thus, as distinct from equality which is more easily observed as distributions of resources across populations, equity is a normative concept with strong moral underpinnings (Graham 2004; LeGrand 1987; Whitehead 1990). To that extent, equity as a health policy goal does not imply erasing differences and giving everybody the same level of services regardless of need or personal circumstances. Instead, equity in health care means ensuring that differences in how resources are distributed among the population are weighted against differences in need for care.

For the purpose of evaluating policy, equity in health care may be defined in various ways including equity of access, equity in per capita financial allocations, health outcomes and so on⁶ (Mooney 1983). This thesis particularly examines equity in access and equity in service provision. Accordingly, equity in access refers to whether all those eligible for the RSBY had the opportunity to gain membership and whether its members had the opportunity to get treatment when needed. On a related note, the issue of equity in service provision explores

⁶ Other aspects of equity in health care include equality of expenditure per capita, equality of inputs per capita, equality of input for equal need, equality of utilisation for equal need (Mooney 1983).

whether RSBY services and permitted treatments were delivered to all those qualified to receive them.

Efficiency

Efficiency in health care financing typically has a technical or productive dimension that indicates an output being produced with least possible inputs (Atun 2004a; Barr 1993). In other words, a programme is technically efficient when services are delivered without wasting resources and keeping costs to minimum levels (McPake & Kutzin 1997). In a broader dimension, efficiency also refers to its allocative function in terms of investing resources in areas where they are likely to have maximum impact on health outcomes. For example, assessing how resources are distributed between primary and secondary care in relation to local health problems may be one issue to look at in order to review allocative efficiency in a programme. Similarly, the division of resources between government and private providers may be another area of enquiry for appraising allocative efficiency. Allocative efficiency may be understood more broadly to mean producing services that people want or value; in essence services that meet their required needs. Therefore, for example, products such as high-technology hospital equipment may be manufactured efficiently in cost terms but these may be services that local populations neither want nor need.

Quality and effectiveness

There are various definitions and measurements of quality in health care (Donabedian 1980; Maxwell 1992; IOM 2001). Hence, health care quality may be assessed across various dimensions including physical amenities and infrastructure, interaction between provider and patient or the clinical outcomes

of care (Andaleeb 2001). Donabedian (1966; 1988) refers to these as the structures, processes, and outcomes of service quality respectively. Furthermore, the reference point for health care quality may be at the level of individual service providers, medical facilities and hospitals, or the wider health system (Evans et al. 2001). In addition, quality of health care may be based on a technical assessment of medical procedures by clinicians or based on patients' views and their satisfaction with care (Andaleeb 2001; Campbell et al. 2000).

In this thesis, quality of services is evaluated from the perspective of the recipients of the RSBY. It focuses on non-clinical or interpersonal dimensions of quality and to some extent on the structures or physical amenities of RSBY facilities as evident from patients' narratives. Hence, it appraises whether services were responsive to clients' needs, were effective in diagnosing and conveying to patients how to manage their problem, and contributed to general user satisfaction.

Effectiveness in this thesis alludes to the extent to which the RSBY fulfils its own goals as well as the health system objectives described above. Examining the effectiveness of health care in terms of clinical outcomes was clearly outside the scope of this research.

RESEARCH QUESTIONS

In order to evaluate the RSBY, this thesis addresses three main research questions.

(i). Why did the Indian government launch a health insurance programme and why now? Why was a model of health insurance chosen over alternative ways of delivering health care to poor families in India?

This question revisits the origins of the RSBY in order to ascertain the programme's intended and implicit goals. It attempts to analyse their feasibility as well as the relevance of the goals to the local context. Accordingly, the first part of the question aims to understand the political imperatives and rationale for the RSBY and the factors that influenced the government's decision to introduce the RSBY. The second component explores the ideas and normative premises that underpin the RSBY's design and its specific benefit and delivery structures. In terms of evaluating the RSBY, this question fulfils an important purpose as it helps establish the robustness of the programme's design for meeting its stated goals. This is a vital part of the analysis as it allows one to determine if any problems emerging in the programme are to do with the way that the RSBY was designed or result from the way that it was implemented.

In order to address this question, in depth interviews were conducted with the decision-makers and formulators of the RSBY in central government, State-affiliated advisory bodies, and external aid agencies, specifically the World Bank and GTZ⁷. Policymakers were asked about the process of formulating the RSBY, the basis for its key features and organisational arrangements and their general views on the RSBY's performance. The interview guide in Appendix C at the end of the

⁷ The German government's technical agency to assist its international development efforts. GTZ became Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH in January 2011. However, it is referred to as GTZ in this thesis since that was the title it went by when this research was conducted.

thesis gives more details on the questions to policymakers. Further information on this study's research design and methodology is available in Chapter 3.

(ii). Is the RSBY being implemented and health services delivered as was intended? If not, why?

It is well-understood in policy analysis theory and practice that when policies fail to accomplish their goals or have unexpected and undesired effects, these are often traceable to their implementation (Barrett & Fudge 1981; Berman 1978; Hill & Hupe 2009; Pressman & Wildavsky 1973; World Bank 2004; WHO 2007a). Hence, this research question aims to explore the implementation climate of the RSBY. It seeks to understand if the RSBY was carried out in ways that promoted its goals and benefited its clients by improving their access to hospital treatments and protecting them from high medical costs. In order to account for the emerging outcomes from the programme, this question analyses the motivations and reported behaviours of frontline RSBY administrators and clinicians.

To address this question, in depth interviews were conducted with state-level labour and health department officials in Delhi, managers and staff at the insurance company, third party administrator (TPA) and non-governmental organisations (NGO) as well as doctors and hospital superintendents in RSBY facilities. The interviews explore managers' and doctors' views about the RSBY, barriers to implementation and their general experience of providing RSBY services. Appendix C contains the interview guide with more details on questions to RSBY administrators and doctors in Delhi.

(iii) How does the RSBY affect programme recipients and patients' access to health care services?

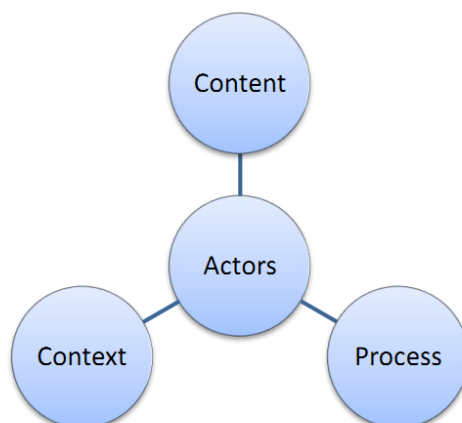
As the end-users of the RSBY, its recipients and patients are considered the best placed to evaluate its effects on them. This question explores whether RSBY membership had resulted in its recipients having greater access and choice of providers and treatments than before and whether it had improved the quality of care they received. The timing of this study, two years after the RSBY's introduction, meant a lack of reliable data to assess its role in improving health outcomes or reducing the degree of catastrophic health spending. Therefore, this research focuses on the most appropriate process indicators such as patients' access and use of services. Equally, it was feasible to collect information on patients' satisfaction with services, widely regarded as a fundamental health system goal (Atun & Menabde 2008; Frenk 1994; Hsiao 2003; WHO 2000b) and arguably central to sustaining the RSBY. Among others issues, questions to programme recipients mainly explore their experiences of enrolment and service delivery in RSBY's health facilities. The detailed interview guide for RSBY recipients is available in Appendix C.

ANALYTICAL FRAMEWORK

A particular challenge for evaluations of health programmes is that it is often difficult to unpick their precise effects on emerging outcomes, which may be shaped by various other socio-economic factors unrelated to the intervention (Wilkinson & Marmot 1998). Hence, it is important to have a robust analytical framework in order to help generate evidence that may reliably explain the results and consequences of the programme.

Two supporting conceptual frameworks guide this study's research design and data analysis approach. First, Walt and Gilson's (1994) policy analysis model comprising actors—context—content—process is broadly drawn upon to provide a holistic lens on the RSBY (Figure 5). This framework recognises that alongside the technical content of policies, actors (individuals, groups, organisations), policy processes (policymaking and implementation) as well as the wider context within which a health reform occurs all influence their impact. Moreover, it lays particular emphasis on studying the interactions between the four elements in affecting policy change, hence enabling a comprehensive analysis of the RSBY. This model and its components are expanded upon in individual chapters that provide a fuller explanation of actors, content, process and context as they relate to the RSBY.

Figure 5: Key elements of the policy analysis framework (Walt and Gilson 1994)



The second guiding framework adopted for this analysis is an actor-centred “responsive” (Stake 1975) or “constructivist” evaluation approach (Guba & Lincoln 1989). In general, responsive or constructivist evaluation calls for evaluating a programme’s effectiveness from the point of view of its various stakeholders

including policymakers, administrators, and service users. It, therefore, requires that evaluation criteria for a policy or programme be based on the “issues” raised by multiple actors in the evaluation setting (Abma 2005; Guba & Lincoln 1989; Stake 1975b). Programme evaluations conducted within a responsive or constructivist framework will evaluate a programme’s performance not only against its pre-established objectives but will also attempt to derive context specific and hence, more locally relevant benchmarks of a programme’s performance. Moreover, this framework is useful to study the interrelationships between various elements within a programme setting. This is considered an important part of programme evaluation in order to understand the effect of an intervention on wider health system goals such as improved health, financial protection and patient satisfaction (Atun 2004a; Frenk 1994).

A constructivist framework also provides systematic and useful guidance for researchers on structuring their analysis and presenting research findings. For example, as a first step in programme evaluation, results are organised based on the stakeholder group to which they belong. Evaluators are then advised to develop “consensus” between the range of “claims, concerns, and issues” raised by programme participants in order to derive broadly relevant themes, which are used to draw policy relevant conclusions. Accordingly, the three empirical chapters of the thesis are designed to look in-depth at the RSBY’s key stakeholders, the policymakers (chapters 4), its administrators and medical providers (chapters 5) and patients (chapters 6) and understand the outcomes and effects of the programme from their point of view.

There are, of course, various other programme evaluation models that are conducive to a qualitative research design. For example, “connoisseurship evaluation” involves a more subjective approach in which the evaluator makes assessments about a programme based on their own expert knowledge and personal judgement (Patton 2002, p.172). Alternatively, “utilization-focused” evaluation seeks to appraise programmes in a way that is relevant to its “primary intended users” that are likely use the information generated for specific purposes (Patton 2008). It normally involves a prior process of negotiating and identifying with select stakeholders the relevant aspects to study. In essence, an exclusive group of individuals pre-determines the framework for the evaluation in a utilization-focused evaluation. In contrast, the scope of a responsive or constructivist evaluation is broader, encompassing all stakeholders with the purpose of increasing the “usefulness of findings to persons in and around the program”(Stake 1975a). The “responsive” or “constructivist” model was the preferred analytical framework for the thesis because it aims to generate a broad-based and holistic evaluation of a programme. Hence, it is better aligned to the aims of this thesis, which are not simply to evaluate the RSBY’s performance against its own objectives but also to place it within the context of health system goals and evaluate its role in meeting patients’ needs.

THE SETTING: DELHI STATE

This thesis is a case study of the RSBY in Delhi state in India (Map1). Delhi has a unique administrative status within India’s political geography. It is partly administered by the central government as a union territory but is also officially recognised as a quasi-state with a provincial legislature and its own elected

government (Government of Delhi 1992). It consists of nine districts, one of which, New Delhi functions both as the national and state capital of Delhi. Delhi has a population of about 17 million people (Office of the Registrar General and Census Commissioner 2011). Over 1,00,000 people in Delhi are homeless and about 10 million, more than half its population, live in slums, unauthorised colonies and squatter settlements with few civic amenities (Agarwal 2011). According to official data in 2008, a little over two million people in Delhi consisted of people living below the poverty line (BPL) (Government of Delhi 2009).

Map 1: Location of Delhi



An overview of the RSBY in Delhi

Delhi was among the first three states in India to launch the RSBY in April 2008, with the state's Labour Commission overseeing the programme. A public-sector insurance company was awarded the contract to administer the RSBY that

year and again in 2009-10 when this study was conducted. The insurer, in turn, had outsourced the running of the RSBY to a private third-party administrator (TPA); intermediary agencies authorised to perform various administrative tasks related to claims processing on behalf of insurance companies in India. Hence, the TPA handled most of the key operations for the RSBY that included enrolling members, contracting hospitals, managing financial transactions and extensive record keeping. Essentially, it was at the forefront of implementing the RSBY in Delhi.

Initially, the Labour Commission only targeted RSBY benefits to local residents who had already been issued below-poverty-line (BPL) cards by the state's Food and Supplies department. Cardholders, estimated to be about 0.3 million families, needed to go to local state-franchised ration offices and register based on their BPL ration cards⁸. The programme did not have a good start in terms of enrolments and only about 14% of the target population signed up to the RSBY in 2008 (Samajik Suvidha Sangam 2012).

Meanwhile, local nongovernmental organisations (NGOs) working with the state's welfare wing, Samajik Suvidha Sangam (SSS) or Mission Convergence⁹ had pointed out to state authorities that large numbers of impoverished and unorganised workers were deprived of the RSBY because they lacked BPL cards¹⁰.

⁸In theory, all long-term local residents in Delhi will have a ration card issued by state authorities that entitles them to subsidised rations. Normally, differently coloured cards are issued to distinguish below poverty line (BPL) and above poverty line (APL) ration seekers. Accordingly, yellow or red cards are reserved for those that are BPL and the "poorest of the poor" among them. White cards are issued to APL individuals in Delhi.

⁹ This thesis refers to the agency as Mission Convergence. NGO departments working on state government programmes in Delhi are labelled Gender Resource Centre-Suvidha Kendras (GRC-SK). However, except when mentioned in quoted text, they are called NGOs in this thesis.

¹⁰ This information is based on an internal note prepared by the labour department for the state's Cabinet and obtained from official sources during fieldwork for this thesis (LC 1).

These NGOs had recently begun collaborating with Mission Convergence to carry out a series of surveys in order to identify “vulnerable” individuals in specific localities in Delhi. By mid-2009, they had already identified over 0.5 million households who were considered vulnerable on a range of non-income measures including old age, disability, and insecure employment.

The state labour department had in the meantime renewed their contract with the insurance company earlier in 2009. A second annual round of RSBY enrolments was due to begin in July 2009. With a view to improve RSBY membership figures in Delhi, state labour officials were inclined to take account of the feedback from NGOs and hence they proposed extending the programme to newly surveyed vulnerable individuals. The national Labour Ministry approved this measure but made it clear that the central government could only fund up to 0.3 million households, which was the total number on the official BPL list¹¹. Despite the Ministry and later the state Cabinet’s approval to extend the RSBY to vulnerable people in Delhi, the actual process of getting the databases in order and preparing local NGOs to implement the programme with the TPA was long-drawn out and complex. Given the exceptional circumstances in Delhi, the RSBY’s four-month enrolment period that was to conclude in October 2009 was formally extended until the end of January 2010.

Through the seven-month period from July 2009 until January 2010, there were 53 NGOs involved in identifying and mobilising local households for the RSBY. NGO offices, in effect, also became RSBY enrolment centres from where TPA teams registered new members. That year, over 0.2 million families were enrolled.

¹¹ Ibid.

Most new members were those enlisted by NGOs and identified as “vulnerable” (Samajik Suvidha Sangam 2012). Over 17,000 cases were also treated at RSBY hospitals. Therefore, the RSBY in 2009 was structurally different from the previous year in allowing non-BPL families to enrol and involving local NGOs in implementation. While the second year enrolments were underway, about 80 private hospitals, nursing homes, and clinics were part of the official network of RSBY health care providers. By the time the research was conducted, official records listed over 100 empanelled providers¹².

ORGANISATION OF THE THESIS

Chapter 2 provides the background and literature review of the thesis. It describes the key differences between health care arrangements in the developed and developing world and assesses the philosophical and economic imperatives for health care reform and universalising health care in emerging economies. The chapter goes on to outline the key trend across developing countries in Asia, Africa, Latin America and East Europe for transforming health care delivery using some form of (quasi) health insurance. In this context, the discourses and debates about social health insurance for low- and middle-income countries (LMIC) are explored. Further on, the chapter details the health care system in India and identifies the key challenges in the way health care is currently financed and delivered. The chapter goes on to discuss the traditional approach to social security in India and outlines some of the existing social protection programmes for underprivileged populations in the country. The final section attempts to analyse recent health policy developments in India in the context of global

¹² However, in the course of fieldwork, I encountered several providers on the list who said they were no longer active in the RSBY. Some chose not to renew their membership while others had not treated RSBY patients in the past several months.

discourses and trends towards expanding coverage to historically underserved communities.

Chapter 3 presents the methodology of the thesis. It provides the rationale for adopting a qualitative approach and explains the selection of Delhi as the case study. It then goes on to describe the main methods used for data collection, giving details on the sampling of study sites and key informants and explains the strategy used for coding and analysing the data. The chapter concludes by identifying the principal limitations of the methodology. However, it is important to point out that a reflexive approach is used throughout the chapter by attempting to make transparent how my presence as the researcher may have affected the research process.

The next three chapters (Chapters 4, 5, 6) present the main findings of the thesis. Each chapter is designed to address one of the three research questions described previously. Chapter 4 examines the conception and formation of the RSBY by engaging with the traditional actors in policymaking: the State officials and experts who devised the programme. The chapter intends to understand the explicit and intrinsic goals of the RSBY by exploring the thinking and ideas of the programme's designers.

Chapter 5 moves on to investigate the on-the-ground implementation of the RSBY by engaging with the frontline administrators and NGOs who enrol families in the programme. It explores their experiences of participating in the RSBY, identifying the constraints and challenges they face as they implement the programme and their ideas for improving service delivery. The next section of the chapter investigates the delivery of medical services by RSBY clinicians. It explores

their motivations for joining the programme, their views on RSBY's medical benefits and its method of reimbursing clinicians for their services.

Chapter 6 is based on exploratory interviews with the service users and patients of the RSBY. It is designed to evaluate the programme from their point of view and to understand whether the RSBY affects their access to good quality services and treatment use.

Chapter 7 is the concluding chapter. It revisits the background and rationale for this study and outlines its key aims and methods. It encapsulates the findings from the research and highlights their relevance and contribution to policy. Lastly, the limitations of the thesis are identified and areas for further research pointed out.

Chapter 2: Background and Literature Review

INTRODUCTION

Many nations today are confronted with the twin challenges of spiralling medical costs alongside an upsurge in the demand for health care. Given finite resources, health policymakers worldwide are struggling with finding ways to fund and deliver services in ways that strike a reasonable compromise between cost-efficiency and local health care needs (Oliver & Mossialos 2005; Saltman 2002; Thomson et al. 2009). Typically for developing economies, there are many additional challenges. Problems stem from the greater scarcity of resources as compared to more developed countries and the fact that there are often many more impoverished people who need to be provided for and brought into the health care system.

Health care reforms will normally involve reorganising how systems are funded and services within them delivered. With regard to financing services, there are mainly three key functions of health financing structures, namely revenue collection, risk pooling and purchasing (Kutzin 2001; McIntyre 2007; PHFI 2011; WHO 2010). In principle, appropriate funding mechanisms ought to raise sufficient resources for essential health care services (revenue collection), collate funds equitably by accounting for varying health risks and income levels in the population (risk pooling) and finally, distribute these resources in ways that

maximise health gains at minimum costs, thereby ensuring technical and allocative efficiency in the system (purchasing) (Gottret & Schieber 2006; Kutzin 2001). Before exploring the range of health care reforms occurring across low- and middle-income countries (LMIC), it may be pertinent to examine some of the key ways in which health care is currently financed and organised across large parts of the developed and developing world.

Broadly speaking, there are three main methods of health financing in an advanced Western context: publicly financed and delivered National Health Services (NHS), contributory Social Health Insurance (SHI), and voluntary Private Health Insurance (PHI) (Burau & Blank 2006; Freeman 1998; OECD 1994). Some may well argue that classifying health systems in this way does not capture their inherent complexity and their increasing tendency to combine elements of both public funding and SHI (Kutzin 2000; Gottret & Schieber 2006). Nevertheless, other analysts contend that each “model” will normally have varying implications for the costs, quality, and choice of services available within a system (Freeman 1998; Normand & Busse 2002; Van der Zee & Kroneman 2007; Wagstaff 2009). To be clear, the intention here is not to debate the superiority of one or the other “model”. Instead, designating health systems as NHS, SHI, or PHI is one way of highlighting their principal features and policy consequences in order to contextualise the subsequent discussion on the introduction of insurance-based programmes across several developing countries.

Methods of financing health care

With the exception of the United States of America (USA), most health care systems in the developed world are mainly financed through general taxes or

social health insurance (SHI)¹³ or a mix of the two (Oliver 2009). At the outset, it is important to note that both NHS and SHI are essentially public systems of health care to the extent that they are “controlled by the government in its role of public authority” (WHO, 2003). In contrast, the United States follows a distinctive and what many consider a highly inequitable method of financing health care through private and voluntary health insurance¹⁴ (Davis et al. 2007; Gluckman et al. 2008; Schoen et al. 2006).

In the main, systems like the British NHS are publicly funded from general government revenues with publicly owned and operated health care facilities. Their centralised administrative structure normally gives the State significant amounts of political and economic leverage over spending decisions in NHS systems. The State can, therefore, ensure that services are universally available and that residents are entitled to a reasonably comprehensive set of health care services (Oliver 2005). Secondly, the monopsony power of public authorities as the principal buyer of health care services will also usually drive down medical and pharmaceutical charges; thereby, restraining overall costs within an NHS. In addition, centralised management may further limit total expenditure within the system by ensuring low running costs.

On the other hand, SHI based systems that are generally common across continental Europe¹⁵, Japan, and Israel derive their funds from compulsory payroll

¹³ Tax-funded national services and SHI systems are often termed “Beveridge” or “Bismarckian” systems respectively, referring to the national leaders identified with their creation (Van der Zee & Kroneman 2007).

¹⁴ Although a public safety net for low-income individuals and the elderly exists in the form of the publicly funded Medicaid and Medicare programmes.

¹⁵ Social Health Insurance (SHI) provides the broad framework for organising the health care system in 27 countries (Carrin et al. 2004) and is common across continental Europe in countries like Germany, France, Switzerland, and the Netherlands.

taxes or wage-related contributions from employees and/or employers (Mossialos & Dixon 2002). They are often characterised by a pluralistic delivery structure with multiple insurers and private medical providers active in the health sector (Hsiao & Shaw 2007). Their organisational structure makes for greater administrative complexity and generally also results in SHI systems being costlier to run as compared to publicly funded health systems¹⁶ (Nicolle & Mathauer 2010). Since health benefits are based on contributions and not residence (as in NHS), there is a greater tendency for segregated services and differential service provision within SHI systems. Yet, public control over the SHI regimes means that governments will normally try and minimise disparities through some form of risk adjustment for the different levels of risk faced by insurers (Buchner & Wasem 2003). In effect, the State reallocates funds to cover the uninsured as well as non-working dependents, thereby ensuring universal health coverage.

Despite variations in funding and delivery arrangements, both NHS and SHI share a fundamental social base and orientation (Saltman 2002). This partly stems from their historical evolution during the post-war period that saw the emergence of the welfare State across Western Europe and a social contract based on some measure of State intervention and expanded public spending (ibid.). In view of this shared past, within both systems health care is considered a public good benefiting society at large and hence, not a marketable commodity for individual personal gain. Moreover, social solidarity is a core and non-negotiable principle underlying both tax-based and SHI systems and enacted through multiple cross-subsidies from the young to the old, rich to poor, healthy to sick and from individuals to

¹⁶ Although there are exceptions: relatively low-cost SHI systems like Japan where a single purchasing authority keeps down administrative costs and tightly regulates provider payments and the supply of services (see for example, Glied 2009).

families (Saltman 2002). Rooted in values of social cohesion and community-based fairness, most developed health care systems thus ensure that health care coverage is universal and that “need” rather than “ability to pay” determines people’s access to care (Saltman et al. 2004).

Given existing debates about health care financing that provides effective coverage at reasonable costs, the pitfalls of private health insurance (PHI) are often more numerous and forcefully asserted than any relative merits (Mossialos et al. 2002). On the positive side, private insurance arguably provides the greatest choice to consumers in terms of their insurer and medical package. Some may contend that private commercial insurers are more responsive to customer needs and at providing higher quality services (Danzon 1992). While opinion is divided on service quality within private insurance systems, the evidence more conclusively shows they have inflated administrative costs caused by the presence of multiple, competitive insurers (Oliver 2009). In addition, PHI systems tend to have high costs resulting from specialised, high-technology care and excessive treatments (Starfield 2000). Moreover, highly privatised insurance markets like the United States or South Africa, where more than 20% of health financing occurs through private and voluntary subscriptions to insurance, large numbers who cannot afford to pay are effectively excluded from the system (Van Doorslaer et al. 2006; Wagstaff et al. 1999). Less well-regulated private insurance markets also tend to have higher inequity on account of insurers keeping out or “cream-skimming” high-risk and less lucrative customers such as people who are sicker or older (Tapay & Colombo 2004).

Broadly comparing the merits and demerits of tax-funded, SHI and PHI systems: in general, tax-financed health services are usually considered more equitable in terms of per capita spending, access and service provision and also tend to be more economical than SHI or PHI (Mossialos & Dixon 2002; Wagstaff 2009). SHI systems are more decentralised with coverage often differing across region or occupations (Hsiao & Shaw 2007). They are somewhat costlier than an NHS model but generally provide greater choice to their users (Saltman et al. 2004). While offering personalised services, private health insurance may nevertheless deliver highly uneven access and coverage when there is weak government intervention. PHI systems are also typically the costliest of the three models because of their fragmented nature (Mossialos & Dixon 2002).

Besides general taxation, SHI, and private insurance, out-of-pocket (OOP) spending comprises a fourth method of funding health care. These are non-refundable cash payments by users to pay for treatment, doctors' fees, medication and supplies as well as informal charges and payments to providers (World Bank 2013a). Although less significant in an OECD context where on average 19% of health care spending comprises OOP funds (OECD 2011), over 50% of health care funding in 47 low-income countries comes from direct payments by patients (WHO 2007c). However, it is a widely acknowledged and well-documented fact that OOP and user fees are highly inequitable methods of financing health care, not only reducing poorer people's access to services but also having catastrophic¹⁷ economic effects on them (Lagarde & Palmer 2008; Meessen et al. 2011; Ridde & Morestin 2011). Indeed, health economists and a host of international agencies

¹⁷ After basic needs have been met, spending more than 40% of household income directly on health care (WHO 2010, p.5).

including the WHO strongly urge that nations introduce prepayment mechanism for funding health care to ensure effective risk pooling and enhanced access for those in need (WHO 2005; WHO 2010).

Health care systems in the developing world

Much of the foregoing discussion about the relative merits and costs within tax-funded NHS systems and SHI is based, however, on the experiences of more advanced, Western economies. In trying to apply these models to low- and middle-income countries, it is thus important to understand the general structure and specific constraints that health systems in low-income countries face. For one, a central problem for many developing health systems is the low levels of funds allocated to them despite them having much larger populations and bearing a higher share of the global disease burden as compared to richer countries (Rao & Choudhury 2012; WHO 2012e). For example, WHO statistics show that 34 OECD countries with less than a fifth of the world's population accounted for over 80% of global spending on health (ibid.). Governments in low-income countries spent an average of \$23 per capita on health care in 2009 (WHO 2012f) which is significantly below the \$54 figure proposed by a recent WHO task force in order for low-income nations to provide a basic package of health care for all (Stenberg et al. 2010). Moreover, government health spending as a proportion of total health spending in low-income countries was about 38% against the 62% average for wealthier nations (WHO 2012f). Such disparities in health expenditure may be partly to do with the overall scarcity of resources in low-income countries with yearly per capita incomes of less than \$1005 compared to more affluent regions like the U.K. or the United States with averages of about \$36,000 and \$ 50,000

respectively (World Bank 2012a). Furthermore, raising more resources locally through, for example, income taxes, is often not easily accomplished in developing countries given their enormous informal and low-wage earning sector (Gottret & Schieber 2006).

Furthermore, limited public funds for health care are apparently spent in inefficient and inequitable ways in many such nations (Gottret & Schieber 2006; Pearson 2002). For example, developing countries usually spend more on paying staff salaries than on infrastructure and supplies in public hospitals. A recent study in South Africa also finds that provinces with the greatest disease burden often received far fewer public funds as compared to better-resourced areas with higher spending capacities (Stuckler et al. 2011). Furthermore, there is evidence to show that governments in developing countries often prioritise expensive tertiary services even though there is a greater need for low-cost primary or preventive care (Gottret & Schieber 2006).

Besides limited finances, health systems in developing countries also face a huge scarcity of human resources and physical infrastructure (Cassels 1995; World Bank 2009; WHO 2006). For example, the WHO estimates that there is one doctor per 5000 people in low-income regions, which is in sharp contrast to wealthier nations where a doctor serves about 300 people (WHO 2012f). Whereas a hospital bed in Japan will normally service about 77 people, in poorer countries like Ghana and Myanmar an average hospital bed caters to over 1000 patients (ibid.).

From patients' perspective, under-resourced and overburdened public health care facilities often mean long waits to get treated or not getting needed

drugs and essential services. Absenteeism among health workers, disrespectful and unresponsive attitudes towards patients (Lindelov & Serneels 2006; Russell 2005) and demands for informal payments are well-documented problems within public sector services in developing and transitional countries (Ensor 2004; Lewis 2007). Grave shortcomings within public services typically induce patients into spending huge amounts of personal funds at relatively costlier private facilities. This also makes for a highly inequitable system where poorer populations either cannot afford to pay for treatments and when they do, the effects may be catastrophic causing financial ruin and worsened poverty. For example, each year, 1,00,000 households in Kenya and about 2,90,000 people in South Africa are estimated to fall below the poverty line due to out-of-pocket payments on health care (WHO 2010).

Imperatives for health care reform in developing countries

Emerging global consensus on universal health coverage

There is now a growing consensus within the global health community and donor institutions more generally to universalise health coverage in developing countries. This is reflected in statements by key global actors in health like the WHO and the United Nations General Assembly (Chan 2012; UNGA 2012; WHO 2005). It is also evident in several agencies including the World Bank, USAID, and Rockefeller Foundation providing various forms of technical, financial, networking and information assistance to support developing countries universalise health coverage¹⁸.

¹⁸ For example, UHC Forward (<http://uhcforward.org>), Harmonization for Health in Africa (<http://www.hha-online.org/hso/>), Health Systems 20/20 (<http://www.healthsystems2020.org/>), Joint Learning Network for Universal Health Coverage (<http://jointlearningnetwork.org/>), and the

The WHO defines universal health coverage as “all people hav(ing) access to services and...not suffer(ing) financial hardship paying for them” (WHO 2005; WHO 2010, p.ix). Although it is historically recognised that health is a fundamental human right and hence important for all of a country’s residents and citizens (WHO 1948), there appear to be additional factors driving the high levels of policy attention on universalising health coverage. For one, growing awareness that poor health is rarely confined to individuals or regions but has wider repercussions for other groups and countries gives global society a stake in ensuring good health for everybody (Sachs 2012). A second influential factor and perhaps of particular interest to developing countries is the now well-recognised positive association between health improvements and economic advancement (Bloom & Canning 2000; DfID 2000; Wagstaff 2002; WHO 1948). Whereas earlier, the positive effect of high economic growth on health and development outcomes was emphasised in global policy documents, they now increasingly promote good health and human development as prerequisites for nations advancing economically (DfID 2000; GTZ 2005; GTZ-ILO-WHO 2005; WHO 1999; WHO 2005; World Bank 1993).

Focussing on poor populations in developing countries: rationale and policy challenges

In the context of universalising health coverage, global advocates urge developing countries to focus on their most deprived populations who are generally in worse health and with poorer access to health care services as compared to other groups. Studies show that indigent people usually have worse health outcomes than better-off groups and have significantly higher rates of

malnutrition, child morbidity and infant and maternal mortality (Gwatkin et al. 2007; Wagstaff 2002). They generally suffer inferior health because of poor diets and sub-standard work and living conditions. However, their situation is often made worse by their absolute lack of resources which prevents them getting the medical attention they need (DfID 2000; Dodd & Munck 2002; WHO-Europe 2001). This not only harms them physically but also financially because of their inability to work (Xu et al. 2007). In developing countries, poor people tend to be more severely affected as subsidised State-run services are low quality and inadequate and the absence of formal financial protection means these groups have to pay for health care at point-of-use (Van Doorslaer et al. 2005). This situation could have especially brutal consequences for impoverished families who may either cut back on other basic spending on food and clothing or else become indebted by borrowing money or selling personal assets (Peters et al. 2002; Van Doorslaer et al. 2005). In other words, poor people may become poorer as a result of getting medical treatment.

These problems are not unknown to policymakers in developing countries who may indeed wish to improve services for the poor. However, there are evidently numerous economic and political challenges they face in effecting health care reforms. Arguably, a central factor is the limited fiscal capacity of governments in developing countries, as discussed earlier (World Bank 2012a). Furthermore, across all contexts, there are often formidable vested interests standing in the way of redistributive reform which is perceived to harm their personal interests (Hacker 2004; Wilsford 1994). By reconfiguring existing distributions of who funds (public or individual), who runs (State or markets), and who delivers health care (public or private providers), reforms often intend

altering the position of more powerful groups in society. Hence, for example, middle-class taxpayers may be unwilling to contribute more taxes or subsidise services for the poor. They may also fear having their own benefits reduced as occurred in Thailand where formal workers who were part of the Social Security Scheme (SSS) fought against its expansion to other groups (Hanvoravongchai 2013). In addition, there may be further opposition from commercial interests—a a strong health insurance lobby which sees its income sources diminish as a result of restrictions on private insurance (Bond & Kgara 2009) or private clinicians who fear losing out on earnings from informal sources if payment systems become more transparent (Carrin 2002).

Under the circumstances, it is hardly surprising that many times health reform efforts have failed or been significantly scaled down as a result (Morone 1995; Navarro 1995). In the past, powerful lobbies of health providers and professionals have successfully gained significant concessions on reforms such as in the British NHS where general surgeries were allowed to run as private businesses (The National Archives 2013). Elsewhere, these groups negated reforms entirely as happened with President Clinton's plan of 1993 which aimed to provide universal health care to all Americans (Morone 1995). More recently, pharmaceutical reforms in South Korea in 2000 that intended to separate drug prescribing from drug dispensing faced strong opposition from doctors who stood to lose an important source of revenue from the sale of medicines (Kwon 2003). Extensive lobbying and pressure tactics including strikes by doctors ensured significant changes in the reform and a large hike in medical charges for treatments (ibid.).

Reforming health care is clearly, therefore, a formidable task for policymakers in developing countries. Despite this or perhaps as a result, a number of different and innovative methods of providing services to poorer populations are now being tried out in such regions.

CURRENT TRENDS IN DEVELOPING COUNTRIES

As part of developing countries' efforts to expand health care for traditionally excluded populations, a number of them have adopted some form of social health insurance (SHI) in which a third-party entity pools premiums and funds an explicit set of services for its members. This trend towards SHI is evident across many middle-income countries in Latin America, large parts of Africa and Asia as well as among several transitional economies in Central and Eastern Europe (CEE). Some of the frontrunners among developing countries to introduce health insurance programmes for poor and vulnerable groups are Latin American countries like Chile, Colombia, and Mexico. Chile, for example, has a long established SHI programme (1981) which covers three-quarters of the country's population. Run by a large, non-profit public insurer (Fonasa), this scheme entitles its members to a range of preventive and curative services (Bitran 2013). Similarly, in 1993, Colombia carried out large-scale health reforms to create a subsidised health insurance programme for poor individuals and informal workers (Montenegro Torres & Acevedo 2013). This functions alongside the existing contributory scheme for formal workers, which partly funds the subsidised scheme. In Mexico, the largely government-financed Seguro Popular insurance programme (2003) gave 50 million Mexican people, previously excluded from

formal insurance schemes, the chance to get needed treatments without spending catastrophic amounts on it (Bonilla-Chacín & Aguilera 2013).

This trend towards an insurance-based approach is also evident across large parts of Africa. Most notable examples include Rwanda and Ghana which scaled-up and integrated multiple community-based health insurance schemes under a common national system (World Bank 2013b). In Nigeria, five million people in the formal and informal sectors are now part of the contributory National Health Insurance Scheme (NHIS). This scheme aims to eventually extend coverage to the entire Nigerian population by subsidising the premiums for vulnerable groups like the poor and elderly (Joint Learning Network 2013c). Similarly, the Kenyan government plans to universalise health coverage through its existing social health insurance programme that currently covers mostly formal workers (*ibid.*).

In another part of the world, over the 1990s, many post-Soviet regions in Central and Eastern Europe¹⁹ began a shift from the traditional tax-financed public service to a system financed by health insurance funds (Wagstaff & Moreno-Serra 2009). Among the more successful examples in terms of health insurance coverage are Estonia (1992) (Atun, Ohov, et al. 2005) and Kyrgyzstan (1998) (Borowitz & Atun 2006) where a combination of compulsory payroll taxes, individual contributions and government transfers are used to fund a national insurance fund that purchases health care on behalf of the entire population.

¹⁹ Similar initiatives were undertaken in Hungary (1989), Lithuania (1991), Czech Republic (1992), Latvia (1994), Slovakia (1994), and Poland (1999).

Meanwhile across large parts of Asia including in China, Indonesia, Philippines, India, and Vietnam, health insurance benefits are being offered to impoverished and deprived groups via government subsidies (Lagomarsino et al. 2012). China, for example, is currently running separate contributory insurance programmes for working and non-working urban residents as well as a third scheme for rural populations (World Bank 2013b). In Indonesia and India, government-sponsored health insurance programmes for the poor were introduced in 2004 and 2008 respectively (Harimurti et al. 2013; Nagpal 2013). Recent reforms in Philippines and Vietnam have attempted to create an integrated health insurance system managed by a single fund and covering formal workers as well as other groups (Chakraborty 2013; Somanathan et al. 2013).

Distinctive histories, economies, and politics contribute to a great diversity in the individual country programmes of health insurance for excluded populations. Countries often differ in the finer organisational aspects of their insurance regimes, with key differences in methods of collecting and pooling funds as well as purchasing arrangements. For example, countries like Ghana, Philippines, and Vietnam have a single centralised fund for the entire population, whereas China, Colombia and Mexico run separate schemes for those not in formal employment (Frenk et al. 2009; Lagomarsino et al. 2012). In terms of financing, some countries including Vietnam and Indonesia use general public revenues to fund those with inadequate means, whereas others like Kenya and Nigeria require voluntary contributions from informal and self-employed workers (Joint Learning Network 2013c). Service delivery arrangements also vary to some extent although in most countries health care is obtained from a mix of private and public sector facilities (Lagomarsino et al. 2012).

Transitioning to Social Health Insurance: Policy debates on SHI for developing countries

A growing literature on the merits and demerits of SHI and its feasibility in poor settings accompanies the huge interest it generates across policymakers in developing countries. Yet, so far, there is mixed evidence on the effects of SHI systems in increasing the use of medical services or in reducing catastrophic spending by the insured. For example, a recent systematic review of social and community health insurance schemes in Africa and Asia finds little evidence linking SHI to improved service quality or social inclusion (Spaan et al. 2012). More positively, it reports that SHI may encourage greater health care use among members and protect them financially from high medical costs. In contrast, another review of State-led insurance schemes in China, Mexico, Colombia, Vietnam and the Philippines finds the evidence inconclusive on whether SHI improves utilisation and reduces out-of pocket spending by patients (Acharya et al. 2013). Both sets of research, however, attribute ambiguous results on the impact of SHI to variable methodologies used by the studies they looked at.

In assessing arguments for or against SHI in developing countries, it is important to be clear that there is a limited research base backing up either supporters or critics of this approach. Empirical studies on SHI in low-income settings are few and often small-scale: studying single projects, non-longitudinal in design and focussed on few indicators like enrolment and fiscal sustainability (Ekman 2004; Mills et al. 2004). Yet, there are important policy issues raised by existing debates that inform understanding about the political appeal of SHI and its feasibility in low-income countries.

More funds for health care through SHI?

An attractive argument for economies facing severe resource shortages alongside a growing demand for health care is that SHI in developing countries can help raise more funds for existing health care systems. The fact that people may be more willing to contribute to SHI since they get a clearly defined health benefit in return is thought to help elevate fund collections under SHI systems. Moreover, unlike tax-based financing, contributions under SHI regimes are explicitly secured for health, making health budgets less vulnerable to politically driven cuts (GTZ 2005).

However, real-world scenarios in developing countries may end up reversing the positive effects above. Two of these are particularly important in the context of optimism about more resources for health care through SHI. The first challenge relates to the structure of the labour market in developing countries. The fact that large proportions of workers in low- and middle-income countries are in informal employment²⁰ makes it pertinent to consider how people without an identifiable employer or workplace will be accessed. Equally, as a large number of informal workers in developing countries are often unsalaried, low-income earners, they are perhaps unlikely to be able to contribute significantly into an SHI system. This was apparently the case with India's Universal Health Insurance Scheme for poor households where despite the considerable State subsidy on premiums, enrolments remained low (Ministry of Finance 2006). Secondly, arguments about SHI generating more resources for health care may hold no

²⁰ In the past, SHI expansions were linked to economic growth and increases in the number of formal workers able to make contributions to the system. In contrast, recent global patterns indicate greater informalisation of labour occurring worldwide and across many emerging nations (Chang 2001; Srivastava 2012; Schmidt 2006).

water if policymakers get tempted to cut back their own health spending, expecting SHI contributions to compensate (Wagstaff 2010). This occurred in Kazakhstan where government health budgets were trimmed down following the establishment of SHI (ibid.) Hence, SHI systems may be as vulnerable as general tax-based systems to unpredictable reductions in the overall resources for health services.

Effectiveness and quality of service delivery in SHI

In many developing countries, national health services and the public bureaucracies running them are perceived to be inefficient and wasteful (Mills 1997). Moreover, fixed budgets and assured salaries are often thought to encourage complacent attitudes among staff and give them little incentive to be efficient. In contrast, the fact that trained, quasi-independent professionals manage funds under SHI is arguably a point in their favour.

SHI structures are also considered more conducive to the introduction of market mechanisms and competition in health care delivery, thereby setting the right financial incentives for providers to be more effective (GTZ 2005). However, for this to work, first and foremost, there needs to be a sufficient supply of qualified medical professionals and facilities that are willing to be part of the SHI (Bhat & Saha 2004). Secondly, ensuring that reimbursement rates and methods of claiming payments are attractive to medical providers is likely to be particularly challenging in contexts where they are accustomed to few regulatory checks on how they price and charge patients for their services. Hence, under a regulated system of SHI, doctors may fear monetary losses by losing their private sources of revenue. For example, in the initial years of Vietnam's SHI, providers were hostile

and reluctant to treat patients because they found that under the new regime, users were no longer willing to pay them informal fees that normally supplemented their low salaries (Carrin 2002). In another scenario, doctors may worry about being overworked and underpaid by a system that encourages excessive demand from patients. A case in point is the Hospital Association of South Africa that is strongly opposed to the proposed National Health Insurance on precisely such grounds. It argues that the system is unlikely to improve access or quality of care since there is presently a limited supply of doctors who will inevitably be induced to ration services through “waiting lists” and “bidding wars” (Hospital Association South Africa 2010, p.134).

The second argument about SHI contributing to better quality services is based on the logic that monetary contributions by members gives them a stake in the system and stimulates patients to keep up pressure for good services. However, this theory may be undermined by the existence of separate insurance programmes for different population groups and when health services inequitably benefit relatively wealthier groups who pay higher contributions. For example, despite near universal coverage in Colombia, there are vast inequities between the range and quality of services available to more affluent individuals covered by private insurance and those for indigent groups under the State-subsidised insurance regime (DeGroot et al. 2005; Tsai 2010). A similar situation exists in Thailand where the health insurance scheme for civil servants offers far more generous benefits than the schemes for workers and poorer individuals (Hanvoravongchai 2013). Essentially, not only does this lead to a segmented and less efficient health system, but also “(b)enefits meant exclusively for the poor often end up being poor benefits” (Sen 1992, p.15). Hence, an effective SHI may

require better coordination and integration with existing risk-pooling methods in a country (Hsiao & Shaw 2007).

Costs and sustainability of SHI systems in developing countries

Ordinarily, insurance-based systems tend to have higher costs as compared to those funded from general taxes (Carrin & Hanvoravongchai 2003; Saltman et al. 2004). Costs may be higher mainly because SHI systems are complex and often need sophisticated methods and qualified technical staff to run them. Routine SHI activities such as enrolling members, collecting contributions, processing contracts and settling claims with medical providers all involve considerable expenditure (Nicolle & Mathauer 2010). SHI often needs strong institutional structures including functional banking and communication networks, health care facilities and legal services. A fundamental issue for developing countries is whether governments have enough resources to invest in such systems. Furthermore, it is debatable whether they have the administrative structures to effectively collect, pool and redistribute funds or if they have the requisite capacity to develop risk-adjustment mechanisms compensating local insurers for different levels of “bad risks”. Moreover, even when countries have the requisite information systems and organisational capacity such as the U.S.A., health insurance schemes nevertheless involve significant administrative costs (Enthoven & Fuchs 2006).

In order to keep costs under check, insurance-based systems will also require effective regulatory and monitoring mechanisms for insurers and medical professionals. In their absence, pluralistic providers may be left free to drive up the price of premiums and medical services. The current evidence from developing countries indicates that considerable efforts may be needed by them in this

direction. For example, poor enforcement of laws, weak capacity to effect contracts and few checks on medical practices are commonly reported problems in many low- and middle-income countries (Bloom & Standing 2001; Mills 1998; Peters & Muraleedharan 2008).

The cost-effectiveness of SHI also depends on their design and implementation structure (Schoen et al. 2010). For example, costs may be significantly higher in an insurance-based system with multiple competing insurers. Such systems arguably lack the monopsony power of a national health service where the State as the solitary purchaser of services is often in a stronger position to negotiate with providers and drive down treatment prices.

Furthermore, there may be specific cost implications for governments in developing countries given their large numbers of indigent people who will be unable to afford contributions. In effect, if services are to be equitable, formal workers may need to contribute more for the uninsured as they do in Germany paying 16% payroll contributions (Wagstaff 2010). A more feasible and favoured alternative being tried out in countries including Vietnam, Ghana and the Philippines is for the State to partially or fully fund payments for the uninsured (Lagomarsino et al. 2012). State administrations will now have to consider the affordability of subsidising contributions especially considering that in many developing countries informal workers are estimated to be in excess of 50% of non-agricultural workers (ILO 2012) and tax-revenues are relatively small (Bird et al. 2008).

Moreover, given the vast unmet need for medical treatment in many low-income countries, health insurance may lead to increased health care utilisation. In

turn, huge claims on insurance funds are likely to raise insurance premiums or user copayments, which may be unaffordable and difficult to sustain. For example, in the context of rising insurance costs, questions are already being asked about whether the Indonesian government will continue to fully sponsor poor beneficiaries under its Jamkesmas health insurance scheme (Joint Learning Network 2013b).

Hence, while there are many positive attributes of SHI, ultimately it is the design of programmes that determines their effect on health outcomes in particular settings.

THE HEALTH CARE SYSTEM IN INDIA

Human development and epidemiological profile

India is a geographically vast and densely populated country in South Asia with over a billion people and a per capita GDP of \$1489 (World Bank 2012b). Incredible economic growth over the last two decades has transformed India from its long-standing low-income status into now becoming a lower-middle²¹ income country (World Bank 2011). However, in contrast to its economic achievements, India cuts a sorry figure on the human development front. It ranks a dismal 134 of 187 countries on the UN Human Development Index, a composite measure of life expectancy, literacy and per-capita income (UNDP 2011). In 2010, about a third of all Indians or 350 million people were estimated to be below the national poverty line²² (Planning Commission 2013b). The country is also home to a third of all

²¹ In 2011, low-income countries had per capita incomes of up to \$1,025 while per capita incomes in lower-middle income countries ranged from \$1,026 - \$4,035 (World Bank 2011).

²² Individuals with an average daily consumption expenditure of INR 26 (\$1= INR 50) in rural areas and INR 32 in urban areas. The World Bank similarly estimates that about 33% of the country's

malnourished children in the world (UNICEF 2013) and a fifth of global maternal deaths occur in India (WHO 2012d).

On the health front, there have been significant improvements since the country's Independence in 1947—life expectancy is higher, child and maternal mortality rates have come down, and diseases like small pox and polio have been successfully eradicated. Despite this, many challenges remain. Infectious diseases like tuberculosis, malaria, typhoid and cholera continue to afflict many and to this day account for 30% of India's disease burden (John et al. 2011). Globally, over a fifth of tuberculosis patients and 56% of leprosy patients are likely to be Indian (Planning Commission 2013b). Correspondingly, India is now also confronted with a growing number of patients with chronic medical problems like diabetes, hypertension, and heart disease (Patel et al. 2011).

Furthermore, India's health indicators compare poorly with those of other emerging nations like China, Thailand, and Brazil. For example, the country's infant mortality rate²³ of 47 per 1000 births is about three times that of China and Brazil (WHO 2012f). In fact, even poorer countries like Bangladesh and Nepal outperform India on this measure with figures of 38 and 41 respectively (ibid.). In 2010, even as sanitation facilities were available for 90% of people in Sri Lanka and Thailand, two-thirds of India's population lacked access (World Bank 2012b).

Even within the country, there are enormous variations in health outcomes in rural and urban India as well as across states (Balarajan et al. 2011). There are also large differentials between population groups. Perhaps not surprisingly,

population in 2010 was living on less than \$1.25 a day at 2005 international prices (World Bank 2012b)

²³ The proportion of children estimated to die before the age of one.

women and poorer communities are often the worst affected (Paul et al. 2011). For example, the child mortality rate was three times higher for the poorest 20% of Indians as compared to the wealthiest quintile: 116 against 39 (WHO 2012f). Wealthier Indian women were six times more likely than the poorest 20% to have experienced child-birth in an institutional setting (Balarajan et al. 2011).

Undeniably, the extent and range of India's epidemiological challenges is immense. While a host of personal, social, and economic factors may be important in accounting for such problems, part of the explanation for their existence must surely lie in the country's health care system.

Health care delivery in India

Evolution and current arrangements

Health care delivery in India is an intricate patchwork of public and private suppliers. Public sector services in India include rural and urban facilities for primary health care, dispensaries, teaching hospitals, government hospitals for secondary and tertiary care as well as central and state government-run hospitals for insured workers (NSSO 2006; WHO-SEARO 2004). Correspondingly, India's private health sector is a dense mix of individual practitioners, small-scale clinics, nursing homes, multi-speciality hospitals, pharmacies and diagnostic centres. Furthermore, formal health care services in India, public and private, include professionals qualified in both western medicine as well as indigenous practitioners of ayurveda, yoga, unani, siddha and homeopathy (Rao et al. 2012). At the same time, there is a vast workforce of informal and untrained providers of allopathic medicine in rural and urban areas, making for a deeply complex and pluralistic health care system in the country.

Newly independent India's health policy was initially guided by the recommendations of the Health Survey and Development Committee that proposed a State-run health service for India, much like the British NHS with mostly free services delivered through salaried staff (Bhore 1946). Interestingly, it had also considered a social health insurance model but deemed it unviable in the context of widespread poverty and difficulties in collecting payments (Bhore 1946).

In practice, however, it has proved perennially difficult for public services in India to meet the needs of an ever-expanding population, especially with few State funds coming their way. Despite their large number, the supply of public facilities in India falls way short of local requirements. On average, there is less than one hospital bed per 1000 Indians, far behind the global average of 3 beds and even lower than the 1.7 average for low-income countries (WHO 2012f). Official data also estimates a deficit of over 40,000 primary health care centres in rural areas (MoHFW 2012) and a recent study finds that an average patient in a village in India needed to travel about 4 to 6 km to reach the nearest facility (Gill 2009). In addition, many public facilities in rural areas face huge scarcities of trained doctors, specialists and medical supplies (MoHFW 2012). Moreover, there are stark disparities in the availability of health infrastructure in urban and rural India. Rural areas, with over 70% of India's population, have less than half the number of beds of government hospitals in urban areas (CBHI 2011). Rural allopathic health services also receive comparatively fewer public funds (11.8%) in comparison with urban health services (29.2%)

In principle, all Indians have access to government hospitals in return for a heavily subsidised fee. For below poverty line (BPL) individuals, most medical services are ostensibly free of cost. In practice, however, many of the medicines that patients need are often not available at under-funded public hospitals and need to be bought from outside (Planning Commission 2013b; Selvaraj & Karan 2009). Moreover, cost recovery policies in place across several public hospitals in India now require patients to pay for services that they originally did not pay for including outpatient charges, hospital admission fees and diagnostic test charges (Prinja et al. 2012). Although exemptions are in place for BPL, many individuals lack formal identification documents and hence find it difficult to obtain needed care. To add to these problems, public facilities in India are often understaffed, overcrowded, and unhygienic. Patients routinely need to wait a long time before they can get to see a public doctor or get tested and treated (Jha 2004; Kumar 2011). Moreover, there are reports of public providers demanding informal payments and bribes to admit patients or make a bed available to them (Lewis 2007; Thampi 2002). Therefore, as things stand, an adequate and comprehensive public service for health care is clearly not available to all Indians.

Gaps in public provision have contributed to the extraordinary rise of India's now sprawling private health sector. However, the growth of private services was mostly chaotic and unplanned— commercially run clinics and hospitals mushroomed across the country with few or poorly enforced rules on location, pricing, and professional ethics (Nandraj et al. 2001; Sen et al. 2002). India's private health care sector is a bewildering mix of providers of varying sizes and qualifications. Small clinics and diagnostic centres coexist alongside large super-speciality hospitals. Besides trained allopathic professionals, there is a

growing brigade of unqualified individuals including traditional birth attendants, herbalists, bone-setters and faith healers in India dispensing drugs and medical advice (Ganatra & Visaria 2004; M. Rao et al. 2011). It is particularly disturbing to find that many individuals with little or no formal training have set up functional allopathic practices in India. In fact, a recent study estimates that over a third of allopathic physicians in the country, mostly those in rural areas, have limited or no training at all in allopathic medicine (Rao et al. 2009). While State subsidies and tax rebates on acquired land and imported equipment boosted corporate expansions into health care, these facilities are rarely known to follow rules on giving free services to the poor (Bajpai & Saraya 2010; Chakravarthi 2011). Overall, not only is health care delivery in India fragmented across a range of private providers but ineffective monitoring also results in patients getting poor quality medical advice and rash drug prescriptions from untrained individuals (Das & Hammer 2007; Kamat 2001). Despite such problems, key Ministers in the current UPA government as well as various official documents strongly favour private participation in health care provisioning in India (MoHFW 2002; MoHFW 2005; PMO 2008). In the context of inadequate public services and a large and well-entrenched private sector, collaborations with private actors are deemed to be a practical option for improving people's access to health care (Health Steering Committee 2012; Planning Commission 2008b).

As far as human resources and infrastructure is concerned, the predominance of India's private health sector is well established. A recent study shows that over 70% of all health workers and most medical doctors in India are employed in the private sector; although most nurses still are government employees (Rao et al. 2009). In fact, official figures estimate that 80% of doctors

and 49% of hospital beds in the country are in the private sector (Health Steering Committee 2012). Notably, the private sector is now also establishing a presence in ancillary health care markets for pharmaceuticals, diagnostics and medical education in India (NCMH 2005).

Utilisation of public and private health care

At present, the private sector is the leading supplier of health care services in India. Across all income groups in rural and urban India, over 70% of all forms of treatments take place in private facilities (NSSO 2006, p.21). When sick, the first point of call for most Indians is an informal and ill-qualified provider, who may be a traditional birth attendant, faith healer or herbalist (Mohan Rao et al. 2011). Overall, 78% of all outpatient care in the country is privately provided (Health Steering Committee 2012). The private sector is also the principal source of hospital-based care in India, accounting for 58% of all hospitalisations in rural areas and 62% in urban locations (NSSO 2006). As far as public sector facilities are concerned, national surveys reveal declining use with a rise in living standards (ibid.). Even so, relative to their population size, richer Indians make more use of public hospitals than the poor who are much larger in number (Mahal 2003).

On the other hand, high usage of private facilities across all classes in India is striking considering that private medical care is generally more expensive than similar treatments in public institutions (NSSO 2006, p.33). For example, the price of outpatient care is likely to be one and a half times more in private facilities as compared to government hospitals and hospital treatments could be twice as costly as a public facility (Selvaraj & Karan 2009). The country's urban and rural poor are, therefore, deeply reliant on public hospitals for getting inpatient care as

well as for preventive services like immunisation and antenatal care (Mahal et al. 2001). Nevertheless, for medical advice and emergencies, their initial point of contact is normally an untrained local provider (Rao et al. 2012).

Das and Hammer (2010a) present fascinating evidence from Delhi where they find poorer groups had reasonably easy physical access to providers and in fact, use more health care services than relatively better-off individuals. Therefore, according to them, access and availability of doctors is a lesser problem than the quality of care they provide. In this respect, they report high levels of poor medical advice being given to patients despite over 70% of providers in their sample being “qualified” medical doctors (Das & Hammer 2010b). The authors also find that better skilled providers unsurprisingly tend to be located in richer localities, which also implies that poorer people in Delhi are more likely to receive sub-standard treatment compared to wealthier residents.

Who finances health care in India? Public versus private sources for health care

In 2009, India spent about 4% of its national income on health (WHO 2012f). While similar to average total health expenditure in lower-middle income countries, it is significantly below the global average of about 9% (ibid.). It is also important to note that average health expenditure per person in India (\$124) was nearly three times less than other emerging economies like China (\$347) and Thailand (\$327) (WHO 2012f). Besides the fact that resources for health per person in India are relatively few, it is also noteworthy that the share of

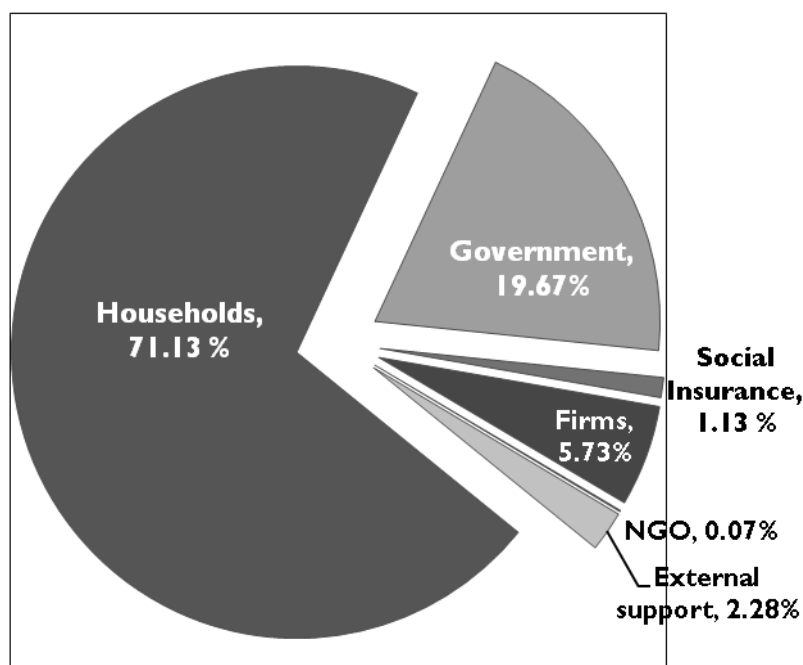
government²⁴ spending on health was just about 1% of GDP in 2004-05. This is considerably lower than the 5 to 6% rate of government spending indicated by the WHO for achieving universal coverage in low-income countries²⁵.

The lion's share of India's health funding, therefore, came from private sources—individuals and households contributing an astonishingly high 70% of the country's funds for health care (Figure 5) (NHA 2009). Furthermore, nearly all expenditure by households was in the form of out-of pocket and direct payments at the point-of-use. As an indicator of users' needs, it is noteworthy that households spent more on obtaining outpatient care (66%) and relatively less on hospital-based treatments (about 23%) (ibid.).

²⁴ Public expenditure in India includes expenditure by the central and state governments as well as spending by local bodies (NHA 2009).

²⁵ Although some commentators contest a formal WHO norm, the World Health Report 2010 indicates that total health spending of 4% of GDP is too little to achieve universal coverage (WHO 2010, p.98).

**Figure 6: Sources of funds for health care in India, 2004–2005,
(% of GDP)**



Source: NHA 2009

Furthermore, while the amount of public finances for health in India is visibly low, funds are also distributed in ways disproportionate to local health priorities and regional needs. For example, urban facilities are often privileged over rural services and public hospitals receive a much higher proportion of government funds (32%) as compared to primary health care facilities (18%) (NHA 2009). Similarly, public health activities such as antenatal care and immunisations, received far less public resources as compared to curative treatments²⁶. Moreover, there are huge regional variations in public expenditure. For example, per capita health spending in Himachal Pradesh was INR 630²⁷, nearly seven times Bihar state's average of INR 93 (Balarajan et al. 2011). Huge

²⁶ As noted in the earlier section, curative care in public hospitals is highly skewed towards better-off groups, who consume more services as compared to poorer groups.

²⁷ \$1= INR 50

gaps in public funding inevitably contribute to shortages in human and material resources at public facilities for health, as discussed in the previous sections.

In locating the reasons for low public spending on health in India, it is also worth noting the role of state governments in financing health care. In India's federal system, states are constitutionally responsible for funding and providing health services. However, the central government has access to most tax revenues (Rao & Choudhury 2012), leaving states with little fiscal space for increasing their health expenditure. As a result, state governments often depend heavily on grants and funds from the central government. Moreover, even though state governments account for three-quarters of public expenditure on health, up to 80% of this money is spent on staff salaries and wages (Peters et al. 2003). In other words, there are relatively fewer resources invested locally on basic health infrastructure and medical supplies.

Furthermore, some are of the view that powerful international actors play a role in influencing health spending decisions in India by directing public funds towards specific diseases and overlooking arguably more important health concerns. For example, Sridhar and Gómez (2011) report that despite their relatively small contribution to overall health financing in India (see Figure 3 above), foreign donors have disproportionately high levels of influence on health spending. They find this reflected in the fact that the country's National AIDS Control Programme receives a far greater quantity of central government funds as compared to other diseases with higher caseloads. Similarly, Vashisht and Puliyeel (2012) cite evidence showing an increase in other more virulent forms of polio as a direct consequence of India's large-scale polio eradication programme launched

at the behest of international organisations including WHO, UNICEF and the US Center for Disease Control. While arguing that funds could have been better spent on primary health care, the authors make a strong case against countries adopting donor-funded disease-specific programmes (ibid. 2012). Although in some contexts the merits of donor-driven programmes in raising political awareness about neglected diseases and improving governance arrangements are noted (Gómez & Atun 2012), planners in India generally believe that vertical (often donor-driven or funded) programmes have generated inefficiencies by duplicating delivery structures (Health Steering Committee 2012).

Notwithstanding the political economy of health financing in India, there are clear and often negative effects from insufficient government health spending. Modest funds inevitably contribute to inadequate investment in public facilities and personnel. As discussed earlier, State-run health services often face severe shortfalls in basic materials, equipment, and human resources. For various reasons, a well-functioning public sector for health is important for any health system and perhaps only more so in developing countries. Public services are needed, for example, to provide for the vast number of poor people in low-income contexts who cannot afford costlier private treatments. Moreover, a strong public system for health may also function as an important competitor to the private sector by keeping up pressure to ensure good quality and reasonably priced care (Sen et al. 2002). As the Indian case reveals, the near absence of public health care facilities in some regions is a key reason for the growth of private services, which since the mid-1970s has expanded into traditional public sector strongholds like hospital care and diagnostics (Chakravarthi 2011). An unfettered private service,

as described in the earlier section, may have also intensified rural-urban inequities in India and also contributed to escalating treatment costs.

There is compelling evidence to show that the nature of financing health care in India with its heavy dependence on direct payments by patients makes people vulnerable to poverty and worsens health. While many Indians are known to avoid treatment when sick (Berman et al. 2010; NSSO 2006), the poorest are more than twice as likely as better-off people to avoid treatment (Peters et al. 2002). Moreover, both rural and urban Indians spend a tenth or more of their yearly consumption expenditure to meet health care and hospital costs. According to a recent study, over 60 million Indians slip into poverty each year because of out-of-pocket spending on health services (Berman et al. 2010)²⁸. Most such people became impoverished paying for outpatient care— doctors' consultation fee and medicines, and a smaller percentage because of costlier hospital-based care (Shahrawat & Rao 2011). Loans and sale of personal possessions sustained over 50% of all hospital-based cases occurring in India in 2004-05 (Duggal 2007). Not surprisingly, a recent World Bank study across 300 villages in India finds that health shocks such as a sudden illness, injury, or death are the most common causes for local families descending into poverty (Narayan et al. 2009).

The above account of health financing and delivery in India reveals that health care services for the country's impoverished and vulnerable populations are mostly inadequate and unaffordable. As reported, services are frequently unreliable and sometimes may even be harmful given the poor quality of medical advice given to patients. Insufficient funding of the public sector and weak

²⁸ Other studies using earlier data or older methods of evaluation estimate figures ranging from 32 million (Garg & Karan 2009) to 39 million (Bonu et al. 2007).

regulation of private providers appear to be huge contributing factors in this respect. At the same time, it may also be pertinent to explore the current state of health protection mechanisms in India in order to assess how these possibly affect patients' access to health care services.

Existing financial protection and risk pooling measures in India

Scope and coverage of statutory health protection schemes

One finds a clear two-way split in the State's traditional approach to welfare delivery in India with contributory social insurance for workers and social assistance through cash or income transfers for the general poor (Remesh 2009). While not enforceable as a public right, the Indian Constitution nevertheless recognises that health care as well as social security for workers is a public responsibility (Ministry of Law & Justice 1950). However, statutory social security is mainly available to formal labour in India and public sector and industrial workers²⁹ have broad-based protection against illness, death, and disability. For example, State employees through the Central Government Health Scheme (CGHS) and low-income, blue-collar workers in the organised sector³⁰ through the Employees' State Insurance (ESI) Scheme have access to comprehensive health benefits including ambulatory and in-patient care. These are the two largest health insurance schemes in India and jointly cover about 59 million people³¹ (Health Steering Committee 2012). The ESI is a contributory scheme and funded jointly by the State, employers, and employees. Both ESIS and CGHS run their own health

²⁹ Formal sector workers also have additional security for some non-health related risks. For example, there is an obligation to save under the provisions of the Employees' Provident Funds and Miscellaneous Provisions Act, 1952. In addition, they are entitled to supplementary income on leaving work (Payment of Gratuity Act, 1972), an allowance for workplace injuries or death (Workmen's Compensation Act, 1936) and maternity benefits (Maternity Benefit Act, 1961).

³⁰"Unorganised workers" is the term normally used in India. However, "informal" and "unorganised" are used interchangeably in this text.

³¹ Data for 2009-2010.

centres but of late, have also begun contracting private sector facilities (CGHS 2012; ESIC 2012). The blueprint on social security for formal workers which resulted in the ESI Act of 1948 was developed by an official committee (Adarkar 1954), which interestingly was set up at the same time as the Bhore committee mentioned in an earlier section and which had recommended an NHS-style model of health care for India. Some commentators believe that the early development of welfare measures for public and formal workers was inevitable given India's post-colonial policy focus on heavy industrialisation and promotion of public enterprises (Singh 2008). In contrast, policies and programmes for informal workers are of more recent origin and have come mostly after 1991, following large scale economic restructuring and consequent to the growth in informal employment (National Statistical Commission 2012).

Besides the CGHS and ESI schemes, there are provincial and departmental health insurance benefits for people in public services such as Postal Services and the Railways department. In addition, there is a contributory programme for military pensioners³². Private health insurance is also available from a number of public and private insurance companies but unsurprisingly it is better-off urban populations that normally subscribe to these (Planning Commission 2008b, p.82).

In general, formal welfare arrangements for low-paid workers in India are patchy and few. Poor workers are normally those in informal employment, which comprises those working in unregistered establishments, and not covered by any form of labour legislation. They could also be self-employed or contractual labour working in formal enterprises (NCEUS 2006). An expert committee report

³² Ex-servicemen Contributory Health Scheme (IRFC 2012)

estimates that until 2000, merely 6% of informal workers in India had some form of social protection from the State whether it was for old age, disability or medical needs (NCEUS 2006, sec.4). For example, there are statutory provisions for some low-income occupational groups like building and construction workers, miners, beedi (Indian-cigarette) makers and those working in film production³³. The national Labour Ministry oversees the running of various social protection schemes for these workers, which are funded by specialist Welfare Funds financed from taxes, duties and State grants³⁴. Other federal ministries also run subsidised, contributory programmes of health insurance for weavers and handicraft makers³⁵.

In addition, poor BPL individuals and informal workers in India have had occasional access to some form of social protection through stand-alone national programmes launched from time to time³⁶. However, these have been residual and partial measures, narrowly focussed on particular groups (landless workers, agricultural workers, older workers above 55 years) or singular risks (death, disability, old age, maternity). On their part, individual state governments also run motley social assistance programmes for the elderly poor, widows, and disabled people in their constituencies. Furthermore, certain vulnerable groups like tribal people and self-employed women have access to some form of health coverage through special NGO-run programmes (Karuna Trust 2012; SEWA 2012).

³³ The Building and Other Constructions Workers' (Regulation of Employment and Conditions of Service) Act 1996; The Mica Mines Labour Welfare Fund Act 1946; The Limestone and Dolomite Mines Labour Welfare Fund Act 1972; The Iron Ore, Manganese Ore and Chrome Ore Mines Act 1976; The Beedi Workers Welfare Fund Act 1976; The Cine Workers Welfare Fund Act 1981 (MoLE 2012b).

³⁴ Building and construction workers contribute to their fund.

³⁵ Handloom Weavers' Comprehensive Welfare Scheme, Handicraft Artisans Comprehensive Welfare Scheme, Pension to Master craftspersons (Ministry of Textiles 2012).

³⁶ Krishi Samajik Suraksha Yojana (2001-2004) for agricultural workers.

On the whole, however, a small minority of informal workers in India have some form of sickness cover through these disparate national, provincial, and local efforts. As is the case with social security more generally, the nature of work and one's domicile often determine membership. As a result, people in particular occupations and living in certain provinces have often benefited more than others have from such initiatives.

RECENT POLICY DEVELOPMENTS IN INDIA (2000-13):

THE DRIVE FOR UNIVERSAL HEALTH COVERAGE (UHC)

The past decade has seen heightened political interest in India in the health sector and in extending health coverage to less-privileged groups. In 2003, for example, the National Democratic Alliance (NDA) led by the centre-right Bharatiya Janta Party (BJP) launched a state-subsidised contributory Universal Health Insurance Scheme (UHS) for impoverished Indians. The then Finance Minister, Jaswant Singh, had declared in Parliament that the UHS intended to "correct" the lack of good health services for "less advantaged" Indians, offering them financial protection and greater choice (Ministry of Finance 2003). Initially targeting seven million people, the UHS was a standard insurance policy available through various public sector insurance companies. Individuals and families paid a graduated premium although there was an additional subsidy if they were below the poverty line (BPL). UHS members were reimbursed for hospital expenses up to INR 30000 (\$600).

Subsequently in 2004, following on from the recommendations of a State-constituted advisory committee, the National Commission for Labour³⁷, the NDA unveiled its ambitious Unorganised Sector Workers' Social Security Scheme (USWSSS), targeting 370 million informal workers. At first pilot-tested in 50 districts in India, the programme was to be scaled up nationally if it did well. The USWSSS involved mixed sources of financing from employees, employers and the government. Like the UHIS, the scheme reimbursed the worker for hospital expenses of up to INR 30,000. However, both the UHIS and USWSSS had few people sign up to them. Although various factors contributed to the lack of subscribers, an important reason according to a subsequent Health Ministry appraisal was the fact that the UHIS did not cover important services like maternity care, which target groups desired. The Ministry's report, therefore, concludes that the "(e)xclusion of essential health care needs are likely to make any policy unattractive"(NRHM 2005)³⁸.

Meanwhile, the centre-left United Progressive Alliance (UPA) replaced the NDA government in 2004. The Congress party led UPA with its "welfarist" proclamations was a critical force behind a tranche of health care reforms and State-run programmes. Early into its tenure, the UPA government set up the National Commission on Macroeconomics and Health (NCMH) to look into more efficient health care delivery and forging public-private partnerships in the health sector. Apparently, "(g)rowing realization that the health of the people of a nation significantly contributes to its economic growth", was a key factor that prompted

³⁷ There are further details on this Labour Commission in Chapter 4.

³⁸ The USWSS programme was closed in 2005. The UHIS was subsequently revised to restrict it to people below the poverty line (BPL) and the government subsidy on the premium was enhanced. Insurance companies still offer the UHIS although the number of subscribers are few with less than 4 million members in 2009 (La Forgia & Nagpal 2012).

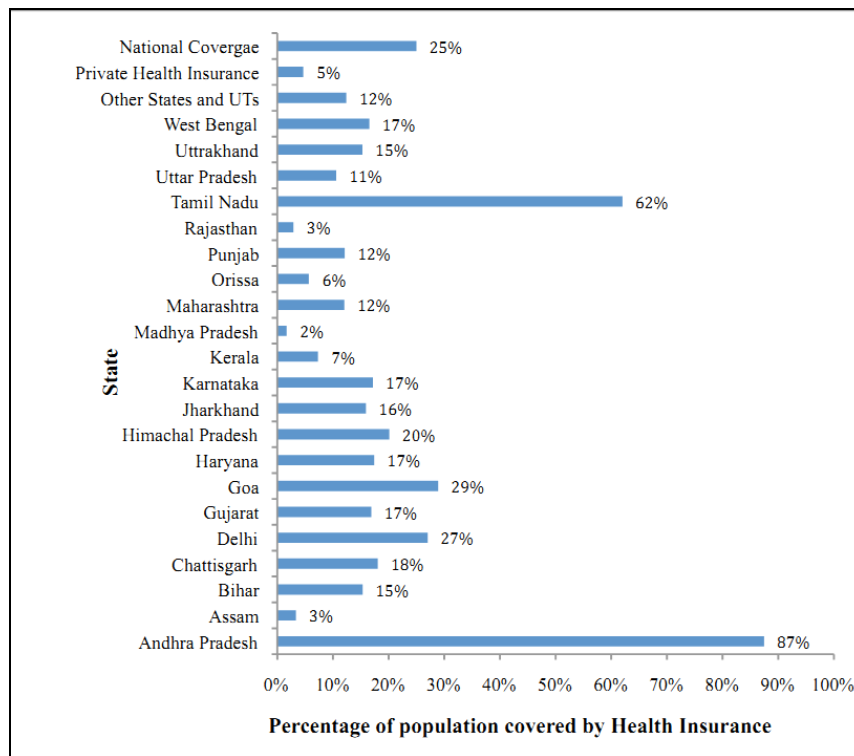
the establishment of the Commission (NCMH 2005, p.v). In its list of recommendations, the NCMH had advised the government to increase public expenditure on health if it intended achieving the UN Millennium Development Goals (MDGs) by 2015. It also suggested having a social health insurance scheme for secondary level care “as impoverishment takes place at this level” (NCMH 2005, p.8). Accordingly, in charting out its vision for its five-year term (2004-09), the UPA had a clear policy statement on raising public spending on health to “at least 2-3% of GDP” (NCMP 2004, p.7). While primary health care was to be a key focus area in the UPA’s health policy, it also committed to introducing a national health insurance scheme for the poor as part of its efforts to raise total government health expenditure.

With the objective of improving health provisioning and increasing public spending on health, the UPA was quick to launch two new programmes in 2005: the National Rural Health Mission (NRHM) to strengthen public primary health care facilities in rural areas (MoHFW 2005) and the Janani Suraksha Yojana (JSY), a conditional cash transfer scheme for improving pregnant Indian women’s access to hospitals. Correspondingly, the UPA government sponsored an ambitious national health insurance programme for poor Indians called the Rashtriya Swasthya Bima Yojana (RSBY) in 2008. As mentioned in the introduction, this programme intended preventing catastrophic health spending by enabling access to hospital-based secondary care for its members (MoLE 2013). A striking development since the RSBY’s launch is the subsequent and rapid growth in various state-led regional health insurance programmes for impoverished groups. Recently, schemes have been (re)launched in three Southern states of Andhra Pradesh (AHCT 2007), Tamil Nadu (TNHSP 2009) and Karnataka (SAS 2009).

Some states like Himachal Pradesh and Delhi have devised additional schemes to top-up RSBY services with tertiary care benefits for members (La Forgia & Nagpal 2012).

The role of these government-sponsored health insurance programmes in expanding health coverage in India has been quite remarkable. In 2007, before these schemes were launched, about 75 million people or less than a tenth of Indians were estimated to have any form of health insurance coverage whether through a statutory scheme, community-run programme or voluntary private insurance (PHFI 2011). Since the introduction of these state sponsored programmes, total health insurance coverage in the country appears to have registered a significant leap with a quarter of all Indians now believed to be part of a public or voluntary health insurance plan (Figure 7) (ibid.). In a telling assessment of their importance, an expert committee report estimates that at present over 80% of the country's total insured population is covered by one of these government-led programmes (PHFI 2011, pp.25–26). As figure 7 below shows, states like Andhra Pradesh and Tamil Nadu that are implementing especially large-scale health insurance programmes of their own have a much higher proportion of their total population insured as compared to other states that may be only implementing the RSBY.

Figure 7: State and nation-wide coverage of health insurance in India



Source: (PHFI 2011, p.25)

It was also opportune for the UPA to have won a second term in government (2009-14) that enabled it to continue and expand its ongoing efforts in the health sector. For example, although overall government spending on health in India still remains low, the national administration has over time invested more funds into programmes like the NRHM and RSBY, also extending them to new regions and population groups (NRHM 2010; MoLE 2013). It is also significant that the government now has a clear policy statement on universalising health care for all Indians (PMO 2012b). Although the centre-left UPA has indeed been instrumental in pushing on with health reforms in India, various other factors have also been influential for the emergence of a national agenda on universal health coverage (UHC). For one, India's membership of key global forums like the WHO may well have exposed national policymakers and planners to emerging global

conversations on UHC. Furthermore, as a new actor on the international stage, for example as part of the BRICS³⁹ groups of emerging economies, it appears to be important for India to match up to developments in other countries that aim to universalise health care. Illustrating this ambition, a recent State-commissioned report on UHC declares that the country is now motivated “not only to act in conformity with a globally progressive commitment to health equity but also to become a leader of the movement by creating the best contemporary model of UHC” (HLEG 2011, p.2).

Frequent reports in the national media on the RSBY’s success in enabling vast numbers to get treated (Ghildiyal & Mathur 2010; Menon 2009; Sen 2010) along with international commendation by the United Nations, World Bank and GIZ (GTZ-GmbH 2010; UNDP et al. 2011) created a generally positive public perception about the RSBY. This also stirred political interest in health insurance as a strategy for universalising health coverage in India. With a view to elaborate its vision for a universal health system in the country’s next Five Year Plan (2012-17), the UPA administration hence commissioned various expert groups to study the matter. In 2010, this government established the high-level expert group on universalising health care (HLEG) to develop an action plan. The HLEG’s terms of the reference explicitly ask it to “(e)xplore the role of health insurance system...with high subsidy for the poor and a scope for building up additional levels of protection on a payment basis” (HLEG 2011, p.316). Simultaneously, the country’s premier planning agency, the Planning Commission, constituted a panel to review existing health insurance arrangements in India (PHFI 2011). In

³⁹ An association of emerging and newly industrialising economies including Brazil, Russia, India, China, and South Africa.

conjunction with the above developments, the Health Ministry also formally requested a World Bank team to research existing government sponsored health insurance programmes to evaluate their feasibility in a wider context of universal health coverage (La Forgia & Nagpal 2012).

The recommendations emanating from the high-level expert group and those from the World Bank study, however, differed significantly in the basic framework they proposed for expanded health care. The high-level expert group (HLEG) suggests that government health spending be significantly increased from 1% of GDP currently to 2.5% by 2017 and at least 3% by 2022 to enable it to fund a basic package of health care for all that is free at the point-of-use (HLEG 2011). Essentially, the HLEG report seems to recommend a publicly financed national service run mainly by the public sector although with a role for contracted private providers.

On its part, the World Bank report argues that the anticipated increase in government health expenditure is unlikely to occur in the near future for a range of reasons including low tax collections in the country and multiple demands on the State's funds. The central government is thus unlikely to have the resources needed for universal and comprehensive coverage in the way that the HLEG proposes. Instead, the World Bank report recommends "pragmatic pathways to universal coverage" through a series of measures aimed at integrating current public programmes of health insurance. Accordingly, it suggests that the RSBY and other sub-national state government health insurance schemes for the poor be integrated under regional authorities that will, in turn, contract insurance companies to purchase services from a range of public and private providers. Even

as the State will continue to sponsor those below the poverty line (BPL), the report asks that vulnerable non-BPL make co-payments when using facilities. Similarly, existing statutory programmes like ESIS, CGHS and various departmental schemes are also advised to pool their resources under a centralised agency, although distinct from the regional authorities proposed for the RSBY and other government sponsored schemes. Furthermore, the report's authors anticipate that the private insurance market will continue to grow through middle class and wealthier subscribers who can afford to pay for it. According to the World Bank report, through its proposed measures government-sponsored schemes could be extended to cover three-quarters of the Indian population (La Forgia & Nagpal 2012).

Against this background, the Planning Commission initially proposed to “explore the possibilities of introducing a government funded health insurance plan for every citizen along the lines of the RSBY, which is currently limited to the poor and for certain select groups...” (Planning Commission 2011a, p.94). However, confronted with massive opposition from the Health Ministry and civil society organisations, the Commission was forced to reconsider its original proposal.

In its revised draft released earlier in 2013, the Planning Commission is more cautious in its proposals for universal health coverage (UHC) and the RSBY in particular (Planning Commission 2013b). It recognises that UHC is a long-term goal, which may take two or three plan periods (10-15 years) to accomplish. It, therefore, proposes that over the next few years (until 2017), various financing and delivery models be experimented with across all states in the country. The

Commission also suggests using “the platform and existing mechanisms of RSBY to cover the entire population below the poverty line (by 2017)” (ibid. pg. 9).

As far as the HLEG and the World Bank recommendations are concerned, the UPA government seems disinclined to take any drastic actions that may involve overhauling current financing and service delivery arrangements or reorganising existing government health protection programmes (CGHS, ESI, RSBY). Based on the Planning Commission’s advice, the UPA government announced its immediate plans to fund state-level pilot projects providing essential generic medicines free-of-cost at public hospitals and government-linked pharmacies. Yet, going by recent newspaper reports, even these plans have already been scaled down with a decision now to fund initial pilots in only 10 districts in India (Forbes India 2013; Live Mint/Wall Street Journal 2013).

Nevertheless, the RSBY remains an important part of the central government’s medium-term strategy for expanding health coverage. From a singular intervention to prevent catastrophic health spending in India, it is now perceived in national and international policy circles as an important method of extending medical services to some of the poorer groups in India (Joint Learning Network 2013c; UHC Forward 2013). Accordingly, programme budgets have been consistently raised and the RSBY is gradually being opened out to new groups of low-income workers. The political support and government’s intentions for the RSBY are also evident in the speeches and pronouncements of key national leaders. For instance, the country’s current President, Pranab Mukherjee, recently declared the following:

We must strengthen the mechanism of health insurance. The Rashtriya Swasthya Bima Yojana... should provide access to comprehensive primary, secondary, and tertiary medical care... (and) should touch every one below the poverty line. (Mukherjee 2013)

Initially designed as a stand-alone and time-bound programme to last until 2013, the recent drive for universal health insurance has thus given the RSBY new momentum and added stability.

Chapter 3: Methodology

INTRODUCTION

This chapter explains the research design and principal methodological features of this study. It begins with an account of its ontological and epistemological underpinnings and explains the rationale for devising the project within a qualitative framework. It then goes on to discuss the primary methods used to collect, organise and analyse the research material as well as important ethical considerations for sampling, data analysis and reporting of study outcomes. Reviewing and reflecting on the research process in a manner which is “logical, traceable and clearly documented” aids the construction of an audit trail (Schwandt 2007) that serves to emphasise rigour in the process of enquiry. A methodological appraisal also helps establish the “dependability” of research findings and for judging their “authenticity” considering that there may be a range of interpretations of a given state of affairs (Guba & Lincoln 1985).

EVALUATION FRAMEWORK AND QUALITATIVE

RESEARCH DESIGN

The methodology for this study was located within a broad policy evaluation framework. Programme or policy evaluation is described as a “systematic assessment” of their “operation and/or outcomes” benchmarked against “explicit or implicit standards” in order to help “improve” their effectiveness and inform future policies (Weiss 1998, pp.4–19). While

programmes are commonly assessed against their declared aims, evaluation of health services may also require making “value judgments...(about) both the(ir) objectives and instrumentalities” (Donabedian 1972, p.104). Accordingly, as discussed in Chapter 1, the assessment criteria for the RSBY relate to the programme’s goals as well as wider health system objectives including equity, quality, efficiency, effectiveness, and consumer satisfaction (Atun & Menabde 2008; Hsiao 2003; McPake & Kutzin 1997). This study set out to develop a comprehensive account of various features, processes and activities related to the RSBY, having had limited information to hypothesise about which of them may be more important and relevant to the emerging outcomes from the programme. Hence, a qualitative strategy was the most suitable and feasible for this research.

Early in the study, it was clear that as a relatively new programme and in its initial stages of implementation, there was limited information and statistical data on the RSBY. Research efforts at the time were preliminary quantitative assessments of enrolment (Sun 2011), hospital infrastructure and patient usage (CHIAK 2009; Grover & Palacios 2011; Hou & Palacios 2011). This general lack of information about the RSBY was an important reason for adopting an exploratory and qualitative approach to investigate the programme. Researchers in the qualitative tradition are more concerned with identifying the contextual conditions favourable to certain policy outcomes rather than establishing causality between variables (Mahoney & Goertz 2006; Ragin 1999). Hence, unlike more positivistic approaches, this study does not make generalisations based on numerical measures of policy inputs (RSBY funds, physical resources) or outcome indicators such as membership figures and hospitalisation data.

This study's methodological approach is guided by a "subjectivist epistemology" (Denzin & Lincoln 2005, p.24) that values multiple impressions of the phenomenon being investigated and thus portrays diverse opinions and experiences of the RSBY. More specifically, the study design is informed by its three research questions. These relate to the RSBY's conception, its implementation, and utilisation by current recipients. Looking at the different ways in which RSBY's stakeholders—its formulators, implementers, medical providers, and service users—experienced the RSBY and their interpretation of events arguably leads to deeper and more holistic understanding of the programme's functioning and early effects.

The adoption of qualitative methods was most appropriate to gather RSBY stakeholders' perceptions and ideas about the programme. It was important to hear directly from RSBY formulators in order to go beyond official rhetoric and understand the politics behind the RSBY. Similarly, engagement with RSBY managers and clinical providers revealed detailed information on service delivery processes and actual implementation of the programme. Finally, and perhaps most critically, an in-depth, qualitative approach helped reach out to the RSBY's vast community of end-users, comprising low-paid and often illiterate slum-dwellers. Such populations normally have fewer opportunities to participate in policy dialogues or analysis of their effects on them (McGee & Brock 2001; Mehrotra & Jarrett 2002). Hence, detailed qualitative investigation helped give "voice" to this important constituency of welfare recipients.

REASON FOR SELECTING DELHI AS THE CASE STUDY

I used a case study approach to investigate the research questions, focussing on the RSBY's evolution in Delhi state over the two years since its launch in April 2008. A case is defined as a single instance of the phenomenon being investigated, usually with explicit boundaries of location and time (Schwandt 2007; Stake 1995). There are persuasive arguments for using case studies that are not related to whether quantitative or qualitative methods are used. A key proponent of the case study approach, Robert Yin (2003, p.13) points out that this technique is useful to analyse "a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident." While a case may be intrinsically valuable and important to examine in its own right, case studies also perform a more functional role in generating better understanding of wider trends (Stake 1995). Furthermore, case studies offer a logical course of action when a researcher cannot control the circumstances or policy environment in which a programme occurs or when the effects from an intervention may not be immediately obvious (Keen & Packwood 2000). Besides conceptual reasons for employing a case study technique, this was also a pragmatic decision given that I was a single researcher with limited time and resources at my disposal. Hence, it was important to set reasonable boundaries on this study's scope.

While there are various strategies for selecting cases, the objective of the evaluation normally guides the identification of cases (Patton 2002). Hence, researchers may choose a "typical" or "average" case that does not significantly diverge from the norm in terms of how structures and processes normally work.

Although what transpires within it may not be widely generalised, the typical case will nevertheless be insightful for understanding similar phenomena or occurrences in other settings (Patton 2002). At other times, especially when resources are few, analysts may opt for fewer cases but displaying “maximum variation” in order to identify common patterns and more general tendencies. A third approach is to pick “deviant or extreme” cases that differ considerably from the average or standard case in exhibiting high levels of success or failure (Patton 2002, p.230). This may be intended to derive meaningful lessons from them that may be more widely applicable.

This study was located in the state of Delhi. As the national capital with a largely urban population, Delhi may not be typical of other Indian states in terms of its socio-economic and demographic profile. Nevertheless, when it was selected for this study it was broadly representative of RSBY institutions, administrative arrangements and delivery processes that are standardised nationally. At the same time, there were both strategic and practical reasons for locating this study in Delhi state. For one, at the time of this research, Delhi had relatively more experience running the RSBY as compared to most other regions since it was one of two other Indian states and union territories where the scheme was initially implemented (Palacios et al. 2011). As the national capital, it was also an ideal location for accessing both central and state-level actors and institutions associated with the programme. Additionally, Delhi was a logistically sound choice as I was generally familiar with areas here and had an established personal network that I was able to draw on for accessing a few senior-level interviewees.

DURATION OF FIELDWORK

Most data collection for this study took place during six-months of field research in Delhi from April until October 2010.

On an earlier visit to Delhi in August-September 2009, I contacted a few senior officials in the state's health department as well as managers at the insurance company, the third party administrator (TPA) and two local nongovernmental organisations (NGOs) implementing the RSBY who could help me identify key individuals for future interviews. In addition, I met with a couple of health economists at the World Bank, one of whom was then closely associated with preliminary evaluations of the RSBY. The purpose of these meetings was also to pilot-test some of my initial research ideas with them given their proximity and knowledge about the RSBY. Discussions with front-line NGO staff were especially helpful for understanding the procedures they followed to inform and enrol local eligible families into the RSBY.

More recently in August 2011, follow-up meetings were conducted with three policy experts in Delhi to revisit some of my original questions in light of emerging data analysis. Two of them were individuals I had previously interviewed as part of my sample of RSBY policymakers and the third was a senior health economist in the State-affiliated National Institute for Health and Family Welfare (NIHFW) who had led a rapid assessment study of the RSBY's implementation in Delhi.

DATA COLLECTION

This research uses a mix of data collection techniques that include documentary review, semi-structured interviews, and direct observation of important RSBY sites and activities (Table 1). Correspondingly, this study is informed by the insights of multiple individuals and organisations closely associated with the RSBY. Triangulating various methods and sources of information in this way was an important technique to validate emerging findings, thereby making for analysis that is more credible (Denzin 2009; Sandelowski 1995).

Table 1: Methodological and data triangulation

METHOD MIX	DATA SOURCE
Documentary review	60-80* key documents national plans, laws, political manifestos/speeches, meeting minutes, guidelines, reports, presentations, websites (refer to Appendix B for website details)
Observation	32 health care facilities and 1 NGO
Semi-Structured Interviews (SSI)	164 audio records and transcripts

**Illustrative*

Documentary review

Relevant policy documents were obtained from key informants as well as general web-based searches on the RSBY's inception and functioning using key words such as "RSBY", "Rashtriya Swasthya Bima Yojana", "RSBY evaluation" and so on. I drew extensively on the RSBY website as well as central and state government websites (Appendix B) for official documents such as national plans

and legislations, government reports, political speeches and party manifestos. In addition, statistical information and relevant publications produced by international agencies like the World Bank, German Agency for International Cooperation, GIZ, International Labour Organisation (ILO) and the World Health Organization (WHO) were also consulted. During fieldwork in 2010, I gathered a considerable number of official and unofficial publications including internal correspondence, minutes of meetings, RSBY promotional literature, and unpublished working papers. Information material was also collected during a national-level RSBY conference that I attended in July 2010 (RSBY National Workshops 2010).

Policy documents and field notes were read thoroughly and manually coded based on the research questions, analytical framework and emerging codes in interview transcripts. Excerpts from texts were copied onto an Excel spread sheet and thematically grouped under relevant headings such as “rationale for policy”, “objectives”, “origin of idea”, “role of international organisations” and so on. The spreadsheet could be easily searched for key words and phrases, allowing quick retrieval of extracts and quotations.

Direct observation

In 2009, I visited an NGO-run centre in Delhi where I was able to directly observe the procedure for enrolling new RSBY members. During fieldwork the following year, hospital staff demonstrated the use of RSBY software, helpfully re-enacting for me the processes by which they admitted RSBY patients and the method of filing online claims with the TPA. I was often allowed to visit the wards where RSBY patients were staying and observe the kind of amenities offered to

them especially taking note of factors such as cleanliness and space. At each hospital, displays with information on the RSBY or on their current pricing (consultation fees, room rates) and facilities were also recorded. In addition, I maintained a diary with detailed field notes reporting my general observations about each hospital visit.

Semi-structured interviews

Table 2 below gives details on the respondents interviewed for this study. The sample of interviewees represents four groups of participants that included national-level policymakers, state-level administrators and implementing agencies, medical providers, and RSBY recipients.

Table 2: Semi-structured interviews

	NUMBER OF ORGANISATIONS REPRESENTED	NUMBER OF INDIVIDUALS INTERVIEWED
Policymakers (national)	5	7
Implementers (state)		
<i>State government</i>	2	5
<i>Insurance company</i>	1	2
<i>Third party administrator (TPA)</i>	1	6
<i>Nongovernmental organisations (NGO)</i>	15	28
Healthcare providers	32	32
Recipients/patients	-	84
TOTAL	56	164

For each respondent group, separate topic guides containing 10 to 12 main questions as well as additional prompts were developed (Appendix C). These were

reviewed by my doctoral supervisor. Questions were designed to learn about interviewees' attitudes, perceptions, routines, work practices, and general experiences related to the RSBY. The topic guides for interviews with RSBY implementers and recipients were also translated into the local Hindi language and were "back-translated" into English to check for linguistic clarity and conceptual uniformity (WHO 2012c). The topic guides for policy formulators and implementers were pilot-tested with two senior state government officials in Delhi's health department and service user questionnaires were similarly trialled on two RSBY members prior to beginning formal interviews. Questions were accordingly revised and reordered so that later respondents could understand them more easily. Although recorded, these interviews were not used in the final analysis. The topic guide for RSBY providers did not need to be substantively changed and all interviews with medical professionals were included in the final sample.

Interviewees were also given an information sheet with details about this study, ethical conduct during the research, and the implications of their participation (Appendix C). Whereas most meetings took place in respondents' offices and workplaces, RSBY recipients were mostly interviewed in their homes, NGO offices or at RSBY hospitals. There were no noticeable differences in the responses across the three settings. In general, service users were enthusiastic in talking about their medical problems and discussing the RSBY. They had an especially vivid recollection of their experiences at RSBY hospitals, often recalling precise events and details about the course of treatment. All conversations were audio-taped, except one interview with a hospital superintendent for which only written notes were permitted. Subsequently, interviews were transcribed in

English and Hindi. Although I typed out most recordings myself, I used a paid assistant to help transcribe some of the interviews with NGOs workers and RSBY recipients. Nevertheless, I crosschecked each interview transcribed by the research assistant to ensure the accuracy and quality of their typescript. In order to ensure that the nuances of what RSBY recipients said was not lost in translated texts, it was a conscious decision on my part to transcribe interviews with service users verbatim in Hindi rather than translating them directly into English. The qualitative software NVivo version 9 (QSR International 2012) employed for this study allows the import of non-English language scripts and audio recordings. This enabled recipient interviews to be read and analysed in Hindi and only quoted material needed translating into English. Considerations while accessing and conducting interviews are discussed in greater detail later in this chapter.

SAMPLE SELECTION AND SIZE

The key organisations associated with the RSBY included the central Ministry of Labour and Employment (MoLE), the state government's Labour Commission and its welfare division called Mission Convergence, a public sector insurance company, the third party administrator (TPA) contracted by it, local NGOs and a large number of private hospitals, nursing homes and clinics in Delhi (Table 3 and Appendix A). Sites for this study included 32 hospitals and 15 NGOs in the state. Hospitals were randomly chosen from the official list of RSBY providers in order to represent a range of locations across Delhi. The selection of NGOs was both purposive and based on referral or snowball sampling strategies. Similarly, respondents for this study were recruited purposively and using snowballing techniques. Purposive sampling involves identifying knowledgeable

informants who are well-placed to provide detailed information and clarity on the research questions as well as reflect multiple and complex dimensions of the phenomenon (Patton 2002; Richards 1996). A preliminary document review and informant meetings in 2009 guided the initial selection of participants but this sample continued to expand during fieldwork based on emerging information and interviewee references. Figure 8 below presents the phases of the study.

Figure 8: Phases of the study

Phase 1	Documentary review
DESIGNING THE STUDY	Preliminary meetings with key informants + Observation (enrolment process) (Aug to Sep 2009)
	Prepared topic guide and initial list of interviewees
Phase 2	Pilot-tested interview guide
DATA COLLECTION	Observation (hospital transactions, facilities)
(April-Oct 2010)	154 Semi-structured interviews with participants recruited using purposive and snowball sampling techniques
Phase 3	Developed initial codes (interview transcripts+ field notes)
DATA ANALYSIS	↓
	Identification of sub-themes (inductive process)
	↓
	Data triangulation (documentary sources)
	↓
	Interpretation, analysis and reporting

Interviews were conducted until a point of “saturation” was reached and no new information was forthcoming. The final sample came to include organisations and individuals closely associated with the RSBY both in their professional

capacity and as benefit recipients. Study participants also comprised all the main stakeholders in the RSBY who were able to provide information on a range of RSBY activities. This included national policymakers and planners, state-level officials and corporate managers, health care providers as well as RSBY members and patients. Further details on sampling each of these groups are discussed below.

Policy formulators

I interviewed seven high-ranking policymakers for this study (details in Appendix A). While the respondent sample may appear small, it consists of very senior politicians and central government officials who were closely associated with conceptualising and creating the RSBY programme. The following four participants were directly connected with the RSBY's creation: the former Labour Minister who headed the Ministry charged with designing and introducing the RSBY, the Director-General Labour Welfare— a senior civil servant in the Labour Ministry who is in-charge of rolling out the RSBY programme across the nation and two senior technical experts who earlier led the Social Protection departments of the World Bank and the German federal technical cooperation agency, GTZ in India. Along with the Director-General, the two external experts formed a task force or core group that fleshed out and planned the launch of the RSBY. The other three interviewees had a less explicit association with the RSBY but were intimately familiar with the political events preceding its launch and policy deliberations during the programme's conception. They included two high-ranking advisors in the national Planning Commission and a top-level panellist on the six-member State-appointed National Commission for Enterprises in the Unorganized

Sector (NCEUS) that drafted the Social Security Act of which the RSBY is a part (Government of India 2008b).

Of the sample, the Director General and GTZ official continue to be directly involved in planning and overseeing RSBY implementation across the country. Despite having moved overseas since the study was conducted, the World Bank specialist still works on the RSBY in a consultative capacity. The remaining three officials are now only distantly connected with the RSBY mainly because theirs had even originally been an advisory role in the RSBY.

The questions to policymakers were mainly to do with their role in the RSBY's creation, rationale for its design and general ideas about the programme's performance and overall direction.

Prior to interviews, I contacted most officials through post and e-mail. Participants normally consented to the interview only after follow-up telephone calls and e-mails. I used personal contacts in Delhi to access the former Minister and the GTZ expert. However, local acquaintances only helped to the extent of an initial introduction, after which I established direct communication with the former Labour Minister's office and the GTZ expert to arrange interviews, which occurred some weeks later. These contacts were not involved in any stage of the interview process and hence the authenticity of the responses was assured.

In choosing participants, I used the commonly-employed technique of "reputational snowballing" (Farquharson 2005, p.347), whereby informants were asked to recommend other people that could provide information on the RSBY.

Often the same names would recur in conversations and this increased confidence in the credibility and suitability of the respondents sampled for this study.

Implementers

Table 3 below gives a detailed breakup of the managers and doctors interviewed for this study.

Table 3: RSBY implementers interviewed

GROUP	JOB PROFILE	NO. OF INTERVIEWEES
Delhi Government	Labour Commissioner, Deputy Labour Commissioner, Mission Convergence Chief, RSBY Manager, RSBY database Manager	5
Insurance Company	RSBY Regional Manager (North & East India), RSBY Manager (Delhi)	2
Third party administrator (TPA)	Chief Executive Officer (CEO), Former Vice-President (Operations), 1 Mid-level RSBY Managers, 1 Data Manager, 1 Liaison Officer (Hospitals), 1 Liaison Officer (NGOS)	6
Nongovernmental organisations (NGO)	22 Managers 6 Workers	28
Medical providers	26 Doctors; 6 Hospital Administrators <i>(discussions with 13 Software Managers)</i>	32

State government

In Delhi, the state government's Labour Commission oversees the implementation and running of the RSBY. Its welfare division called Mission Convergence is closely involved with generating and updating the databases on eligible individuals in Delhi and providing these to the central government. The

Mission is also responsible for coordinating its network of NGOs to help with informing local families about the RSBY and making their office space available to TPA enrolment teams.

By scrutinising official documents and through discussions with a couple of senior health officials in the Delhi government, I narrowed down on five key state administrators to interview for this study. The Labour Commissioner, Deputy Labour Commissioner and the departmental head of Mission Convergence led state-level planning for the RSBY and took important decisions on its implementation arrangements. The other two respondents were middle-level officers at Mission Convergence who handled RSBY data records and supervised local operations at the NGOs.

As with officials in national government, I directly contacted most state administrators via phone calls and e-mail. The Labour Commissioner was the only official approached through a known contact in the state's health department. They, in turn, put me in touch with the Deputy Labour Commissioner who was the key state officer in-charge of the RSBY from 2008 to 2010 and had represented the Delhi government in all RSBY-related meetings organised by the central Labour Ministry.

Interviews with this group of state officials mainly focussed on their views, general perceptions, and experiences of managing the RSBY. Questions explored topics such as institutional resources and capacities for implementation, constraints and challenges faced and how these were overcome by them as well as their relationships with other frontline agencies like the insurance company, TPA, NGOs, and doctors (details in Appendix C).

Insurance company and Third party administrator (TPA)

In Delhi, the insurance company contracted by the state government to implement the RSBY had in turn outsourced the role of administering the programme to a private third party administrator (TPA). In effect, the TPA was in-charge of most operational activities for the programme, which included enrolling members, recruiting hospitals, settling payments and managing all transaction records. Two senior managers at the insurance company were interviewed. They were the key coordinators for RSBY activities at a regional level (North-East India) and locally in Delhi. In addition, six individuals at the TPA who were involved in various capacities with RSBY implementation in Delhi were selected for interviews. They included the Chief Executive Officer (CEO), a former senior RSBY director in charge of operations, a middle-level manager who supervised local enrolments, a back office data manager responsible for handling all RSBY records and claims data from hospitals, as well as two junior executives that networked with RSBY providers and local NGOs. All eight participants from both the insurance company and TPA were associated with the RSBY since its launch in Delhi in 2008. Hence, they were in a good position to give a general overview of the programme as well as provide detailed information on initial barriers and challenges to implementation.

Non-governmental Organisations (NGO)

Local NGOs helped enrolment teams inform, mobilise, and register eligible people from their neighbourhoods into the RSBY. At the time of this study, there were 53 NGOs that had been involved with RSBY activities. I eventually arranged meetings at 15 NGOs. The sample of NGOs was selected purposively based on information available from departmental and NGO websites as well as through

snowballing techniques. Hence, organisations were chosen to broadly represent areas across Delhi and based on their knowledge about the RSBY. Chain sampling or a snowballing approach based on interviewee references was adopted in order to identify organisations with varying experiences of the RSBY, resulting in the final sample of 15 NGOs.

At all NGOs, I met with at least two relevant personnel, usually their RSBY manager and one or more field workers. Interviews addressed issues to do with their general experiences of the RSBY and their interactions with other stakeholders especially the TPA and recipient populations.

Health care providers

About 90 private nursing homes and small hospitals were part of the RSBY network in Delhi when this study was conducted (April-October 2010). Their contact details were available from the information pamphlet handed to RSBY enrolees when they registered for the programme. Although the state labour department and official RSBY websites also included discrete directories of participating hospitals in Delhi, I found some discrepancies between the three sets of records. I decided to draw a sample of clinical providers from the hospitals named on the information pamphlet since beneficiaries were more likely to have accessed facilities listed on it.

To ensure a wide range of participants, I included facilities from across Delhi's nine districts, randomly picking the second or third name on the district-wise list. I visited 33 facilities in all but only the responses from 32 are recorded because one of them was new to the RSBY and had neither much knowledge nor experience of the programme. Respondents were generally of three kinds— those

associated with the RSBY since it began in 2008, new members with less than a year's experience and a small number with no reported work with RSBY patients. I met with at least two people at most facilities, a clinician-cum-owner or health care administrator as well as the technician/receptionist who managed online transactions. I contacted all facilities through post but arranged interviews through follow-up phone calls and e-mails to individual providers. Only one doctor contacted for the interview was unwilling to participate in the study for undisclosed reasons and was replaced by another facility from the list.

RSBY recipients and users

I conducted face-to-face interviews with 84 individual members of the RSBY from as many as 77 households. Nearly 90% of respondents had recently accessed RSBY hospitals in order to get a family member treated or avail of the services themselves. Of the remainder that had not utilised RSBY facilities, one family had apparently not received their membership card, another interviewee had not so far needed treatment, and seven respondents had used other public or private facilities mainly because of their unfamiliarity with RSBY hospitals. Purposive sampling was used to recruit participants for this study (Corbin & Strauss 1990). The main criteria for inclusion was that they were adult (over 18 years) members with self-reported or visible use of RSBY hospitals. The sampling strategy also involved identifying programme recipients with wide-ranging experiences of the RSBY in different locations. In this respect, it was useful to go through local NGO workers and occasionally RSBY doctors who facilitated meetings with patients who happened to be admitted in hospital while I was visiting. As NGOs and RSBY hospitals were spread across Delhi, interviewing their local clients enabled a geographically heterogeneous sample of RSBY recipients to

emerge⁴⁰. Although it was not intended to be statistically representative, women are over-represented in this sample of RSBY users (55 women, 29 men). The respondents were more evenly balanced between those who were employed and individuals mainly engaged in household work (40:44).

Patients were interviewed either while they were undergoing treatment at RSBY hospitals or within six months of having obtained medical care at a participating facility. Interviews normally began with general questions about how people were approached for the RSBY, their awareness about the programme and procedures for joining the programme. Later queries asked about their experiences at RSBY hospitals, prompting and probing to explore feelings about the services offered to them, reasons for using or not using RSBY facilities and whether they had faced any problems while accessing treatment or paid anything for services. At times, participants would launch into discussions about their experiences at RSBY hospitals, in which case I made sure to return to other relevant questions about mobilisation and enrolment at the close of interviews.

There were a few instances where RSBY recipients were interviewed at NGO offices, although most interviews took place in participants' homes. I conducted all interviews in the local Hindi language. Before starting interviews, I explained the content of the introduction letter to them, highlighting the clauses on confidentiality, use of personal data and the right to withdraw at any stage of the research (before publication). This seemed to satisfy most respondents and even though they were offered a translated version of the information sheet in Hindi, few were interested to have it. All participants gave their verbal informed consent for the interviews and agreed to have them audio recorded.

⁴⁰ The use of "gatekeepers" to access local communities is discussed later in this chapter.

There are well-known merits and drawbacks in offering cash or in-kind incentives to research participants (Grady 2001; Tishler & Bartholomae 2002; Wilkinson & Moore 1997). This is especially so when they belong to economically and socially disadvantaged groups and preventing unwarranted influence and biased responses is a major concern (Grant & Sugarman 2004; Reiser 2005). However, I decided against paying interviewees mainly because I did not wish to offend personal sensibilities nor affect the randomness of coming across atypical cases or service users with unusual experiences of the RSBY. Moreover, there were arguably few transaction costs for participants in this study since I accessed them at locations where they already happened to be and they took part in the study voluntarily.

DATA ANALYSIS

A specialist computer-assisted qualitative data analysis software (CAQDAS), NVivo version 9 (QSR International 2012) was used to organise the research material, which given the large number of interviews may have been difficult to manage and analyse manually. All interviews were transcribed in Microsoft Word 2007 and along with their audio recordings imported into NVivo. Besides providing a single point for storing and easy retrieval of the raw data, NVivo has useful tools to help with coding and analysing the research material. Hence, while reading the transcripts, data (phrases, sentences, or paragraphs) were simultaneously coded and deposited in free-standing, individual “nodes” that were assigned a label to reflect their properties. Nodes could also be hierarchically arranged by having sub-categories linked to a higher-order node that was later helpful when explaining certain results. For example, a node for “enrolment problems” was followed by child-nodes organising the possible causes:

“eligibility”, “lack of information”, “scepticism” and so on. It was also particularly helpful for later analysis to have been able to annotate and create “memos” recording observations and emerging ideas while reading the texts.

The process of interpreting and analysing the data was essentially an inductive one of allowing the data to “speak” and have themes emerge from the concepts and ideas expressed in the material. However, as other researchers point out (Hennink et al. 2011; Pope et al. 2006), in reality, there was also a complementary deductive dimension to the analysis in this study⁴¹. For example, initial ordering of the interviews was guided by the research questions and data was systematically organised according to the respondent grouping to which they belonged (formulators, managers, doctors, and so on). Similarly, some codes were also developed based on the topic guide and key issues identified through earlier literature reviews (for e.g. “user choice”, “cost-efficiency”, and so on).

From its early until more advanced stages, the analysis proceeded iteratively and involved a constant back and forth movement between raw data and thematic codes. For example, to ensure an accurate interpretation, I frequently scrutinised coded excerpts from interviews in the context of what was said immediately before or after by reading their surrounding text. Similarly, I repeatedly listened to audio recordings of the interviews to pick up subtle cues in the conversation such as verbal intonations and pauses in speech that were accordingly annotated in the coded passages.

⁴¹ Deductive analysis is not uncommon in applied qualitative research where the objectives of the study are explicit from the start and often used by researchers to develop a thematic frame for analysis (Dimitrova et al. 2006; Pope et al. 2006). Therefore, given that this study was guided by an evaluation framework with the clear purpose of assessing the processes and effects of the RSBY, the deductive aspect of the analysis were perhaps to be expected.

In the main, a process of thematic coding and analysis was followed (Flick 2009; Silverman 2005). In practical terms, this manifested in the following way. I began by randomly picking out six to eight interview transcripts belonging to a respondent category, say doctors, or NGOs. The purpose of this exercise was mainly to get a general understanding of the programme and its processes. I read each interview thoroughly once or twice, coding it along the way based on the key words or general ideas they reflected. This process was repeated for each interview, saturating the initial set of codes with new information while also producing additional codes. This entire cluster of codes was then re-assessed by going through the text contained under each. In the process, some codes were renamed and where possible, two or more were merged under a single analytic category conveying a more general theme. The object of this exercise was to refine the codes in the search for a comprehensive analysis rather than merely reducing the number of codes that by itself would have served little purpose. This was an important step in the process of assimilating the views of respondents on an issue, say the “drivers for the RSBY” or the programme’s benefit cap of INR 30,000 and getting a sense of their collective experience of it.

The data was frequently interrogated through key word searches enabled by NVivo’s “query” function that could be manipulated to check for what one or more respondent groups had to say about a topic. This was an important way of counter-checking and exploring connections between the data in order to explain emerging results and consequences. In addition, manual tables and Excel spreadsheets were generated to cross-tabulate responses by interviewee sub-groups; for example, surgery versus non-surgery patients, managers versus

frontline staff and so on. Through this exercise, common patterns across respondents as well as points of divergence between them could be detected.

Furthermore, interview material, documents, and their respective coding categories were frequently compared to identify points of “convergence, divergence, and contradiction” between them (O’Cathain & Thomas 2006, p.107). Not only did this process validate the findings from the interviews but also helped derive a more holistic understanding of the RSBY.

REFLECTIONS ON RESEARCH PROCESSES

Ethical considerations

This study was assessed and approved by the Central University Research Ethics Committee (CUREC) at the University of Oxford. All research activity for this study was accordingly carried out within a rigorous ethical framework and strictly adhered to principles of voluntary participation, informed consent, and data confidentiality. Participants were informed verbally and in writing about their choice to opt out of the study at any time prior to publication of its findings. They were also explicitly told and reminded that any information communicated to me was confidential and would later be anonymised to ensure that individuals and organisations were not recognisable in published results.

The range of participants from across institutions and organisational hierarchies meant that distinct issues had to be addressed in each interview situation. For instance, I was concerned about government functionaries only giving me the “official line” and not talking about other important and relevant matters. Keeping this in mind, I prepared additional probing questions in advance to work around this issue. Also, in the course of interviews with policymakers, I

subtly returned to questions that I felt needed more substantive information by rephrasing them. As Duke (2002) reports of her elite interviewees, I also encountered situations where I was asked by doctors or NGO managers to name other people and their colleagues that I had interviewed. However, to maintain confidentiality and anonymity of participants, I often gave a general response to such questions— for example, indicating organisations or localities I had visited rather than individuals I had spoken with. Similarly, in my reported findings, I make certain that participants are not personally identifiable by focussing on their formal positions rather than individual attributes or personalities. As predicted by Aberbach and Rockman (2002), there were times when respondents, normally managers or doctors, would want to first know the main hypothesis of my study. I normally deflected such questions until the end of the interview both to prevent “contamination” of their responses as well as to make best use of available time with them (2002, p.674).

There are also a range of considerations conducting research with welfare recipients and disadvantaged communities (Mitchell & Irvine 2008; Wilkinson & Callister 2010). For example, interviewees may see the researcher as an intermediary to convey their grievances to relevant government agencies. Conversely, they could fear the researcher as an agent of local authorities and worry about losing their benefits were they to voice any complaints. Therefore, prior to interviews, I explicitly informed RSBY recipients about my intentions for carrying out the study as part of my doctoral thesis, making it clear to them that I had no links with government nor any other influential organisations or persons. As anticipated, this did help generate more open dialogue and there was little

evidence of RSBY recipients being fearful or having unfounded expectations from the interviews.

Most interviewees agreed to have their responses digitally recorded except for a hospital administrator in South Delhi who despite assurances of confidentiality preferred that written notes of the conversation were taken instead. Similarly, an NGO manager in East Delhi and doctors at two separate health units asked that I switch off the audio recorder before they responded to certain topics. This was often in response to questions asking them to comment on problems in delivering RSBY services or their relationship with other state and private actors involved in the RSBY. In all these situations, they were prepared, however, to have their responses written down instead.

Using gatekeepers to access RSBY recipients

The use of gate-keeping authorities like NGO workers and health care professionals in a clinical setting to reach RSBY users inevitably raises questions about sampling bias and the extent to which participation in the study was voluntary. RSBY providers and administrators were generally better off socially and economically as compared to programme recipients. In addition, they were in a position of authority in relation to local clients as they dispensed RSBY benefits. Therefore, worries about their overweening influence over programme recipients were natural. However, any adverse effects from this unequal relationship were reduced in three important ways. For one, more often than not, NGO workers only facilitated an initial introduction with RSBY members after which additional members were reached through “snowballing” techniques (Denzin & Lincoln 2005). This meant there was little opportunity to generate a sample determined by

those that implementers considered suitable. Secondly, I made sure to personally explain the terms and conditions of the research study to each individual, reassuring them about the use of findings and handling of interview data and making sure that they understood. Participants were also given the opportunity to raise any concerns and ask additional questions about the study. They were thus able to decide voluntarily whether to participate or not. Thirdly, I found some NGO field workers were RSBY members themselves and belonged to the same community from which they enrolled other people into the programme. As social peers, it was unlikely that they could exert undue pressure on others to participate in the study. I also tried to ensure that interviews were conducted without a third party present although a few meetings with RSBY users did occur when a NGO worker was close at hand or listened in on the discussion. However, their presence was not found to obstruct an open dialogue with beneficiaries. As discussed, this was perhaps because of the fact that most of them were RSBY members themselves.

On the other hand, the unequal power relationship between providers and treatment seekers means that researchers have to be especially careful when patients are interviewed in the presence of hospital staff (Holloway & Wheeler 1995). However, all except three interviews that took place within a hospital environment were private interactions with RSBY users. Moreover, in only one of the three instances was a doctor present for the duration of the conversation with a patient. In the other two cases, I capitalised on the periods during which the hospital staff member was engaged elsewhere to ask specifically about patients' experiences within health care settings. Otherwise, I focussed the discussion on general questions about enrolment and the RSBY's design. Patients interviewed in

hospital wards were generally forthcoming and easily expressed strongly negative views about providers and the practice. In contrast with research elsewhere (Schneider 2002), this indicated that the clinical setting did not constrain users from freely expressing themselves.

Accessing respondents and navigating interviews

I directly contacted most respondents although a few national and state officials were accessed through personal acquaintances in Delhi. I found that my association with the University of Oxford was particularly helpful in facilitating appointments with senior officials and several managers and doctors who recognised this as evidence of my credibility as a researcher. As mentioned earlier, RSBY recipients were mostly interviewed in their own homes when it was convenient for them to talk. Since interviews involved no additional transport or opportunity costs for them, they were not remunerated. While all other participants were interviewed in their office premises, it may have also been professionally and culturally inappropriate to offer financial compensation to government officers and other managers and doctors working on the RSBY.

As several respondents were busy professionals, organising meetings with senior managers and doctors was especially time-consuming and required many follow-up visits and phone calls. At other times, participants like RSBY recipients were only available during their afternoon lunch-breaks or late in the evening, after work. This clearly required flexibility on my part as far as the timing of interviews was concerned. Since I did not want to miss any opportunity to meet respondents, I sometimes had to conduct more than one or two interviews on given days. It is important, however, to point out that multiple interviews in the

course of a day did not negatively impact the quality of interactions but on the contrary, were often useful to keep up the momentum for dialogue. This was especially true when interviewees belonged to the same respondent category and so each interview added depth to the questions asked. Moreover, I had to be prepared to capitalise on spontaneous offers by NGO workers or doctors to introduce me to RSBY recipients soon after I had finished interviewing them. At a few NGOs, registration activities for other welfare-oriented programmes were underway during my visit to their offices. This was opportune because alongside discussions with NGO managers and staff, I was able to conduct successive one-on-one interviews with RSBY beneficiaries. It was also helpful for a preliminary assessment of the emerging data by comparing and contrasting the responses from different RSBY stakeholders.

Interviewees, whether government officials or private professionals, were for the most part forthcoming in their responses despite being pressed for time. Some RSBY recipients, however, were more taciturn in their responses. Normally, I had to press on by asking them additional open-ended questions that needed them to elaborate on topics such as how doctors and medical staff had responded to them and the services they were offered by RSBY hospitals. I found it was useful to ask general questions about the medical problem they had faced and which had resulted in them going to an RSBY hospital. Often this stimulated more dialogue on the nature of treatments offered to RSBY patients.

Since interviews with RSBY recipients were often conducted in compact living quarters and relatively close-knit communities, there were times when a one-on-one interaction developed into a group discussion with a family member or neighbours trying to join in the conversation. I normally handled such

situations by directing my questions to the person being interviewed and requesting other people not to intervene in the dialogue.

I independently conducted each interview in English or Hindi depending on the comfort level of the participants with either language. Being bilingual was a particular advantage because I could understand the use of specific phrases. Moreover, it built a comfortable environment for interviewees who found it easier to express themselves as they switched from one language to the other.

OVERALL LIMITATIONS AND THEIR RECONCILIATION

This study is subject to the general limitations of qualitative work (Denzin & Lincoln 2005; Patton 2002). It looks at the RSBY's enactment in a specific setting and its impact on one particular group of poor individuals — people living in urban slums and public housing in Delhi. Typically, qualitative research is criticised for its small-sized samples that make it difficult to generalise findings to other settings. However, qualitative studies such as this question the belief in a single representation of reality and are essentially intended to represent variety and plurality (Tobin & Begley 2004).

As mentioned earlier, the fact that I was a solitary female researcher working with a fixed budget and time limit had been an important factor in choosing to restrict the research arena to Delhi. However, I made a concerted effort to represent a range of voices from those most closely associated with the RSBY and able to give important insights into the programme. I also tried to develop a broad-based analysis and used a variety of methods to access information. Each method and data source acted as a counter-check for what the other reported (Denzin 2009). As a result, not only did this establish greater

confidence in the research findings but also helped develop a deeper, more comprehensive understanding of the RSBY.

About one year into data analysis, I had follow-up meetings in August 2011 with two RSBY formulators interviewed earlier and a senior health specialist who had then recently evaluated the programme in Delhi. Although I did not reveal to them the particular results from my study, these “member checks” (Lincoln & Guba 1985, p.314) shed greater light on research findings and supported further analysis and theorising about the RSBY .

However, despite this, there are intrinsic limits to what qualitative work can achieve. As Patton (1999) observes of qualitative research in general, the results from this study are also likely to be both specific to the local context and the time when it was conducted. The focus on Delhi and its unique experience of the programme is clearly not representative of the RSBY’s general situation and performance. In addition, it is likely that the results may neither reflect situations and events in certain neighbourhoods nor the experiences of relatively less-empowered service users. Equally, the focus on current RSBY recipients clearly meant lesser attention on eligible families who may have been rejected for some reason and those that knowingly or unknowingly did not participate in the programme. While it was not practical in this study to access this group of hard to reach, eligible non-members given limited time and resources, a fuller assessment of the RSBY will require that their viewpoints be incorporated. The study also does not measure “hard” outcomes but instead analyses RSBY “process measures” to extrapolate based on the manner of programme delivery (Calnan & Ferlie 2003). There is, therefore, clearly need for further longitudinal research that develops measurable indicators for service quality, health status and economic outcomes

from the programme. While there is need to go beyond Delhi to examine the RSBY in other regions, this study nevertheless provides useful insights into programme delivery and utilisation experiences in an urban environment. These may be useful pointers for future work in this area.

Chapter 4: Traversing the political pyramid

*Analysing the views of policymakers on creating
the RSBY*

INTRODUCTION

Studying the origins of the RSBY

It is almost a truism that the design of policies profoundly shapes their results and consequences (Hill 2009; Howlett et al. 2009; Knoepfel et al. 2011). While this clearly makes it important to examine their design as part of evaluating the performance of policies, all too often policy design is narrowly equated with the technical content of policies (Reich 1995; Walt & Gilson 1994). On the other hand, policies are contended to have both “instrumental” and “normative” dimensions: the former relate to their structure and form while their normative features include their underpinning values, rationales and premises (Schneider & Sidney 2009, p.105). Contained within policies, therefore, are policymakers’ visions of which goals are worth pursuing and the mechanisms for achieving them (Hall 1993; Knoepfel et al. 2011; Rein 1976). Hence, in order to establish the robustness of policy design not only will it be important to have knowledge of its structure and substantive content but also an understanding of its underlying values, goals and assumptions.

Policy theorists contend that policymaking is rarely a neatly defined exercise of matching strategies to policy goals but is more often influenced by a variety of political, social, economic, and administrative factors (Howlett 2005). Knowing why certain policy devices are adopted may be crucial to assess their suitability for reaching intended policy goals. By studying the structures and processes of policy formation one can hope to unveil the myriad influences that dictate specific policy choices and strategies. Understanding the formulation of the RSBY is, therefore, a key starting point for this analysis.

Accordingly, this chapter investigates the genesis and early development of the RSBY. In keeping with the research aim, it (and Chapters 5 and 6 that follow) is guided by an actor-centred analytical approach that recognises the centrality of policy actors in influencing and effecting policy change (Howlett et al. 2009; Knoepfel et al. 2011; Walt & Gilson 1994; Yeates 2008). Focussing on the role of top-level policymakers and government advisors involved with creating the RSBY, this chapter examines the emergence of the RSBY and the rationale for its creation. It seeks to understand the adoption of an insurance-based approach and the thinking behind specific policy features, benefit rules, and service delivery arrangements. Being better informed about the policy “instrument” (insurance) and its “settings” (technical features) (Hall 1993) is intrinsically important to assess the RSBY. However, investigating policymakers’ ideas and perceptions about the programme is also crucial for gauging the values underpinning the RSBY and thereby, its underlying basis and objectives. From a policy analysis perspective, this means better understanding of the “paradigm” guiding policymakers in terms of what they identify as the root cause of a problem and giving them direction for designing “relevant” and “right” interventions in

response (Rein 1976). This is useful for gaining insights into how policymakers construe the programme's success and the implicit measures they use to judge this.

From the standpoint of evaluating the RSBY, this chapter is the first critical step to establish the robustness of the RSBY design. It thus lays the foundation for later evaluating whether emerging problems in the RSBY may have occurred because of gaps in the programme's formulation or indeed emanated from implementation deficits.

OVERVIEW OF METHODS

Relevant policy documents and publications were thematically reviewed for information on the RSBY's history, political actors involved in its creation as well as general knowledge about its substantive content and stated goals. This initially included web-based searches of parliamentary and political speeches, official press releases, departmental websites and RSBY guidelines and related policy documents. Subsequently during fieldwork, additional material such as minutes of meetings, conference presentations, research papers, unpublished papers, and grey literature was obtained from key informants. However, in order to look beyond prosaic official statements and understand the deeper basis of the RSBY, seven high-ranking officials and experts were interviewed using a semi-structured topic guide. This sample included the former Labour Minister in the UPA government during whose tenure the RSBY was forged, government administrators and planners as well as two senior Social Protection experts at the

India offices of the World Bank and the German federal agency, GTZ⁴². Using a combination of methods and a wide spectrum of data sources validated and strengthened the findings (Denzin 2009). While the sample of interviewees is relatively small, it comprises top-level politicians and officials who were closely connected to the RSBY's conception and creation. The initial sample of interviewees was drawn based on information from newspaper reports and the RSBY website and this eventually snowballed into the final sample of seven participants. Throughout the text, interviewees are referred to by their official titles, although where necessary these are modified to ensure that participants cannot be identified by name. More detailed information on the methodology is available in Chapter 3.

FINDINGS: ORIGIN AND EVOLUTION OF RSBY

“Not a bolt from the blue”⁴³: Imperatives for the RSBY

Texts and interviews revealed that the RSBY was launched against a backdrop of high-level policy debates in India on introducing social security legislation for unorganised⁴⁴ sector workers. Even though most respondents noted that the welfare of informal workers was high on the agenda of the present Congress Party-led, United Progressive Alliance (UPA) government, it was evident that the process of enacting a new law had previously been set in motion by earlier administrations. In 1999, the UPA's predecessor, the National Democratic Alliance (NDA) led by the centre-right Bharatiya Janta Party (BJP) had set up a formal

⁴² GTZ became GIZ in January 2011. However, the GTZ acronym is used throughout the thesis as this agency was involved with the initial development of the RSBY.

⁴³ Phrase used by the former Labour Minister in his interview.

⁴⁴ In India, unorganised workers is the term used to denote informal workers. Unorganised sector employees are essentially unregistered workers without access to formal social security measures. “Unorganised” and “informal” workers are used interchangeably in this text.

Labour Commission which besides deliberating on general matters of worker welfare was specifically asked to develop an “umbrella legislation for ensuring a minimum level of protection to the workers in the unorganised sector” (MoLE 2002, p.6). Strikingly, this was only the second time in the country’s post-colonial history that a formal government-appointed body was constituted to discuss labour issues; the first having been set up over three decades ago in 1966 (MoLER 1969). Thus, while the interest in formalising welfare for informal labour clearly seemed to have cut across party lines in India, it had evidently also re-emerged as an important policy issue quite recently, in the last decade or so. Official documents unambiguously state that the stimulus for the (renewed) political interest in social security for workers emanated from wider structural changes brought about by large-scale economic reforms in the 1990s.

The need for setting up of the Second National Commission on Labour was felt due to vast changes occurring in the economy during the last three decades especially in the nineties due to globalization, liberalization and privatization. (Planning Commission 2006, p.9)

The Labour Commission’s report champions the view that labour is “human capital” and not a cost. Further, it upholds the need for social security for workers to help them cope with economic and structural changes, thereby retaining their efficiency and aiding the country’s “international competitiveness” (MoLE 2002, p.6). More recently, the national Planning Commission’s mid-term appraisal report (2007-2012) gives a similar justification for the well-being of workers:

An effective social security system... is an instrument for sustainable social and economic development. It facilitates structural and technological changes, which require an adaptable and mobile labour force. With globalization and structural adjustment policies, social security assumes a renewed urgency. (Planning Commission 2011c, p.214)

Policy documents thus highlight a strong economic rationale and instrumental purpose of social security arrangements for vulnerable workers in India.

Meanwhile, any intended action by the NDA on enacting a new law was nipped in the bud by the UPA's unexpected victory in the national elections of 2004. It was evident that this new administration was strongly committed to labour security as demonstrated in its National Common Minimum Program that expressly mentions setting up a body to carry out a focused study on "the problems facing enterprises in the unorganized, informal sector" (NCMP 2004, p.3). Established in 2006, the National Commission for Enterprises in the Unorganized Sector (NCEUS) was, like the earlier commission instituted by the NDA, instructed to draft a social security bill for informal workers. Intending to address the primary risks faced by this group of workers, namely health shocks, maternity-related issues, old age, disability and death, an old age pension scheme and a health insurance programme were two central features of the proposed bill (NCEUS 2006). However, the UPA had apparently had a hard time pitching the bill to parliamentary bodies that were unhappy with its restricted benefits. But the former Labour Minister, Oscar Fernandes of the UPA, considered their demands unreasonable given the fiscal constraints of the government:

The Standing Committee of Parliament was not willing to accept this.. They were saying, "What you're giving is not adequate. Add many more things like bonus, pension, gratuity." None of these things are feasible... when you have resources improve on that." (Former Labour Minister)

While the NCEUS proposal on health insurance was a standard social security programme based on worker contributions and run by a centralised fund

(NCEUS 2006), the RSBY was officially unveiled as a stand-alone and wholly government sponsored programme in 2007.

The UPA Government has introduced the Unorganised Sector Social Security Bill, 2007, which envisages social security schemes for workers in the unorganized sector. In anticipation of the bill being made into law, the Government has launched three major schemes to effectively put in place a social security net... (including)... Rashtriya Swasthya Bima Yojana... (Government of India 2008a, p.19)

The timing of the RSBY's launch is perhaps noteworthy because as the quote above reveals the government had not waited until Parliament passed the new social security law. This indicates that political pressures on the government may have come from other quarters. In this context, it appeared that imminent national elections in 2009 and uncertainty about when the legislation for informal workers would go through Parliament may have made it imperative for the UPA to devise potentially vote-winning, populist measures like the RSBY. This hypothesis is supported by the fact that the Congress Party's election manifesto of 2009 urges public support for it based on the UPA's progress towards "health security for all" through programmes like the RSBY (AICC 2009). Similarly, respondents revealed a sense of urgency within the government that manifested in intense political pressure on Labour Ministry officials to roll out the RSBY quickly. Hence, the World Bank expert commented:

They wanted to have something to announce on (2nd) October 2007, (Mahatma) Gandhi's birthday. There were three things... expansion of the Indira Gandhi Old Age Pension Scheme... Aam Aadmi Bima Yojana which is life insurance... (This) was just a political announcement, subsequently there was a programme... And then the third one was RSBY...in fact, (Director-General) was under pressure to even issue the smartcard on October 2nd... He wanted to think it all through and get it done right but there was a big rush. (World Bank advisor)

Political drivers for the RSBY

All interviewees acknowledged the role of the UPA administration in pursuing the social security agenda and pushing forward with formal legislation and establishing ancillary welfare schemes like the RSBY alongside. Having been the Labour Minister at the time, Oscar Fernandes described the intense pressure he had come under as top-level leaders like Prime Minister Manmohan Singh and Congress President Sonia Gandhi, had impressed upon him the urgency of enacting legislation for the unorganised sector.

...we have been debating for over years to provide them something...It never happened. But the UPA government felt that we should do something for these workers...It is the brain-child of the Congress President and the Prime Minister... that we should do something for the unorganised labour...Almost every week I was getting a reminder or a call from either... "Where we have reached? Are we getting it done or not!" (sic)(Former Labour Minister)

While the strong backing for informal worker welfare from powerful UPA leaders may have created a favourable political environment for the RSBY, the key champions for an insurance-based approach were apparently other high-ranking politicians in the government. For example, the respondent from the NCEUS contended that influential individuals in the UPA who were "more inclined towards social insurance" or considered it "a viable route" were the principal drivers for the RSBY coming into existence. He also felt that despite the government having significantly changed the social security programmes they had proposed, the NCEUS report was the conceptual basis for measures like the RSBY.

While national politicians were the primary actors behind the RSBY reform, texts and interviews also revealed the significant role of a few key officials in

steering the programme. For example, media reports and interviewees including those from the World Bank and GTZ highlighted the personal zeal of the Director-General at the Labour Ministry who helmed the RSBY nationally.

(Insurance companies) weren't that interested (in the RSBY)... it took a lot of convincing that this could be done...Ultimately, because Mr. X was able to get critical mass... enough states ready to go... insurance companies...said, "Look, this could get big...we don't want to miss being there..." (World Bank) had nothing to do with convincing the state governments (but)...Mr. X spent many, many hours. In the first month, he went to twenty states...Travelling all the time...I think X was the key person driving this (RSBY)... did a vast majority of everything. What we did is...put some resources... some procurement. (World Bank advisor)

Therefore, through personal visits and dialogues with reluctant provincial administrators the Director-General had evidently encouraged many state governments to embrace the RSBY and helped sustain the momentum for the programme.

Role of external agencies and experts

Through their local offices, international organisations like the International Labour Organisation (ILO), the World Bank, and the GTZ were also closely involved in providing technical assistance on the RSBY to the Labour Ministry. Particularly with the World Bank, their influence seemingly endured all the way through the programme's inception, launch, and subsequent implementation. Moreover, the World Bank and GTZ were often active and vocal RSBY representatives for the central government at various forums and conferences with state-level implementers of the programme (RSBY National Workshops 2009; 2010; 2011). The significance of these agencies for the RSBY is clear from official reports and organisational publications which acknowledge their substantive contribution to the programme's design (Palacios et al. 2011; PHFI 2011). For

example, a recent GTZ publication draws attention to the World Bank's involvement "in shaping RSBY from the start" and its own role in "designing and implementing the scheme" (GTZ-GmbH 2010, p.7). But interestingly, it lays special emphasis on the RSBY's domestic origins and states that it "was entirely designed and developed by the Indian Ministry of Labour and Employment" (GTZ-GmbH 2010, p.7).

Despite such assertions, interviews revealed that the World Bank and GTZ were cardinal to the RSBY's creation and evolution. For example, the Director-General at the Labour Ministry asserted that the RSBY "wouldn't have happened but for the support that (they) got from the local team of the World Bank... (and)... it's happening today because of the World Bank and GTZ." This official who was given the responsibility to lead the RSBY initiative cited his lack of knowledge about health insurance as the grounds for why he had sought assistance from international technical experts to design the RSBY.

...when we were asked to do this job I didn't really know what to do. So after...a few sleepless nights, I jotted down about 300-odd questions trying to understand what health insurance is...We set up a task force with experts from ILO, World Bank, which looked into those questions and evolved the first paper for health insurance which came to be called Rashtriya Swasthya Bima Yojana. (Director-General, Labour Welfare)

On their part, respondents from the World Bank and GTZ revealed that they were in an ongoing and continuous dialogue with the Indian government on issues related to social protection including pension reform and health insurance. Specifically, the partnership between the Labour Ministry, ILO, and the World Bank was formalised a few years before the RSBY's launch when a separate task force to look into social security for unorganised workers was set up. The World Bank expert also indicated that this task force was established at the behest of the

Director-General who shared their broad vision and ideas for the social security system in India. He explained that the Director-General had apparently responded well to an article that he had written along with another World Bank colleague in which they had critiqued the NCEUS proposals for being too ambitious and not feasible in the Indian context. Unlike NCEUS recommendations, they were suggesting a graduated social security system that advanced from pensions to life insurance and eventually led up to health insurance initiatives. However, the World Bank expert went on to reveal that the suddenness of the top-level directive to the Director-General to put together a national health insurance programme made him automatically turn to this pre-existent task force for advice.

When Mr. X came in (to the Labour Ministry), we met with him. He immediately formed a task force on this issue of extension of social security coverage... Then a couple of months into his tenure... he was given the mandate to health insurance... The same group continued to discuss it... three of us from the World Bank and Y (from ILO)...So we started brainstorming on how this could be done. (World Bank advisor)

This team soon came to include the GTZ as well. As the following interviewee describes, this agency had decided to collaborate on the RSBY partly because of its interest in health insurance as a mechanism of health care delivery but also because of the evident enthusiasm towards the RSBY displayed by key officials in the Labour Ministry.

GTZ was working with the Ministry of Health and health insurance was one of the components on which we were supporting Government of India...even earlier. So when the (RSBY) scheme came, though it was with the Ministry of Labour but since it was a health insurance scheme and health insurance was one of our mandates, we thought maybe we can get involved with that. Especially when we talked to the people who were involved from the government of India side in the scheme, we felt that it has a lot of potential. More than the scheme, the people like Mr. X (Director General) and other people who were involved in the scheme. (GTZ advisor)

This core group of international experts and Indian government officials had apparently looked at other local and overseas health insurance programmes for ideas and policy features that were exportable to the RSBY and to the Indian setting. While not prominently referring to themselves, experts from these international agencies had clearly played a part in introducing specific features in the RSBY such as a membership fee, flexibility regarding how insurance companies set premiums and the RSBY's technology-based transaction systems. They were also significant for the RSBY design at the broader level in terms of how RSBY operations were run, especially in the decision to have private sector professionals manage the programme.

One other element that was important was to minimise any potential for the government to kind of influence the process of paying claims and so on... So rather than have the government have to worry about 5000 hospitals and (what) each one is doing... they just don't have the administrative machinery to do that...you offload that and you set up the incentives so that the insurance company...it's in their interest to make sure that there is less fraud. (World Bank advisor)

Furthermore, texts and interviews were more explicit in describing the instructive roles of these agencies in setting rules for service providers, drafting sample contracts and medical packages and designing monitoring and information systems for the RSBY. A recent GTZ publication highlights their assistance to India's RSBY programme and describes their role the following way:

GTZ...provide(s) support to the government in preparing the documents that constitute the regulatory framework and to devise stipulations for implementation. These documents include templates for tendering by insurance companies, guidelines that clearly define each stakeholder's role in implementation, and draft agendas and participation lists for workshops on RSBY. (GTZ-GmbH 2010)

In a similar vein, the GTZ interviewee described how they and the World Bank had remained closely involved with the RSBY long after its launch and now had clearly demarcated roles in running the programme.

So at this point of time other than the government of India, these two main development agencies, World Bank and GTZ who are actually working very closely with government of India on this scheme. There is a small... informal core group but World Bank, GTZ, Ministry of Labour—people are there from these three agencies and some other government of India agencies... which sits every week and reviews the progress— what are the issues and how it's happening... With the World Bank and GTZ we have very clear areas more or less defined...For example, the IT related matters and the smart card is more where the World Bank provides support. But in the insurance related or the health related or the finance related matters...GTZ provides more support. (GTZ advisor)

Why health insurance?

Respondents stated that the RSBY model and an insurance route were generally felt to have been preferable to alternative financing and delivery methods involving the public system. It became important to discuss this question in some detail in order to gain insights into the practical and ideological concerns that guided the RSBY. Official statements and documents underline that the RSBY was not intended to replace public sector services but was an “important step in supplementing the efforts being made to provide quality health care to the poor and underprivileged population” (Planning Commission 2011c, p.155). The UPA administration seemed to have mooted the RSBY as an “experiment” that with its high membership figures had now proved worthy of wider expansion (PMO 2011). Conveying a similar view, a senior Planning Commission official noted:

It's not that we are thinking only about insurance... It is happening in bits and pieces... (W)e are committed to increase the expenditure on (health). The issue was that do we spend on more of the same approach⁴⁵ or do we

⁴⁵ Publicly-run national services.

think about something which yields results... I mean we can't say that this (RSBY) is definitely going to yield a good result... we'll see. See these are controlled knobs. Now we have to see which control knob has to be released further...and which tightened. So that's why... we have an option of the control knobs with us. (Health Advisor-1, Planning Commission)

As indicated in the above response, there seemed to be a general perception among interviewees that India's public health care system was physically inadequate to offer widespread coverage to the population and to deal with an increased demand for health care.

Apart from the physical outreach, it was quite clear that the public sector was not being able to perform because it did not have...the basic minimum wherewithal...So the only way to bridge this gap at least in the short-term to medium-term was to provide a social insurance type of solution. But with a difference ...the government would...provide the...premium. (Senior member, NCEUS)

Similarly, policy documents openly state that poor people in India are driven to spend heavily on hospital treatments because “the public owned health infrastructure leaves a lot to be desired” (RSBY 2013, p.3). Hence, health insurance can help “overcome(e) financial handicaps, improv(e) access to quality medical care and provid(e) financial protection against high medical expenses” (ibid.).

A health insurance model was also perceived to be advantageous from a macroeconomic perspective in terms of its ability to help overcome local supply-side shortages and encourage private sector investment and growth. The former Labour Minister emphatically argued this point and highlighted that a major national programme that covered “almost half” of India's billion-strong population offered a ready-made market and a natural stimulus for private development of health care infrastructures. It was less clear, however, whether these were merely retrospective reflections by participants or had actually influenced the decision to introduce a national programme of health insurance. Nevertheless, it was an

opinion shared by other officials and international experts. In a similar vein, a senior government planner contended that a health insurance programme could potentially open up entrepreneurial opportunities for international business, generally aiding economic expansion in India.

India is the second largest population. If everybody gets insured then our market becomes the largest market in the world. So that means all company would like to come here (sic)...So if you have got a ... good profitable model...then everybody would like to work here. (Health Advisor-2, Planning Commission)

For most respondents, however, one of the chief merits of health insurance was its potential to check dishonest financial practices. Hence, the presence of professional insurance companies was believed to curb corruption in service delivery. As the GTZ official commented:

Government can become purchaser...like (British) NHS has or like Thailand...but for that you have to have very strong systems. And in a place where you have lots of corruption ...lots of weaknesses in the system...it can be exploited very easily...But (the) presence of insurance sector...can help...you can take advantage of their strengths... (GTZ advisor)

Similar views were expressed by the NCEUS advisor who felt that alternative mechanisms like fixed-price vouchers or exemption schemes were likely to fail because they would inevitably be implemented by wasteful and possibly corrupt public agencies.

(E)xemptions mean somebody has to reimburse that private sector...Who's that somebody?...Who's going to check whether that 30000 (rupees) has been charged correctly or incorrectly?...So there's some government agency which comes in... to examine each and every bill...Given the way our government agencies are working in the business...That's exactly what we didn't want them to do for the scale that we are talking about. It would have been a horrendously bad system... (Senior member, NCEUS)

According to some senior State officials, health insurance was also a more transparent method of welfare delivery. For instance, the Director-General indicated that since hospital claims were determined by patient usage under a health insurance system, fund flows could be more easily tracked as compared to the traditional budgeted transfers to public hospitals.

We did something for 60 years. We tried that model which is called the supply-side management of health care. This is a demand-side management. Wouldn't it be better to allow that man (patient) to decide what he has to do or to keep pumping money somewhere without knowing where it is going?... (Director-General, Labour Welfare)

All three responses above hence reflect an inherent mistrust of State-run systems and bureaucracies. They, thereby, reveal that ideological factors were as important as practical issues of capacity and costs for the development of a health insurance model.

RSBY's allocation to the Ministry of Labour

Respondents were asked the reason why the RSBY was located within the Labour Ministry instead of the Health Ministry as one may expect of a State health insurance programme. Interviews indicated that this was mainly because RSBY was conceptualised as a social security measure for informal workers and was less to do with general expansion of health care services in India. The former Labour Minister argued that the RSBY was a focussed intervention for unorganised workers and this gave the Labour Ministry an incontrovertible mandate to run the programme. He further enunciated his point about Labour's suitability to oversee the RSBY by stressing that at the national level there was lesser need for specialist or technical knowledge to manage health-related initiatives.

Health Ministry can deal with it but whom are they going to cover? Not the population as such... (For) Employees State Insurance⁴⁶ ... (some may say) Labour Ministry cannot run a hospital but we are running. Railway's job is not to run a hospital but they are having hospital for their employees (sic). Military—it is not their job to give health to the soldiers but they have to cater... (RSBY) is a scheme of the Labour Ministry. Social security is from the Labour Ministry. (Former Labour Minister)

In the wake of the NCEUS report in 2006, several meetings were apparently held at the Planning Commission to discuss the introduction of a health insurance programme for unorganised workers. Interestingly, at this point both Labour and Health Ministry officials were involved in these dialogues and there was also discussion on whether to locate the new programme within the Ministry of Health.

So once this (NCEUS) report was out, thinking went on as to what should be done...in terms of health coverage. There was already a Universal Health Insurance Scheme⁴⁷ but the uptake of it was not too good. So then... how do we take up people within this unorganised sector? The deliberations took place over here... and then we were also looking for who is going to take it up. Whether the Ministry of Health or somebody...Ministry of Labour. (Health Advisor-I, Planning Commission)

However, some like the GTZ advisor contended that the Health Ministry had been openly reluctant to take responsibility for a national-level health insurance programme.

Basically, the scheme was offered to Ministry of Health first...because health is their mandate. But they refused to implement the scheme... They said it's too complex...let the state (governments) do what they want to do. We don't want to get involved with this. (GTZ advisor)

On a related note, the Director-General revealed that most other Ministries were opposed to dealing with health insurance, which was generally perceived to be a “difficult subject” and because worldwide, insurance-based programmes were running into implementation problems. Interestingly, the GTZ advisor disclosed

⁴⁶ As discussed in Chapter 2, a statutory social security scheme for organised sector workers in India.

⁴⁷ For further details on this scheme, see Chapter 2.

that even within the Labour Ministry's internal bureaucracy, civil servants had been taken by surprise when they were initially asked to design and lead a health insurance programme.

...it was given to the Ministry of Labour because (they) were involved in terms of designing part of it...Though initially Director-General and all said we have nothing to do with either health or insurance, so why is it coming to the Ministry of Labour? (GTZ advisor)

Nevertheless, most State officials downplayed any political juggling between the Labour and Health Ministries over the RSBY. In general, they saw the RSBY as a social security measure and thus well within the Labour Ministry's mandate to administer.

...it came (about) as a social security measure for the unorganised labour. So it is a welfare measure for the labour sector... (On the other hand, Health Ministry) is only taking health as a generic, not focusing on the health (of) A, B, C... (Health Advisor-II, Planning Commission)

The RSBY model

Policymakers' reflections on specific features of the RSBY and the processes by which decisions about them were made gave important insights into their underlying assumptions, preferences, and visions for the programme.

Targeting workers or citizens?

On the face of it, the RSBY seemed to be inspired by the UPA's concern for social justice and egalitarianism as reflected in its formal declarations on social inclusion, broad-based welfare and citizen empowerment (Government of India 2008a; NCMP 2004; Planning Commission 2008a). However, underpinning the RSBY was a broader policy approach that endorsed the instrumental role of welfare programmes in improving people's productive capacities. This was

evident in various policy documents and declarations by UPA leaders. For example, while acknowledging the government's moral responsibility towards India's "working classes" with "nothing more than their labour power" to sustain themselves (PMO 2005), Prime Minister Singh elsewhere suggests that the policy solution lies in creating "special programmes for livelihood support for the poor and vulnerable, aimed at directly increasing their income earning capabilities" (PMO 2011). The RSBY website echoes a similar sentiment to explain the rationale for the programme given that for poor BPL people "an illness...represents a permanent threat to their income earning capacity" (MoLE 2013).

In his interview, former Minister Fernandes gave further expression to such ideas on encouraging human capital formation through measures like the RSBY. He pointed out that people's health status fundamentally affected their ability to work and support themselves and hence good health was the "first basic requirement" for poor workers as it made them productive. This was apparently one of the main reasons why health benefits were prioritised in the UPA government's plans for improving social security arrangements for informal workers. Hence, the former Minister stated:

NGOs...labour organisations...were not happy...They sa(id) what you're doing is not enough...(Informal workers should) get all the benefits that organised labour is getting...We (government) don't have that kind of money. We may need crores of rupees (billions) to do that. So what we told them is that we will take the step. To provide them the first basic requirement...If you are healthy, you can work, you can earn. If you are not healthy...you cannot eat. It is a vicious cycle. So first be able to do your daily work ...and with that you'll be able to earn till you are fit. (Former Labour Minister)

Revealing the underlying economic rationale for targeting welfare benefits to informal workers, the NCEUS report notes that productive workers also make for more active consumers of goods and services.

...(in) a developing country such as India, social security ...helps to develop a healthy and contented workforce...A workforce with higher capability and security could contribute to higher growth, which, in turn, would enhance the aggregate demand in the economy through higher purchasing power of this vast mass...The mutually reinforcing nature of this relationship needs to be recognised and exploited. (NCEUS 2006: 13)

The NCEUS respondent, however, was keen to differentiate his own position and that of the Commission from the way the RSBY unfolded and came to only target BPL workers. While the NCEUS had desired fuller coverage for all unorganised workers, they had apparently also considered this a more practical option given how difficult it was to identify and locate BPL households in India. Yet, it was interesting that the NCEUS official did not consider social insurance a feasible method to universalise health care coverage in India. According to him, health insurance and implicitly, the RSBY, were realistic measures only for working populations.

In the world, there are families which have workers and families which are living on doles and social assistance. There are only two kinds of people. So we looked at it from the workers end because that was the mandate of the NCEUS. The other people would in any case be eligible to social assistance...The route would not be social insurance. (Senior member, NCEUS)

On the issue of more inclusive and expansive RSBY coverage, it is now known that the programme is being extended beyond those that are officially poor (For further details see Chapter 7 on the Evolution of the RSBY). Yet given that it originated as a scheme for workers and was located within the Labour Ministry, the focus remains on “occupational groups” of registered building and

construction workers, beneficiaries of the national rural employment programme, domestic workers and street vendors (Government of India 2011; PIB 2011a; RSBY 2011b). This not only reflects but also reinforces an attachment to the labour market as an important marker for RSBY membership.

Financing arrangements

As per RSBY rules, the central and state governments pay an annual premium per family to insurance companies from their general budgets. No contributions are needed from RSBY members although they pay a registration fee of INR 30⁴⁸ that in principle funds the administration⁴⁹ of the programme. This user-payment was evidently introduced at the behest of a senior member of the World Bank team who had felt it would serve as a good reminder to recipients to use RSBY services when the need arose. However, it was clear that the Director-General had a “very hard time selling” this idea to senior government officials who were strongly opposed to charging poor individuals.

Similarly, it had not been straightforward for task force officials to tackle the issue of setting RSBY premiums. Yet, they were clear about not having a standard rate apply across all regions as was the case with the NCEUS proposed health insurance scheme. RSBY designers had also desired to set an upper limit on how much insurance companies could charge per household. This monetary cap

⁴⁸ \$1=INR 50

⁴⁹ It is unclear whether there is a system to ensure that state governments do indeed use these payments for administrative purposes. For example, an internal communiqué obtained from labour officials in Delhi revealed that in the initial period registration fees paid by RSBY members was being adjusted against the state’s share of the insurance premium.

on insurance fees mainly aimed to spell out the State's financial liability for the RSBY⁵⁰.

...probability of cohort being hospitalised for a BPL family in rural India is reflected...in the surveys. But if you had insurance it would be a completely different consumption... So nobody had any idea what the premium should be...(T)he key decision was—don't hard-quote it. Don't say this is the magic number... (but) let's put a cap because government has to know what the maximum expenditure is going to be ... And then let the market determine what it's going to be. (World Bank advisor)

Although discussions with insurance companies had apparently preceded the fixing of an upper limit, the World Bank advisor acknowledged that the calculation itself was unscientific and “very back-of-the envelope stuff”. Therefore, with insufficient data to guide an actuarial analysis, the premiums eventually quoted by insurers were often based on intuitive estimates. As the GTZ advisor explained:

Everybody is going (down a) blind alley...Everybody quoted something based on some experience, whatever they have...But there were no data available...So most of the time insurance company quoted premium just like that...And it was more based on some assumption, some hunch just to get the market or whatever you can say. (GTZ advisor)

With regard to reimbursing contracted doctors, task force officials clearly wanted payment arrangements to be unlike traditional systems of fixed salaries and budgeted allocations to government hospitals; a method they deemed inefficient and wasteful.

...when (government) pay(s) directly to the hospital, there is no incentive for anybody to contain cost. Because if you have a system where the money is parked with you...then why do you want to contain cost.. (GTZ advisor)

⁵⁰ INR 750 (\$15). Moreover, the central government pays up to but no more than INR 565 (about \$11) per family.

This resulted in the RSBY's consumer-led payment system which was expected to be more cost-efficient and also incentivise providers to provide good quality care to RSBY clients.

Participants were also asked to comment on the general funding scenario for the RSBY and its future sustainability. There were mostly mixed reactions to this. While advisors at the Planning Commission and NCEUS were generally cautious in their views, most other respondents were more confident about the RSBY's financial viability. The GTZ respondent attempted to dispel worries about future increases in insurance premiums destabilising the RSBY. He contended that even hefty upward revisions would make negligible demands on public funds and that, therefore, State commitment was a more important factor for the RSBY's continuation.

...this is a very small amount... Even if the premium goes double...it'll not be more than 0.14% of GDP... because if the government commits to it then it is not a huge amount. (GTZ advisor)

The NCEUS advisor picked up on this last point to note that the RSBY's reliance on State funds was of immense consequence for its evolution and survival. He indicated that the future course of the RSBY was heavily dependent on domestic politics and the current administration's policy priorities.

The funds are still moving via the Ministries and via the budgetary route. Therefore, there is always an "if" and a "but" about how they will expand, how much they can expand, what would be the central government commitment in... future years. (Senior member, NCEUS)

Limited health benefits

Interview discussions about the RSBY's benefit structure addressed its two principal limitations: restricted hospital-based care and an annual ceiling of INR

30,000 (\$600) on the value of treatment available to recipient families. While it was not entirely clear from the responses why RSBY treatments were capped at 30,000 rupees, the programme seemed to have simply followed precedents set by earlier health insurance schemes⁵¹ for BPL and unorganised workers in India (NCEUS 2006). However, this restriction also appeared to have been a deliberate measure to keep the RSBY within fiscally manageable limits. For example, a senior Planning Commission official indicated that since the RSBY was an experiment, it was more realistic for them to restrict the amount until the programme's performance was evaluated. By not being overly ambitious, a benefit cap of INR 30,000 was also seen to have more staying power with important stakeholders like insurance companies.

Arguing that there were limits to how much the government could offer as health benefits, the NCEUS respondent contended that what the RSBY currently offered its members, namely inpatient care worth INR 30,000, gave them adequate financial security.

We had to work around with different figures to say what would be most feasible—just hospitalisation (or) hospitalisation and outpatient. What is the kind of coverage which would take care of a fairly significant part of the risk which workers bear...Clearly the sky's the limit when it comes to medical expenses... What we proposed was very modest...just 30,000. But given that the average cost of hospitalisation in 2004-05 was only around 9,000 (rupees), the point is that you're taking care of about three times the mean... a very significant improvement over the existing situation. (Senior member, NCEUS)

Furthermore, practical considerations to do with administration seemed to have been an important reason for offering only inpatient care under the RSBY. For example, the Director-General believed that there was a greater chance of

⁵¹ The Unorganised Sector Workers Social Security Scheme (2004) and Universal Health Insurance Scheme (UHIS), 2004. Earlier discussed in Chapter 2.

overuse by patients if ambulatory services were included as part of RSBY benefits and that that such treatments were more difficult to monitor⁵².

My personal take is that for OPD (outpatient) it should be government (public service provision) because insurance cannot handle OPD. There will be moral hazard in it. But for inpatient there has to be a combination of government and private hospitals, thereby giving the poor man a choice. (Director-General, Labour Welfare)

Other respondents also felt that the inclusion of State-run primary health care facilities in the RSBY was not feasible because of serious capacity constraints in the public sector. In this respect, the World Bank respondent reflected on the challenges they had faced in preparing even relatively better-equipped public hospitals for the RSBY:

The reason (outpatient care) wasn't included from the beginning was the practicality of it. It was just not going to be practical to track outpatient services in this way...It's been a struggle to get public hospitals...equipped to handle smartcard transactions. To do it at the PHCs⁵³ and lower levels is going to be very difficult... (If you gave somebody the right to go ten times to outpatient services, they'll go ten times. So it's not an insurable type of risk. (World Bank advisor)

Involving private service providers to deliver RSBY services

Much like their rationale for an insurance-based model, most respondents felt that it was necessary to involve companies and private providers in the RSBY because of the limited capacities of local bureaucracies to implement large-scale programmes of this nature. It also seemed that the RSBY had always intended having private professionals take on important tasks to do with service delivery. There was a general perception among respondents that this could improve health care infrastructures in the country by promoting private sector growth. In this

⁵² The RSBY has recently started pilot-projects in a few districts to test the feasibility of making outpatient services available to its members (MoLE 2013).

⁵³ State-run Primary Health Care Centres.

respect, the former Labour Minister also felt that this freed up limited State resources that could then focus on more pressing economic priorities and ventures.

We have involved entirely the private sector. Reasoning is if you run the hospital well, you'll get enough patients and you'll give them the best of service... (Public system) is not adequate... for (its) infrastructure you have to...provide enough money. We don't have enough money for every sector. Number one is infrastructure itself—roads, bridges, power. Power is number one requirement in the country... So which sector you're going to spend money? If somebody's doing, let them do it. We pay for it. (Former Labour Minister)

While most interviewees including State officials, advisors, planners and Task force members agreed that there were limits to public provision, the World Bank participant noted more general problems with health care supply in India and was the lone voice to discuss the limitations of the private sector.

...there's really not much hospital regulation going on. That's a big issue. So the RSBY gets done in very hostile environment in terms of the situation with hospitals, which are very unregulated and very...poor quality in many cases. Public and private (hospitals). (World Bank advisor)

Both experts from the World Bank and GTZ also considered it detrimental to patients' interests to have a system where State hospitals and public agents had absolute control over funds and spending decisions. However, they believed the RSBY could be used to encourage competition between public and private hospitals and hence promote more efficient operations.

(Private sector participation) is primarily to contain cost and bring more services to people.... You bring competition between public hospitals and private hospitals... So they have an incentive that whatever money they earn, they can use it for their hospital...And what it does... if a hospital improves then it does not only improve for RSBY patients, it improves for everybody. (GTZ advisor)

This was also the rationale for opening up the RSBY to multiple private insurance companies. Nevertheless, it seemed to have been equally important for RSBY designers to prevent local monopolies from developing and to keep up pressure on hired companies through short-term contracts that needed to be annually renegotiated. This was noted by the respondent from the World Bank:

...if you're not competing with anybody, if you're just handed over a state, you're not going to feel much pressure to do a good job...incentive for insurance company to perform adequately (is because) the next round (of enrolments) is going to come up for bids again. Now we've gone from one year to three years (contracts), which is sensible but you're not guaranteed....So there's constant pressure ...You want to make it worthwhile for the company to invest their resources...but not so worthwhile that they know that they're locked in for 10 years with solid revenues. They have to work at it. (World Bank advisor)

Besides competition among service providers as the basis for private sector participation in the RSBY, another issue prominently discussed in the interviews was the expansion of patient choice in terms of where they accessed health care services.

...government health machinery is already getting developed...but...it takes a little time...Instead of the government being mere provider of services let (it) make an arrangement of providing a choice of services. Because there have been reports...feedback that though the public health system is getting evolved but the quality is not good, responsiveness is not that much, accountability issues are there. (Health Advisor-I, Planning Commission)

It is probably the first scheme to empower the BPL person ... giving him a choice of the point-of-delivery. Public Distribution System he is tied down to a shop...In RSBY he can walk into any empanelled hospital, public or private anywhere in the country ...He decides which hospital he would like to go. (Director-General, Labour Welfare)

However, respondents also admitted that getting private stakeholders to become involved with the RSBY had not been easy. Insurance companies had apparently considered it “just another government scheme” and were uncertain

initially because of the RSBY's complex and expensive administration. It appeared that once state governments were persuaded through the personal urgings of the Director-General, private enterprises were also more easily convinced about the RSBY's scale and profitability. The interviews revealed that the programme had to be "marketed" to local stakeholders and providers by emphasising the personal and financial gains to them from the programme. Official RSBY documents and its website similarly extol the RSBY's market-oriented model with economic incentives for all stakeholders built into its design (RSBY 2011a). There is also a liberal use of market terminology in policy documents, with references to RSBY as a "product", its successful "market(ing)" to stakeholders and its "business model" (RSBY 2011a, Swarup 2011). Elaborating further on this theme, the Director-General drew attention to the novelty and workability of promoting the RSBY in this way.

...this scheme was not thrust on anybody. It was marketed...This terminology is not used in government parlance. Marketed in the sense of conveying the value that the scheme has for each of the stakeholders...whether it is insurance (companies)...hospitals...state governments...district administrations. Once they understand the value in the scheme, the scheme will happen. (Director-General, Labour Welfare)

DISCUSSION AND CONCLUSION

This chapter examines the conceptualisation and creation of the RSBY in India. It retraces the RSBY's political origins in order to explore the politics behind the programme and learn about its underlying motives and goals. This analysis gives insights into important questions such as: why the need for such a programme arose, what the options before policymakers were and why they made the choices that they did. This chapter thus develops a fuller understanding of the

RSBY's design by drawing attention to the values and assumptions underpinning it. In the final analysis, this will help evaluate if negative outcomes or unintended side effects were fundamentally to do with the way the programme was designed or its subsequent implementation. Equally, this chapter also generates better knowledge about the actors, institutional structures, administrative arrangements and processes of policymaking in a developing country context and in doing so contributes to wider policy analysis literature (Gough & Wood 2004; Horowitz 1989; Keeley & Scoones 1999; Kilkey et al. 2012; Mooij & de Vos 2003; Rudra 2007; Thomas & Grindle 1990).

It was evident that the RSBY came about in a background of increased political interest and national debate on extending social security to India's unorganised workers. The findings suggest that the pressure for social protection reforms in the country had become stronger over the 1990s when informality and insecurity of livelihoods surfaced as important concerns following large-scale deregulation and privatisation of the Indian economy. As an explicit policy commitment of the incumbent UPA administration, it had apparently pushed for the establishment of a new social security law for unorganised workers. However, as is often the case with legislating new policies in democratic settings, getting the new law approved seems to have been a long-drawn out, protracted process of parliamentary deliberations. In the meantime, an upcoming national election arguably put added pressure on the Congress-led, UPA government to devise substantive policy measures demonstrating its achievements in office. The results show that even as it waited for its proposed law to go through Parliament, the UPA administration rapidly launched a series of welfare programmes and "flagship" schemes including the RSBY. Thus, political circumstances at the time, specifically

slow parliamentary dealings and an impending national election, appear to have propelled the introduction of the RSBY.

The findings also reveal that within domestic political circles, the RSBY was generally considered a social investment that could improve the efficiency of Indian workers and thus contribute to future economic development in the country. The RSBY hence constituted a “productive” diversion of the State’s resources given its potential to enhance the overall “competitiveness” of the Indian economy. Furthermore, issues to do with the economy and economic growth seem to have been primary concerns for the UPA administration. This was clearly demonstrated in the Labour Minister’s assertion that private actors needed to be involved in delivering the RSBY in order to allow the government to focus on more pressing economic matters like power and infrastructure development. These findings suggest that prevailing political thinking and policymaking within India was strongly “developmentalist” (Kwon 1997) and “productivist” (Holliday 2000; Wilding 2000) in its orientation. Commonly used to describe East Asian welfare systems in countries like South Korea and Japan, an important feature of a “developmentalist-productivist” welfare approach is that the economy takes priority over all areas of public policymaking (ibid.). Correspondingly, social policy is considered a supplementary instrument and an enabler for economic growth. As the literature highlights, since efficiency and productivity rather than human “needs” or “rights” guide social policies, welfare measures tend to be devised in limited ways: programmes for restricted and often the more productive sections of the population and with an underlying emphasis on human capital formation (Holliday 2000; Kwon 2005).

This finding perhaps explains why national policymakers gave importance to expanding health care in India and also shows how they justified this investment in policy debates. The relatively low orientation of government towards social spending unless it was deemed “productive” may have also contributed to the measured approach in designing the RSBY. Hence, the programme’s focus on only the “poorest” (BPL) among the poor. Similarly, only costlier forms of care, secondary treatments in hospitals, which policymakers felt were more likely to have catastrophic financial consequences for users were covered. Furthermore, there was an annual monetary limit on treatments with INR 30,000 available to a family of five and no provision for carrying forward unspent balances to the next year.

It is also worth noting that the period when the RSBY was under discussion coincided with growing international dialogue on universalising health care (WHO 2005). The foregoing discussion, however, indicates that the RSBY grew out of political concern for informal workers in India and developing human capital for economic growth. To that extent, the RSBY’s birth was not necessarily a response to global calls for universalising health care. As will be discussed in later chapters, the RSBY’s association with the UPA government’s current welfare-driven agenda of universalising health coverage thus appears to be an ex-post-facto development (GTZ-GmbH 2010; La Forgia & Nagpal 2012; Joint Learning Network 2013a).

It is also significant to note that the RSBY was largely a centralised initiative, backed and led by senior politicians and State officials in the national administration in India. The central government’s dominant role in the RSBY was also evident in the fact that it was mainly high-ranking public administrators and

senior planners that took important decisions about the programme. This finding is significant given the increasing emphasis within the global social policy literature on the influential role of donors and multilateral agencies on policymaking activities in developing countries (Deacon 2007; Gough & Wood 2004; Surender & Walker 2013; Yeates 2008). Theorists identify two main forms of leverage exercised by external actors over policies and priority setting in low-income countries: one, emanating from their position as financial donors (GEG 2008; Okuonzi & Macrae 1995) and secondly, through less overt forms of influence such as global knowledge transfers (Dolowitz & Marsh 2000; Stone 2004). In contrast, the results in this study show that national policymakers in India were the main champions and drivers of the RSBY. Although the content and institutional structure of the RSBY were fleshed out in conjunction with external specialists from the World Bank and GTZ, the policy instrument of health insurance and programme goals were clearly conceived within a national policy domain.

Nevertheless, it is important to acknowledge that the complexity and novelty of enacting a health insurance reform seemed to have created a space for international expertise to be drawn in to help develop the finer points of the programme. The findings show that the Labour Ministry's pre-existent collaboration with international specialists from the World Bank and ILO continued through the early stages of the RSBY's formulation and soon included a representative from GTZ as well. These policy technocrats were seen to aid and inform senior State bureaucrats on matters to do with health insurance and their inputs were undoubtedly important for the RSBY's structural make-up. As a result and perhaps not surprisingly, the RSBY also came to reflect many of the prevailing

ideas of these bilateral and multilateral agencies on privatisation and market competition⁵⁴. Accordingly, ideological critiques of public services, their inefficiency, and intrinsic corruptibility drove the overall implementation structure of the RSBY.

The RSBY design team of civil servants in the Labour Ministry and external specialists revealed a deep-seated scepticism of publicly run services and an abiding faith in the effectiveness of market-based health care provision. This profoundly shaped the RSBY. While government institutions and officials were accorded a general financing and stewardship role in the RSBY, its administrative apparatus clearly intended to bypass public bureaucracies and local state agents. Accordingly, private participation for ground-level management of the programme was encouraged and insurance companies, third party administrators (TPA) and NGOs invited to join the programme. Similarly, based on the poor reach and capacity of public health care facilities, RSBY formulators allowed the entry of private hospitals and clinics into the programme; also ostensibly as a measure to increase patient choice of service provider. All the way through its conceptualisation and formation, RSBY's designers were careful about the costs of the programme. Hence, with a view to effecting greater cost-efficiency in the RSBY, they encouraged the development of "quasi-markets" (LeGrand 1991) through a demand-led financing model in which "money follows the patient's" choice of provider. Essentially, this measure aimed to spur competition among RSBY providers who in bidding for more revenues and clientele were expected to deliver better quality services to patients. At a broader level, this is another case reflecting

⁵⁴ For more on the current thinking and practice within some international organisations, see Buse et al. 2013; Koivusalo & Ollila 2008; Surender & Walker 2013.

the growth of choice-led policies worldwide, with similar arguments about user choice in public services leading to improved efficiency and welfare outcomes having been made in the course of government reforms in other settings including more developed nations (Blomqvist 2004; Fotaki 2007; Newman & Kuhlmann 2007). In the U.K. for example, more consumer choice has been a central focus of education and health care reforms since the late eighties and continues to be an important part of government policy in recent years (Ball 2012; Propper 2010).

In revealing the key drivers and determinants for the RSBY, the results from this research draw attention to the goals and values underpinning the programme. Overall, it is apparent from the findings that efficiency, competition, and individual choice were paramount concerns for Labour Ministry officials and external technical experts. Even responses from top-level politicians and public officials upheld these matters as eminently important. Notably absent from the interviews and policy discourses surrounding the RSBY were matters to do with aligning the RSBY's financing and benefit structure to reflect redistributive goals or broader principles of social solidarity.

Importantly, the findings also reveal policymakers' assumptions about the local environment and of actors within it. They clearly anticipated certain outcomes based on the RSBY's design and expected service providers to be suitably incentivised to enrol and treat the maximum number of people; thereby advancing the RSBY's goals of financial protection and greater access to services. To that extent, the RSBY is emblematic of a bureaucratic vision that perceives programme implementers to be rational agents driven by personal economic and material gain. However, to make for more compelling results and to fully

comprehend the programme's effects and consequences, it is crucial to hear from RSBY's implementers and medical providers and learn about their experiences in the programme.

Chapter 5: From policy corridors to the implementation arena

Exploring the views and practices

of RSBY's managers and clinical providers

INTRODUCTION

Why study RSBY implementation?

This chapter investigates the implementation of the RSBY and the delivery of medical services through the programme. It is a widely acknowledged fact in both academic and policy circles that the way programmes are implemented affects their outcomes in important ways and particularly that policies are often not delivered as intended (Barrett & Fudge 1981; Berman 1978; Hill & Hupe 2009; Pressman & Wildavsky 1973; World Bank 2004; WHO 2007a). Agencies like the WHO and World Bank also recognise the importance of policy implementation for the success of policy and have produced a range of documents on improving service delivery for better health outcomes (Spratt 2009; WHO 2007b; World Bank 2004). On the one hand, an “implementation gap” (Dunsire 1978) may result in policies not fulfilling their goals. Equally, unplanned-for implementation practices will inevitably have unexpected and undesired consequences. Hence, when evaluating programmes, it is imperative to assess why delivery problems occurred and what the barriers and challenges were to effective policy implementation. This

calls for investigating the RSBY's implementation structure and environment in Delhi.

Studying implementation as a discrete "stage" in the policy process seemingly creates an artificial divide between policymaking and implementation activities since both processes inform and feed into one another (Hill 2009; Howlett et al. 2009; Knoepfel et al. 2007). Nevertheless, a linear approach of studying RSBY formulation in Chapter 4 and programme implementation in this chapter is conceptually useful for evaluating the RSBY.

The vast policy literature also recognises the importance of implementers' attitudes towards the programme, their "buy-in" being considered vital to a programme's effectiveness (Matland 1995; O'Toole 1986; Palumbo et al. 1984). In this respect, implementers' support for a policy may be determined by several factors. Some analysts believe that better management from the top can improve policy implementation; for example, through more funds and resources, better communication of policy objectives, improved incentives and regulatory controls (Sabatier & Mazmanian 1979; Van Meter & Van Horn 1975). Conversely, a prominent group of "bottom-up" theorists contest such a narrow view of implementation and regarding it as a linear, rational process with a direct chain of authority and generally compliant delivery agents (Barrett & Fudge 1981; Elmore 1979; Hjern 1987). Instead, it is argued that like policymaking, implementation too is deeply political and involves a variety of conflicting ideas, interests and influences (Brugha & Varvasovszky 2000; Reich 1995; Walt & Gilson 1994). Hence, for example, in some contexts organisational cultures and existing norms may influence health care providers into behaving in a negative or stereotypical way

towards service users (Gilson & Erasmus 2004). Researchers also find that welfare workers manage stressful workplaces with scarce resources and heavy workloads by developing routine ways of typifying clients and singling some out for benefits (Lipsky 2010). For various reasons, therefore, frontline service providers may behave in ways that are contrary to policy expectations and with consequences that diverge significantly from the original aims of policy. Therefore, taking an actor-centred perspective to understand the motivations and behaviours of RSBY's managers and clinical providers is important to the overall aim of evaluating the RSBY. This is an important step in the analysis because it brings in the insights of those with hands-on knowledge of the RSBY and who are effectively co-constructors of the programme. It is also valuable to study RSBY implementation in order to understand the factors that enable or constrain its current functioning. This may help draw lessons about the model's applicability in other locations.

OVERVIEW OF METHODS

This chapter explores the experiences of people who implemented the RSBY in Delhi and essentially put the policy into effect. It aims to ensure that the RSBY's evaluation is firmly rooted in the assessments of those with direct knowledge and experience of the programme. The findings reported here are mainly based on documentary analysis and semi-structured interviews (SSI). Texts consisted of a range of state government reports and internal records as well as RSBY-related documents such as pamphlets, information sheets and general data obtained from the third party administrator (TPA) and nongovernmental organisations (NGOs). In addition, face-to-face interviews were conducted with 41 RSBY administrators representing the state government, insurance company, TPA and NGOs as well as

32 private doctors and hospital managers in Delhi (Table 3 in Chapter 3). State officials represented the Labour Commission and Mission Convergence. From the insurance company and TPA, senior managers as well as junior-level staff were interviewed. The sample of community workers was drawn from 15 NGOs and included senior managers and field-level personnel. Questions to all respondents were designed to gather information on their motivations for participating in the RSBY and their general experiences of running the programme.

The sample of NGOs was pluralistic in terms of the scale of their operations—some with longer years of experience and operating in other regions of the country besides Delhi. Most of these organisations were set up by professionals or altruists as non-profit societies and are funded by multiple private donors. Their collaboration with Delhi government’s Mission Convergence began in 2008 to help deliver state welfare programmes to local vulnerable communities. The NGO branch associated with the Mission was called Gender Resource Centres (GRC) or Samajik Suvidha Kendra (Community Welfare Centre)⁵⁵. They normally cater to 15,000-20,000 households (approx. 100000 people) and were allocated fixed localities in which to work. They receive funds from the state government mainly to carry out vocational training programmes and provide counselling services to local slum populations.

In this study, health care providers were the doctors-cum-owners or senior hospital superintendent/administrators of private medical facilities in Delhi. The majority of facilities were small clinics or nursing homes with fewer than 20 beds

⁵⁵ The text refers to them as NGOs.

and run by doctors themselves. The sample also included two relatively large hospitals with over 50 beds, one of them run by a charitable trust.

For definitional clarity, the terms “administrator/implementer” and “provider” are used through the remaining chapter to distinguish between state and professional managers of the RSBY and medical practitioners. Professional titles and those of a few organisations have been modified to preserve confidentiality and to direct attention to the content of what was said rather than individual personalities. Further details on the methodology are available in Chapter 3.

KEY FINDINGS

RSBY administration in Delhi: views of state officials, professional managers and frontline NGOs

Local capacities and strategies to locate families

From the previous year, there was a remarkable five-fold increase in RSBY enrolments in Delhi in 2010 when this study was conducted. From about 41,000 members in 2008-09, over 200,000 registrations were recorded at the end of the enrolment period in early 2010. However, it is important to note that despite the significant growth in RSBY membership, over 60% of the target population in Delhi remained without RSBY coverage. Yet, within state government circles, the upsurge in enrolments was widely seen as a sign of the RSBY’s successful implementation in the region.

According to state officials, a key contributing factor for higher enrolments was the fact that eligibility for the RSBY in Delhi was now extended beyond below

poverty line (BPL) families to also include “vulnerable” individuals who were recently surveyed by local NGOs under Mission Convergence. Consequently, NGOs familiar with the new databases were also drawn into important RSBY activities such as information dissemination and community mobilisation. As a state official noted, the combined effect of these two changes was significant for improving RSBY membership in Delhi.

(Earlier)...we were totally dependent on the officials and staff from Food and Supply department... because we do not know who the BPL cardholders are. (Each) food inspectorate would call in the BPL cardholders (to enrol in the RSBY). We did a little bit of radio and press publicity... (but) because we were not sure who the target is, it was difficult for us to have access to them... (This time) Mission Convergence was a logical partner because...not only did they have the (new) database, they also had the NGOs associated with them for identification of these families... (Assistant Labour Commissioner, Delhi)

Although newer records and NGO participation may have helped increase RSBY enrolments in Delhi, NGOs reported several problems finding and enrolling potential recipients for the programme. Many of them highlighted large discrepancies between their own databases and RSBY lists supplied by the central government. Not only did NGO staff find that data from other localities was mixed up with records for their areas, but they also discovered many local vulnerable families missing from RSBY lists. This, not surprisingly, made it difficult for them to mobilise eligible people for the RSBY. The following comment from an NGO manager illustrates this point:

...it was not known which data belongs to which place...Because...the data was not separated according to (our) catchment area. It was (for a larger area) like Mangolpuri...ward... But in a ward or bloc there may be two or three NGOs working... But the data... was very vague... a hodgepodge. Some (BPL data) from the Food and Supply department and some from (our) survey... (NGO Officer, North West district-1)

Locally, some improvisations were attempted to track down potential recipients. For example, TPA and NGO managers picked out familiar names or addresses from RSBY records and targeted individual families. While data problems clearly added to existing workloads at most NGOs, respondents also more generally felt overworked with the RSBY. This was mainly because RSBY enrolment centres normally functioned out of NGO offices and therefore interviewees often needed to do many extra tasks that they were not, in principle, responsible for.

Although initially we were told that we don't have to be around for the registration process but we had to be present. (RSBY) was a full time job for us. One of our community mobilisers was needed simply for controlling such large crowds, somebody was needed during enrolment and another person needed to be in the field calling people (to enrol). So our work was hampered...The entire staff, A to Z, (was involved)...because at times we were just sorting out problems. (NGO Officer, North West district-2)

Many respondents also argued that the enrolment targets they had been set were unrealistic and unachievable in the short time they had to inform families.

You see, (they) have given 14,000 (names)... and we had only one month...In a day if you can do 200 enrolments, it would only come to 6000 (total). It is not possible for us to do 14,000 enrolments. (NGO Officer, North West district-1)

Furthermore, many NGO managers felt constrained by the lack of extra funds for the RSBY especially as it demanded significant amounts of time and personnel. Organisations evidently did not have access to any additional finances to run the RSBY. They had a fixed budget to run all of the state's welfare programmes, over 40 at the time. Although a few respondents stated that implementation of other programmes had "suffered" as a result, most NGO managers felt that it was unrealistic to expect them to focus their efforts entirely on the RSBY and ignore other activities in the bargain.

NGO's limitation is...implementing some programme on a budget. There is a budget for each component... You have a fixed amount for each component. And there is no flexibility. (We) have to spend the money under this head only. There is no proper money for implementing this (RSBY). (NGO Officer, Northwest district-1)

Some also highlighted that their lack of formal grants for the RSBY made them less accountable for how it was run.

...The TPA should (be) answer(able) as the responsible agency. I'm not responsible. I am responsible to explain to the community...to motivate the(m). But the responsibility of implementation lies with that agency who is actually getting the money for this whole thing. (NGO Director, South district-2)

As part of locally devised payment arrangements, the TPA was committed to pay NGO managers and outreach staff a fixed amount of INR 2.5 (about 5 cents) per enrolled family to help with administration costs. Interviews, however, revealed that many NGOs had not received this incentive fee and the few that had were paid several months after enrolment work ceased. Indicating that it was a token amount anyway, most NGOs had rarely followed up on these payments.

Initially they had said that the (NGO) Coordinator would be paid some 2.5 rupees per card for enrolments... But if you talk to many NGOs, they didn't get that money... So there are lots of problems. Everything exists on paper... Practically, it is not there. (NGO Officer, South district-5)

Even state officials at Mission Convergence were keen to highlight the fact that most NGOs worked on the RSBY without any extra funds for managing a programme that entailed significant running costs for them. Often, as a result, NGOs activities were dependent on their own resources and the extent to which they were willing to employ them on the RSBY. Mission staff, therefore, recognised that their NGOs in Delhi had mixed success in mobilising local communities for the RSBY.

You are asking (NGO) people to do the mobilisation but not providing any funding... (RSBY) needs a lot of...equipment...infrastructure...that has to be adequately funded...our GRCs have to use their own manpower...Ideally we should fund these... (Mission Convergence Director)

...the GRCs were not paid anything... some GRCs who were very proactive...they did their own IEC⁵⁶...from their own budget and they were able to mobilise the community well. So the experience has been of varying degree. (RSBY Manager, Mission Convergence)

Regarding their own capacities and resources, a number of NGO managers reported small workforces including mobilisers and field officers to oversee RSBY enrolments. While only a few respondents were candid about targeting nearby homes and not travelling to more distant localities to inform families, others indirectly conveyed that this routinely occurred. For example, most, NGO interviewees were keen to portray themselves in a good light and discussed how they coped despite limited staff. A prominent method involved drawing on their existing networks with local pradhans⁵⁷ and leaders of female self-help groups who helped spread word about the RSBY among their supporters.

...we selected the stakeholders in the community... who help to implement ...they may be like a pradhan... a leader of the community ...to whom the people listen. So we selected (a) hospital... and (a) councillor of this area. We selected their office because we know many people will visit there... This way we could... mount up the enrolment. (NGO Officer, North West district-1)

We have Self-Help Groups within the community. There are many people from various neighbourhoods who are indirectly associated with them...So they are very good messengers for me. We also have 200 people on our vocational trainings...We have to target these people first...because for two mobilisers to inform a 100,000 population is a very tough task...So we find peers from among them to mobilise. (NGO Officer, South district-5)

TPA agents unfamiliar with local communities reported a similar strategy to mobilise families for the RSBY in areas where they worked independently of NGOs.

⁵⁶ Information, Education and Communication.

⁵⁷ Unelected leaders with political clout and connections to local authority.

According to a senior TPA manager, they solicited help from area chiefs and informal political agents to help them reach out to potential RSBY users.

We were coordinating with (agents of) MLAs and MPs⁵⁸ also. Because they were looking at the vote-bank, which is directly catering to MLAs and MPs. (T)hey are very aware of the kind of localities they have... and they have good influence in these areas...(Former RSBY Director, TPA)

From an administrative perspective, these were clearly pragmatic arrangements to ensure that information about the RSBY was conveyed to a maximum number of prospective recipients. However, the three responses above gave a strong message that families with stronger political or social links to local stakeholders stood a better chance of being informed and enrolled in the RSBY than perhaps those who lacked such connections.

In the context of scarce funds and staff, one may have expected NGO managers to be thankful for the fact that a third party was in-charge of enrolments. Yet, most NGOs were critical about the apparent unprofessionalism displayed by the TPA in not sending sufficient personnel and material supplies for enrolment work. Some NGO managers alleged that the TPA in Delhi had employed a limited number of ad-hoc staff to manage enrolments, which had resulted in agents not spending adequate time in each neighbourhood. Moreover, information material meant for families allegedly did not arrive nor did enrolment teams carry enough equipment, batteries, and printers to make and deliver RSBY cards on the spot, as they needed to do.

... Every centre should have had a printer, but every centre did not. They would tell us that not enough cards are being generated at your place and we will only give you a printer if you reach the daily target of 200. So lot of...a week's printing was pending... (NGO Director, Central district)

⁵⁸ Members of state legislature (Legislative Assembly) and national Parliament.

NGO managers, who needed to monitor RSBY enrolments to check fraud, argued that this also made it difficult for them to validate whether enrollees were genuinely eligible for the RSBY.

TPA agents only had their laptop... So without the printer how could we make the card? If the enrolment and printing is done simultaneously then one can verify if a family is needy. But this cannot be done if only enrolments are taking place and not the printing. (NGO Officer, South district -3)

With the delays in printing, often RSBY cards were sporadically returned to NGOs, long after enrolment. NGOs argued that not only was it difficult for them to find and trace families they were not personally acquainted with but they could also not spare the time to make frequent visits to farther off slum neighbourhoods.

No problem if (RSBY) cards are made immediately. But if it's after two or four days, then delivery is a big problem... We still have cards lying with us. They only have the name and photo—it is not possible to identify... Sometimes we take it to the jhuggis (slums)... (But) we cannot go...every single day. (NGO Officer, West district-1)

Anxieties about the future: views of TPA and NGO managers

Giving deeper insight into the TPA's reasons for under-investing in staff and equipment, the company's Chief Executive Officer (CEO) explained that for the TPA, the RSBY was a "project-oriented job" of a limited duration and one from which they did not expect big profits. Moreover, they realised that the financial damage to them could be higher unless they curbed their spending on the RSBY. The CEO indicated that it was, therefore, pragmatic for the company to not have large establishment costs and instead hire local help and rent machinery for the RSBY.

Financially, (RSBY) is not so lucrative...It's a very tight rope... Because... all activities are costing (a lot)... you have to send teams to the field...door to

door campaigning... make a complete kit of items (like) laptops, scanner, fingerprint (machine)... very huge and costly equipment... but you have to also associate with... vendors...who (have)...teams ready, machines ready ...because it's a project oriented job. Once the project is over, the manpower you don't require... (TPA Chief)

On a related note, a former TPA manager acknowledged that more resources and investment on the RSBY by the company could have improved service delivery. However, they argued that having to bid for RSBY work year-on year⁵⁹ made them risk-averse and unwilling to spend heavily on the programme. They conveyed strong feelings of insecurity about the company's future role in the RSBY because of the short-term nature of its contract for the programme.

... if I know that I'm going to do this scheme for the next five years, I'll be investing more on infrastructure, providing better facility, having a permanent set-up... good manpower... permanent employees... (Currently) I am not sure...So that holds me back from few things that I can add on... (Former RSBY Director, TPA)

Like some in the TPA, a few NGO managers in Delhi also indicated that they may have responded better to the RSBY under different contractual arrangements. They resented the fact that under RSBY's existing implementation structure their authority and first-hand knowledge of local vulnerable families was continually tested. These managers specifically desired direct and independent charge of the RSBY in their areas. At the same time, they believed that greater control over funds and decisions about deservingness for the RSBY would help many more people benefit.

...the GRC works in the area and is familiar with who is and is not vulnerable... there will be good output and 100% output (enrolment) once you give GRC the power and make them the decision maker... What is given to (TPA)...that budget give to the GRC...With funds, the GRC can also

⁵⁹ Under new rules introduced at the end of 2012, TPAs on an annual contract have the option of extending their contract for an additional two-year period if they get themselves vetted by an external quality assurance auditor (see MoLE 2013 for details).

recruit temporary staff, decide where to set up camp...GRC should (get) the data and be told that this is the total output (enrolments) required. Now you are free to decide how to do it. (NGO manager, East -1)

It is not for the NGO. If it was the NGO's own (programme), then one is more sensitised ... Because I am the authority, I say (to my staff), "...these 100 (people) have come so...none of you will leave. You have to complete this" ...But other people will say no... So I think for all this a direct intervention is needed. (NGO Director, South -3)

Delivery of health care services: experiences of RSBY medical

professionals in Delhi

Imperatives and incentives for participation by private medical providers

Though outside the study period, it is important to note that there has been a dramatic fall in the number of private hospitals in Delhi participating in the RSBY—from over a hundred in 2010 to a mere 40 in 2012-13 (MoLE 2013)⁶⁰. It is also remarkable that the RSBY did not and continues not to run at any public hospital in Delhi and is only available at small nursing homes and private clinics in the state. This is despite a formal and written commitment by the Delhi government to involve public hospitals in the RSBY, as is revealed by internal documents obtained from state government sources. State-level labour officials explained that the absence of public hospitals in Delhi was mainly to do with delays in setting up suitable management structures within them that could retain RSBY funds for hospital improvements without needing to transfer them to the state's "common kitty". However, other informants and documents hinted that

⁶⁰ Although the RSBY website currently lists 35 RSBY hospitals in Delhi (2012-13), I recently discovered another record on the website listing closer to a hundred hospitals in Delhi. On contacting the insurance company for confirmation, I was told that 40 hospitals had treated RSBY patients this year and hence the website only lists the names of "active" hospitals. According to them there are currently over 100 hospitals that are still part of the network in Delhi. However, a very senior source in GIZ who oversees the RSBY nationally confirmed to me that only 40 hospitals are currently empanelled and available for RSBY patients in Delhi.

political factors, particularly inter-departmental politics may have played a part in excluding government hospitals. A senior insurance company manager for Delhi reported bringing up this issue with labour department officials but the latter apparently could not take an independent decision on involving public hospitals since these came under the administrative ambit of the state's health department⁶¹. Interestingly, in a recent publication, an external agency expert closely associated with the RSBY recalls that public hospitals in Delhi were also reluctant to participate in the RSBY because they claimed to provide free services to the poor anyway⁶² (Grover & Palacios 2011, p.169). As interviews in Chapter 4 made explicit, it appeared that normative considerations may have also played a part in the more active involvement of private hospitals in Delhi. Alluding to an earlier conversation of his with state officials on the subject, the senior manager from the insurance company revealed a familiar refrain about government hospitals in Delhi lacking the physical capacity to deal with large funds and heavy patient loads.

... (We were) informed that (government hospitals) do not have the proper space, do not have the manpower... So once they allow the RSBY scheme in their hospital, there will be (a) rush...They are already overloaded... (RSBY-Delhi Manager, Insurance Company)

Similarly, senior executives and managers in the TPA argued that even smaller private facilities in Delhi were better equipped than government hospitals to provide good quality care to RSBY patients. In this respect, they also pointed out that RSBY's modest rates were only likely to appeal to small-scale providers with

⁶¹ Interestingly, internal documents obtained from state officials reveal similar inter-departmental politics at the state level as occurred between central Health and Labour Ministries over the RSBY (Chapter 4). An internal communiqué reveals that the state's labour department had initially proposed that the health division run the RSBY. However, health department officials had turned down this offer citing the RSBY's focus on BPL populations as contrary to their broader mandate of health for all. (Ref. 1a.)

⁶² This was also indicated by a Task Force official that I interviewed.

lower establishment costs as compared to larger specialist hospitals. The TPA appeared, therefore, to focus their energies on persuading lower-end private facilities with fewer beds and lesser charges to join the programme.

The big hospitals...are not ready to sign for (RSBY)...because for them 10,000 (rupees) is nothing. That's one day's room charges...generally they are C-class hospitals (for RSBY in Delhi)... hospital beds are less than 15. (TPA Chief)

In Delhi, there are 350 hospitals approximately...(We) contacted about 200 ...small and medium kind... they must have all the facilities like X-ray, oxygen ... Costly hospitals will not easily agree with the package rate because they have higher luxury charges. Even in their normal bedded rooms, there are air conditioners... the(ir) staff ...is well-educated and well-trained... There is quite a lot of investment there. So they do not agree to the package rate. (TPA Manager)

Despite this, insurance company and TPA managers reported that private health care facilities in Delhi were initially reluctant to join the RSBY for several reasons but mainly because of worries about its low rates. Providers' financial concerns were evidently heightened by the fact that they needed to spend personal funds to install RSBY's software and technical equipment. However, many doctors stated that they were convinced to join once they became aware that high demand from RSBY clients could possibly make up for low treatment charges. A few respondents also felt that the scheme gave them an opportunity to increase their revenues and be less selective when accepting new cases from their local clientele of poor people.

The kinds of patients I have are from the lower socio-economic strata. And lot of people go back not getting definitive surgeries done because they don't have the money...It's a business, right! You can do charity for one person but not hundred people every day. So you are making money (through the RSBY). (Doctor-3, Southwest district)

On a related note, some doctors pointed out that private facilities in Delhi were always on the lookout for new sources of revenue given high levels of

competition among hospitals and clinics for local custom. As a result, many such providers became interested in the RSBY and looked to it as a way of increasing their clientele and earnings from RSBY patients as well as from the latter's wider social network .

...people who are not covered by the RSBY card... relatives of poor patients are quite rich. I mean they can pay money... So those people also come to my centre... They pay me full amount. So I get indirect business also. (Doctor-1, Central district)

For some providers, having a third party pay for treatment of poor individuals apparently resolved moral dilemmas and feelings of guilt when normally refusing services to people who could not afford to pay.

They are getting the treatment... and we also have a clear conscience. And it is not an economic burden for us that we have to be charitable each time, end up paying our own money. You are getting something. (Hospital Administrator-3, East district)

Now the number (of poor patients) has increased... Previously they had to compromise. In case we (said), "Okay go and buy these medicines", they were not in a position to...But in today's time if they have a problem like viral fever... They get admitted over here for a day or two...They get free medicines also. (Hospital Administrator-8, West district)

Interestingly, some clinicians felt motivated towards the RSBY because it apparently gave them an opportunity to improve their professional expertise by bringing them in contact with poorer patients with more complex medical conditions. They revealed that such atypical cases were more prevalent among less affluent and disadvantaged communities since morbidities were often allowed to fester for longer. However, doctors were quick to add that these patients were nevertheless costlier to treat.

It is giving us good exposure to different kinds of patients. A good surgical experience... This being a poor class since they are unable to go to a hospital ...so we are also getting an opportunity to see certain kind of

unusual cases... That is one advantage. But the price... is very less. Because they're very poor...their general health is not good. We have to spend a lot. (Doctor-7, North district)

Being academicians, (doctors) love to treat difficult cases. When we are organising seminars, conferences...We try to discuss difficult cases...Rare cases... So that we can have more knowledge and more ways of tackling such problems and such problems are more in such groups. (Hospital Administrator-8, West district)

Health care providers' reactions to RSBY benefits and payment system:

Balancing remunerations with capacity and medical risk

Providers overwhelmingly felt that RSBY rates were unreasonably low because they did not reflect the actual monetary costs of treating patients. They were especially frustrated with the RSBY paying them a daily allowance of INR 500 (about \$10)⁶³ for treating general ward patients and expecting them to provide a range of services including tests, medicines, and food within that amount.

For 500 (rupees) you cannot treat a patient, admit him, give him all the medicines, all the investigations. Doctors...consultants are coming (from outside). ...He is charging 700-800 rupees per day per patient. So how can we cover this all! (Doctor-9, West district)

Even as providers gave different estimates for the amount that would suffice to cover their costs, they singularly demanded an increase in their existing allowance for non-surgical care. Many doctors argued that they simply could not afford to treat patients at a per-diem rate of INR 500 since they were small establishments that often had to procure specialist consultants and diagnostic services from outside.

... we are taking so many machines on rent...If you have a big, large set up without...any rental...then you can definitely treat them at this price. But we ourselves are taking so many things on rent. For example, we are

⁶³ The RSBY used to pay a slightly higher amount of INR 750 (\$13) for patient treated in the intensive care unit of a hospital. This amount is since revised to INR 1000.

getting doctors, MD, orthopaedician (sic) or general surgeon...so it adds to cost factor. (Doctor-4, South district)

Although RSBY doctors were paid differently for surgeries— getting a higher and fixed package price for each procedure, they also generally disapproved of these amounts, which were considered significantly below prevailing market rates in Delhi. A few respondents objected to the pricing of specific surgeries, arguing that RSBY tariffs took no account of the extra costs that hospitals incurred on materials and external specialists and the medical risks borne by them.

We have a gall bladder surgery, which is done for 10,000 rupees. Now these are laparoscopic. There will be a surgeon involved, there will be (an) assistant...an anaesthetist ... materials. Need the patient to stay two days. Now divide it—1500, 2000 (rupees). Nobody is going to come at that rate! See there are risks also. It is not like you're selling a slipper...If a slipper is defective, he (customer) comes back to you and you say, "Okay take another one" ... But here you are dealing with a human life. (Doctor-3, Southwest district)

RSBY doctors also felt it was unrealistic to have fixed packages and pricing for treatments because medical practice was not formulaic and based on quick, ready-made diagnosis. Further, they argued that pre-set tariffs left little room for treating more complex cases that may require additional resources. Therefore, they felt that by fixing treatment rates, the RSBY not only made false assumptions about medicine but also curbed their professional practice.

Medical science does not go by this one plus one equals two! There can be lots of variations... patient can have complications or (need) excessive medicines...They are comparing medical sciences with...vegetable buying...Even those rates are not fixed...but these rates are fixed by government. (Doctor-5, North district)

There are certain ailments you cannot fix the amount because once you open a patient, only then you can see what is the ailment inside...multiple complications...Whatever we can do, we do it. Otherwise, government hospitals are there to help such people. (Doctor-1, Central district)

There were also concerns about the legal implications for doctors in case of serious treatment failures and patients taking grievances to court. This evidently made it important for them to evaluate their own ability to deal with RSBY patients instead of thinking about maximising patient volumes. In this respect, several providers explained that there were limits to what they could provide RSBY patients based on their personal expertise and infrastructural resources.

Patient comes to you—80-yr old with peritonitis. How can you operate? I don't have an ICU. How will I take care of him after the operation? ... It's not only the money part, you have a bad name in the whole locality. (Doctor-3, Southwest district)

Patients used to come (for) dialysis. How can I do the dialysis...I'm not a urologist. It is a simple thing. My nursing home is a paediatric service... if somebody says do this job, how can I do it? (Doctor-6, West district)

While it is common to find policy documents and RSBY administrators promote the scheme as a lucrative one for doctors based on potentially large patient volumes, respondents had mixed reactions on this. There were a few providers, often those located in relatively better-off localities, who reported that they had received hardly any RSBY clients since joining the programme. Meanwhile, a couple of other doctors contended that varying levels of intensity per case eventually balanced out any chance of significant profits for them.

It is rarely a profit. There is a lot of loss to a set up if you do not have good number of patients...Even then it doesn't compensate (for low rates)...One patient doesn't need much, other patient needs more. So it comes at par. (Doctor-7, North district)

In terms of the technical aspects of the RSBY, there were generally affirmative statements from respondents. Most doctors reported that the RSBY's transaction software was easy to manage. Compared to other insurance schemes, they also liked the fact that the RSBY did not need them to go through elaborate

pre-authorisation processes with the insurer/TPA before treating a patient. However, despite these positive assessments, many medical providers reported long delays in getting reimbursed for RSBY treatments. While arguing that they had limited personal funds to draw from as they waited to get paid, doctors were also more resentful because they felt they had compromised already by accepting RSBY's low rates.

...The TPAs are giving some ten excuses and we are the sufferers. We are treating the BPL at such compromised rates and not getting the payment from the TPA. (This way) We'll be dead...if you ask me...this is the dark part of the scheme. So we require money, at least to work on the no profit, no loss scheme. (Doctor-4, South district)

Of particular concern were the strategies adopted by some doctors in dealing with the problem. For example, one doctor reported how, in desperation, they had begun rejecting RSBY patients in order to get the insurer to settle their financial claims.

...We don't get the money... and nor do we know when to expect it...I said to them, "I've spent four lakh (0.4 million) rupees and my money is blocked... I'm not a large corporate who can invest a lot of money...if you don't give my money how can I treat patients!" I asked them to terminate my contract and refused to treat their patients... sent away 4 or 5 patients ...because I get so many (RSBY) patients daily...(Doctor-1, South district)

Feasibility of RSBY treatments: risk avoidance and adjustment

by doctors

Many doctors reported the negative effects of RSBY remuneration rates on their clinical practice, as they felt it compelled them to become selective in accepting and treating patients. Some reported that they were unwilling to compromise on the quality of clinical care and hence turned away all non-surgical patients.

I do not take medical (cases)...at all...Because (for) fever if I give them only disprin⁶⁴, that is not done! The patient may be suffering from (more severe) dengue... unethical job I cannot do... I refer them to those nursing homes who are doing it ... I entertain only surgical patients. (Doctor-6, East district)

I will take him (patient) for surgical packages, which I have accepted. But when he becomes ill, I will not take him...In a way we have also left (RSBY). We are doing it yet not really...at our choice we take the patient, at our choice we refuse the patient... (Doctor-2, North district)

Providers also admitted that they assessed each patient on a case-to-case basis. Depending on the reimbursement rate and their estimated transaction and overhead costs, they decided whether a patient was worthwhile to treat.

...suppose there is detachment of the retina, now although RSBY has a package for that for 8,000 or 12,000 (rupees) but the cost for that is bothersome for us. So we will refuse it... Package is less and there is a lot of work involved, it takes a lot of time...there is a vial we have to put. It is a costly affair. (Doctor-3, North district)

If patient stays here for five days then we get only 3,000- 4,000 rupees. Total bill in a normal patient would be 40,000 rupees. So in these kinds of cases, we stabilise the patient and refer him to government sectors. (Doctor-7, West district)

Health care facilities also reported that they frequently received RSBY patients with less serious problems who did not need to be hospitalised. However, since RSBY benefits were only available for inpatient care it created a particular dilemma for doctors faced with patients needing ambulatory services. Even while many doctors claimed to offer free consultations to RSBY users, they nevertheless prescribed medicines and tests which patients needed to pay for. A sizeable number of medical providers, however, followed a firm pay-or-leave policy for patients needing outpatient care.

Scheme is only for patients who need hospitalisation...And if he (patient) desires to use the scheme for an illness which does not warrant admission,

⁶⁴ Aspirin.

we'll ask him either to pay or allow him to go away (to) any other hospital which can cater to this kind of problem. (Doctor-5, North district)

A few doctors also acknowledged that they sometimes hospitalised patients in order to treat them through the RSBY.

Fifty percent patients come for OPD⁶⁵ purposes. I tell them, "Look I'll only get paid if you're hospitalised". So they get admitted. Ten percent cannot stay because they need to get back to work. I tell them they have to pay my consultation fee. Then they give 50 rupees... There's a patient who's been here three or four days. Had come expecting...everything... and on top of that wasn't ready to stay...I said, "Impossible!" ...for the investigation, ultrasound and medicines they have to stay in the hospital... (Doctor-1, South district)

Moreover, some respondents referred to the fact that huge demand for limited hospital spaces in Delhi ensured high occupancy rates at their facilities; hence implying that they had little incentive to needlessly admit RSBY patients. Yet, there were a few doctors who reported that they were compelled to hospitalise patients who threatened to report them to the authorities or pleaded for treatment because they lacked money. While accepting the undesirability of such actions, they felt it struck a reasonable compromise between getting paid and patients being treated without paying out-of-pocket.

Definitely some of the patients are being admitted who do not require it. I have vacant beds, patients are creating a ruckus...Alright, let's admit him... for a day or two... (Doctor-2, Central district)

We have to admit the patient (needing outpatient care). We have to occupy the bed. So that is not correct...They should incorporate OPD (outpatient) services not necessarily all indoor. Then we can choose and select which patient is to be kept and which is not to be kept...And certain patients do not really need admission ... (Doctor-7, North district)

A few doctors also revealed that RSBY patients regularly pressed hospitals to let them leave for work during the day and return to their beds in the evening.

⁶⁵ Outpatient care department.

Some respondents felt this kind of flexibility was needed in order to be able to deliver on the RSBY.

These patients because they are poor...daily wage (earners)...majority of the patients ask us, "Give us treatment. Give us injections. We'll go home. We'll go to the job...if we don't go to the job, we'll lose the job"... we try to adjust—to some extent we admit, sometimes we give injections. We send them home. Let them do their job. They come again in the evening ...So we have to manage. If we become very strict then nothing can be done. (Doctor-1, Central district)

Furthermore, it was apparent that RSBY treatments were more feasible for certain kinds of facilities where specialised services like anaesthetics or gynaecological procedures were performed in-house by doctors running the practice as this eliminated the need to pay external experts.

If I were just an MBBS⁶⁶ doctor then I'd need to call all kinds of specialists...I have to pay them...Then I don't make money at all. But as I'm a surgeon, my wife is a gynaecologist, so we don't need to call too many people. So it becomes viable for us. (Doctor-3, Southwest- district)

Some doctors candidly discussed keeping patients in hospital for longer as a way to recover their costs of treatment.

If my expenses are 900 rupees in the first day...I will try to keep (patient) for two days because I will get 500 rupees per day...For two days I will get 1,000 rupees... after 24 hours if I send the patient, I lose 400- 500 rupees. (Doctor 2, Central district)

A few respondents were also outspoken about the fact that revenues from other private, fee-paying customers helped make up for any extra costs to facilities from treating RSBY patients. At the same time, it was not uncommon for doctors to ration services for RSBY clients and assign them a fixed quota of beds.

⁶⁶ Abbreviation for Bachelor of Medicine, Bachelor of Surgery. The professional qualification conferred on graduation from medical school in India and some other countries.

... We are getting good amount from other patients, so we can adjust the amount (spent on) these poor people ... because we have got limited space we cannot increase (RSBY beds)... we have made special ward for them. We try to keep them there only... If rooms are full, then we see whether very serious patients come with this BPL card, only then we admit them. Otherwise, we can postpone the admission...There is one BPL ward. We have kept that ward for these patients only. There are four beds in that room. (Doctor-9, West district)

We have allocated... five beds for BPL cards. If that is exceeded, then either we ask them to wait or see them in the OPD⁶⁷ and send them away or else advise them to go to other hospitals. (Doctor-1, Southwest district)

The small scale and limited infrastructure of many RSBY facilities made them reliant on external sources for diagnostic tests and investigative procedures. Providers did not normally cover these additional costs for their private patients and were, therefore, unwilling to make an exception for RSBY customers. Hence, they routinely asked RSBY patients to access and purchase these services on their own.

We don't have the CT⁶⁸ (facility) here. We will only provide what is available in our nursing home. What is offered outside, we cannot do... Yes, for a normal (non-RSBY) patient we send an ambulance and get it done...The patient makes the payment for that. (Hospital Administrator-2, East district)

Coping with RSBY patients and tariffs: Concessions on quality of care?

Doctors frankly discussed the negative impact of low compensation rates on their treatment practices. Several respondents said they were conflicted between what was economically feasible to provide and the patients' interests.

When the patient is very sick, we don't compromise...but there are some times... Suppose if I want to start something, some higher antibiotic or some life saving drug(s), which are costlier..., there I have a problem. (Doctor-4, North district)

⁶⁷ Outpatient department.

⁶⁸ Computed Tomography (CT) scan, a medical imaging procedure.

They are providing 500 (rupees) which includes medicines and laboratory investigations. Suppose a patient requires a CT scan, the minimum charges for which are 1,500 to 2,000 (rupees)...how can you provide this? You cannot provide good services to the patient. (Doctor-2, West district)

Interestingly, doctors openly discussed making modest changes to their treatment practices by which it became feasible for them to treat RSBY patients at existing rates. A few health professionals reportedly made do with RSBY prices by persuading external consultants to subsidise their fees for users. More troubling was the following response from a hospital administrator who hinted that their staff were trained to negotiate with external consultants and prescribe fewer tests for RSBY customers.

...in a private case we have to go for all the tests... a doctor advises. But when it comes down to such type of patients... then the staff indirectly tell the doctors (that) this is a RSBY patient. So in that way again the things are made normal. In case a doctor writes few tests... We can't say no. Staff have to... (be) one step ahead of it. They need to be alert for RSBY patients that if the doctors... write few tests or so, you need to discuss with them that "Sir this is a RSBY patient..." So this is how we do it. (Hospital Administrator-8, West district)

At other times, several providers reportedly took to using less-expensive, generic drugs and materials on RSBY patients. For instance, interviewees at three RSBY-empanelled eye surgeries reported that RSBY patients had received cheaper lenses than those normally used on private fee-paying clients, although it was apparent from the findings that such lenses were also less durable. Unsurprisingly, most clinicians stressed there was no stark difference in the efficacy of low-cost health care solutions as compared to costlier options. There were also others who felt that this was, nevertheless, a vast improvement over what poorer individuals were accustomed to getting.

We diagnose most of the patients on the basis of clinical judgements. It is not necessary we should go for costly investigations for making a

diagnosis...Cheaper medicines are available. It is not necessary we should go for higher, costly medicines. (Doctor-1, Central district)

We are putting foldable lens for 3,000-3,500 (rupees). It is a very good lens for the patient who can't afford even 100-rupee lens sometimes. So that is a good thing... (Doctor-1, Southwest-district)

Treatment is the same. The cost of the medicine may change. If there is a cash-paying patient I would like to use the best available antibiotic in the market which is definitely a costlier one. Suppose if it comes to the BPL (RSBY) one, I would like to go for...nominal or the normal antibiotic...which is also working on the patient... But definitely, on the cash-paying patient I would not like to... (Doctor-4, North district)

Respondents also stated that they would often arrange RSBY-related consultations and surgeries alongside scheduled appointments for other private patients in order to economise on costs. However, it was apparent that RSBY patients were not always prioritised for treatment and could need to wait until a provider deemed the number of non-RSBY surgeries sufficiently large to enable economies of scale.

We don't do more than five surgeries...if we have four private, we will take one RSBY and if we have three then we will take two...We have (their) full record...So we contact (them) to say today you cannot have your surgery, come next day. (Doctor-3, North district)

DISCUSSION AND CONCLUSION:

REACH EXCEEDING GRASP?

This chapter attempts to understand the RSBY's implementation environment in Delhi. It explores the viewpoints and experiences of state officials, private companies, NGOs, and doctors running the programme. This chapter identifies the factors that aided or obstructed service delivery in the RSBY. It also draws attention to how particular aspects of the RSBY's design such as the remunerations it gave doctors and its restrictions on hospital-based care created

some perverse incentives for the way that services were delivered to end-users. Thereby, the findings from this chapter generate useful evidence for improving RSBY implementation. This analysis also brings to light the relative strengths and weaknesses of NGOs, business, and private doctors for delivering the RSBY. It, therefore, informs current thinking and practice about using pluralistic and non-state agents for welfare delivery. While the results are directly important to the RSBY's make-up and constitution, they are also more general reflections on using and incentivising private sector actors to be effective agents of welfare in developing countries (Health Economics Unit 2012; Kumaranayake 1997; Otiso 2003).

The findings reveal a lack of fiscal and human resources within local organisations, which apparently constrained their ability to deliver the RSBY. While state authorities were clearly keen to maximise the reach of the RSBY through the involvement of local NGOs, yet they seemed unable or unwilling to make suitable arrangements to equip these organisations for RSBY implementation. For example, not only did NGOs receive no operational grants from the government but there were also no formal systems in place to ensure fair and reliable payment of incentives to them by the third party administrator (TPA). While a common rationale for private participation in welfare delivery is their greater efficiency as compared to public service bureaucracies (Preker 2003; World Bank 2004), these results indicate that NGO involvement in the RSBY may in fact have stemmed from the state government's desire to get the RSBY done on the cheap (and perhaps less to do with the ideological positions of state officials).

Furthermore, the short-term nature of contracts (or the complete lack of formal contracts in case of NGOs) was also a significant influence on local delivery agents and seemingly encouraged them to focus on quick outputs rather than go the extra mile to deliver services. Some NGOs felt devalued by state authorities not giving them independent charge of the RSBY. In this respect, having an outside agency run the programme in their areas apparently resulted in a reduced effort by them on the RSBY. On its part, the TPA seemed risk-averse to heavy investments in the programme and hence deliberately under supplied equipment and trained staff for enrolment sites. Moreover, RSBY cards were apparently mass-produced rather than delivered on the spot (as they needed to be) possibly to minimise the operational costs of the TPA. It was, therefore, evident that for both NGOs and the TPA, a “project imperative” (Tendler 2004) made them consider the RSBY a short-term venture which in their minds did not mandate high levels of material or personal investment by them.

More positively, both sets of frontline implementers generally appeared to support RSBY goals and demonstrated a strong desire to continue working on the programme. However, ultimately the lack of proper data records, funding and performance incentives seemed to have undermined local efforts. Policymakers, therefore, clearly need to think about having such infrastructures in place in order for this sort of decentralised delivery system to work.

It was also evident that resource-strapped NGOs and frontline agencies had harnessed local political and community leaders to help mobilise their supporters and people known to them to join the RSBY. This indicates that individuals with better networks among themselves and with stronger bonds to local leaders may

have more easily accessed information about the programme. Hence, we find Robert Putnam's (2000) classic distinction between "bonding" and "bridging" social capital represented in this case as well. While bonding networks of trust and support within homogenous communities may have promoted group solidarity (bonding), vertical linkages between local leaders in positions of authority and communities helped bridge the information and social divide between them. Furthermore, such strategies of frontline organisations drawing on existing local networks for enrolment activities may have resulted in more marginalised individuals without such connections being left out of the RSBY. Similar outcomes on the exclusion of people in the "wrong" networks have also been reported by another study on a government-run welfare programme in the Indian state of Maharashtra (Pellissery 2005). While demonstrating a lack of institutional capacity at the local level, this finding, therefore highlights a possible "dark side" (Du Toit & Neves 2006; Ostrom 2000; Putzel 1997) and the negative effects of social capital in privileging certain better-connected populations. At the same time, this finding also conforms with existing policy implementation theory in highlighting that some amount of discretion by local level agents is an inevitable part of service provision (Kamuzora & Gilson 2007; Maynard-Moody & Musheno 2000). Perhaps more importantly, it is revealed that the actions of frontline actors were possibly their methods of coping with work pressures resulting from heavy demand for their services and their lack of personal or organisational resources (Walker & Gilson 2004; Lipsky 2010). Taken as a whole, these findings suggest that when planning for the involvement of local and non-state actors in service delivery, policymakers may need to take account of both existing levels of institutional capacity as well as unequal power relations within communities.

Turning to health care delivery, there is a striking similarity in the attitudes of the TPA and private sector doctors towards the RSBY. Like the former, RSBY doctors had a relatively tempered response to the programme and appeared to be strongly profit-oriented in how they rendered RSBY treatments. They were aggrieved by the RSBY's pre-fixed payment structure, which they felt undermined their clinical knowledge and professional autonomy. However, there were sharper and more widespread negative reactions from doctors towards RSBY treatment rates that were alleged to be significantly below existing market prices in Delhi. This clearly affected treatment provision by doctors. For example, low remuneration rates apparently motivated many of them to selectively choose RSBY patients on a case-to-case basis, depending on potential financial gains to them. In other words, RSBY facilities seemingly admitted RSBY patients who were cheaper to treat and on whom they needed to spend a smaller amount of time and/or medical resources. Fewer investigations and using less-expensive generic drugs on RSBY patients emerged as two popular coping strategies by which doctors managed to treat patients within RSBY's low tariffs. On a related note, the results also show some RSBY facilities controlled the number of RSBY cardholders they treated, normally by allocating a fixed number of beds and hospital spaces to them. Taken as a whole, these results suggest that doctors in Delhi generally regarded RSBY revenues as a top-up to other perhaps more lucrative sources and that it was not a mainstay for their practice. There is a possibility that private medical providers in rural areas with perhaps lesser competing demand for their services from non-RSBY customers in relation to an urban metropolitan like Delhi may have reacted differently to RSBY tariffs. However, recent reports from other states like Chhattisgarh and Karnataka reveal that private doctors there too are

refusing to treat RSBY patients because of low reimbursement rates or delayed payments to them (Bagchi 2013; Jaiswal 2013; Rajasekhar et al. 2011) Hence, any future leverage that policymakers may have had over providers in influencing treatment quality is somewhat diminished in light of this finding. An overwhelming number of RSBY medical providers were chiefly concerned about preserving personal resources and hence displayed what are expressively termed self-interested “knavish” behaviour, which is discussed later in this section (LeGrand 1997; LeGrand 2006).

The RSBY was clearly designed to have “business” appeal for doctors and to that extent was not far off the mark in assuming that personal profits could be an important driver for effective service provision. However, as the findings show, the level of RSBY compensations was simply not attractive enough for participating doctors, because of which they were not sufficiently motivated to treat all eligible patients or medical problems. A public service orientation among RSBY doctors was relatively less apparent even though some doctors in this study were more charitably inclined and gave up or reduced their outpatient fees for RSBY clients. The evident and well-entrenched commercial ethos of for-profit private health services demonstrated in this study resonates with research in other unregulated health systems such as South Africa (Doherty 2011; Marriott 2009; McIntyre 2010). This literature highlights the importance of better regulation and monitoring of private provisioning and also recommends that governments in developing countries invest in their public health services in order to develop a strong countervailing force to the private sector (ibid.). Another strategy to ensure that service delivery is in line with programme goals is for policymakers to devise a range of monetary and non-financial incentives that keep providers motivated

towards implementing them effectively (Hongoro & Kumaranayake 2000; Kumaranayake 1997; Peters & Muraleedharan 2008).

In order to improve how medical treatments are delivered in the RSBY, there is reasonable evidence in this study to show that modifying the scheme's monetary incentives for doctors may contribute towards better service provision by them. In designing such incentives, it is also relevant to take into account theoretical and empirical insights from other research on welfare delivery. For example, in his seminal work on human motivation and policy execution, Le Grand (1997; 2006) argues that service providers tend to fall along an axis of "knaves" or self-seeking individuals driven by personal interest and those that are "knights" motivated by a public service ethos and an altruistic desire to help others for no personal gain. According to Le Grand (1997), since policymakers are likely to have limited knowledge of what precisely motivates delivery agents, they are best advised to construct policies that simultaneously address both knightly or altruistic tendencies as well as likely "knavish" or self-serving behaviours. Specifically within a medical setting, studies show that doctors will perform better if incentive structures are designed in flexible ways which are not perceived to "discipline" (quotes mine) their clinical expertise and agency (Marshall & Harrison 2005; Wibulpolprasert & Pengpaibon 2003). Designing appropriate incentives to affect how private clinicians practice is especially relevant for the RSBY given that all participating facilities in Delhi and over two-thirds of its approximately 12,000 hospitals nation-wide belong to the private sector (MoLE 2013).

Earlier in Chapter 4, the rationale for limiting RSBY benefits to hospital-based treatments became apparent. RSBY's designers had apparently assumed

that hospitalisation cover would offer greater financial security by protecting its members from costlier forms of medical spending because inpatient treatments tended to be more expensive than ambulatory or primary health care services. In addition, RSBY designers had evidently been dissuaded from including primary and ambulatory benefits because they perceived administrative difficulties in finding suitable suppliers and monitoring frequent episodes of outpatient service use. However, this analysis shows some perverse incentives resulting from RSBY's restricted offering of hospital-based benefits. For example, there were instances where hospital-based care was apparently offered to patients who seemed to have needed outpatient services. A parallel development was that many RSBY doctors refused to treat relatively less serious patients if they could not pay outpatient charges. While in the first instance, inefficiencies result from hospitalising patients when cheaper treatments may have sufficed; the second case indicates that medical problems may be thwarted from getting detected in time and make it more likely that patients will return to the service in poorer health when they are costlier to treat. Hence, on both occasions, , there are negative cost implications for health services overall.

Although these findings relate to the RSBY in Delhi, they nevertheless contain general lessons for improving policy implementation elsewhere via various financial and non-financial measures. Firstly, it is clear that local agencies often need to be made more "fit for purpose" through supplementary resources and capacity building. Secondly, more formal and longer-term contracts with companies and NGOs may improve motivation levels and help generate more material investment and personal involvement in the RSBY. Finally, it emerges that remuneration rates for RSBY doctors may need to be indexed to market realities as

per the locality (rural/urban) and perhaps in places like Delhi be structured to give providers greater flexibility in administering treatments.

Chapter 6: “You’re asking the baker how good the cake is. You’ve got to ask the people ...eating it...”⁶⁹

Service users’ and patients’ experiences of the RSBY

INTRODUCTION

Users’ views of a service and its salience to policy analysis

There is growing recognition that consumer satisfaction and the extent to which health services meet patients’ expectations and needs is central to evaluating the quality of care (Andaleeb 2001; Donabedian 1992; Epstein et al. 2010; Mead & Bower 2000). All health policies and programmes are ultimately meant for their clients and patients and as the end users of a service, they are the ones most directly affected by an intervention. Therefore, knowing what they think of a service is perhaps the ultimate test of whether a policy is working and benefiting those it targets. Many also see this as a way of constructing more

⁶⁹ A remark by the Director General Labour Welfare when interviewed.

patient-oriented services, which as evidence shows may improve cost-efficiency of services, improve treatment adherence and contribute to better health outcomes (Beach et al. 2006; Epstein et al. 2005; Kaplan et al. 1989).

While the significance of involving patients in the evaluation of health care is increasingly realised in more advanced health systems (Coulter & Ellins 2007; Department of Health 2000; Fitzpatrick & White 1997; Kerssens et al. 2004; Surender et al. 1998), users' views in assessing the quality of care are relatively neglected in research in the global South (Andaleeb 2001; Baltussen et al. 2002; Rao et al. 2006). This is especially true when patients also happen to be poorer and relatively distanced from formal channels to communicate their feedback to policymakers, as is normally the case with clients of welfare programmes like the RSBY.

Even as the number of formal evaluations and independent research on the RSBY grows, there are surprisingly few studies that assess its performance from the standpoint of its users. Of the ones that include the perspective of RSBY patients, most existing studies are structured surveys to test levels of awareness, usage patterns, and satisfaction with services (Amicus Advisory Pvt. Ltd. 2011; Mott McDonald 2011). This chapter thus seeks to contribute to this knowledge gap by examining in depth programme recipients' experiences of service delivery and health care provisioning through the RSBY in Delhi.

With respect to the methodology for capturing the attitudes and experiences of users, there are powerful advocates who believe that qualitative measures can help develop a more comprehensive account of patients' satisfaction with health care services (Avis et al. 1997; Calnan 1988; Fitzpatrick & Boulton

1994; Williams 1994). For example, Williams (1994) highlights the limitations of quantitative surveys of user satisfaction in terms of their inability to uncover the underlying factors that account for patients either being content or unhappy with particular aspects of a service. He goes on to argue that the responses of service users to survey questions may stem from different assumptions than those on which questionnaires are based. For example, people may have pre-defined notions about the clinical competence of doctors in a clinic and may in fact be commenting on the interpersonal rather than technical quality of care received. In other words, their answers may derive from prior expectations or beliefs, which are outside the realm of the health service. Therefore, the underlying reasons for satisfaction with services may be different from what the survey question is about. In effect, satisfaction surveys may overvalue or undervalue some measures that are, indeed, important to patients and will play a part in their seeking and complying with medical advice. These underpinning factors need to be carefully probed through in-depth dialogue with patients. Qualitative methods of enquiry may thus prove fruitful in getting to the bottom of what patients mean when they profess satisfaction or dissatisfaction with services (Fitzpatrick & Boulton 1994; Mays & Pope 2000).

Furthermore, a sound analytical framework is needed to organise and understand the large number and variety of responses produced when patients are asked their view of a service. Key goals of health services as outlined in reports by international organisations and the RSBY's main aims were studied to benchmark the RSBY's performance as far as its recipients and patients were concerned. For example, access and affordability are two key criteria for the RSBY as it mainly aims to improve patients' access to services and to prevent them

making catastrophic payments for health care (RSBY 2012a). A third important matter to gauge was that of health care quality given that it is internationally recognised as a fundamental goal of a health service (WHO 2007a). This is because even though costs and availability of health care may be important to patients, the quality of services will undeniably affect their utilisation of services and the resolution of their health need or health outcomes. While there is prolific literature detailing and explaining what makes for good quality services, Donabedian (1966; 1980; 1988) in his seminal work on health care quality gives weight not only to the structure and outcomes of treatment but also the processes of delivery. While evidence on the structure and design of services or procedural aspects may be available from other informants, patients are a principal source of knowledge on the interpersonal aspects of care, which is a key process measure of health care quality.

OVERVIEW OF METHODS

This chapter draws on 84 face-to-face interviews conducted in 2010 with RSBY recipients in Delhi. Most had joined the programme in fall-winter 2009-2010 and were first-time members. A smaller number had also enrolled the previous year in 2008 when the RSBY was launched. Interviewees were familiar with RSBY health care services as former or existing patients or as accompanying carers. Patients had been treated for general medical problems as well as obtained surgical treatment through the RSBY; less than a quarter of the sample however had used their cards more than once. Respondents in Delhi reported routine medical treatments for fever, localised pain, swelling and gastrointestinal problems like diarrhoea, vomiting, and typhoid as well as ophthalmic procedures

and surgery for gall-bladder stones, intra-uterine and gynaecological problems. This was in keeping with national trends on most common treatments obtained by RSBY users (PHFI 2011, p.108).

The sample was purposively selected from across Delhi's nine districts, and included 55 women and 29 men. Although detailed demographic information was not collected, respondents themselves frequently offered information on residence, marital status, and employment. The main criteria for selecting participants were that they were adult (over 18 years) RSBY members with self-reported or evident use of RSBY hospitals. The vast majority of the sample was married with children and lived in state-allocated public housing and slum colonies. Working adults in the sample were employed in a range of low paying occupations mainly as vendors, domestic and factory help and NGO workers. Interviewees also included non-working, young mothers and elderly people living with an earning family member and co-dependent on RSBY benefits. Most participants were interviewed in their homes or in hospital wards. With a view to understand recipients' perceptions about the RSBY and its effects on them, questions were designed to explore participants' experiences of gaining RSBY membership and accessing and using RSBY hospitals. Further details on the methodology are available in Chapter 3.

KEY FINDINGS

Barriers and facilitators to enrol in the RSBY

In most cases, respondents received information about the RSBY from local agents who were either NGO workers or neighbourhood “pradhans”⁷⁰. A small number were made aware through government-licensed ration shop⁷¹ owners from whom they obtained subsidised food grains. For the majority of recipients, the fact that they heard about the programme from those they knew and trusted was apparently a strong motivating factor to join the programme.

Our area’s leader called and said I should take part in this venture...told me to bring two photos and said he would manage the rest... They tell us about new schemes that we can benefit from...they tell their own people...the ones who are in their favour and support them...Now it’s not as if they’d tell the ordinary person... (Moin, male, 60+ years)

... (NGO mobiliser) lives nearby...Our relationship has always been one where they tell us, “Do this, it’ll be good for you”. Before taking any step, I always ask their advice. So they got our card made. (Binod, male, 40+ years)

Yet, a number of interviewees believed that many eligible people from their locality who were away on work or personal business were prevented from joining the RSBY because of its short enrolment period of a few days or weeks. There were also a handful of cases where additional dependent children were allegedly left out of the RSBY as programme rules only permitted a total of five people per family to enrol. It was more common, however, to come across respondents who reported that their relatives were excluded from the RSBY

⁷⁰ Informal and unelected local colony chiefs, normally with links to local councillors and those in positions of authority.

⁷¹ Fair Price Shops.

because they were unlisted in official records; thereby revealing that RSBY databases were often out of date or incomplete.

Actually, I had taken along all four children but they told me that two of them were not listed. So I said that if the other two names (of children) are there, then do it for them. (Swati, female, 30+ years)

We could not get the (RSBY) card through the NGO because our house had not been surveyed. Then my father-in-law helped us get it made in another locality. We had initially wanted it issued on my husband's name. But the people there couldn't understand his name. Said it was too long. They suggested I get the card on my name. So it's in my name now. (Susan, female, 20+ years)

Like the respondent above, it was interesting to find a few other interviewees disclose that they and other acquaintances had gained RSBY membership in spite of missing paperwork or inaccurate documents such as above-poverty-line (APL) cards, which in principle disqualified them from the RSBY. Such responses often hinted at the possibility of local agents using their discretion to confer RSBY benefits on some people despite their evident lack of appropriate documents.

I have a white (APL) card but I showed them my application slip for a BPL card...So based on that they made it...even though I don't have a BPL card yet. (Farah, female, 20+ years)

Clearer evidence of arbitrary and discretionary enrolments by frontline agents came from the significant number of interviewees reporting that they were registered for the RSBY on other people's names because RSBY records allegedly did not list them.

I was added on with my brother...His family included his wife and two sons. I wasn't listed with them. But at the time, the situation was such that anybody who was going there was getting it (RSBY card)...Perhaps someone didn't need it (and so did not turn up). So they had to be replaced by somebody else... (Amu, female, 20+years)

They told me clearly that my name was not on the list. Then they said, "Get it made on some other name". I said, "Why should I? I do not want to get into any scam!" I came away. (Hanut, male, 30+ years) I was with him. (But) I got it made with my two kids...My name is Sunita; they made it Sasha on the card. (Hanut's wife, female, 30+ years)

A surprisingly large number of interviewees also reported knowing several individuals who they believed were entitled to the RSBY and knew about the programme but had chosen not to participate. Of these non-enrolees, some could not sign up because they evidently neither possessed a BPL card nor a voter card confirming their identity. On the other hand, it appeared that many others had not joined the RSBY because they were wary or sceptical about the programme. There seemed to be considerable disbelief within the local community about actually benefiting from RSBY membership. In fact, sceptics had apparently even tried to discourage other people from applying for the RSBY by alleging that it was a moneymaking fraud for agents to make off with the INR 30 registration fees collected from them. Recalling one such episode, a respondent noted:

Generally, people are suspicious about it... They think this is just a sham of a programme to collect 30 rupees and make a quick buck off them. They're being told to get cards made but there will be no treatment... (Gayatri, female, 30+ years)

Similarly, another RSBY member who was also an NGO worker described the following:

When I was in the jhuggi-jhopris⁷² telling people about the RSBY, there was a peanut-seller going past. He quickly said to everybody around him, "Don't get into this jam. Such-and such hospital is charging two lakh (0.2 million) rupees." So I told people not to be swayed by what he was saying and get the card made. The people in the slums who respect us (NGO workers), got it made. (Roopa, female, 50+ years)

⁷² Slums and squatter settlements.

Therefore, besides procedural problems related to the short duration of enrolments and faulty data-records, suspicion of local delivery channels deterred many potential recipients from participating in the RSBY. Interestingly, a few current users confessed to feeling the same way initially when they first heard about the RSBY. However, they said they were reasonably convinced to test it out for themselves once they saw others in their area enrol and on becoming better informed about it through reliable community leaders. Some interviewees also felt that joining the RSBY was a worthwhile risk to take since they did not have much to lose monetarily. Hence, despite their continued uncertainty about actually gaining from the RSBY, most respondents felt its INR 30 membership fee was a small amount to pay for what could potentially be a huge benefit for them.

In the beginning, everyone thought it was futile (to enrol) and the cards worthless. In fact, even I felt the same way. Then Pinky didi⁷³ at the centre explained to me... The thing is one rarely receives any benefits or services ... (Later) I decided to get it made. After all, it's only 30 rupees... not much to lose... (Sushma, female, 20+ years)

Patients' use of RSBY services

Improved availability of treatments

Overall, most respondents reported better availability of curative treatments, especially surgeries because of their membership of the RSBY. Earlier several patients had apparently experienced long admission and treatment delays in public hospitals and had either avoided medical care altogether or waited for significant periods in order to be seen by a government doctor. Either way, their medical problem had remained unresolved for long periods until they had obtained RSBY membership. In contrast to commonly used public hospitals, RSBY

⁷³ Sister.

facilities were generally quick to admit patients, offer surgery and were often more responsive towards them.

(My daughter's) shoulder was broken. At Safdarjung (public hospital), the doctor said that I should bring her back when she was older... I stopped going there for her treatment. He (doctor) used to make us run around a lot and did not do any work... Then a colleague recommended MN (RSBY hospital)...I met the doctor there and explained her problem. He said it could be treated...Spent about half-hour with us... Examined her shoulder... Did an X-ray...Two days later, carried out a CT scan...Later (that month) they operated her. (Salman, male, 30+years)

It is such a problem in government hospitals. I have been running from pillar to post the past six months. They are always saying, "Come back tomorrow. Come back in 15 days...today the laboratory assistant isn't available... (or) the medical report is not ready (or) it is ready but inaccurate so needs to be revised"...Then when I went again, they would say they now have cancer patients and I'll have to come back in six months...In March, I got my RSBY card and in April, I had my operation (Akshat Kumar, male, 50+ years)

Interestingly, even before they had access to private doctors through the RSBY, some patients had been unwilling to attend public sector hospitals where they believed treatment was poor. They, therefore, preferred to self-medicate and endure their pain or wait until they had gathered enough funds for private treatment. For such patients, therefore, the RSBY seemed to improve their access to medical services and also made treatment more affordable for them.

If (RSBY) weren't there, I would have been pushed and shoved in a government hospital. Whereas here it took three days, there it would have taken fifteen days. Over there, they would set a later date for the surgery. Plus, they are so crowded... I probably would have just tolerated my pain...In fact, that is exactly what I was doing at the time. Getting medicines from here and there (until) the local councillor told me about the (RSBY) card... (Gauri, female, 20+ years)

We were treated (through RSBY), that's benefit enough!... I was running around trying to mortgage the few measly things I had. Someone was willing to give me 2000 rupees, another would offer 3000. Private (doctors) were asking for 10,000... I was so worried ... I did not take my son to JS (public hospital) because I had heard the treatment there is not good ... Was buying medicines for my son yet he was in utter misery... Then

suddenly I remembered (I had) the (RSBY) card... (Noorie, female, 50+ years)

Some patients also said they had preferred using RSBY facilities rather than public hospitals in Delhi where treatment often turned out to be more expensive than anticipated. This response was surprising given that, strictly speaking, public hospitals provide free services to BPL patients and this should have meant that in terms of their costs, RSBY treatments were no different from those at a government hospital in Delhi. However, as some patients pointed out, RSBY facilities covered their basic treatment costs more comprehensively by providing them with most essential drugs and devices during their hospital stay. In contrast, when admitted in local public hospitals, it seemed that patients were frequently asked to bring medical supplies like injections and bandages from outside. In addition, they also had to buy prescribed medicines from external sources.

... We get medicines here (RSBY facility). At RH (public hospital) we are told to buy medicines from outside...There is real no medical care there. Even if one needs a syringe, they tell us to buy it from the market...Here, there is no problem. I'm not spending a single paisa⁷⁴. (Hira, male, 50+ years)

I could have been operated at GH (public hospital) but then I'd have had to buy all the material...injections, bandages, sutures... So rather than spend myself why not use a private (RSBY) hospital! (Gayatri, female, 30+ years)

To summarise, the statements above strongly indicated that not only was the RSBY improving access to clinical services for its beneficiaries in Delhi but also helping them avoid spending large amounts on obtaining services from expensive private doctors.

⁷⁴ Equivalent of a penny.

Reasons for patients avoiding RSBY treatments

Despite respondents' generally positive reviews of treatment availability at RSBY facilities compared to government hospitals in Delhi, a significant number of patients needing medical help had apparently avoided using RSBY services. Aware that RSBY only provided hospital-based treatments, many patients surmised that routine and common illnesses were untreatable through the programme.

Getting stones removed or any other such big disease can be treated (through RSBY). In any case, they (doctors) won't admit us for small illnesses...Say, one gets fever and goes running to them, they won't accept us...A lady was telling me that I should only go (to RSBY doctors) for big problems. For fever or other small illnesses, she suggested I get medicines from any dispensary. (Noorie, female, 50+ years)

Many felt, therefore, that unless severely debilitated, there was little point going to RSBY hospitals. Consequently, some patients reported using "neighbourhood doctors" by which they implied local and informal suppliers of cheap medicines.

It has been many days since the card was made but I am yet to use it. At one time, I was terribly sick and bought medicines from outside... The biggest problem (with the RSBY) is that one does not get medicines and has to be hospitalised. (Zarina, female, 20+ years)

Throwing more light on why patients would knowingly not use RSBY services, a respondent explained that hospitalisation often involved significant extra costs for them in terms of lost opportunities to work and earn.

Look, it isn't necessary to always get treatment through this (RSBY) card. Not everyone has the time. If they think they can manage at home with an odd medicine... Nobody (willingly) wants to be hospitalised...I run a small store and I have had to lock it up (to care for my wife in hospital). I could have earned 100-200 rupees but I have lost those earnings. (Udit, male, 40+ years)

The above responses indicate that the RSBY's restricted rules, only allowing its use for inpatient care, dissuaded some programme recipients from utilising RSBY facilities.

A few respondents also stated that they had avoided RSBY services because they anticipated treatment to cost more than the RSBY monetary cap of INR 30,000. For example, an interviewee explained that they knew longer-term illnesses were more expensive to treat because these usually involved frequent tests and extra medicines. Moreover, they contended that some private doctors they had earlier consulted had told them that their treatment was likely to be a costly affair. Yet, although this respondent believed the RSBY's INR 30,000 was insufficient to cover their medical costs for them, it seemed that such perceptions might have been unfounded since they had not actually checked with RSBY providers about possible treatment charges and were relying on what other, perhaps non-RSBY doctors had conveyed to them.

For a small disease, (30,000 rupees) is okay but not if it is a long-term problem...Like my daughter has liver disease so she's being treated at Pant (public) Hospital...(In private hospitals) 30,000 won't be enough... They said it would cost a lot of money...all the medicines, then all the check-ups there...Then doing an endoscopy again and again...Costs a lot. (Susan, female, 20+ years)

Similarly, another respondent said they knew from previous experience that prolonged hospital stays involved many extra treatment costs. Hence, they were afraid to use their RSBY card assuming that a longer stay in hospital would inevitably result in medical charges exceeding RSBY's upper limit of INR 30, 000.

(My son) needs an operation...But I'm scared about the money...I suddenly got this thought that even though at the moment they say (RSBY treatments) are free, suppose later on I'm asked to pay double the amount

because the treatment costs more than 30,000...I don't have that kind of leeway (on my current salary)...(Rano, female, 50+ years)

It appeared, therefore, that a few recipients needing more intensive or longer-term treatments curbed their usage of RSBY facilities because they were anxious about exceeding its monetary threshold. As the two preceding responses show, this may have also spilled over into users restraining their use of RSBY services without actually knowing the cost of care.

Rationing and managing RSBY benefits

Furthermore, it was evident that a fear of going over the RSBY's current ceiling of INR 30,000 was an underlying worry for many other patients as well. Discomfited at the thought of having to pay out-of-pocket for any additional services, some respondents had checked in advance with RSBY doctors about treatment pricing to ensure that later they would not ask them to pay extra money.

My bill came to 26,400 (rupees)...My son had asked beforehand (at the hospital)... in case later they demanded more... and we would not be able to pay. He asked them right in the beginning, before I was hospitalised. They had said they will do the treatment within 30,000 rupees and would warn us in case the treatment costs go up... (Akshat Kumar, male, 50+ years)

Apprehensive about supplementary charges, even hospitalised patients kept an eye on costs while undergoing treatment at RSBY facilities and were willing to get fewer services as long as they did not have to pay any additional cash out of pocket.

I asked somebody there, perhaps a doctor, about being in an air-conditioned (intensive care) room... I did not want to be in a more expensive room and asked to be sent to another cheaper room upstairs. I was scared about being overburdened (with extra expenses) if this room cost twice what the other did... (Binod, male, 40+ years)

On a related note, many patients described actively seeking out information from hospitals on how much they were charged for medical care or the balance that remained on their cards. They felt this information was important for them so that they did not overspend and could ration their current use of RSBY services for potentially serious ailments in the future.

When I asked them, they told me my bill was about 5000. Gave me the break-up—the charges for each day of treatment. I (re) calculated the amount...and asked why they had charged me extra. That money could help us for other illnesses... (Saroj, female, 40+ years)

Recently, my nephew had an operation...I told him to show me the bill and check the balance. Were we to carry on getting treated without any money in our pockets... if (doctors) do extra treatment where will we produce the money from? So I wanted to see how much of my money was left over. Depending on how much we had spent already, we could decide on further treatments. So after the operation, we had 13,000 remaining. (Amu, female, 20+ years)

Moreover, some respondents also discussed preserving and prioritising RSBY funds for certain kinds of illnesses. Most patients felt hospital-based care was only warranted when an ailment was “big” and “serious”. As a result and as the RSBY intended, patients normally managed on their own if they needed ambulatory services and drugs.

...why would anybody use the (RSBY) card for a small illness? Why would they waste their money?...one can always get better by having a 20-25 rupee pill. So it is best not to use our 30,000 rupees...God forbid, any major problem can occur in the future and this card can help with that. (Ratan, female, 40+ years)

This card can be used only for hospitalisation...The fact is that if I have some sort of fever or a headache... they are ordinary matters. Anybody can manage by going even to doctors here in the neighbourhood or buying some cheap medicine. It is best to use this card mainly for big illnesses. (Shriya, female, 20+ years)

Patients' experiences at RSBY hospitals

Perceptions about quality of treatments

Respondents were reasonably satisfied with RSBY treatments despite most reporting modest levels of care at RSBY hospitals. In general, RSBY patients with more complex conditions that had needed intensive or surgical care seemed happier with their treatment. These patients often reported getting high levels of clinical care at RSBY hospitals, timely medicines, meals, and attentive medical staff.

I rang the bell and immediately they asked what I needed. When I was in pain, they gave me an injection. If I needed to use the bathroom, they took me. Also, they give meals on time—porridge twice a day, tea and snacks. Whatever others may say, personally it was great for me! (Binod, male, 40+ years)

The staff is very good. They are giving me medicines on time, food on time, carrying out tests and investigations at the right time. They are talking to us kindly. What more could I ask for? (Moin, male, 60+ years)

However, there were a significant number of patients who disapproved of available facilities at certain RSBY hospitals or were critical of the medical staff they had dealt with there. Several interviewees reported that the RSBY doctors they had consulted had ignored their complaints of fever, physical pain, and minor injuries. At some RSBY hospitals, doctors had apparently told patients that they could only treat them for conditions that were “serious” or medical “emergencies”. While some patients were asked to pay for outpatient services, there were others whom providers had outright refused to treat. Such respondents' narratives indicated that patients needing medical attention for routine medical problems had often not found it easily available through the RSBY.

(Doctors) are not treating small illnesses... like they won't treat diarrhoea, vomiting among children or an injury...They refused when we took my mother...she was stung by an insect on her eye and it was swollen...Then we got medicine from one of these private doctors who sit around in the area ... (Daman, female, 20+ years)

This is the second time I have come. The first time I came, they said it couldn't be done...I was bitten by a dog... all the government hospitals are far...They said that this injury on my foot would get okay. So I said fine and came away. I did not meet the doctor. Met the nurses...They said get 150 rupees then we will do an X-ray...So I came away quietly. (Karishma, female, 20+ years)⁷⁵

There were also frequent complaints about medical providers and nursing staff from patients who were treated in the general ward of RSBY facilities. These recipients seemed to have been treated for less acute illnesses and neither reported surgery nor complex medical tests during their hospital stay. The most common complaint from them was about the low quality of medicines made available to them and which had little effect on their ailment.

What's there to say about their treatment! Over there, all that treatment involved was (patients getting) a saline drip with some vitamin...One pill in the morning and another in the afternoon...That's it! (Vimla, female, 50+ years)

From the above, it seemed that patients often had different experiences of medical care based on whether they had needed surgery or general curative services. For example, it was more common to find non-surgical patients who were refused treatment by an RSBY facility. In general, they also received fewer services as compared to surgical patients for whom basic tests, medicines, and sometimes meals as well were supplied by RSBY providers at no extra cost to users. Responses hence indicated some disparities in service delivery between individual RSBY clients. This distinction in treatment was confirmed by the following

⁷⁵ The doctor had asked her to wait until they confirmed with the insurer if it would cover the costs of rabies injections under the RSBY (Based on interview with Doctor-2, South West district).

interviewee whom hospital authorities had apparently told that higher-value surgery cases were entitled to more services than other RSBY patients were.

... (Hospital) said that on our 500-rupee package they cannot give us medicines nor travel costs... one does not get food, medicines, or transport... they say there is a separate package for that. Only surgery patients get all this. Like there are two other surgery patients here with us, so they got all this. When we asked, they said it is different for surgery patients and for our patient. (Ricky, male, 20+ years)

Therefore, it appeared that the different ways in which the RSBY reimbursed doctors for surgeries and non-surgeries had an effect on the kind of services offered to RSBY clients. Although programme rules were fairly permissive in allowing beneficiaries to be treated for any medical problem needing hospital-based care, as discussed earlier (Chapter 1 and Chapter 5), the RSBY had more generous individual pricing for surgeries. On the other hand, RSBY doctors received a fixed per-diem of INR 500 rupees (INR 750⁷⁶ for intensive care) for non-surgical treatments.

As a result, it was perhaps not surprising that surgical patients, a significant number in this study sample, were generally positive in their assessment of RSBY services. They liked the fact that doctors had been quick to admit them and long-standing problems were now resolved. Surgery to remove abdominal stones and obstetric procedures were among the more common treatments that interviewees reported. However, the fact that many of these patients had needed relatively simpler and quick surgeries neither involving long stays in hospital nor multiple or complex procedures was often an important point in their favour. In contrast, there were a couple of cases where quick discharges, soon after surgery, had

⁷⁶ Since revised to INR 1000.

reportedly worsened the health of patients and compelled further treatment. As one such respondent described:

My sister-in-law was not happy with the treatment. She said they discharged her soon after she delivered her baby. Did not check to see if she was all right. Did not give any medicines ...We had got the card made for my wife's delivery (Shyam, male, 30+ years)...But then when this happened with her I was put off and didn't use the card...She had some internal bleeding. They had not treated her properly. Then she had to go elsewhere to get treated. (Shyam's wife, female, 20+years)

Furthermore, interviews collectively conveyed a strong sense of the generally limited organisational capacity of RSBY facilities⁷⁷. Patients needing more advanced diagnostic tests including endoscopy and CT scans were evidently asked to procure these from outside suppliers since some RSBY hospitals did not possess the necessary equipment.

I went to the hospital in my locality and described my problem. They gave me the names of two other (RSBY) hospitals...They said they did not have the "binoculars" machine (for my surgery)... (Irfan, male, 20+ years)

On a related note, specialists and surgeons had to be called in from outside at some hospitals where respondents were treated. As a result, they reported long delays in having surgery or medical tests carried out.

It has been seven days today. There have been no X-ray, no check-ups...I have pain in my chest...They've prescribed X-ray, ultrasound... but don't do them...There is no one to do them...They always say, "Somebody will come tomorrow" ...It's useless for me to stay here without treatment...They're not letting me leave...They say, "Wait we'll treat you today, tomorrow." In this way, they keep delaying... (Rajneesh, male, 40+ years)

In general, attentive medical staff and clean and comfortable surroundings were, ancillary concerns for most patients. It was hardly surprising that what mattered most to respondents was whether they felt physical respite or had their

⁷⁷Field notes recording my observations during visits to RSBY hospitals similarly reveal differences among RSBY hospitals in terms of their infrastructure and facilities.

symptoms ease after treatment. Naturally, patients were unhappy when their problems were undiagnosed and they remained doubtful about its cause. When they did not feel better despite being hospitalised, many ascribed this to the fact that they were not given good enough medicines because they were RSBY patients. Others were also critical about doctors not carrying out detailed investigations and medical tests to determine their problem.

They hospitalised my husband the same day (we met the doctor). He was admitted for six days but I'm not lying he didn't feel the tiniest bit of relief. There was this tiny bottle of glucose they gave all patients ...The doctor came just once a day. It wasn't as if he got any special medication... one can tolerate poor amenities (no heating, insufficient blankets) as long as proper tests and investigations are carried out. (Narayani, female, 50+ years)

The treatment is not right...the doctor would come just once, take a look and go away. For the most part, I was given an injection and made to sleep. That's it!...After all, I had a headache. They should have done a CT scan but they didn't do anything. I asked the doctor and they told me to get it done from outside. Then what is the (RSBY) card for?... Just gave one odd pill... (Nayaka, female, 30+ years)

Respondents also occasionally said they decided not to (re)use RSBY services because a close family member was poorly treated at an RSBY facility. For some it was not only the manner in which they were treated but also the poor health outcomes after treatment which made them turn to other government and private doctors.

...I didn't find the treatment good because (the doctor) did not pay any attention when we described the problem. Just hurriedly scribbled a prescription while standing at the reception...That's why I didn't go back another time. Went to the government-run hospital. (Suman, female, 30+ years)

My son was very sick recently ...I took him to X (private) hospital. Not with the card (but) on my own ...When it did not benefit my husband then there was no point using the (RSBY) card this time...This time, I spent 40,000 rupees in 5 days (on son's treatment). (Narayani, female, 50+ years)

Diluted and diminished care: co-payments and treatment delays at RSBY facilities

A few RSBY patients needing surgical care also reported that one or more providers whom they had initially contacted had refused to treat them unless they paid part of the treatment costs. According to patients, therefore, doctors had been unwilling to treat them at current RSBY rates.

We had the addresses and phone numbers of hospitals. Many of them refused (over the phone) and said that we will have to pay half the costs of surgery ...and also pay the bed charges... (Noorie, female, 50+ years)

At other times, doctors were uncompromising if RSBY cards did not work. Hospitals needed to check patients' biometrics and take their thumb impressions to generate their medical history for the RSBY. If for some reason this did not happen or if the beneficiary could not afford to pay part of the treatment costs, doctors refused to treat them.

...my thumb impression doesn't work...I went to A hospital...pressed down my thumb many times. Even rubbed it on the ground. Tried many tactics. They said, "Your thumb impression isn't there, you will not be treated". Then they didn't treat me...So now I'm having medicines from the private doctor... (Durga, female, 50+ years)

They had begun my son's treatment...Then when the card didn't work, they got angry... I was very ashamed because I had no money... there were quite a few people sitting around... They said the treatment had already cost them 2000-2500 and asked me to pay at least half...What was I to do, I just came away...They had already removed the IV drip etc... (Yadav, male, 40+ years)

Even though respondents generally chose to go to RSBY facilities that were nearest to home, many reported spending their own money on travel. While this could possibly mean that facilities were not always convenient to reach for patients, what was clearer was that several recipients were not getting the travel

allowance mandated to them by the RSBY. Moreover, hospitals normally only offered patients the diagnostic tests and basic supplies that were available with them. When asked about extra payments while undergoing treatment, patients frequently reported paying for services that the RSBY should have covered. Respondents often brought food from home and paid for travel themselves, services that RSBY hospitals were meant to provide or pay for. It was also not uncommon to find patients who reported paying an initial consultation fee to the hospital, even though these were relatively small payments ranging from 20 to 100 rupees. Many times, however, family members of RSBY patients had to purchase medical supplies or more expensive medicines for treatment from outside sources.

I was hospitalised on Friday. They put on the IV drip... did blood tests and some other tests...But the doctor couldn't figure out what the lump on my throat was ...So he advised me to get a scan...He said it'll cost 2500-3000 but I'd need to have it done from outside because they didn't have the machine. Then I got the CT scan done...Later at night, after going through the report, he advised me to go home rather than spend the night lying around in hospital. So they removed the glucose...and sent me home. Then I came back the next day for the operation... (Akshat Kumar, male, 50+ years)

Initially I deposited 5000 rupees with them. Then after the operation they wrote down another test and took money for that as well...On the first day before hospitalisation, they had told me that I would need to spend an extra 5000 rupees at a minimum. They said, "This is outside our range." I agreed to pay however much it cost. (Ravi, male, 40+ years)

Many non-surgery patients also described a standard practice among doctors of charging patients for a minimum number of days irrespective of whether they had stayed in hospital through that period or been discharged sooner. In this way, some hospitals apparently claimed extra amounts from the RSBY.

I was hospitalised for two days but they had to make a discharge slip showing five days of hospitalisation... It works like that in all hospitals...They keep the card to signify that the patient is still in hospital. After five days, they release the card... (Sushma, female, 20+ years)

Moreover, a few patients reported that despite not feeling better and conveying this to doctors, they were discharged from hospital. Some respondents were apparently told that their problem could not be resolved. Instead, they were given a medical prescription and sent home.

I told them that I did not feel okay. But they said, “No, Amma⁷⁸, you are alright” and discharged me... Then I went again...my hands and feet were pale... I said, “Give me some medicine, some injection. Do something! When I’m not okay why have I been discharged.” ... (But) the doctor said, “No, you’re fine Amma. You go.” They didn’t give me a single pill... (Kashmiro, female, 60+ years)

When I was in pain they gave me quite a few injections. But then when it didn’t get better they told me to go. Said it’ll only get better with medicines at home. (Ravi, male, 40+ years)

Some reported hospital authorities telling them that a longer stay in the hospital would cost them extra money on their cards.

They operated my husband and discharged him the next evening...With his urine bag attached!...If he stayed, they said they would charge extra, 500 rupees per day for bed charges...because the bill for surgery didn’t cover that...I argued with them...But they refused and told me to take him home and come back in a week to remove the bag... (Ratan, female, 50+ years)

This indicates that the prospect for claiming extra amounts from the RSBY was clearly a factor in hospitals treating RSBY patients. Altogether, the responses also reveal that the revenue potential of individual patients may have also impacted the frequency and duration of care.

⁷⁸ Indian word for “Mother”.

Overstepping RSBY boundaries? Accommodation of clients' needs

Patients in the sample also reported obtaining various non-surgical treatments through RSBY doctors. According to their descriptions, more common problems included body aches, blood pressure, fatigue, and vomiting. It was not always clear whether these patients had needed hospital-based care as some reported that they had gone home for short periods during their hospital stay. Therefore, even though patients were shown by hospital authorities to have remained in hospital through the duration of their treatment, this did not represent the real situation.

I've been back home three times so far...I just let another patient know...after the doctor does a routine check-up and gives me medicines I sometimes go home...I return before the doctor's two p.m. round... (Sharmila, female, 50+ years)

Like my house is nearby so he (hospital staff/doctor) said, "If you feel like going home, go after 6 p.m. because somebody can come to check. But you'll have to be back by 9 a.m. So that if somebody comes to check we can show that the patient is here"... So after they removed my IV drip I came away...went back the next morning... (Sunita, female, 20+ years)

Although the RSBY does not cover medical consultation and drugs unless a patient is admitted in hospital, interviewees revealed that some providers ignored this rule and provided free medicines and medical advice through their cards. Hence, responses indicated that hospitals may have defrauded and profited from the RSBY by providing users excluded services that were relatively inexpensive for them to supply and saved them the costs of admitting patients.

I went every third day to get medicines... the card stays with them. I put my thumb impression each time they give medicines. (Kokila, female, 60+ years)

I took my mother to the orthopaedic doctor... they did not hospitalise. Gave medicines... the doctor told us to go to the computer person and give our

thumb impression, only after which we will get medicines... we do not pay doctor's fees nor pay for medicines. (Suman, female, 30+ years)

While users were generally happy so long as they were treated, they lacked precise knowledge about the services available to them and sometimes could not hold doctors liable even if they felt they were charged too much for treatment.

I thought my treatment could not possibly cost so much. They explained that even though my teeth were being fixed⁷⁹, they'd need to show it as something else. I just left it at that because I don't have much knowledge...After all, one can only speak if one knows... (Shikha, female, 40+ years)

Even when hospitalised through the RSBY, some patients alluded to the fact that certain medical services and diagnostic tests were only available to them if they were admitted in hospital. This RSBY rule about hospitalisation sometimes encouraged admissions in order for patients to have diagnostic tests and for investigations to be carried out.

When they began prescribing tests I said, "Sir, they have a smart card and cannot afford tests just like that." Then (doctor) agreed to admit them. (Gayatri, female, 30+ years)

The doctor said my sister needed a CT scan...We told him we had no money. He considered and then said, "We'll have to admit her." They then hospitalised her for 3 or 4 days and gave her some fluids. On the fourth day, they had her scanned somewhere outside...For free...After admission everything is free...otherwise one pays 50 rupees fee and on top of that they write down the medicines (to buy) (Babit, male, 18+ years)

DISCUSSION AND CONCLUSION

This chapter explores RSBY recipients' views about the programme and their descriptions of service use. It looks at the RSBY from their perspective— the issues that matter to them and how having this health benefit affects their general

⁷⁹ The RSBY excludes dental care from its list of services.

well-being. Their stories draw attention to the RSBY's effectiveness in meeting their treatment needs, while also gaining important insights into the programme's limitations with respect to its equity, quality, and cost-effectiveness. The findings in this chapter are important from a policy and research perspective given that most empirical studies with RSBY recipients involve standardised surveys that test enrolment and utilisation patterns, awareness and satisfaction levels (CTRD 2012; Mott McDonald 2011; The Research Institute 2012; Westat India Social Sciences 2010) with relatively fewer in-depth or qualitative assessments⁸⁰ of service users' ideas and experiences of the programme (NIHFW 2011; Seshadri et al. 2012). In many ways, therefore, this study is unique in giving "voice" to the clients of the RSBY and through their narratives drawing attention to the RSBY's fulfilment of its own goals and its recipients' needs.

The findings show that RSBY membership enabled several patients to get treated for more acute medical problems and especially helped many get quicker surgical care. Under previous circumstances, most patients had apparently deferred medical treatment until they could get an appointment at nearby public hospitals or had managed to scrape together enough funds to pay for costlier private care. The fact that such patients reported quicker treatments through their RSBY cards indicates the programme's positive effects in improving their access to clinical services and helping them avoid high levels of direct spending on private treatments. However, the results also reveal the RSBY's limitations in terms of assisting recipients with more common and routine problems by not offering them

⁸⁰ These include research involving focus group discussions (FGDs) with RSBY enrolees in a district in Gujarat state (Seshadri et al. 2012), interviews and FGDs with programme members as part of a rapid appraisal of the RSBY's implementation in Delhi (NIHFW 2011) and most recently, a GIZ evaluation involving qualitative interviews with users (GIZ & Prognosis Consultants 2012).

primary care. In other words, when health problems first surfaced, patients were often unable to get medical advice, diagnostic tests, and medicines through the RSBY. As a result, many early-stage medical problems may have gone undetected by the system. Instead, patients were prompted to self-treat or seek counsel from local providers of dubious quality. This also underlines the fact that overall health care arrangements even outside the RSBY were insufficient to meet the huge demand for primary health care services among local impoverished communities (Agarwal et al. 2007). More specifically, self-medication increased the risk of patients' health getting worse through possibly inappropriate medication and advice. It also made a return to formal services more likely when they were sicker, in need of extra medical services and hence costlier to treat. Inevitably, therefore, the health system is distorted in a less effective and uneconomical direction. This result is significant in light of international evidence showing that an orientation towards primary health care within services leads to more satisfied users, greater cost efficiency, and better health outcomes (Atun 2004b; Doherty & Govender 2004; Macinko et al. 2009; Starfield et al. 2005). In particular, the availability of primary care facilities may help poorer patients find a regular source of care which is related to better prevention and detection of problems, lower hospitalisations and reduced overall expenditure (Starfield 2011).

Furthermore, limited hospital-based benefits in the RSBY also seemed to encourage various perverse practices in RSBY facilities. For example, there were instances where RSBY clients needing diagnostic services were being hospitalised in order to have medical tests and investigations carried out. On occasion, providers appeared to have claimed payments from the RSBY for extra days of treatment even though patients were discharged sooner or had reportedly spent

nights out of hospital. At other times, some patients only received outpatient services and medicines from RSBY doctors but under the pretext of being admitted in hospital. On the one hand, these findings draw attention to the considerable and varied nature of health care needs among RSBY members. In addition, they indicate that the RSBY's restrictions on hospital-based care did not curb the substitution of outpatient treatment with perhaps more expensive inpatient care. Recent studies in China similarly show that if hospital-based treatments become cheaper (or more affordable through reimbursement) patients tend to reduce their consumption of outpatient services while correspondingly increasing their use of inpatient care (Zhou et al. 2011). From the perspective of the RSBY, it would seem that such forms of under-treatment and over-treatment were not technically efficient since the same services could perhaps have been provided at lower cost through other means. The frequency of such occurrences may thus have negative implications for the long-term fiscal sustainability of the RSBY.

In terms of the quality of care, there were few reports of doctors discriminating between fee-paying clients and RSBY patients. However, respondents reported variable levels of care for individual RSBY patients at participating facilities. Unlike many patients that had needed or undergone treatment for non-surgical ailments, surgery patients were generally positive about RSBY facilities and service quality. Not only were non-surgery patients more likely to have been refused treatment at RSBY hospitals, but also frequently complained about the quality of medication or improper diagnosis by doctors during hospitalisation. This indicates that patients needing surgery stood a better chance of getting treated and normally received more services as compared to users with general medical problems. Based on the results, different

reimbursement methods, higher package prices for surgeries and relatively low per-diem rates for non-surgical care, seemingly induced RSBY providers to favour surgery clients. The fact that the RSBY did not guarantee its patients a uniform service points to the emergence of a two-tier system of provision within the RSBY that has important implications for the equity of access to hospital services for recipients. Moreover, this result corroborates the findings in Chapter 5 and also corresponds with other research linking different methods of paying providers with the administration of treatment and the quality of care (Broomberg & Price 1990; Busse & Schwartz 1997). Moreover, there is evidence, although limited, showing that particular types of patients may be better off than others may be under certain reimbursement systems. For example, one study found that reimbursing clinicians per case or paying them an advance per-diem both resulted in reduced hospital stays and this affected psychiatric patients more than surgery or medical patients (Lave & Frank 1990). Other research reported differences in health outcomes between high and low income individuals depending on whether they were covered by a fee-for-service system⁸¹ or a capitation method with a pre-fixed payment per patient (Ware et al. 1986).

It is also important to note that RSBY recipients in the study were often pragmatic and prudent in spending RSBY resources. For example, they were reasonably cautious in their use of RSBY facilities, often not rushing in for treatment if they felt that self-medication could resolve their condition. Patients generally perceived that it was cheaper to buy off-the-counter drugs rather than spend time and money travelling to RSBY hospitals or miss work as a result. Patients also indicated that they were tempted to self-treat rather than see an

⁸¹ Fee-for-service pays providers a sum for each item or service they provide.

RSBY doctor so as to conserve RSBY resources for possibly more critical treatment needs in the future. In this respect, they showed some awareness about treatment costs and unspent balances on their RSBY cards. Like other research in the U.S.A. where high deductible⁸² insurance plans were found to encourage cost-conscious behaviours among patients (Fronstin 2012), these results also suggest that the benefit structure of insurance plans can influence patients into becoming more cost conscious and possibly make the health scheme more cost-effective. Therefore, on the face of it, the rationality and self-restraint shown by patients may be a positive sign from the perspective of containing costs within the RSBY. However, the findings also show some patients avoiding RSBY services without really knowing the actual cost of treatment or simply because they assumed theirs was a “minor” problem that the scheme would not cover. Patients seemed, therefore, to be self-censuring and holding back from using RSBY services not because they did not need treatment but either because it was unavailable through the RSBY or fearing that the treatment of smaller problems would eat into their total cash limit of INR 30,000, which was best safeguarded for future emergencies.

Taken as a whole, the above results demonstrate the vast need for health care among respondents that remained unmet despite the RSBY. Perhaps most crucially, the fact that RSBY patients could not legitimately obtain basic treatments, medical tests, and drugs through the RSBY signals its partial benefit for its members. This is an important finding in light of evidence showing that many more people in India are impoverished because of smaller but more frequent out-of-pocket payments on outpatient care as compared to more expensive but occasional hospital treatments (Berman et al. 2010). In other words,

⁸² The amount that a patient needs to spend before the insurer pays for treatment.

by only offering hospital-based care to its members, the RSBY seemed not to address a major cause of catastrophic health spending in India, which is what the programme intended preventing. Other studies in Vietnam and China similarly report that outpatient spending is the foremost cause of health-related impoverishment with a far greater negative impact on poverty relative to hospital care (Wagstaff & Doorslaer 2003; Yip & Hsiao 2009). The evidence, therefore, underlines the importance of designing context-specific government programmes that take account of local patterns of health spending and accordingly give assistance where it is most needed (Yip & Hsiao 2009).

With regard to gaining membership of the RSBY, it was evident that informal social networks involving local politicians and NGOs played a crucial part in mobilising and fuelling RSBY enrolments. Trust and reciprocity were clearly central features of these relationships and were key reasons why recipients decided to join the RSBY. This finding is consistent with other research which highlights the welfare benefits for individuals of being associated with local groups and influential actors in poor communities (Caeyers & Dercon 2012; Haddad & Maluccio 2003; Narayan & Pritchett 1999). There may be, however, a negative dimension to these social linkages since responses also suggested that less well-connected individuals had a lower chance of being informed and enrolled in the RSBY. Equally, it is important to note that distrust of local delivery systems had a negative effect on enrolments because it apparently made several people wary about actually benefiting from RSBY membership. Given this context, emerging evidence of potential recipients being left out because of incomplete official databases and frontline administrators arbitrarily issuing RSBY cards under false

identities could potentially affect future enrolment in the RSBY, especially if people come to see it as a discriminatory or fraudulent process.

Finally, the foregoing discussion is also significant from a methodological perspective given concerns about the reliability of patients' subjective views of a health service (Avis et al. 1995; Williams 1994). However, as the results show RSBY recipients were often well placed to identify important weaknesses in the organisation and delivery of services. For example, they revealed various perverse incentives for doctors as a result of the RSBY's focus on hospital-based treatments. They were also in a good position to reveal the functioning of local social networks and thereby, highlighted the need for policymakers to attend to local social divisions and inequalities when designing targeted programmes.

Chapter 7: Conclusion

This thesis evaluated the Rashtriya Swasthya Bima Yojana (RSBY), the government-sponsored health insurance programme for Indians below the poverty line (BPL). It seeks to add to existing knowledge on State-funded initiatives of health care for poor and disadvantaged populations within developing countries (Joint Learning Network 2013c; World Bank 2013b). The question of how relatively under-resourced nations can try expanding health care to the poor is an urgent and topical one given currently high levels of global attention on universalising health coverage (Chan 2012; WHO 2010; UNGA 2012). Universal health coverage is promoted as a key goal for countries in order for them to fulfil the fundamental right of their citizens to good health. Furthermore, universal coverage is widely regarded as “an investment in people that empowers them to adjust to changes in the economy and...support(s) a transition to a more sustainable, inclusive and equitable economy” (UNGA 2012, p.5). In this context, countries are urged to develop health financing systems that encompass prepayment of funds and pooling of health risks in order to prevent impoverishing out-of-pocket payments at the point-of-use (UNGA 2012; WHO 2010).

According to the World Bank, roughly 30 middle-income countries have recently introduced measures to hasten their move to universal coverage and several other low and middle-income countries intend similar action (World Bank 2013b). Given the range of nations involved, it is not surprising to find that country-level approaches for universal coverage often vary from one national context to another. For example, in some countries like India, Indonesia and

Georgia reforms are more incremental with public funds being spent on special programmes targeting poorer and more marginalised groups (Harimurti et al. 2013; Nagpal 2013; Smith 2013). Alternatively, the Philippines, Vietnam, and Ghana have started out by taking a more integrated and universal approach combining contributory social health insurance (SHI) and tax-funded health insurance for indigent groups within a single regime (Chakraborty 2013; P4H 2013; Somanathan et al. 2013). Furthermore, individual country initiatives for less affluent populations often also vary significantly in their design, in terms of the benefits they offer, how they are financed and their provision of services. Particularly in terms of their financing, it is noteworthy that although a number of new government health initiatives for the poor in developing countries are commonly labelled “health insurance”, there are often regional variations in how contribution rates are calculated, whether these are paid into a central fund or individually managed by a range of insurers and if local-level transfers are risk-adjusted to account for variable risks across localities. Arguably, each of these elements of financing impinges on the fiscal health and future sustainability of programmes. Each country’s experience, nevertheless, offers important lessons and context-specific insights into the governance, financing and organisational arrangements that could help other developing nations make the transition to universal health coverage.

In this respect, India’s Rashtriya Swasthya Bima Yojana (RSBY) is an example of a centrally managed and financed health insurance programme that covered an estimated 170 million people in early 2013. Important objectives of the RSBY include “providing financial protection against high medical expenses” and “improving access of identified families to quality medical care for treatment of

diseases involving hospitalization” (RSBY 2012a, pp.3, 14). Launched in 2008, the programme came about as part of the national United Progressive Alliance (UPA) government’s agenda to formalise social security for unorganised workers in the country (Government of India 2008b). Meanwhile, domestic political interest in expanding health coverage to the country’s poor and disadvantaged with the ultimate aim to universalise health coverage has risen remarkably. While top-level Ministers and officials in the Indian government have endorsed the idea of universal health coverage in various regional and global forums (BRICS Health Ministers 2013; PIB 2012a), the country’s latest Five Year Plan document (2012-17) pledges “to expand the reach of health care and work towards the long term objective of establishing a system of Universal Health Coverage (UHC)” in India (Planning Commission 2013b). This makes the RSBY increasingly relevant in terms of its potential role within the broader strategy of universal coverage.

Various factors account for the programme’s political and practical appeal in the context of universal health coverage. Its national scale and rapid expansion across 28 of India’s 35 states and union territories, covering 70% of the country’s 629 districts is widely regarded as a sign of the programme’s success (PMO 2011; PMO 2012a). Moreover, nationally, in the media and policy documents (Planning Commission 2013b) as well as on a more global scale, there is a strong perception about the RSBY’s success in enabling hospital treatments for millions and its innovative use of a technology-enabled “smart card” for more efficient operations (GTZ-GmbH 2010). In fact, the UNDP recently identified the RSBY as one of 18 “good social protection floor practices for South-South learning”(UNDP et al. 2011, p.5). Despite these positive affirmations about the RSBY, there is little consensus among health policy experts on its future role in the national strategy for universal

health coverage. The two key State-appointed expert groups that deliberated on the matter came up with quite distinct operational plans for progressing towards universal health coverage. Whereas one recommended the RSBY's merger within a publicly funded health service (Planning Commission 2011b), the other proposed that the programme be scaled-up and integrated with other state government-run health insurance schemes to create a cohesive social insurance system (La Forgia & Nagpal 2012).

This was the background in which the Planning Commission released a draft version of its Five Year Plan for the country (2012-17), which declared its intention to universalise health coverage by scaling up the RSBY (Planning Commission 2011a). However, it was compelled to reconsider its initial plan in the face of strong opposition from the Health Ministry and activists that saw this as a route to privatisation and commercialisation in the health system (Krishnan 2012; The Hindu 2012). Although more muted, the revised Five Year Plan has nevertheless decided to extend the RSBY's term until at least 2017 (Planning Commission 2013b). Moreover, the central government has hiked its financial stake in the programme and as part of its ongoing efforts to bring more informal workers under a social security net has further expanded it to new categories of workers including taxi drivers, rickshaw pullers and rag pickers (Ministry of Finance 2013). These are arguably signs that the RSBY remains an important part of the Indian government's short to medium term plans for extending health coverage to some of the country's poorest individuals.

This thesis has looked at various aspects of the RSBY from its conception to its administration and actual use by recipients. It intended to evaluate how

successful the programme has been against its stated goals of making services more affordable and accessible for its members. The thesis also considers the relevance of the RSBY to the local context and its clients' needs. It, thereby, adds to emerging knowledge on government-sponsored health programmes for the poor in developing countries. Accordingly, this thesis examined three key research questions: (i). Why did the Indian government launch a health insurance programme and why now? Why was a model of health insurance chosen over alternative ways of delivering health care to poor families in India? (ii). Is the RSBY being implemented and health services delivered as was intended? If not, why? (iii) How does the RSBY affect programme recipients and patients' access to health care services? The main findings from the thesis and their policy implications are summarised below.

ANALYTICAL FRAMEWORK AND METHODOLOGY

This study broadly drew upon two conceptual frameworks to help structure the thesis and guide the analysis of results. First, Walt and Gilson's (1994) analytical model for health policy with its focus on actors-content-process-context and the relations between them informed the analysis. Secondly, an actor-centred "responsive" (Stake 1975) or "constructivist" (Guba & Lincoln 1989) evaluation approach was applied to analyse the results from this study. In this thesis, "actors" refer to the individuals and agencies that are most closely associated with the RSBY as its formulators, implementers, and service users. The constructivist framework emphasises an inclusive approach to programme evaluation that interprets and assimilates the views of the main stakeholders in an intervention (Guba & Lincoln 1989). It thus has a broader evaluation canvas that extends

beyond simply assessing a policy's performance against the objectives set by policymakers (Abma 2005). The constructivist framework is useful to develop an integrated analysis of the RSBY by exploring the connections between the data from key informants and assess its combined effect on the programme's outcomes.

This thesis has a strong exploratory focus and, in part, this warranted applying an in depth, qualitative approach. The research is designed as a case study of the RSBY's operations in Delhi. For practical and strategic reasons, Delhi was a useful choice of location because it made it easier to access national and state-level stakeholders simultaneously, saving time and money during research. More importantly, Delhi has relatively longer experience of running the RSBY as one among the first three Indian states to implement the programme.

Based on Denzin (2009), methods were triangulated and the findings informed by documentary analysis, semi-structured interviews with key RSBY stakeholders and observation of important sites including enrolment centres, hospitals and the slum areas where beneficiaries lived. Similarly, data was collected from mixed sources including a range of key policy documents and multiple actors and agencies associated with the RSBY. Each account helped corroborate reports from other sources and thereby strengthened the validity of the results obtained.

The three research questions (RQ) of the thesis were addressed to a particular constituency among RSBY's main stakeholders: hence, RQ1 about the programme's formation to policymakers, RQ2 about service delivery to implementers and health professionals and RQ3 on the subject of service use to RSBY recipients and patients. By using in depth exploratory research methods, this

study goes beyond political rhetoric to reveal the underpinning goals and objectives of the RSBY. Similarly, detailed engagement with the RSBY's managers and clinical providers, both of whom render and critically shape the programme, was useful in highlighting how the programme was implemented in its early years, what worked and which aspects of the RSBY did not work well. Moreover and perhaps most crucially, this study relays the viewpoints and experiences of RSBY recipients in the programme. Having been marginal actors in RSBY policymaking processes, its numerous recipients and patients rarely get an opportunity to make their voices heard. Yet this constituency is most directly impacted by the RSBY and hence their thoughts and experiences in the programme are perhaps most relevant to improving and making it a success. Above all, a holistic engagement with RSBY's key stakeholders enabled a well-rounded and comprehensive evaluation of the programme, from inception through to its delivery.

KEY FINDINGS

Domestic origins and collaborative design: role of national and external actors in forging the RSBY

Chapter 4 showed that the RSBY was grounded in domestic politics and internal policy priorities in India. It was also clear that the national government led by the left-leaning United Progressive Alliance (UPA) and its leaders were central to the RSBY's creation. Even as impending national elections seemed to be the immediate trigger for the RSBY's launch, the programme was evidently drafted as part of the UPA administration's social security efforts for expanding coverage to low-paid informal workers in India. The results thus indicate that at the time of its creation, the RSBY was neither a response to emerging global calls for

universalising health care (Chan 2012; WHO 2005; WHO 2010) and nor did it seem to intend overhauling health care arrangements in India. Instead, it was a “home grown” marginal policy measure specifically and selectively targeted to low-income workers in the country.

This is a significant finding given the prevailing emphasis in global social policy research on the deep-seated and abiding influence of donors and multilateral agencies and more recently, global “non-elite actors and movements” on forming public policies in developing countries (Deacon 2007; Gough & Wood 2004; Surender & Walker 2013; Yeates 2008). The World Bank, for example, is often considered a key external actor shaping health policies in developing countries through direct financing of their health programmes as well as broad-based measures to check public spending (Koivusalo 2006). Analysts also contend that the World Bank’s influence on health policies stems principally from its financial clout as a foremost lender for infrastructural and social development projects in low-and middle-income countries (Buse et al. 2013). In this context, it is argued that national policymakers are inclined to accept the World Bank’s conditions for health programmes in order to ensure funding for other sectors in the economy such as infrastructure or energy (ibid.). Hence, as a result fiscal or corporate concerns may have an overweening influence over health policies rather than local health priorities (Koivusalo & Ollila 2008). In this study, however, it is important to note that national policymakers and central administrators were the main drivers for the RSBY and the idea and fundamental concept behind the reform clearly emanated from internal policy elites. Admittedly, the finer details of the programme were developed in conjunction with policy advisors from external agencies given the lack of technical knowledge needed to design a health insurance

scheme within the national government in India. Nevertheless, Labour Ministry officials were assertive players in the process of formulating the RSBY and were the final authority in decision making about the RSBY.

As Chapter 4 showed, there was clearly a role for outside actors, namely technical experts from the World Bank and German development agency, GTZ⁸³, in designing the RSBY. Theirs was ostensibly an advisory role and to that extent, the technical assistance from the above institutions did not come with the “strings” and conditionality normally associated with external financial aid (Buse & Walt 1996; Okuonzi & Macrae 1995). Yet, given their active and continuous involvement in designing and implementing the RSBY, they were indeed consequential for the programme’s evolution. Guided perhaps by the institutional leanings of such actors towards market-based solutions (Buse et al. 2013; Koivusalo & Ollila 2008), RSBY designers devised a competitive quasi-market for the RSBY involving both public and private medical providers. Besides involving private doctors and businesses, demand side financing and user choice were introduced by directing RSBY funds to clients rather than health care providers. From an administrative perspective, private participation in the RSBY was also considered a logical step considering the perceived weaknesses in the public sector. It emerges that a strong critique of State bureaucracies and public services, their inefficient and often corrupt practices, generally underpinned the RSBY and guided its implementation structure. Therefore, outside experts from the World Bank and GTZ were strong ideological influences on the RSBY and as its designers made a noteworthy imprint on the programme’s content and structure.

⁸³ Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH

In this context, it is also interesting that prominent health reforms in other large middle-income countries such as Brazil, South Africa, and Thailand were similarly championed and grew out of local political histories and politics. For example, Brazil's universal, publicly-funded Sistema Único de Saúde (SUS) health system came into existence in the post-authoritarian period, heavily pushed forward by a powerful group of local health reformers (Cornwall & Shankland 2008). Similarly, Thailand's revolutionary 30-baht⁸⁴ scheme of 2001 had apparently found a strong promoter in its newly elected Prime Minister, Thaksin Shinawatra, who had won the popular mandate having pledged to introduce low-cost health care for the poor (Hughes & Leethongdee 2007). This scheme effectively universalised health coverage in the country by enabling its non-insured poor populations to access a set of defined benefits for a standard fee of 30 baht (US\$ 0.80) per visit. Although, in contrast, long-standing debates on introducing national health insurance (NHI) in South Africa have not translated into formal policy as yet, the fact that health financing reform was a significant part of the post-apartheid African National Congress (ANC) government's agenda is cited as an important factor propelling national deliberations (Pillay & Skordis-Worrall 2013). As in the case of India and the RSBY, it was arguably the change in national leadership and government in Brazil, South Africa and Thailand that catalysed the movement for and promulgation of health reforms.

Productivist vs. welfarist underpinnings of the RSBY

It appears from the research presented here that the RSBY emerged from a "productivist" (Holliday 2000; Wilding 2000) mindset within the central government which considered the programme an investment in human capital for

⁸⁴ Currency unit in Thailand.

advancing economic growth in India. “Productivist” or “developmentalist” (Kwon 2005) welfare capitalism, distinguished by its overwhelming emphasis on economic activity and productivity, was variously reflected in Chapter 4. This was evident in the former Labour Minister’s telling statement about the main policy priorities of the UPA government being ones directly related to the economy, namely power and infrastructure. It was also demonstrated in his views about healthier workers being more active and hence able to earn more. Policy documents and political declarations similarly highlight the need for improving labour efficiency to improve India’s prospects in a competitive global marketplace. In this context, improving health care services for unsalaried workers to enhance their productive capacities became an important concern for the government, hence paving the way for the RSBY.

It was unclear whether it was fiscal constraints (as the Labour Minister argued) or indeed political choice that inhibited the central government from offering comprehensive and universal welfare services across all informal workers. Nevertheless, it was apparent in this study that by framing the discourse on welfare provisioning for informal workers in “developmental” terms and the advantages of giving them health benefits, the UPA was able to win crucial political support for the RSBY. Despite the political rhetoric about the RSBY as a measure for promoting the well-being of India’s poor (Government of India 2011; PMO 2012c; RSBY 2012a), the programme was firmly located within the Labour Ministry and both welfare needs and needy populations were narrowly defined. Hence, the RSBY was designed as a selective and marginal benefit intended for the “poorest” BPL families and offered them partial benefits in the form of hospital-based treatments.

The results thus reveal prevailing norms among policymakers on who ought to be helped and the basis for judging “deservingness”. Significantly, the findings also highlight the marked absence of a language of social justice and health care as an entitlement of citizenship in framing the RSBY. To that extent, the programme marks a significant departure from the health reforms in Brazil, South Africa, and Thailand discussed earlier. Unlike the RSBY, proposed or ongoing reforms in these three countries are attempting radical change within their existing health systems and are explicitly directed towards egalitarian access and comprehensive health care as a right of citizenship (Cornwall & Shankland 2008; Hughes & Leethongdee 2007; Pillay & Skordis-Worrall 2013). This more comprehensive and universalist approach towards health reforms arguably results in the evolution of more stable institutional arrangements that potentially make it more likely that programmes will be sustained (Basaza et al. 2007; Huber et al. 2002; Ndiaye et al. 2007). Moreover, De Allegri and colleagues (2009) argue that establishing a programme within a legal and regulatory framework demonstrates political support for policy, which in turn encourages greater investment and better coordination at the local level.

Role of policy design for effective service delivery

Incentives for enhancing motivations and agency of service providers

Chapter 4 revealed that a strong critique of public services, an alleged lack of public capacity and perceived private sector efficiency guided RSBY policymakers in opting for large-scale private participation by firms, NGOs, and private doctors to deliver the programme. With the aim of achieving cost-efficient and responsive service provision, they also introduced demand-side financing

mechanisms (fee-for-service where money follows patients) which effectively made a health care facility's revenues dependent on the total number of RSBY patients it served. However, the results in Chapter 5 demonstrate that the reality of RSBY implementation in Delhi was often far more complex than policymakers had anticipated. Hence, we find that professional practices did not always follow expected patterns nor did frontline managers and doctors respond to the RSBY as was generally assumed by decision-makers. As far as RSBY doctors in this study were concerned, monetary incentives clearly mattered to them. Financial gains from serving RSBY customers was an important reason for their involvement in the programme. Some clinicians however felt patronised by the RSBY's system of reimbursement that did not allow them to charge an itemised fee for service but instead paid them a pre-fixed package price. Moreover, the vast majority of doctors in this study felt that they were not fairly compensated by the RSBY and that its compensation rates were significantly lower than the likely costs to their practice. Although RSBY clinicians in this study did not seem averse to working at reduced rates, they strongly resented what they alleged were unrealistically low RSBY tariffs. Here, it may be important to note that the sample consisted entirely of private and urban hospitals where average treatment costs are usually higher than in public or rural hospitals in India (NSSO 2006). Even so, as reported in chapter 5, the huge drop in RSBY facilities in Delhi from over a hundred when this study was conducted in 2010 to merely 40 private providers this year (2012-13) (MoLE 2013) is significant because it indicates a possible negative effect of providers being dissatisfied with payment structures. Underlining the importance of making RSBY's medical tariffs attractive to doctors, a recent study on RSBY implementation which reveals a striking disparity between high levels of

enrolment versus negligible use of RSBY hospitals by recipients in Karnataka state proposes the involvement of medical providers in facilitating greater utilisation (Rajasekhar et al. 2011). The authors of the study contend that currently while RSBY premiums motivate insurers to maximise enrolments, there is little reason for them to encourage utilisation especially as this cuts into their own profits. Therefore, providers with a personal stake in seeing treatment rates improve could play a part in improving use of RSBY facilities. However, Rajashekhar et al. (2011) underline that for this to occur medical tariffs will need to be sufficiently attractive to RSBY doctors (Rajasekhar et al. 2011).

Furthermore, it was most worrying to find doctors being candid about the fact that RSBY's low treatment prices induced them to provide selective treatments and services to RSBY patients (Chapter 5). This was also illustrated in RSBY recipients' accounts in chapter 6 which revealed that the quality of care was often variable across patients (surgery vs. non-surgical patients) and from one RSBY facility to another. Overall, therefore, RSBY's payment rates seemed to affect both the extent of private participation as well as individual doctor practices as far as treatments were concerned.

The findings also give little evidence of RSBY structures positively influencing the quality or responsiveness of service provision. For enlisted medical facilities, the only significant change in terms of standard routines was installing and using new software and equipment for admissions and payments. However, even the highly regarded system of online transactions that was to enable better monitoring in the RSBY was found to be easily manipulated; for example, through avoidable hospitalisations and inaccurate bills by doctors. In a recent effort to

reform the medical delivery system, RSBY authorities developed a quality improvement plan in 2012. This sets explicit targets for hospitals to upgrade their infrastructure and management systems including record-keeping and accreditation practices in order to avoid expulsion from the scheme (MoLE 2012c). However, going by the results in this study which show RSBY hospitals having little financial stake in the programme, it seems unlikely that they will be motivated to improve service quality without direct financial incentives.

On the subject of RSBY administration, the explicit involvement of non-governmental organisations' (NGOs) by policymakers seemed to be based on a common perception about their familiarity and better access to local communities as compared to public agencies making them better candidates for welfare delivery (for e.g. Preker 2003; World Bank 2004). However, in this study, NGOs' monetary and human resource constraints appeared to have limited their capacity to reach out to and mobilise eligible people for the RSBY. It also emerged that their lack of a formal contract and ambiguity about their precise role in the RSBY diminished their general motivation towards the RSBY. On a related note, the third party administrator's (TPA) perception about the ad-hoc nature of their RSBY contract⁸⁵ seemingly resulted in them not investing sufficient infrastructure on the programme. It was, therefore, not surprising that various problems to do with finding families to enrol or delays and non-delivery of RSBY cards were commonly reported.

⁸⁵ In what may be a significant development, new rules now allow TPAs to apply for a two-year extension to their annual contract but only after they are thoroughly audited and accredited by a formal authority (MoLE 2013). However, a TPA will need to pay an annual fee between INR 40,000 (\$800) and 50,000 (\$1000) (excluding taxes) in order to get accredited. It will be interesting to see if the business potential of the RSBY is enough to prompt existing agencies into making this investment and improving quality of services.

The overall picture emerging from the above results indicates that RSBY's frontline implementers and medical providers were not suitably incentivised to deliver services and perform their jobs as they should have done. This echoes other research in highlighting the importance of appropriate monetary and non-financial incentives in positively influencing stakeholders to adopt and implement programmes effectively (Atun et al. 2005; Rajasekhar et al. 2011). The above results are therefore significant from the perspective of the RSBY's long-term viability because they demonstrate that its payment structure may have implications for the number of medical providers who in future are willing to participate in this initiative. Above all, these findings indicate that incentivising service provision is likely to be an evolving process which may demand an active and long-term, continuous engagement from policy makers.

Need to reallocate RSBY spending on primary and outpatient care

According to the results in chapter 6, RSBY membership clearly enabled many patients to get surgery and other curative treatments at RSBY facilities. In general, RSBY's private hospitals in Delhi were more responsive and quicker to treat patients than public hospitals reportedly were. Inpatient care at RSBY hospitals also seemed to involve fewer personal costs for patients since it included drugs and medical supplies as part of the service and was of a generally higher standard than the government hospitals patients normally used. This study, therefore, shows that the RSBY had some positive effects on treatment availability and service quality for its users.

However, in order to have a fuller evaluation of the RSBY's effectiveness, it is important to consider the above results in light of the other findings reported in

chapter 6. From the point of view of RSBY patients, a key fact to emerge from this analysis is the vast need for health care that remains unmet despite RSBY membership. Patients in need of primary and outpatient treatments could not get these through the RSBY simply because the programme did not provide these services to its members. However, by only offering expensive hospital care, the RSBY did not plug what was a frequently reported problem among interviewed patients: their need for basic medical treatments, medicines, and diagnostic tests. This finding is particularly significant given that existing empirical research shows that most health-related impoverishment in India occurs as a result of frequent spending on outpatient care (Berman et al. 2010). Therefore, to the extent that the RSBY intends preventing catastrophic health consequences for poor patients, the results indicate that it may be only partially successful on that front. Studies in Vietnam and Mexico similarly report that expenditure on outpatient treatments and medicines is often a more significant cause of medical impoverishment as compared to patients' spending on hospital services (Knaul et al. 2005; Wagstaff & Doorslaer 2003). On a related note, research in China highlights the limited impact on health-related poverty of medical schemes which only offer hospital-based benefits since most out-of-pocket payments are on expensive outpatient treatments for chronic problems (Yip & Hsiao 2009). The evidence, therefore, impresses upon policymakers the need to design health programmes according to local patterns of morbidity and health spending in order to improve their effectiveness (Nandi et al. 2012; Yip & Hsiao 2009).

Furthermore, in contexts where poor patients have limited access to primary care practitioners as potential gatekeepers, the results also show that it may not be cost-efficient for government programmes to offer exclusively

hospital-based benefits. For one, it may contribute to avoidable hospital admissions for problems which are perhaps easily and effectively treated in an ambulatory setting (Casanova & Starfield 1995; Pappas et al. 1997). Secondly, there are also long-term cost implications of the health system not treating early stage medical problems when patients have a better chance of recovery. This not only raises the possibility of them becoming sicker through self-medication but may also have a destabilising effect on overall costs within formal services from having to spend more resources on treating patients in worse health. Empirical evidence complements this finding by demonstrating that primary care-focussed health systems, which function as a first point of contact for patients and provide comprehensive care for a range of problems, are normally more cost-effective than specialist-oriented systems which are more inclined to use costlier technology and carry out additional diagnostic tests and investigations (Atun 2004b; Doherty & Govender 2004; Friedberg et al. 2010; Starfield 2011).

Role of locally embedded delivery systems

An interesting finding was that people's reservations about existing delivery systems had an apparently negative effect on their participation in the RSBY. On the other hand, the credibility of local politicians and NGOs based on people's pre-established association with them emerged as an important stimulus for enrolments in the RSBY. This result corresponds with other research showing relatively greater levels of public trust in locally embedded institutions (Bratton & Liatto-Katundu 1994; Huijts et al. 2007) as compared to State-run services that are increasingly perceived as corrupt and discriminatory (Fjeldstad 2004; Lavalley et al. 2008; Paul 1998). However, the findings also demonstrate a "dark side" to local

social networks given that these are more likely to benefit known and familiar persons and exclude individuals that are relatively distanced from them. Moreover, the risk of clientelism and nepotism in enlisting people for the RSBY may be further enhanced given the programme's targeted approach, which as the findings show, could give frontline administrators a chance to enrol people in an arbitrary and discretionary manner. Other research similarly shows how community-level power differentials may negatively impact on programme delivery because of which local elites may prevent some poor people from claiming their rightful benefits from government programmes (Pellissery 2005) or may end up capturing benefits meant for the rural poor (Francis 2006). The evidence presented in this study thereby highlights the importance of evolving targeting strategies in ways that take into account unequal power relations in local communities. Equally, policymakers will need to fully take on board relative levels of public confidence in various public and non-state local delivery agents while identifying suitable organisations to administer the RSBY. Finally, appropriate regulatory and incentive structures may be needed to ensure fairer enrolment in the programme.

EVOLUTION OF THE RSBY (2010-13)

Since the fieldwork for this thesis concluded in the autumn of 2010, several changes and developments have taken place within the RSBY. With its operational systems stabilising and large numbers enrolling, policymakers are more confident about the RSBY's technical feasibility. As a result, from a programme mainly intended for below poverty line (BPL) families, the RSBY is steadily being extended to many near-poor individuals among building and construction

workers, recipients of the MNREGA⁸⁶ scheme, street vendors, and domestic workers. This is ostensibly part of the UPA government's efforts to expand health insurance coverage across informal sector workers. Earlier in 2013, taxi drivers, sanitation workers, rag pickers and mine workers also became eligible for the RSBY (Ministry of Finance 2013). Although the Labour Ministry remains the primary funder for many new groups, to some extent, the source of funds for the RSBY may diversify through its expansion. For example, the premium for building and construction workers is paid from a welfare fund to which they contribute as well (MoLE 2013). Similarly, the Railway Ministry will fund the bulk of payments for railways porters and hawkers alongside a part contribution by the recipients themselves (PIB 2012b). The RSBY is incrementally being extended to a few of these newly eligible non-poor workers across each state as central authorities work out the finer operational details of involving each group (RSBY Connect 2013).

Changes are also underway in the medical benefits that the RSBY offers. In 2011, pilot programmes were launched in two districts to offer outpatient services including free medical consultations and drugs to 0.2 million RSBY recipients. Under the initiative, RSBY clients are entitled to a maximum of 10 outpatient visits with health care providers earning a fixed amount of INR 100 (\$2) per visit (RSBY 2011a). There are plans to shortly introduce similar outpatient trials in a few additional districts (Jain 2012).

In what could be an important development for the RSBY's future, Finance Minister P. Chidambaram recently declared that he intended develop(ing) a

⁸⁶ Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA) that entitles adults in rural areas to 100 days of paid manual work.

“comprehensive...package for the unorganised sector” by converging disparate social security programmes including the RSBY (Ministry of Finance 2013). A first sign of this occurring is the fact that RSBY recipients are now automatically eligible for life insurance and disability and scholarship benefits offered by the Aam Aadmi Bima Yojana (AABY), a programme for rural landless adults that was announced alongside the RSBY in 2007. Pilot programmes to test the feasibility of merging the two schemes are currently underway in a couple of districts.

RSBY’s prospects and place in extending health services to India’s poor: What do the findings indicate?

Interestingly, some of the shortcomings of the RSBY uncovered by this research are also noted in the government’s latest Five-Year Plan (2012-17) (Planning Commission 2013b). This include its high administrative costs, unchecked provider-induced demand, lack of primary and outpatient services, the tendency to inflate costs through needless hospitalisations, and inattention to local health care needs, particularly regional differences in disease patterns (ibid., pg. 21). Therefore, it is most curious that the Plan goes on to propose that the RSBY remain the mainstay of the government strategy for expanding coverage to all below poverty line Indians even as it suggests, in a rather insubstantial way, that the programme reform itself to provide a “continuum of comprehensive primary, secondary and tertiary care” (ibid. pg. 9).

As discussed in the previous section, the UPA government is now set to open up the RSBY to numerous groups of low-income workers. It is, therefore, clearly an important part of the national strategy to expand health services to

some of the poorest in India. However, an obvious and central question is why the current administration is keen to extend the RSBY despite being aware of its many drawbacks. Are its problems considered insignificant and hence easily resolved? Or is it more a matter of political pragmatism and about taking a path that offers some benefits to the poor but is also least confrontational? A mechanism that functions within present service delivery structures without significantly altering them? Above all, is the government's seemingly incremental approach the best way forward to fill existing gaps in health care and deliver services to poor groups in India?

The reasons for the strong government backing for the RSBY are perhaps better understood by referring to some of the earlier debates that had occurred when the programme was under discussion and was intended specifically for informal BPL workers. As the findings in Chapter 4 showed, the political preference for a "quasi" insurance model was not explained by pragmatism alone but was also ideologically driven. Hence, in practical terms, the chief merit of the RSBY is arguably its ability to work with the well-entrenched private sector in India and extend hospital-based services reasonably quickly. The normative rationale for RSBY expansion perhaps stems from the lack of political faith in the country's public health care system and a deep-seated distrust of the public sector to effectively deliver services to the country's poor.

As far as expanding services to the poor are concerned, the present UPA government seems inclined to the Planning Commission's idea to "move in terms of pilots and incremental coverage" for the time being (Planning Commission 2013b, p.14). In this context, perhaps the current administration sees the RSBY as

a sensible strategy to provide a defined, albeit partial set of medical benefits for the country's poor and unsalaried workers. However, it is clear from this study that in its existing form the RSBY can at best be a stopgap measure to address specific groups of poor people and particular forms of health risks among them. Clearly, the problems thrown up by this study and also acknowledged by the Planning Commission are not so-called "teething problems" of a new programme, which are likely to resolve as overall processes stabilise. There are fundamental shortcomings in the RSBY's conception as a stand-alone, selective measure offering only limited inpatient treatments. The RSBY's evident lack of success in addressing the huge unmet demand for primary and ambulatory care services among its users as well as evidence showing that it may potentially raise overall health system expenditure suggests that it is neither effective in meeting local need nor efficient from an economic perspective. Hence, policymakers may need to think about reforming the programme before they set about expanding it to new groups.

The RSBY's conception as an incremental measure of the government naturally means that there is no explicit legal guarantee for how long it will last and whom it benefits. On the contrary, the RSBY is appended to the Unorganized Worker Social Security Act (2008) which allows the "Central government...to amend the schedules annexed to th(e) Act" (Government of India 2008b, p.3). This arguably weakens the political sustainability of the RSBY. Furthermore, the findings in this study reveal another potential risk to the programme's viability resulting from its heavy dependence on (for-profit) private medical providers. This makes the RSBY vulnerable to them not being willing to participate if they are dissatisfied with prices. As discussed in Chapter 5, there is a 60% drop in the

number of private providers participating in the RSBY in Delhi in 2012-13, as compared to when this study was conducted in 2010. In the long run, given that 70% of all RSBY health care facilities nation-wide are in the private sector⁸⁷, policymakers may need to think about finding a suitable mix of measures to incentivise and regulate participating medical providers.

What explains this inadequate and limited response from the government? Is it, as the former Labour Minister suggested, mostly to do with scarce fiscal resources and, under the circumstances, the best that the government can do? Arguably, economic factors can only provide a partial explanation given that several countries like Brazil, Colombia, and Ghana which introduced more universalist and broad-based policies did so at a time when their per capita incomes were equivalent or even lower than India's current levels (World Bank 2012b; World Bank 2013b). Brazil, in fact, continued to spend heavily on key health and education programmes through periods of economic crisis and budget cuts in other areas (Couttolenc & Dmytraczenko 2013). Some analysts, therefore, contend that politics, political interests and pressures often play a central role in creating and sustaining welfare policies in low-income countries (Graham 2002; Devereux 2001; Hickey 2007). Indeed, "no economic law...prevents societies from deciding to allocate more resources to old-age security and less to some other expenditure" (Beattie and McGillivray 1995 in Devereux 2001, p.22). In this respect, the findings clearly show that policy priorities in India are currently more centred on the economy and on social spending that is deemed to aid economic growth and productivity. Presumably, there is also limited political will to incorporate the RSBY (and the range of other stand-alone measures) into long-

⁸⁷ In March 2013.

term planning for universal health coverage in India. Moving in the direction of an integrated policy may help sustain the programme. More crucially, it is likely to improve the RSBY's effectiveness in providing health care to a majority of India's citizens.

CONTRIBUTION OF THESIS

This thesis makes three main contributions to policy and the academic literature. Firstly, it advances knowledge about the RSBY programme in India and generates better knowledge about this model of health care delivery. It is one of the first in-depth qualitative studies to track the RSBY's evolution since its inception in 2008. Furthermore, it is also among the few evaluations of the RSBY to present a cohesive analysis embedded in the actual experiences of its main stakeholders. To that extent, the insights from this empirical investigation complement existing quantitative analysis of RSBY enrolments and hospitalisation data as well as ongoing surveys with RSBY insurers, doctors, and patients. The findings are particularly relevant given the current UPA government's declared commitment to universalise health coverage in India and ongoing discussions on the RSBY's role in that context. This study comes at a particularly opportune time when there is fervent global debate about reforming health financing in low and middle income countries in a bid to universalise health care services (WHO 2010). It is important to be clear that there are no easy answers to the question of how India or any developing country for that matter should organise health care services to deliver to underprivileged populations. Different social and political histories, institutional and economic structures including the extent of informal employment across developing nations may mean that what is achievable or

feasible in each context may vary. Nevertheless, the thesis contains important practical lessons for more effective policy implementation. In particular, the results highlight the need to bring local institutional capacities up to speed with programme goals by investing more funds and human resources into programmes. Furthermore, the evidence in this study shows that it is possible to incentivise the performance of managers, health professionals, and community workers through both monetary measures as well as non-financial incentives that assure them a reasonable future in programmes. The thesis also encourages policymakers to take decisions on which services to fund based on local morbidity and health spending profiles. Accordingly, government resources may be directed towards primary and ambulatory health care, secondary, or tertiary services. These are fundamentally relevant questions for health policymakers in developing countries facing multiple challenges on account of the vast numbers affected by poor health alongside rising demand and health care costs, thus making it imperative to ration services in a way that is both cost efficient and effective in terms of health outcomes.

Secondly, in revealing the “developmental-productivist” orientation of the RSBY this thesis uncovers an important dimension of the RSBY that is not normally acknowledged in scholarly discussions about the programme. It thereby makes an original contribution to the general body of work explaining the ideological underpinnings of current policies to universalise health coverage in India. Furthermore, by linking the RSBY’s “developmental-productivist” origins to its design and objectives, this study demonstrates how the normative basis of social policies has a direct effect on the choice of policy instruments, which in turn affects policy outcomes.

This thesis makes a third vital contribution to the literature on social policy analysis in emerging and transitional environments (Gough & Wood 2004; Haggard & Kaufman 2008; Kilkey et al. 2012; Kwon 2005; Midgley 2007; Rudra 2007). It generates knowledge on the dynamics of health policy making and implementation in a developing country context. It draws attention to the actors and the processes that create and deliver social policies, the underlying normative basis of public welfare and the instruments and mechanisms of service provision (Devereux & White 2012; Draibe & Riesco 2009; Lim et al. 2010; Lund et al. 2009; Mkandawire 2005; Midgley 2012; Woods 2006). Moreover, the thesis also adds to the substantive work in the area of global social policy that studies new forms of global governance and multiple institutional actors within it (Deacon & Hulse 1997; Deacon 2007; Yeates 2002). The thesis generally supports analyses showing that despite transnational influences from international bodies and civil society actors in shaping social dialogues and policies across many countries, national States are the primary mediator and enactor of policies (Garrett 1998; Hirst & Thompson 1996; Weiss 2000; Yeates 2002). In this respect, the role of the Indian State in forging the RSBY was amply clear in the thesis. This study, however, also demonstrates the abiding influence of international and intergovernmental organisations like the World Bank and the German development agency, GIZ in shaping the RSBY policy. Arguably, some of what they advocated was adopted in the RSBY because it was in harmony with the values and goals that mattered to State elites in India. Therefore, despite the somewhat spurious definition of the RSBY as a form of social insurance (given that it is funded from public revenues), its design reveals the underlying goals of policymakers and their marked leanings towards developmentalism and market promotion. What is also interesting is that

the distinctive approach and underpinnings of the RSBY contrast with the way in which other emerging economies such as Brazil, Thailand, and South Africa are carrying out health reforms towards universal coverage. For example, South Africa's proposed National Insurance has clear redistributive and social justice goals as evidenced in its policy paper (National Department of Health 2011). Similarly, large-scale expansion of health care to the poor in Thailand, Brazil, Colombia, and Chile has been carefully structured and embedded in legislative reform that transforms health care into a right and hence obliges their governments to make provisions to cover all citizens.

LIMITATIONS

It is also important to point out the limitations of this thesis to have a more realistic appreciation of its contribution and value. This study took place two years after the RSBY's launch. What is reported here are, therefore, the early effects and responses to the RSBY. Since then, some modifications in local-level management and organisational practices may have occurred, perhaps inducing different reactions from those presented in this thesis. However, to the extent that the RSBY's objectives, technical content, structure, and organisational functions remain unchanged to the present day, the findings from this study are consistent and highly relevant.

In addition, longer-term goals of the RSBY to reduce health-related catastrophic expenditure and contribute to macro economic growth and productivity were beyond the scope of a cross-sectional study like this. Moreover, as is often the case with in-depth qualitative work, the research findings are specific to the time and place where they took place and the individual

respondents in this study. The fact that this research was located in largely urban Delhi, may possibly make for different results in a non-urban setting. For example, rural areas may face different problems in terms of the overall availability of health care facilities, the mix of public and private providers and the motivations of rural doctors towards the RSBY. Even though current trends would suggest otherwise, one can argue that procedural problems related to data and timely payments in the RSBY may gradually resolve. Yet, there are deeper insights from this empirical investigation which are important for wider policy and practice. To re-state some of them: the importance of understanding service providers' motivations in constructing correct incentive structures for them, appreciating the strengths and weakness of social networks in effecting policy changes and especially the role of third sector and private sector actors in effectively delivering welfare services.

AREAS FOR FURTHER RESEARCH

This thesis makes a case for more qualitative studies of the RSBY in other Indian states and in both rural as well as urban areas. Such research will bring an important comparative dimension to the findings from this study. It may potentially allow more generalised propositions about the programme if similar effects on service providers and patients occurred under different conditions. Furthermore, they will often be an important complement to various quantitative assessments of the RSBY and may help understand the reasons for outcomes such as enrolments or service use differing from one region to another. In addition, longitudinal cohort studies of RSBY recipients may be undertaken to study some of

the longer-term effects of the programme on financial and health outcomes among service users.

Given the central role of medical professionals in sustaining the RSBY, prospective studies could further explore their role, views and attitudes towards the RSBY in other localities. Similarly, this thesis initiates important discussions on the strengths and limitations of NGOs in service delivery. This topic may be further developed through additional work on the role and place of voluntary and non-State agencies in other welfare programmes.

On the subject of service quality in the health sector, a particularly significant but under-researched area of work in a developing country context and India in particular, is the perspective of the end-user or patients. The benefits of client-centred health care in improving patient satisfaction and effectiveness of treatment through medication adherence and greater utilisation are now well recognised (Andaleeb 2001; Donabedian 1992; WHO 2000a). Yet, what factors contribute to making health services more patient-oriented and the challenges to constructing such systems are generally overlooked in developing countries. This thesis sets an important agenda for future work on this topic to help develop health systems that truly have patients at their heart.

APPENDIX A

RSBY policymakers interviewed

Date of interview	Title and organisation
11 June 2010	Senior Technical Specialist (Health Insurance & Health Finance), Social Security Programme of German Development Cooperation (GIZ), formerly GTZ
5 July 2010	Director General Labour Welfare, Ministry of Labour & Employment, Government of India
27 July 2010	Minister of State for Labour and Employment (2006-2008), Government of India
17 August 2010	Former full-time member, National Commission for Enterprises in the Unorganised Sector (NCEUS), Government of India
8 September 2010	Advisor (Health), Planning Commission of India, Government of India
27 September 2010	Lead Specialist, Social Protection (South Asia), The World Bank, New Delhi, India
30 September 2010	Senior Advisor (Health), Planning Commission of India, Government of India

APPENDIX B

WEB-BASED DOCUMENTARY SOURCES⁸⁸

National websites

RSBY	www.rsby.gov.in
Ministry of Labour and Employment	www.labour.nic.in
Press Information Bureau	www.pib.nic.in
Ministry of Health & Family Welfare	www.mohfw.nic.in
Ministry of Finance	www.finmin.nic.in
Planning Commission of India	www.planningcommission.nic.in
Prime Minister's Office	www.pmindia.gov.in

State-level websites

Mission Convergence	www.missionconvergence.org/
Government of Delhi	www.delhi.gov.in
Office of the Labour Commissioner, Government of Delhi	www.delhi.gov.in/wps/wcm/connect/doi_labour/Labour/Home/

External agency websites

World Bank	www.worldbank.org
GIZ	www.giz.de
WHO	www.who.int
ILO	www.ilo.org
Joint Learning Network	www.jointlearningnetwork.org

NOTE: All published sources for the documentary analysis are listed in the References at the end of the thesis.

⁸⁸ Illustrative.

APPENDIX C

Invitation letter, Information sheet, Consent Form and Topic guides

Letter of invitation for interviews

DEPARTMENT OF SOCIAL POLICY AND SOCIAL WORK
Barnett House, 32 Wellington Square, Oxford OX1 2ER
Tel: +44(0)1865 270325 Fax: +44(0)1865 270324
www.spsw.ox.ac.uk



To,
Dr. X,
XX Nursing Home,
Delhi
September 2010

Subject: Research study on Rashtriya Swasthya Bima Yojana (RSBY) in Delhi

Dear Dr. X,

I am a researcher at the University of Oxford in the U.K. and am writing to you with reference to a research study that I am undertaking on the Rashtriya Swasthya Bima Yojana (RSBY) and its implementation in Delhi.

For the purpose of this project, I am interviewing senior policymakers, managers and healthcare providers who have been involved in the roll out of the RSBY. I understand that you were an empanelled service provider for the RSBY and therefore, I would appreciate an opportunity to receive your views in this matter. This is to request an interview with you for this research project.

The interview is aimed to last approximately 30 minutes— though can be made shorter if preferred. Please find attached for your reference an information sheet detailing the methodological considerations for the study. This includes the names of contact persons at the Department of Social Policy and Social Work, University of Oxford, for further information on this research. If you have any questions concerning this matter, please contact me at the email address on the attached sheet.

Please let me know by email if it is convenient for you to meet with me at your office any time tomorrow morning, 9 September or alternatively Monday, 13 September.

I appreciate you are a very busy person but your technical knowledge and insights will be invaluable for this research. I look forward to a positive response from you.

Thank you,
Yours sincerely,
Amrit K. Virk

Information Sheet

Ref: Research on India's Rashtriya Swasthya Bima Yojana (RSBY) in Delhi

Ms. Amrit K. Virk, Researcher, amrit.virk@socres.ox.ac.uk

Dr. Rebecca Surender, Senior Researcher, rebecca.surender@socres.ox.ac.uk

The study has been assessed by the Central University Research Ethics Committee (CUREC) at the University of Oxford. The process undertaken by CUREC entails a rigorous scrutiny procedure that addresses, among others the following questions regarding the interview process.

- **How will the interview be conducted?**

The data and information in this research will be collected by interviews that are aimed to last approximately 30 minutes - though can be made shorter if preferred. I will personally conduct the interviews. Only I, along with a senior colleague involved in this research project, Dr. Rebecca Surender, will have access to the data. If possible, I would like to use a digital recorder for the course of the interview to ensure accurate collection of data.

- **What type of information will be asked?**

I am interested in your views on the functioning and execution of the RSBY. Your technical knowledge and insights will be invaluable in informing this research.

- **How will anonymity be ensured in this research project?**

All the information provided during this interview will be treated confidentially, stored carefully and destroyed after the project is finalised. In all cases, the study will ensure as far as possible, that individual participants are not identifiable in the final project report. Pseudonyms, e.g. "respondent A", may be used to distinguish between different respondents.

- **On participation**

Your participation in this research is voluntary. If you so choose, you have the right to withdraw at any point of the study, for any reason, and without any prejudice, and the information collected and records and reports written can be turned over to you.

- **How will the information be used?**

This data collection work will be used for academic purposes. Upon request, you may receive a copy of the final research document produced.

- **When and where will the interviews take place?**

I would like to conduct the interviews in May-September 2010. It would be useful if the interviews could take place in the premises of your organisation in Delhi. Although, if this is not possible, please let me know and I shall arrange another venue.

CONSENT FORM

Full title of Project: Expanding access to health care for poor communities in developing countries: the case of India's Rashtriya Swasthya Bima Yojana (RSBY), a national health insurance programme for families below the poverty line.

Name, position and contact address of Researcher:

Ms. Amrit Kaur Virk, D.Phil (PhD) student

India address: D-293, Defence Colony, New Delhi-110024, India

U.K. address: Department of Social Policy & Social Work, Barnett House, 32, Wellington Square, Oxford OX1 2ER, U.K. Email: amrit.virk@socres.ox.ac.uk

	Please tick mark below
1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.	
3. I understand that this project has been reviewed by, and received ethics clearance through, the University of Oxford Central University Research Ethics Committee	
4. I agree to take part in the above study.	

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature

TOPIC GUIDES

Topic guide for policymakers

Introduction

Thank you for agreeing to take part in this interview. As I mentioned in the letter/email to you, I am doing research work on the RSBY at the University of Oxford in England. I am interested in talking to you about how the RSBY programme was conceptualised and how it has developed. It would be extremely helpful to get your views in this matter. The information you provide will be used only for academic purposes and written up as part of a larger report on the RSBY. I'd also like to reiterate that all information you provide will be kept confidential. I am happy to answer any questions or clarifications you may have.

Administrative information

Name

Designation

Ministry/Department

Date of interview

Start and end time of interview

Participant number

Interview questions

I'll start with a few questions about the early stages of the RSBY.

- 1) To begin with, I'd like to understand where the idea of having a health insurance programme like the RSBY came from?
- 2) Could you explain to me how your ministry/department came to be associated with the RSBY?

3) What is your memory of how the programme was formulated? When was this?

- Who were the organisations and individuals involved in formulating the RSBY? What role did they play in the initial planning processes for the RSBY?
- Were there any inputs from international organisations, national experts or insurance companies & hospitals at any stage? What role did they play?

4) Could you explain to me if any kind of evidence was drawn on to formulate the RSBY? (For e.g. — study findings; previous experience with SHI; international and regional HI programmes?)

- In your opinion, what makes the RSBY different from other health insurance programmes for poor families?
- How is the RSBY an improvement over earlier government HI programmes like the UHIS? (For e.g.— In what way does the RSBY programme avoid problems they faced such as a standard/undifferentiated insurance plan; lack of awareness among BPL; shortage of medical facilities)

5) I am also trying to understand the reason why government assistance is routed through a health insurance model involving so many organisations and not perhaps simpler mechanisms like health vouchers or exemptions based on a BPL card?

6) In your opinion, what are the advantages of involving the private sector (private insurance companies, private hospitals, NGOs) versus having an entirely publicly-run system involving say, local councillors and public hospitals?

7) As a bold new policy initiative, has the RSBY come up against people who were sceptical or critical of the RSBY, within government circles or outside?

IF YES→ why did they have doubts about the RSBY? Do you think there is any basis to their criticism? Did you need to convince them of the importance of the RSBY?

IF NO→ isn't that highly unusual for a central government programme?

To turn now to how the RSBY is working and its implementation--

8) What have you found to be the general response of state governments, insurance companies and health care providers to the RSBY?

9) How do you think the RSBY is doing so far?

- According to you, what is going well or has gone well so far?
- In your experience, what kind of challenges has the RSBY had to face up to now?

10) There appear to be efforts to scale-up the RSBY and extend its benefits to non-BPL families as well. What are your thoughts on this?

11) Evidence suggests that health insurance programmes function well in settings with well-developed financial structures and reporting and

regulatory capacity. Given the fact that such infrastructure is less developed in the country, do you think the RSBY is a practical model for India? Why do you think so?

12) What is your department's long-term vision for the RSBY?

- Are there also discussions on making the RSBY programme more sustainable in the long term?

13) In conclusion, what are your general reflections about the RSBY since it began two years ago?

- Has the RSBY been being rolled out as you and other planners had anticipated?
- Given a chance, would you have done things differently?

Check for:

Are there any other individuals or organisations that you think I should talk to for this research project?

Closing the interview

I have come to the end of my questions for this interview. I would like to thank you for your time. I am happy to answer any questions that you may have for me.

Topic guide for RSBY administrators/managers

Introduction

Thank you for agreeing to take part in this interview. As I mentioned in the letter/email to you, I am doing research work on the RSBY at the University of

Oxford in England. I would like to talk to you about how the RSBY programme is being implemented in Delhi. Your opinion is very valuable for this research project. It would be extremely helpful to get your views in this matter. The information you provide will be used only for academic purposes and written up as part of a larger report on the RSBY. I'd also like to reiterate that all information you provide will be kept confidential. I am happy to answer any questions or clarifications you may have.

Administrative information

Name

Designation

Organisation

Consent procedure completed?

Date of interview

Start and end time of interview

Participant number

Interview questions

1) I'd like to begin by asking you to tell me a little bit about your organisation's role in the RSBY and how it became a part of the programme?

- When did your organisation become associated with the RSBY?
- Who did you approach to participate in the RSBY programme or who approached your organisation? How?

2) What are the reasons for your organisation joining the RSBY? (Or why did your organisation join the RSBY?)

- a. Who was responsible for taking that decision?
- b. What do you think are the best things about being involved in the RSBY?
- c. Do you find any disadvantages of being involved in the RSBY?

3) Did you have to make any preparations/changes in order to implement the RSBY? (e.g. additional staff; investing in training/infrastructure/equipment; new reporting mechanisms)

IF YES → do you think you had sufficient time to make these changes? Did these changes involve any extra costs for your organisation? **IF NO** → Are you finding any increase in your/your staff's workload because of the RSBY?

I'd also like to understand a little bit more about the practical operations and implementation of the RSBY.

4) Could you talk a little bit about your experience of implementing the RSBY in Delhi?

- What do you find is working well?
- What do you think is not working well? How do you think this can be improved?

5) So far, what has been your experience of enrolling people for the RSBY?

- How do you identify and enrol beneficiaries into the RSBY?
- What has been the response of BPL families?
- Have you had any problems with enrolment?
- How do you think this can be improved?

6) How have you found the experience of working with other organisations involved in the RSBY? (central & state government, providers, NGOs, insurers)

- *For nodal agency:* Based on your experience, what do you think of the response of private actors like insurance companies, private hospitals and NGOs to the RSBY? Were they enthusiastic? If no, how did you persuade them?
- *For insurance company/TPA:* What has been your experience with enrolling clinics and hospitals under RSBY? Have you encountered any resistance or reluctance on their part? How did you persuade them? How has this compared with your organisation's experience of getting hospitals to be part of other HI schemes run by you?

7) Why are only private hospitals a part of the RSBY in Delhi? What do you think about this?

8) Has your hospital been involved with any other health insurance programmes for BPL families in the past?

- How was that experience similar different from your experience with the RSBY?
- 9) More generally speaking, do you think health insurance programmes or the RSBY model is an effective way of improving the access to health services for vulnerable families in your area? What makes you say so?
- 10) Since the inception of the RSBY over two years ago, are there any general reflections or comments about the programme you would like to make?
- What would you say are the strengths and weaknesses of the programme?
 - Are there aspects of the RSBY in which you would like to see your organisation more actively involved...or even perhaps, less involved?
 - How do you think the programme can be improved?
 - Your organisation's strengths and weaknesses to implement the RSBY?

Check for:

Who are the other people in your organisation that are working on the RSBY?

Do you have any reports or documents that I might find helpful for my study?

(Annual report, presentations)

Closing the interview

I've come to the end of my questions for this interview. I would like to thank you for your time. I am happy to answer any questions that you may have for me.

Topic guide for medical providers

Introduction

Thank you for agreeing to take part in this interview. As I mentioned in the letter/email to you, I am a researcher at the University of Oxford's Social Policy Department. I am doing research work on the RSBY in Delhi. I would like to talk to you because I am trying to understand how the RSBY programme is being implemented in Delhi. Your opinion is very valuable for this research project. The information you provide will be used only for academic purposes and written up as part of a larger report on the RSBY. I'd just like to reiterate that all information from this interview will be treated confidentially.

Demographic/administrative information

Name

Designation

Name of hospital/clinic

Location

Consent procedure completed?

Date of interview

Start and end time of interview

Participant number

Interview questions

- 1) I would like to begin by asking you to tell me a little bit about how your hospital came to be a part of the RSBY?

- When did your hospital join the RSBY?
- How did you hear about the RSBY? Did you approach someone or did somebody approach you to join the RSBY?

2) What are the reasons for your hospital joining the RSBY?

- What do you think are the best things about being involved in the RSBY?
- Do you find any disadvantages of being involved in the RSBY?
- Policy documents seem to suggest that providers are keen to join the RSBY because of the financial gains from the programme. What do you think of this statement? (Probe- from your point of view, are treatment charges under RSBY competitive?)

I would also like to understand a little bit more about the practical operations of the RSBY.

3) Did you have to make any preparations or changes in order to implement the RSBY? (e.g. additional staff; investing in training/infrastructure/equipment; new reporting mechanisms)

IF YES → do you think you had sufficient time to make these changes? Did these changes involve any extra costs for your organisation? **IF NO** → Are you finding any increase in your/your staff's workload because of the RSBY?

- 4) Since your hospital joined the RSBY, what has been your general experience of the programme?
- What aspects of the programme are working well, according to you?
What aspects of the RSBY's design are helpful for you?
 - What aspects of the programme do you think are not working well?
How do you think this can be improved?
- 5) What is your experience of working with other organisations & individuals involved with the RSBY (government agencies, World Bank/GTZ, insurance company/TPAs & NGOs involved with the RSBY)?
- 6) What do you think about how BPL populations in Delhi have responded to the RSBY? For e.g. have you noticed any significant difference in the number of BPL patients coming to you since the programme began in Delhi?
- What was your hospital's policy on treating BPL patients before you joined the RSBY? In that case, how did you identify a poor patient?
 - Have you encountered a situation where you find that a BPL person cannot be treated under the terms and conditions of the RSBY? (for e.g. if a person does not need to be hospitalised; expenses are more than INR 30000) What do you do then?
- 7) So far, have you faced any problems with the RSBY? In your opinion, how can the situation be improved and problems avoided?

- 8) Has your hospital been involved with any other health insurance programmes for BPL families in the past?
- How was that experience similar different from your experience with the RSBY?
- 9) From your point of view, do you think the RSBY in its current form addresses your needs as a health care provider?
- Based on your experience or discussions with other providers, how do you think more hospitals can be motivated to join the RSBY?
- 10) In conclusion, would you like to make any general comments about the RSBY, how it is being run or how it is working?
- What do you see as the overall strengths and weaknesses of the RSBY?
 - Improvements?

Closing the interview

I have come to the end of my questions for this interview. I would like to thank you for your time.

Topic guide for recipients/users

Introduction

Good morning, my name is Amrit Virk. I am doing research work on the RSBY at the University of Oxford in England. I would like to talk to you because I am trying to understand what people think about the RSBY programme recently launched in this area. Your opinion is extremely important for this research project. The

information you provide will be used only for academic purposes and written up as part of a larger report on the RSBY. All information you provide during this interview will be treated as confidential.

Administrative information

Participant number

Gender

District

Consent procedure completed?

Start and end time of interview

Date of interview

Interview

Socio-demographic information & enrolment status

- a. What is your name? How many people are there in your family? How many children?
- b. Are you currently enrolled in the RSBY?
- c. Do you remember when you joined the RSBY?

Mobilisation for RSBY

- 1) How did you learn about the RSBY?

Knowledge of the RSBY

- 2) Could you explain to me in more detail how the RSBY works?
 - a. How do you become a member of the RSBY?

- b. How and for what can you use your RSBY card? Where can you use it?

Enrolment experience

3) I would like to know more about your own experience of enrolling for the RSBY.

- a. Where did you go? Who was carrying out the enrolment work? Did you ask them any questions about the RSBY? How much time did it take? Documentation required? Repeat visits to enrolment centre? Helpful/unhelpful staff? Timely receipt of RSBY card? Formal/informal payment to anyone? Language barriers—written & spoken?
- b. Did you experience any kind of problem in being enrolled?
- c. Do you think becoming a member of the RSBY is affordable for you?

4) Could you tell me why you decided to join the RSBY?

- a. Did you discuss the RSBY with your wife or other family members? Did you talk to other people in the community before deciding to enrol?
- b. What do you think are the advantages of joining the RSBY to you and your family and others who have joined the programme? (For e.g. does the RSBY card help you access hospitals and doctors you could not go to before?)

5) What do you think about the services included in the benefit package of the RSBY? What do you think about the 30,000-rupee cap—is this sufficient for

meeting your family's treatment needs for one year? Do you have any suggestions regarding the benefit package?

6) Do you know people in your neighbourhood who could not become members of the RSBY? Why could they not get membership?

IF YES Did this cause any tensions in the community?

IF NO Have there been any discussions in the neighbourhood about the RSBY? What have you heard from others in the community?

Hospital experience of beneficiaries

7) I would now like to ask you a few questions about your own experience of using the RSBY card.

- a. Have you used your RSBY card at a hospital?
- b. How did you choose which doctor or hospital from the list to go to?
- c. Could you describe to me your experience of using your RSBY card at hospitals? Where did you when you reached the hospital? How did the nurses/hospital staff behave towards you? (Treated with courtesy? Waiting time? Treatment by doctor or frontline staff? Conversation with doctor? Additional costs and payments?
- d. Overall, were you satisfied with the treatment you received?
- e. Have you or any person in your neighbourhood encountered a situation where you did not require hospitalisation for an illness? What did you do then?

- f. Have you or any person in your neighbourhood encountered a situation in which the expenses for treatment were over the limit of 30000 Rupees? What happened then? (Denial of treatment? referral to other hospitals?)

8) Are there any general observations about the RSBY that you would like to make?

- a. Do you think it is a good idea of the government?
- b. What do you think about the way the RSBY programme is being run/managed?
- c. Do you have any suggestions to improve the RSBY?

Closing the interview

I am coming to the end of my questions for this interview. I would like to thank you for your time. I am happy to answer any questions that you may have for me.

APPENDIX D

Provisional/Suggested List for Medical and Surgical Interventions / Procedures in General Ward

Source: (RSBY 2013, p.76)

These package rates will include bed charges (General ward), Nursing and boarding charges, Surgeons, Anesthetists, Medical Practitioner, Consultants fees, Anesthesia, Blood transfusion, Oxygen, O.T. Charges, Cost of Surgical Appliances, Medicines and Drugs, Cost of Prosthetic Devices, implants, X-Ray and Diagnostic Tests, Food to patient etc. Expenses incurred for diagnostic test and medicines up to 1 day before the admission of the patient and cost of diagnostic test and medicine up to 5 days of the discharge from the hospital for the same ailment / surgery including Transport Expenses will also be the part of package. The package should cover the entire cost of treatment of the patient from date of reporting (1 day Pre hospitalisation) to his discharge from hospital and 5 days after discharge, Transport Expenses and any complication while in hospital, making the transaction truly cashless to the patient.

Medical (Non surgical) hospitalisation procedures means Bacterial meningitis, Bronchitis- Bacterial/Viral, Chicken pox, Dengue fever, Diphtheria, Dysentery, Epilepsy, Filariasis, Food poisoning, Hepatitis, Malaria, Measles, Meningitis, Plague, Pneumonia, Septicemia, Tuberculosis (Extra pulmonary, pulmonary etc), Tetanus, Typhoid, Viral fever, Urinary tract infection, Lower respiratory tract infection and other such procedures requiring hospitalisation etc.

(i). NON SURGICAL(Medical) TREATMENT IN GENERAL WARD	
The package should cover the entire cost of treatment of the patient from date of reporting (1 day Pre hospitalisation) to his discharge from hospital and 5 days after discharge, Transport Expenses of Rs. 100 and any complication while in hospital. Details of what all is included is give in Section 5.2 of Tender document.	Rs. 500 / Per Day.
(ii) IF ADMITTED IN ICU:	
The package should cover the entire cost of treatment of the patient from date of reporting (1 day Pre hospitalisation) to his discharge from hospital and 5 days after discharge, Transport Expenses of Rs. 100 and any complication while in hospital during stay in I.C.U. Details of what all is included is give in Section 5.2 of Tender document.	Rs. 1000 /- Per Day
(iii) SURGICAL PROCEDURES IN GENERAL WARD (NOT SPECIFIED IN PACKAGE):	
They include the entire cost of treatment of the patient from date of reporting (1 day Pre hospitalisation) to his discharge from hospital and 5 days after discharge, Transport Expenses of Rs. 100 and any complication while in hospital. Details of what all is included is give in Section 5.2 of Tender document.	To be negotiated with Insurer before carrying out the procedure
(iv) SURGICAL PROCEDURES IN GENERAL WARD	
The package should cover the entire cost of treatment of the patient from date of reporting (1 day Pre hospitalisation) to his discharge from hospital and 5 days after discharge, Transport Expenses of Rs. 100 and any complication while in hospital. Details of what all is included is give in Section 5.2 of Tender document.	Please refer Package Rates in the following table

REFERENCES

- Aberbach, J.D. & Rockman, B.A., 2002. Conducting and coding elite interviews. *PS: Political Science and Politics*, pp.673–676.
- Abma, T.A., 2005. Responsive evaluation: Its meaning and special contribution to health promotion. *Evaluation and Program Planning*, 28(3), pp.279–289.
- Acharya, A. et al., 2013. The impact of health insurance schemes for the informal sector in low-and middle-income countries: a systematic review. *World Bank Policy Research Working Paper*, (6324). Available at: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2202686 [Accessed January 30, 2013].
- Adarkar, B.P., 1954. *Report on health insurance for industrial workers*, Printed by the manager, Government of India Press.
- African Development Bank, 2012. Tunis Declaration on Value for Money, Sustainability and Accountability in the Health Sector, A joint Declaration by the Ministers of Finance and Ministers of Health of Africa.
- Agarwal, S., 2011. The state of urban health in India; comparing the poorest quartile to the rest of the urban population in selected states and cities. *Environment and Urbanization*, 23(1), pp.13–28.
- Agarwal, S. et al., 2007. *The state of urban health in India; comparing the poorest quartile to the rest of the urban population in selected states and cities*, New Delhi, India: Ministry of Health and Family Welfare (MoHFW)/ Urban Health Resource Centre (UHRC).
- AHCT, 2007. Rajiv Aarogyasri Community Health Insurance Scheme for the BPL families in the state of Andhra Pradesh. *Aarogyasri Health Care Trust*. Available at: <https://www.aarogyasri.org/ASRI/index.jsp> [Accessed August 20, 2012].
- AICC, 2009. Lok Sabha Elections 2009: Manifesto of the Indian National Congress. Available at: <http://aicc.org.in/new/manifesto09-eng.pdf> [Accessed February 3, 2012].
- Akin, J.S., Birdsall, N. & De Ferranti, D.M., 1987. *Financing health services in developing countries: an agenda for reform*, Washington, D.C.: World Bank Publications.
- Alkire, S. & Seth, S., 2013. Identifying BPL Households. *Economic & Political Weekly*, 48(2), p.49.
- Amicus Advisory Private Limited, 2010. Rashtriya Swasthya Bima Yojana : Studying Jaunpur (Uttar Pradesh). Available at: <http://www.rsby.gov.in/> [Accessed March 9, 2013].

- Amicus Advisory Pvt. Ltd., 2011. Evaluation Study of Rashtriya Swasthya Bima Yojana in Shimla & Kangra Districts in Himachal Pradesh. Available at: <http://www.rsby.gov.in/> [Accessed March 9, 2013].
- Andaleeb, S.S., 2001. Service quality perceptions and patient satisfaction: a study of hospitals in a developing country. *Social Science & Medicine*, 52(9), pp.1359–1370.
- Atun, R., 2004a. Advisory support to primary health care evaluation model: Estonia PHC evaluation project. Available at: <http://www.rahvatervis.ut.ee/handle/1/1364> [Accessed March 22, 2013].
- Atun, R., 2004b. *What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care services*, Copenhagen, WHO Regional Office for Europe.
- Atun, R., Baeza, J., et al., 2005. Implementing WHO DOTS strategy in the Russian Federation: stakeholder attitudes. *Health Policy*, 74(2), pp.122–132.
- Atun, R. & Menabde, N., 2008. Health systems and systems thinking. In *Health systems and the challenge of communicable diseases: experiences from Europe and Latin America*. p. 121.
- Atun, R., Ohov, E., et al., 2005. Estonian health system: analysis of the strengths, weaknesses, opportunities and threats. Available at: <http://rahvatervis.ut.ee/handle/1/1361> [Accessed January 24, 2013].
- Avis, M., Bond, M. & Arthur, A., 1997. Questioning patient satisfaction: an empirical investigation in two outpatient clinics. *Social Science & Medicine*, 44(1), pp.85–92.
- Avis, M., Bond, M. & Arthur, A., 1995. Satisfying solutions? A review of some unresolved issues in the measurement of patient satisfaction. *Journal of Advanced Nursing*, 22(2), pp.316–322.
- Bagchi, S., 2013. Setback to Chhattisgarh health care services. *The Hindu*. March 31, 2013
- Balarajan, Y., Selvaraj, S. & Subramanian, S.V., 2011. Health care and equity in India. *The Lancet*. Available at: <http://www.sciencedirect.com/science/article/pii/S0140673610618946> [Accessed July 28, 2012].
- Ball, S.J., 2012. *Politics and Policy Making in Education: Explorations in policy sociology*, London/New York: Routledge.
- Baltussen, R.M.P.M. et al., 2002. Perceived quality of care of primary health care services in Burkina Faso. *Health Policy and Planning*, 17(1), pp.42–48.
- Barr, N.A., 1993. *The Economics of the Welfare State*, Stanford University Press.

- Barrett, S. & Fudge, C. eds., 1981. *Policy and action: essays on the implementation of public policy*, London: Methuen.
- Basaza, R., Criel, B. & Van der Stuyft, P., 2007. Low enrolment in Ugandan Community Health Insurance Schemes: underlying causes and policy implications. *BMC Health Services Research*, 7(1), p.105.
- Beach, M.C., Keruly, J. & Moore, R.D., 2006. Is the Quality of the Patient-Provider Relationship Associated with Better Adherence and Health Outcomes for Patients with HIV? *Journal of General Internal Medicine*, 21(6), pp.661–665.
- Berman, P., 1978. *The study of macro and micro implementation of social policy*, Santa Monica, California: The Rand Corporation. Available at: <http://www.rand.org/pubs/papers/2008/P6071.pdf> [Accessed February 19, 2012].
- Berman, P., Ahuja, R. & Bhandari, L., 2010. The impoverishing effect of healthcare payments in India: new methodology and findings. *Economic & Political Weekly*, 45(16), p.65.
- Bhat, R. & Saha, S., 2004. Health Insurance: Not a Panacea. *Economic and Political Weekly*, 39(33), pp.3667–3670.
- Bhattacharyya, O. et al., 2010. Innovative health service delivery models in low and middle income countries - what can we learn from the private sector? *Health Research Policy and Systems*, 8(1), p.24.
- Bhore, J., 1946. *Report of the Health Survey and Development Committee. Vol. II.*, Delhi: Manager of Publications, Government of India.
- Bird, R.M., Martinez-Vazquez, J. & Torgler, B., 2008. Tax effort in developing countries and high income countries: the impact of corruption, voice and accountability. *Economic Analysis and Policy*, 38(1), pp.55–71.
- Bitran, R., 2013. *Explicit health guarantees for Chileans : the AUGE benefits package.*, Washington D.C.: World Bank.
- Black, J., Hashimzade, N. & Myles, G., 2009. *A Dictionary of Economics*, New York, U.S.A.: Oxford University Press.
- Blomqvist, P., 2004. The Choice Revolution: Privatization of Swedish Welfare Services in the 1990s. *Social Policy & Administration*, 38(2), pp.139–155.
- Bloom, D.E. & Canning, D., 2000. The health and wealth of nations. *Science*, 287(5456), p.1207.
- Bloom, G. & Standing, H., 2001. *Pluralism and marketisation in the health sector: meeting health needs in contexts of social change in low and middle-income countries*, Institute of Development Studies.

- Bond, P. & Kgara, S., 2009. 'NHI denialists' distort costs of good health. *Amandla*, 10(October), pp.10–11.
- Bonilla-Chacín, M.E. & Aguilera, N., 2013. *Mexican social protection system in health. Universal Health Coverage*, Washington D.C.: World Bank.
- Bonu, S., Bhushan, I. & Peters, D.H., 2007. *Incidence, intensity, and correlates of catastrophic out-of-pocket health payments in India*, Asian development bank (ADB). Economics and research department (ERD).
- Borowitz, M. & Atun, R., 2006. The unfinished journey from Semashko to Bismarck: health reform in Central Asia from 1991 to 2006. *Central Asian Survey*, 25(4), pp.419–440.
- Bradshaw, J., 1994. The conceptualization and measurement of need: A social policy perspective. In J. Popay & Williams, eds. *Researching the People's Health*. Routledge.
- Bratton, M. & Liatto-Katundu, B., 1994. A focus group assessment of political attitudes in Zambia. *African Affairs*, 93(373), pp.535–563.
- BRICS Health Ministers, 2013. BRICS Health Ministers' Communiqué.
- Broomberg, J. & Price, M., 1990. The impact of the fee-for-service reimbursement system on the utilization of health services. *South Africa Medical Journal*, 78(4), pp.130–132.
- Brugha, R. & Varvasovszky, Z., 2000. Stakeholder analysis: a review. *Health policy and planning*, 15(3), pp.239–246.
- Buchner, F. & Wasem, J., 2003. Needs for further improvement: risk adjustment in the German health insurance system. *Health Policy*, 65(1), pp.21–35.
- Burau, V. & Blank, R.H., 2006. Comparing health policy: An assessment of typologies of health systems. *Journal of Comparative Policy Analysis: Research and Practice*, 8(1), pp.63–76.
- Buse, K., Mays, N. & Walt, G., 2013. *Making health policy*, Open University Press.
- Buse, K. & Walt, G., 1996. Aid coordination for health sector reform: a conceptual framework for analysis and assessment. *Health Policy*, 38(3), pp.173–187.
- Busse, R. & Schwartz, F.W., 1997. Financing reforms in the German hospital sector: from full cost cover principle to prospective case fees. *Medical Care*, 35(10), pp.OS40–OS49.
- Caeyers, B. & Dercon, S., 2012. Political Connections and Social Networks in Targeted Transfer Programs: Evidence from Rural Ethiopia. *Economic Development and Cultural Change*, 60(4), pp.639–675.

- Calnan, M., 1988. Towards a conceptual framework of lay evaluation of health care. *Social science & medicine*, 27(9), pp.927–933.
- Calnan, M. & Ferlie, E., 2003. Analysing process in healthcare: the methodological and theoretical challenges. *Policy & Politics*, 31(2), pp.185–193.
- Campbell, S., Roland, M. & Buetow, S., 2000. Defining quality of care. *Social Science & Medicine*, 51(11), pp.1611–1625.
- Carrin, G., 2002. Social health insurance in developing countries: a continuing challenge. *International Social Security Review*, 55(2), pp.57–69.
- Carrin, G. et al., 2004. 'Impact of risk sharing on the attainment of health system goals'. In A. Preker & Carrin, eds. *Health financing for poor people: Resource mobilization and risk sharing (chap. 12)*. Washington, D.C.: World Bank.
- Carrin, G. & Hanvoravongchai, P., 2003. Provider payments and patient charges as policy tools for cost-containment: how successful are they in high-income countries. *Human Resources for Health*, 1(6), pp.1–10.
- Casanova, C. & Starfield, B., 1995. Hospitalizations of Children and Access to Primary Care: A Cross-National Comparison. *International Journal of Health Services*, 25(2), pp.283–294.
- Cassels, A., 1995. Health sector reform: key issues in less developed countries. *Journal of International development*, 7(3), pp.329–347.
- CBHI, 2011. Health Infrastructure, national health profile (NHP) of India. Available at: <http://cbhidghs.nic.in> [Accessed February 24, 2013].
- CGHS, 2012. Central Government Health Scheme, Ministry of Health and Family Welfare, Government of India. Available at: <http://msotransparent.nic.in/cghsnew/index1.asp?linkid=4&langid=1> [Accessed September 3, 2012].
- Chakraborty, S., 2013. *Philippines government sponsored health coverage program for poor households*, Washington D.C.: World Bank. Available at: http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/01/31/000425962_20130131131817/Rendered/PDF/749450NWP0VIET00Box374316B00PUBLIC0.pdf [Accessed March 14, 2013].
- Chakravarthi, I., 2011. Corporate presence in healthcare sector in India. *Social Medicine*, 5(4), pp.192–204.
- Chan, M., 2012. Best days for public health are ahead of us, says WHO Director-General; Address to the Sixty-fifth World Health Assembly; Geneva, Switzerland; May 21, 2012. *WHO*. Available at: http://www.who.int/dg/speeches/2012/wha_20120521/en/index.html [Accessed January 9, 2013].

- Chang, H.J., 2001. An Institutional Political Economy Alternative to the Neoliberal Theory of the Market and the State. *Breaking the Mould*.
- CHIAK, 2009. *RSBY-CHIS Evaluation Survey: Facility Level Survey to Assess Quality of Hospitals in RSBY Network & Post Utilization Survey of RSBY Patient Experience at Empanelled Hospitals in Kerala.*, Trivandrum, Kerala, India: Comprehensive Health Insurance Agency of Kerala, Labour & Rehabilitation Dept., Govt. of Kerala.
- Commission on Macroeconomics and Health., 2001. *Macroeconomics and health: investing in health for economic development. Report of the Commission on Macroeconomics and Health.*, Geneva, Switzerland: World Health Organization.
- Corbin, J.M. & Strauss, A., 1990. Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology*, 13(1), pp.3–21.
- Cornwall, A. & Shankland, A., 2008. Engaging citizens: Lessons from building Brazil's national health system. *Social Science & Medicine*, 66(10), pp.2173–2184.
- Coulter, A. & Ellins, J., 2007. Effectiveness of strategies for informing, educating, and involving patients. *BMJ: British Medical Journal*, 335(7609), p.24.
- Couttolenc, B. & Dmytraczenko, T., 2013. *Brazil - Brazil's primary care strategy.*, Washington D.C.: World Bank.
- CTRD, 2012. Final Report on Evaluation of the 'Rashtriya Swasthya Bima Yojana Scheme' in Chhattisgarh. Available at: <http://www.rsby.gov.in/> [Accessed March 9, 2013].
- Culyer, A.J., 2008. *The Dictionary of Health Economics*, Edward Elgar Publishing.
- Cutler, D.M. & Zeckhauser, R.J., 2000. The anatomy of health insurance. *Handbook of Health Economics*, 1, pp.563–643.
- Danzon, P.M., 1992. Hidden overhead costs: Is Canada's system really less expensive? *Health Affairs*, 11(1), pp.21–43.
- Das, J. & Hammer, J., 2010a. The Indian Poor are Even Sicker Than You Thought. *India Health Beat*, 3(4).
- Das, J. & Hammer, J., 2010b. The Quality of Medical Care in Urban India: A Summary of Recent Research. *India Health Beat*, 3(1).
- Davis, K. et al., 2007. *Mirror, mirror on the wall: An international update on the comparative performance of American health care*, Commonwealth Fund. Available at: http://blogs.usask.ca/SHORE/Davis_mirrormirrorinternationalupdate_1027.pdf [Accessed March 25, 2013].

- Deacon, B., 2007. *Global social policy and governance*, Sage Publications Limited. Available at: [http://books.google.com/books?hl=en&lr=&id=CjfHYpbwJ0IC&oi=fnd&pg=PR9&dq=Understanding+global+social+policy&ots=P5zWuEDODv&sig=EcOx_pi1wC1KNc\]k5xmMZtdwBkU](http://books.google.com/books?hl=en&lr=&id=CjfHYpbwJ0IC&oi=fnd&pg=PR9&dq=Understanding+global+social+policy&ots=P5zWuEDODv&sig=EcOx_pi1wC1KNc]k5xmMZtdwBkU) [Accessed December 6, 2012].
- Deacon, B. & Hulse, M., 1997. The making of post-communist social policy: The role of international agencies. *Journal of Social Policy*, 26(01), pp.43–62.
- De Allegri, M. et al., 2009. Community health insurance in sub-Saharan Africa: what operational difficulties hamper its successful development? *Tropical Medicine & International Health*, 14(5), pp.586–596.
- DeGroot, T., DePaepe, P. & Unger, J.-P., 2005. Colombia: in vivo test of health sector privatization in the developing world. *International journal of health services: planning, administration, evaluation*, 35(1), pp.125–141.
- Denzin, N.K., 2009. *The research act: a theoretical introduction to sociological methods*, New Jersey, U.S.A.: Transaction Publishers.
- Denzin, N.K. & Lincoln, Y.S., 2005. *The SAGE handbook of qualitative research* 3rd ed., California, London, Delhi: SAGE.
- Department of Health, 2000. The NHS Plan: A Plan for Investment, a Plan for Reform.
- Devereux, S., 2001. *Social Pensions in Namibia and South Africa*, Institute of Development Studies. Available at: <http://www.opengrey.eu/item/display/10068/583939> [Accessed April 6, 2013].
- Devereux, S. & White, P., 2012. Social protection in Africa: Evidence, politics and rights. *Poverty & Public Policy*, 2(3), pp.53–77.
- DfID, 2000. *Better Health for Poor People, Issues paper.*, London: Department for International Development.
- Dimitrova, B. et al., 2006. Health service providers' perceptions of barriers to tuberculosis care in Russia. *Health Policy and Planning*, 21(4), pp.265–274.
- Dodd, R. & Munck, L., 2002. *Dying for Change: Poor People's Experience of Health and Ill-health*, World Health Organization, The World Bank, Voices of Poor.
- Doherty, J., 2011. *Expansion of the private health sector in East and Southern Africa*, EQUINET Discussion Paper. Available at: <http://equinetafrica.org/bibl/docs/EQ%20Diss%2087%20Private%20HS.pdf> [Accessed March 6, 2013].
- Doherty, J. & Govender, R., 2004. The cost-effectiveness of primary care services in developing countries: a review of the international literature. *A background paper commissioned by the Disease Control Priorities Project*.

- Dolowitz, D.P. & Marsh, D., 2000. Learning from Abroad: The Role of Policy Transfer in Contemporary Policy-Making. *Governance*, 13(1), pp.5–23.
- Donabedian, A., 1966. Evaluating the quality of medical care. *The Milbank Memorial Fund Quarterly*, 44(3), pp.166–206.
- Donabedian, A., 1972. Models for Organizing the Delivery of Personal Health Services and Criteria for Evaluating Them. *The Milbank Memorial Fund Quarterly*, 50(4), pp.103–154.
- Donabedian, A., 1980. *The definition of quality and approaches to its assessment*, Health Administration Press.
- Donabedian, A., 1988. The quality of care. *JAMA: The Journal of the American Medical Association*, 260(12), p.1743.
- Donabedian, A., 1992. The Lichfield Lecture. Quality assurance in health care: consumers' role. *Quality in Health care*, 1(4), p.247.
- Draibe, S. & Riesco, M., 2009. Social Policy and Development in Latin America: the long view. *Social Policy & Administration*, 43(4), pp.328–346.
- Drèze, J. & Khera, R., 2010. The BPL census and a possible alternative. *Economic & Political Weekly*, 45(9), pp.54–63.
- Dror, D.M. & Vellakkal, S., 2012. Is RSBY India's platform to implementing universal hospital insurance? *The Indian Journal of Medical Research*, 135(1), p.56.
- Duke, K., 2002. Getting Beyond the 'Official Line': Reflections on Dilemmas of Access, Knowledge and Power in Researching Policy Networks. *Journal of Social Policy*, 31(1), pp.39–59.
- Dunsire, A., 1978. *The execution process*, Oxford: Martin Robertson. Available at: <http://library.wur.nl/WebQuery/clc/201759> [Accessed March 3, 2013].
- Du Toit, A. & Neves, D., 2006. *Vulnerability and Social Protection at the Margins of the Formal Economy: Case Studies From Khayelitsha and the Eastern Cape*, Report for the United States Agency for International Development. Programme for Land and Agrarian Studies (PLAAS). Cape Town: University of the Western Cape, South Africa
- Elmore, R.F., 1979. Backward mapping: Implementation research and policy decisions. *Political Science Quarterly*, 94(4), pp.601–616.
- Ensor, T., 2004. Informal payments for health care in transition economies. *Social Science & Medicine*, 58(2), pp.237–246.
- Enthoven, A.C. & Fuchs, V.R., 2006. Employment-based health insurance: Past, present, and future. *Health Affairs*, 25(6), pp.1538–1547.

- Epstein, R.M. et al., 2005. Patient-centered communication and diagnostic testing. *The Annals of Family Medicine*, 3(5), pp.415–421.
- Epstein, R.M. et al., 2010. Why The Nation Needs A Policy Push On Patient-Centered Health Care. *Health Affairs*, 29(8), pp.1489–1495.
- ESIC, 2012. Employees' State Insurance Corporation. Available at: <http://www.esic.nic.in/index.php> [Accessed August 6, 2012].
- Evans, D.B. et al., 2001. Measuring quality: from the system to the provider. *International Journal for Quality in Health Care*, 13(6), pp.439–446.
- Farquharson, K., 2005. A different kind of snowball: identifying key policymakers. *International Journal of Social Research Methodology*, 8(4), pp.345–353.
- Fitzpatrick, R. & Boulton, M., 1994. Qualitative methods for assessing health care. *Quality in Health Care*, 3(2), pp.107–113.
- Fitzpatrick, R. & White, D., 1997. Public participation in the evaluation of health care. *Health & Social Care in the Community*, 5(1), pp.3–8.
- Fjeldstad, O.H., 2004. What's trust got to do with it? Non-payment of service charges in local authorities in South Africa. *The Journal of Modern African Studies*, 42(04), pp.539–562.
- Flick, U., 2009. *An introduction to qualitative research*, Sage Publications Limited. Available at: http://books.google.com/books?hl=en&lr=&id=sFv1oWX2DoEC&oi=fnd&pg=PR5&dq=thematic+analysis+uwe+flick&ots=oys_tSK8AM&sig=od0PSTM SvuBOvWT_lhFA3m5eTTk [Accessed March 24, 2013].
- Forbes India, 2013. Funds crunch holds up universal health plan. *Forbes India*. Available at: www.forbesindia.com [Accessed April 15, 2013].
- Fotaki, M., 2007. Patient Choice in Healthcare in England and Sweden: From Quasi-Market and Back to Market? a Comparative Analysis of Failure in Unlearning. *Public Administration*, 85(4), pp.1059–1075.
- Francis, E., 2006. Poverty: Causes, responses and consequences in rural South Africa. *Chronic Poverty Research Centre Working Paper*, (60).
- Freeman, R., 1998. Competition in context: the politics of health care reform in Europe. *International Journal for Quality in Health Care*, 10(5), pp.395–401.
- Frenk, J., 1994. Dimensions of health system reform. *Health Policy*, 27(1), pp.19–34.
- Frenk, J., Gómez-Dantés, O. & Knaul, F.M., 2009. The democratization of health in Mexico: financial innovations for universal coverage. *Bulletin of the World Health Organization*, 87(7), pp.542–548.

- Friedberg, M.W., Hussey, P.S. & Schneider, E.C., 2010. Primary care: a critical review of the evidence on quality and costs of health care. *Health Affairs*, 29(5), pp.766–772.
- Fronstin, P., 2012. *Findings from the 2012 EBRI/MGA Consumer Engagement in Health Care Survey*, Washington, DC: Employee Benefit Research Institute. Available at: www.ebri.org [Accessed March 9, 2013].
- Ganatra, B. & Visaria, L., 2004. *Informal providers of abortion services: some exploratory case studies*, Centre for Enquiry into Health and Allied Themes (CEHAT). Available at: <http://www.cehat.org/publications/PDF%20files/Informalproviders.pdf> [Accessed September 10, 2012].
- Gandham, N.V.R., Cheokoech, R. & Workie, A., 2013. *Kenya - Improving universal primary health care by Kenya: a case study of the Health Sector Services Fund*, Washington D.C.: World Bank.
- Garg, C.C. & Karan, A.K., 2009. Reducing out-of-pocket expenditures to reduce poverty: a disaggregated analysis at rural-urban and state level in India. *Health Policy and Planning*, 24(2), pp.116–128.
- Garrett, G., 1998. *Partisan politics in the global economy*, Cambridge University Press. Available at: [http://books.google.com/books?hl=en&lr=&id=RoePU0zM7t4C&oi=fnd&pg=PR13&dq=Garrett+G+\(1998\)+Partisan+Politics+in+the+Global+Economy.&ots=PGD7c9bHyu&sig=PZU9009esBdBqRY29MyFsGRMKwg](http://books.google.com/books?hl=en&lr=&id=RoePU0zM7t4C&oi=fnd&pg=PR13&dq=Garrett+G+(1998)+Partisan+Politics+in+the+Global+Economy.&ots=PGD7c9bHyu&sig=PZU9009esBdBqRY29MyFsGRMKwg) [Accessed December 12, 2012].
- GEG, 2008. *Global Economic Governance Programme. Preliminary Report of a High-Level Working Group*, Oxford, U.K.: Global Economic Governance Programme. University of Oxford. Available at: <http://www.globaleconomicgovernance.org/wp-content/uploads/Working%20Group%20Report%20May%202008.pdf>. [Accessed March 7, 2013].
- Ghildiyal, S. & Mathur, S., 2010. India shows way with ‘insurance for poor’ plan. *The Times of India*.
- Giedion, U., Alfonso, E.A. & Diaz, Y., 2013. *The impact of universal coverage schemes in the developing world: a review of the existing evidence.*, Washington D.C.: World Bank.
- Gill, K., 2009. A primary evaluation of service delivery under the National Rural Health Mission (NRHM): Findings from a study in Andhra Pradesh, Uttar Pradesh, Bihar and Rajasthan. *New Delhi, Planning Commission of India*. Available at: http://environmentportal.in/files/wrkp_1_09.pdf [Accessed September 12, 2012].
- Gilson, L. & Erasmus, E., 2004. *Values in use and organisational culture: Exploring the relevance to health systems development*, Johannesburg: Millenium

Project Task Force on Child Health and Maternal Health. Centre for Health Policy.

- GIZ & Prognosis Consultants, 2012. *Evaluation of Implementation Process of Rashtriya Swasthya Bima Yojana in Select Districts of Bihar, Uttarakhand and Karnataka*, New Delhi, India: GIZ-Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH.
- Glied, S., 2009. Single Payer as a Financing Mechanism. *Journal of Health Politics, Policy & Law*, 34(4), pp.593–615.
- Gluckman, M.D. et al., 2008. Achieving a high-performance health care system with universal access: what the United States can learn from other countries. *Annals of Internal Medicine*, 148, pp.55–75.
- Gómez, E.J. & Atun, R., 2012. The effects of Global Fund financing on health governance in Brazil. *Globalization and Health*, 8(1), p.25.
- Gottret, P.E. & Schieber, G., 2006. *Health financing revisited: a practitioner's guide*, World Bank Publications. Available at: http://books.google.com/books?hl=en&lr=&id=LuxmLDCsqnsC&oi=fnd&pg=PR13&dq=Health+Financing+Revisited&ots=Rg6zj3-KQd&sig=eWbRxG-l_GN7Xp2U0010ChntdiU [Accessed September 16, 2012].
- Gough, I. & Wood, G.D., 2004. *Insecurity and welfare regimes in Asia, Africa and Latin America: Social policy in development contexts*, Cambridge Univ Pr.
- Government of Delhi, 1992. *The Government of National Capital Territory of Delhi Act, 1991*, Available at: <http://delhiassembly.nic.in/index.asp> [Accessed February 25, 2012].
- Government of Delhi, 2002. *Economic Survey of Delhi 2001-2002. Public Distribution System (2001-2002). Chapter 19.*, Delhi: Planning department, Government of N.C.T. of Delhi.
- Government of Delhi, 2009. *Economic Survey of Delhi 2008-2009*, Delhi: Planning department, Government of N.C.T. of Delhi.
- Government of India, 2008a. *Government of the United Progressive Alliance (UPA): Report to the people 2004-2008.*, New Delhi: Ministry of Information and Broadcasting, Government of India.
- Government of India, 2008b. *The Unorganised Workers' Social Security Act, 2008.*, Available at: <http://labour.nic.in/act/acts/Unorganised-workers-social-security-act-2008.pdf> [Accessed January 23, 2012].
- Government of India, 2011. *Government of the United Progressive Alliance (UPA): Report to the people 2010-2011.*, New Delhi: Ministry of Information and Broadcasting, Government of India. Available at: pmindia.nic.in/upa_english_22.05.11.pdf [Accessed February 16, 2012].

- Grady, C., 2001. Money for research participation: does it jeopardize informed consent? *American Journal of Bioethics*, 1(2), pp.40–44.
- Graham, C., 2002. Public attitudes matter: a conceptual frame for accounting for political economy in safety nets and social assistance policies. *The World Bank, SPDP Series*, (0233). Available at: <http://info.worldbank.org/etools/docs/library/49173/0233.pdf> [Accessed April 5, 2013].
- Graham, H., 2004. Social Determinants and Their Unequal Distribution: Clarifying Policy Understandings. *Milbank Quarterly*, 82(1), pp.101–124.
- Grant, R.W. & Sugarman, J., 2004. Ethics in human subjects research: do incentives matter? *The Journal of Medicine and Philosophy*, 29(6), pp.717–738.
- Grover, S. & Palacios, R., 2011. The first two years of RSBY in Delhi. In R. Palacios, J. Das, & C. Sun, eds. *India's Health Insurance Scheme for the Poor: Evidence from the Early Experience of the Rashtriya Swasthya Bima Yojana*. New Delhi: Centre for Policy Research, pp. 153–188.
- GTZ, 2005. *Social Health Insurance: A contribution to the international development policy debate on universal systems of social protection*. Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH
- GTZ-GmbH, 2010. *56 Million Steps Towards Universal Coverage: RSBY Health Insurance for the Poor in India*, New Delhi: GTZ Systems of Social Protection on behalf of German Federal Ministry for Economic Cooperation and Development (BMZ). Available at: <http://www.gtz.de/de/dokumente/gtz2010-en-rsby-health-insurance-for-the-poor-in-india.pdf>. [Accessed February 16, 2012].
- GTZ-ILO-WHO, 2005. Extending Social Protection in Health Developing Countries' Experiences, Lessons Learnt and Recommendations. In International Conference on Social Health Insurance in Developing Countries. Berlin: GTZ-ILO-WHO-Consortium on Social Health Protection in Developing Countries. Available at: <http://www.socialhealthprotection.org/conference2005.php> [Accessed February 18, 2012].
- Guba, E.G. & Lincoln, Y.S., 1989. *Fourth generation evaluation*, Newbury Park CA: SAGE Publications Ltd. Available at: http://books.google.com/books?hl=en&lr=&id=k_zxEUst46UC&oi=fnd&pg=PA7&dq=Egon+G.+Guba+and+Yvonna+S.+Lincoln,+Fourth+Generation+Evaluation,+Newbury+Park,+CA:++Sage++Publications,+1989.&ots=_Y88nmITFX&sig=6_R6fqi5PZHIjC2kWbrZRREV8rg [Accessed March 11, 2013].
- Guba, E.G. & Lincoln, Y.S., 1985. *Naturalistic inquiry*, Sage Publications, Incorporated.

- Gwatkin, D.R. et al., 2007. *Socio-economic differences in health, nutrition, and population within developing countries. An overview*. Washington, DC: World Bank.
- Hacker, J.S., 2004. Dismantling the health care state? Political institutions, public policies and the comparative politics of health reform. *British Journal of Political Science*, pp.693–724.
- Haddad, L. & Maluccio, J.A., 2003. Trust, Membership in Groups, and Household Welfare: Evidence from KwaZulu-Natal, South Africa. *Economic Development and Cultural Change*, 51(3), pp.573–601.
- Haggard, S. & Kaufman, R.R., 2008. *Development, Democracy, and Welfare States: Latin America, East Asia, and Eastern Europe*, Princeton Univ Pr.
- Hall, P.A., 1993. Policy paradigms, social learning, and the state: the case of economic policymaking in Britain. *Comparative Politics*, pp.275–296.
- Hanvoravongchai, P., 2013. *Thailand - Health financing reform in Thailand : toward universal coverage under fiscal constraints.*, Washington D.C.: The World Bank.
- Harimurti, P. et al., 2013. *Indonesia-The nuts & bolts of Jamkesmas, Indonesia's government-financed health coverage program for the poor and near-poor.*, Washington D.C.: World Bank. Available at: http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/01/31/000425962_20130131131817/Rendered/PDF/749450NWP0VIET00Box374316B00PUBLIC0.pdf [Accessed March 14, 2013].
- Health Economics Unit, 2012. Incentivising private specialists to work in the public health sector, Expanding 'session work' in South Africa, HEU Policy Brief November 2012.
- Health Steering Committee, 2012. *Report of the Steering Committee on Health for Twelfth Five-Year Plan*, New Delhi, India: Health Division, Planning Commission of India, Government of India.
- Hennink, M., Hutter, I. & Bailey, A., 2011. *Qualitative Research Methods*, London: SAGE Publications Ltd.
- Hickey, S., 2007. Conceptualising the politics of social protection in Africa. *Brooks World Poverty Institute Working Paper*, (04). Available at: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1204542 [Accessed April 5, 2013].
- Hill, M., 2009. *The Public Policy Process* 5th ed., Longman.
- Hill, M. & Hupe, P.L., 2009. *Implementing public policy: an introduction to the study of operational governance*, SAGE Publications Ltd.

- Hirst, P. & Thompson, G.T., 1996. *Globalization in Question: The International Economy and the Possibilities of Governance*, Cambridge, U.K.; Oxford, U.K.; Malden, U.S.A.: Polity Press.
- Hjern, B., 1987. *Policy analysis: An implementation approach*. Paper for the Annual Meeting of the American Policy Science Association, September. pp. 3–6.
- HLEG, 2011. *High Level Expert Group Report on Universal Health Coverage for India*, New Delhi, India: Planning Commission of India. Available at: <http://uhc-india.org/> [Accessed November 23, 2012].
- Holliday, I., 2000. Productivist welfare capitalism: Social policy in East Asia. *Political Studies*, 48(4), pp.706–723.
- Holloway, I. & Wheeler, S., 1995. Ethical issues in qualitative nursing research. *Nursing Ethics*, 2(3), p.223.
- Hongoro, C. & Kumaranayake, L., 2000. Do they work? Regulating for-profit providers in Zimbabwe. *Health Policy and Planning*, 15(4), pp.368–377.
- Horowitz, D.L., 1989. Is there a third-world policy process? *Policy Sciences*, 22(3), pp.197–212.
- Hospital Association South Africa, 2010. Financing Implications of a National Health Insurance Plan for South Africa. Available at: <http://www.hasa.co.za/documents/detail/71/> [Accessed March 17, 2013].
- Hou, X. & Palacios, R., 2011. Hospitalization patterns in RSBY: Preliminary evidence from the MIS. In *India's Health Insurance Scheme for the Poor: Evidence from the Early Experience of the Rashtriya Swasthya Bima Yojana*. New Delhi: Centre for Policy Research, pp. 117–152.
- Howlett, M., 2005. Policy Instruments, Policy Styles, and Policy Implementation. *Policy Studies Journal*, 19(2), pp.1–21.
- Howlett, M., Ramesh, M. & Perl, A., 2009. *Studying Public Policy: Policy Cycles and Policy Subsystems* 3rd ed., Oxford University Press, USA.
- Hsiao, W.C., 2003. What is a health system? Why should we care. *Harvard School of Public Health, working paper*. Available at: <http://lingli.ccer.edu.cn/ahe2012/%5CWeek3%5CHsiao2003.pdf> [Accessed March 17, 2013].
- Hsiao, W.C. & Shaw, R.P., 2007. *Social Health Insurance for Developing Nations*, Washington, D.C.: The International Bank for Reconstruction and Development / The World Bank.
- Huber, G., Hohmann, J. & Reinhard, K., 2002. Mutual Health Insurance (MHO)–Five Years Experience in West Africa. *GTZ GmbH Division 4320–Health and Population, GTZ*.

- Hughes, D. & Leethongdee, S., 2007. Universal coverage in the land of smiles: lessons from Thailand's 30 Baht health reforms. *Health Affairs*, 26(4), pp.999–1008.
- Huijts, N.M.A., Midden, C.J.H. & Meijnders, A.L., 2007. Social acceptance of carbon dioxide storage. *Energy Policy*, 35(5), pp.2780–2789.
- ILO, 2012. *World of Work Report 2012*, Geneva, Switzerland: International Labour Organization (International Institute for Labour Studies). Available at: <http://www.ilo.org/public/english/bureau/inst/> [Accessed September 4, 2012].
- IOM, 2001. *Crossing the quality chasm: A new health system for the 21st century*, Washington D.C.: Institute of Medicine (US) Committee on Quality of Health Care in America, National Academy Press.
- IRFC, 2012. Ex-Servicemen Contributory Health Scheme (ECHS). *Information Resource Facilitation Centre, Indian Navy*. Available at: <http://www.irfc-nausena.nic.in/irfc/medico/eshs.htm> [Accessed September 3, 2012].
- Jain, N., 2012. Provision of Outpatient Care in _Rashtriya Swasthya Bima Yojana– Challenges and Way Ahead. In *Joint Learning Network_ Quality Track Webinar Series*. Joint Learning Network. Available at: <http://www.jointlearningnetwork.org> [Accessed March 22, 2013].
- Jaiswal, A., 2013. Mukhyamantri Swasthya Bima Yojna likely to turn a damp squib. *The Times of India*. 31 March.
- Jha, V., 2004. End-stage renal care in developing countries: the India experience. *Renal Failure*, 26(3), pp.201–208.
- John, T.J. et al., 2011. Continuing challenge of infectious diseases in India. *The Lancet*, 377(9761), pp.252–269.
- Joint Learning Network, 2013a. India: Rashtriya Swasthya Bima Yojna (RSBY). *Joint Learning Network*. Available at: <http://jointlearningnetwork.org/content/rashtriya-swasthya-bima-yojna-rsby> [Accessed February 6, 2013].
- Joint Learning Network, 2013b. Indonesia: Jamkesmas. <http://jointlearningnetwork.org/content/jamkesmas>. *Joint Learning Network*. Available at: <http://www.jointlearningnetwork.org/content/jamkesmas> [Accessed January 31, 2013].
- Joint Learning Network, 2013c. Joint Learning Network: Country Reforms. *Joint Learning Network*. Available at: <http://www.jointlearningnetwork.org/programs> [Accessed January 31, 2013].

- Kamuzora, P. & Gilson, L., 2007. Factors influencing implementation of the Community Health Fund in Tanzania. *Health Policy and Planning*, 22(2), p.95.
- Kaplan, S.H., Greenfield, S. & Ware Jr, J.E., 1989. Assessing the effects of physician-patient interactions on the outcomes of chronic disease. *Medical Care*, 27(3 Suppl), p.S110.
- Karuna Trust, 2012. Karuna Trust Health. Available at: <http://www.karunatrust.com/wiki/index.php/Health> [Accessed August 15, 2012].
- Keeley, J. & Scoones, I., 1999. *Understanding environmental policy processes: a review*, Brighton, UK: Institute of Development Studies, University of Sussex.
- Keen, J. & Packwood, T., 2000. 'Using case studies in health services and policy research'. In *Qualitative Research in Health Care 2nd ed.* London, BMJ Books, pp.50–58.
- Kerssens, J.J. et al., 2004. Comparison of patient evaluations of health care quality in relation to WHO measures of achievement in 12 European countries. *Bulletin of the World Health Organization*, 82(2), pp.106–114.
- Kilkey, M., Ramia, G. & Farnsworth, K., 2012. *Analysis and Debate in Social Policy, 2012*, The Policy Press. Available at: [http://books.google.com/books?hl=en&lr=&id=g1_00TcC8BsC&oi=fnd&pg=PR1&dq=marian+urbina+ferretjans&ots=-U4wj1UuUf&sig=h_QLhY4AFq_2I\]r9d2fKTvUYOFc](http://books.google.com/books?hl=en&lr=&id=g1_00TcC8BsC&oi=fnd&pg=PR1&dq=marian+urbina+ferretjans&ots=-U4wj1UuUf&sig=h_QLhY4AFq_2I]r9d2fKTvUYOFc) [Accessed November 25, 2012].
- Knaul, F.M. et al., 2005. Preventing impoverishment, promoting equity and protecting households from financial crisis: universal health insurance through institutional reform in Mexico. *Preventing impoverishment, promoting equity and protecting households from financial crisis: universal health insurance through institutional reform in Mexico. Working Paper*. Available at: http://www.gdnet.org/CMS/pdf2/gdn_library/awards_medals/2005/medals_cat3_first.pdf [Accessed March 14, 2013].
- Knoepfel, P. et al., 2007. *Public policy analysis*, The Policy Press.
- Knoepfel, P. et al., 2011. *Public Policy Analysis*, The Policy Press.
- Koivusalo, M., 2006. The Impact of Economic Globalisation on Health. *Theoretical Medicine and Bioethics*, 27(1), pp.13–34.
- Koivusalo, M. & Ollila, E., 2008. Global Health Policy. In *Understanding Global Social Policy*. Policy Press, pp. 149–177.
- Krishnan, V., 2012. Ministry opposes plan to overhaul healthcare. *The Mint*. 6 Aug.

- Kumar, Y.S., 2011. Can we make our hospitals more patient-friendly? *Indian Journal of Medical Ethics*, 8(4). Available at: <http://www.ijme.in/pdfs/issue194.html.pdf#page=54> [Accessed September 17, 2012].
- Kumaranayake, L., 1997. The role of regulation: influencing private sector activity within health sector reform. *Journal of International Development*, 9(4), pp.641–649.
- Kutzin, J., 2000. Towards Universal Healthcare Coverage: A Goal-Oriented Framework for Policy Analysis. *Health, Nutrition and Population (HNP) Discussion Paper. Washington, DC: World Bank*.
- Kutzin, J., 2001. A descriptive framework for country-level analysis of health care financing arrangements. *Health Policy*, 56(3), pp.171–204.
- Kutzin, J., 2012. Anything goes on the path to universal health coverage? No. *Bulletin of the World Health Organization*, 90(11), pp.867–868.
- Kwon, H., 1997. Beyond European welfare regimes: comparative perspectives on East Asian welfare systems. *Journal of Social Policy*, 26(4), pp.467–484.
- Kwon, H., 2005. Transforming the developmental welfare state in East Asia. *Development and Change*, 36(3), pp.477–497.
- Kwon, S., 2003. Pharmaceutical reform and physician strikes in Korea: separation of drug prescribing and dispensing. *Social Science & Medicine*, 57(3), pp.529–538.
- La Forgia, G. & Nagpal, S., 2012. *Government-sponsored health insurance in India : are you covered?*, Washington D.C.: The World Bank. Available at: <http://documents.worldbank.org/curated/en/2012/08/16653451/government-sponsored-health-insurance-india-covered> [Accessed November 23, 2012].
- Lagarde, M. & Palmer, N., 2008. The impact of user fees on health service utilization in low-and middle-income countries: how strong is the evidence? *Bulletin of the World Health Organization*, 86(11), pp.839–848C.
- Lagomarsino, G. et al., 2012. Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia. *The Lancet*, 380(9845), pp.933–943.
- Lavallee, E., Razafindrakoto, M. & Roubaud, F., 2008. *Corruption and trust in political institutions in sub-Saharan Africa, Document de travail DT 2008-07*, DIAL (Développement, Institutions et Mondialisation). Available at: <http://www.dial.ird.fr/> [Accessed April 6, 2012].
- Lave, J.R. & Frank, R.G., 1990. Effect of the structure of hospital payment on length of stay. *Health Services Research*, 25(2), pp.327–347.

- LeGrand, J., 1987. Equity, health, and health care. *Social Justice Research*, 1(3), pp.257–274.
- LeGrand, J., 1991. Quasi-markets and social policy. *The Economic Journal*, 101(408), pp.1256–1267.
- LeGrand, J., 1997. Knights, knaves or pawns? Human behaviour and social policy. *Journal of Social Policy*, 26(2), pp.149–169.
- LeGrand, J., 2006. *Motivation, agency, and public policy: of knights and knaves, pawns and queens*, Oxford University Press, USA.
- Lewis, M., 2007. Informal payments and the financing of health care in developing and transition countries. *Health Affairs*, 26(4), pp.984–997.
- Lim, S.S. et al., 2010. India's Janani Suraksha Yojana, a conditional cash transfer programme to increase births in health facilities: an impact evaluation. *The Lancet*, 375(9730), pp.2009–2023.
- Lincoln, Y.S. & Guba, E.G., 1985. *Naturalistic inquiry*, SAGE Publications Incorporated.
- Lindelov, M. & Serneels, P., 2006. The performance of health workers in Ethiopia: results from qualitative research. *Social Science & Medicine*, 62(9), pp.2225–2235.
- Lipsky, M., 2010. *Street-level bureaucracy: dilemmas of the individual in public services*, New York: Russell Sage Foundation.
- Live Mint/Wall Street Journal, 2013. Funds crunch holds up universal health plan. *Live Mint/Wall Street Journal*. Available at: <http://www.livemint.com/> [Accessed April 15, 2013].
- Lund, F.J. et al., 2009. Is there a rationale for conditional cash transfers for children in South Africa? *Transformation*, 70(1), p.70.
- Macinko, J., Starfield, B. & Erinosh, T., 2009. The impact of primary healthcare on population health in low-and middle-income countries. *The Journal of Ambulatory Care Management*, 32(2), pp.150–171.
- Mahal, A. et al., 2001. The poor and health service use in India. *Washington, DC: The World Bank*. Available at: <http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/Mahal-ThePoorAnd-whole.pdf> [Accessed September 15, 2012].
- Mahal, A., 2003. The Distribution of Public Health Subsidies in India. *Health Policy Research in South Asia: Building Capacity for Reform*. Washington, DC: World Bank, pp.33–63.

- Mahamallik, M. & Sahu, G.B., 2011. Identification of the Poor: Errors of Exclusion and Inclusion. *Economic & Political Weekly*, 46(9), p.71.
- Mahoney, J. & Goertz, G., 2006. A tale of two cultures: Contrasting quantitative and qualitative research. *Political Analysis*, 14(3), pp.227–249.
- Marriott, A., 2009. Blind Optimism Challenging the Myths About Private Health Care in Poor Countries. Working Papers. Available at: <http://ideas.repec.org/p/ess/wpaper/id1862.html> [Accessed September 2, 2012].
- Marshall, M. & Harrison, S., 2005. It's about more than money: financial incentives and internal motivation. *Quality and Safety in Health Care*, 14(1), pp.4–5.
- Matland, R.E., 1995. Synthesizing the Implementation Literature: The Ambiguity-Conflict Model of Policy Implementation. *Journal of Public Administration Research and Theory*, 5(2), pp.145–174.
- Maxwell, R.J., 1992. Dimensions of quality revisited: from thought to action. *Quality in Health Care*, 1(3), p.171.
- Maynard-Moody, S. & Musheno, M., 2000. State agent or citizen agent: Two narratives of discretion. *Journal of Public Administration Research and Theory*, 10(2), p.329.
- Mays, N. & Pope, C., 2000. Qualitative research in health care: assessing quality in qualitative research. *BMJ: British Medical Journal*, 320(7226), p.50.
- McGee, R. & Brock, K., 2001. From poverty assessment to policy change: processes, actors and data.
- McIntyre, D., 2007. Learning from experience: Health care financing in low-and middle-income countries. Available at: http://announcementsfiles.cohred.org/gfhr_pub/abstract/s14821e/s14821e_abstract_fr.pdf [Accessed January 16, 2013].
- McIntyre, D., 2010. *Private sector involvement in funding and providing health services in South Africa: implications for equity and access to health care*, Regional network for equity in health in east and southern Africa (EQUINET). Available at: <http://www.equinet africa.org/bibl/docs/DIS84privfin%20mcintyre.pdf> [Accessed March 5, 2013].
- McIntyre, D., Fonn, S. & Padarath, A., 2010. National health insurance: Providing a vocabulary for public engagement. *South African Health Review. Durban: Health Systems Trust*. Available at: http://www.hst.org.za/uploads/files/sahr10_15.pdf [Accessed September 8, 2012].
- McPake, B. & Kutzin, J., 1997. *Methods for evaluating effects of health reforms*, Division of Analysis, Research and Assessment, World Health Organization.

- Available at:
<http://info.worldbank.org/etools/docs/library/122031/bangkokCD/BangkokMarch05/Week2/2Tuesday/S3HealthSysPerformance/MethodsforEvaluating.pdf> [Accessed March 22, 2013].
- Mead, N. & Bower, P., 2000. Patient-centredness: a conceptual framework and review of the empirical literature. *Social Science and Medicine*, 51(7), pp.1087–1110.
- Meessen, B. et al., 2011. Removing user fees in the health sector: a review of policy processes in six sub-Saharan African countries. *Health Policy and Planning*, 26(suppl 2), pp.ii16–ii29.
- Mehrotra, S. & Jarrett, S.W., 2002. Improving basic health service delivery in low-income countries: 'voice' to the poor. *Social Science & Medicine*, 54(11), pp.1685–1690.
- Menon, S., 2009. Right pill for the poor: Govt decision to roll out national health insurance across the country has earned praise. *The Business Standard*. 15 February.
- Midgley, J., 2007. Industrialization and welfare: the case of the four little tigers. *Social Policy & Administration*, 20(3), pp.225–238.
- Midgley, J., 2012. Social Protection and Social Policy: Key Issues and Debates. *Journal of Policy Practice*, 11(1-2), pp.8–24.
- Millman, M.L., 1993. *Access to health care in America.*, Washington, DC: Institute of Medicine, National Academy Press.
- Mills, A., 1997. Improving the efficiency of public sector health services in developing countries: bureaucratic versus market approaches. In C. Colclough, ed. *Marketizing education and health in developing countries: Miracle or mirage?* Oxford, U.K.: Oxford University Press, pp. 245–74.
 Available at:
http://books.google.com/books?hl=en&lr=&id=DCjFk2qu5EkC&oi=fnd&pg=PA245&dq=developing+countries+health+services+waste+and+inefficiency&ots=k4DYgj8w--&sig=eniQ-yqzUB_izG18gmnysjyUwxs [Accessed January 23, 2013].
- Mills, A., 1998. To Contract or Not to Contract? Issues for Low and Middle Income Countries. *Health Policy and Planning*, 13(1), pp.32–40.
- Ministers of the East African Community, 2012. Kigali Ministerial Statement on Universal Health Coverage and Long Term Harmonization of Social Health Protection in the East African Community. Ministry of Health, Rwanda.
- Ministry of Finance, 2003. *Union Budget 2003-04*, New Delhi: Ministry of Finance, Government of India.

- Ministry of Finance, 2006. *Health Insurance-A Horizontal Study. Eleventh Report Committee on Public Undertakings (2005 - 2006). CPU no. 897.*, New Delhi: Ministry of Finance, Government of India. Available at: <http://164.100.24.208/ls/CommitteeR/PU/11threp.pdf> [Accessed August 16, 2012].
- Ministry of Finance, 2012. *Union Budget 2012-13*, New Delhi: Ministry of Finance, Government of India. Available at: <http://indiabudget.nic.in/> [Accessed November 3, 2012].
- Ministry of Finance, 2013. *Union Budget 2013-14*, New Delhi: Ministry of Finance, Government of India. Available at: <http://indiabudget.nic.in/> [Accessed March 16, 2013].
- Ministry of Law & Justice, 1950. *Constitution of India*. Available at: <http://www.constitution.org/cons/india/const.html> [Accessed September 10, 2012].
- Ministry of Textiles, 2012. Office of the Development Commissioner for Handlooms, Ministry of Textiles, Government of India. Available at: http://handlooms.nic.in/hl_schemes.htm [Accessed August 15, 2012].
- Mitchell, W. & Irvine, A., 2008. I'm Okay, You're Okay?: Reflections on the Well-Being and Ethical Requirements of Researchers and Research Participants in Conducting Qualitative Fieldwork Interviews. *International Journal of Qualitative Methods*, 7(4), pp.31-44.
- Mkandawire, T., 2005. *Targeting and universalism in poverty reduction*, United Nations Research Institute for Social Development.
- MoHFW, 2002. *National Health Policy 2002.*, New Delhi: Ministry of Health and Family Welfare, Government of India. Available at: http://mohfw.nic.in/NRHM/Documents/National_Health_policy_2002.pdf [Accessed February 11, 2012].
- MoHFW, 2005. *National Rural Health Mission, Mission Document (2005-12).*, New Delhi: Ministry of Health and Family Welfare, Government of India. Available at: http://mohfw.nic.in/NRHM/Documents/Mission_Document.pdf [Accessed February 11, 2012].
- MoHFW, 2012. *Rural Health Statistics in India 2011*, New Delhi, India: Ministry of Health and Family Welfare, Government of India. Available at: <http://nrhm-mis.nic.in/UI/RHS/RHS%202011/RHS%202011%20Webpage.htm> [Accessed February 25, 2013].
- MoLE, 2002. *The Second National Commission on Labour Report*, New Delhi: Ministry of Labour and Employment, Government of India.

- MoLE, 2012a. *Demands for Grants 2012-13, Ministry of Labour & Employment Coordination Section*, New Delhi, India: Ministry of Labour and Employment, Government of India. Available at: <http://labour.nic.in> [Accessed February 1, 2013].
- MoLE, 2012b. Directorate General Labour Welfare. *Ministry of Labour & Employment, Government of India*. Available at: <http://labour.nic.in/dglw/welcome.html> [Accessed September 4, 2012].
- MoLE, 2012c. Introduction of Quality Management in Health Care Initiative in the RSBY. Available at: <http://rsby.gov.in/> [Accessed March 21, 2013].
- MoLE, 2012d. Rashtriya Swasthya Bima Yojana. *Rashtriya Swasthya Bima Yojana*. Available at: rsby.gov.in [Accessed February 14, 2012].
- MoLE, 2013. Rashtriya Swasthya Bima Yojana. *Rashtriya Swasthya Bima Yojana*. Available at: www.rsby.gov.in [Accessed February 1, 2013].
- MoLER, 1969. *Report of the National Commission on Labour*, New Delhi: Ministry of Labour and Employment and Rehabilitation, Government of India.
- Montenegro Torres, F. & Acevedo, O.B., 2013. *Colombia case study: the subsidized regime of Colombia's national health insurance system.*, Washington D.C.: World Bank.
- Mooij, J.E., 2003. *Smart Governance?: Politics in the Policy Process in Andhra Pradesh, India*, Overseas Development Institute.
- Mooij, J.E. & de Vos, V., 2003. *Policy processes: An annotated bibliography on policy processes, with particular emphasis on India*, Overseas development institute (ODI).
- Mooney, G.H., 1983. Equity in health care: confronting the confusion. *Effective Health Care*, 1(4), p.179.
- MoRD, 2013. BPL Census 2011. *Ministry of Rural Development, Government of India*. Available at: www.rural.nic.in [Accessed March 29, 2013].
- Morone, J.A., 1995. Nativism, hollow corporations, and managed competition: Why the Clinton health care reform failed. *Journal of Health Politics, Policy and Law*, 20(2), pp.391–398.
- Mossialos, E. et al., 2002. *Funding health care: options for Europe*, Open University Press Maidenhead.
- Mossialos, E. & Dixon, A., 2002. Funding health care: an introduction. In E. Mossialos et al., eds. In *Funding Health Care: Options for Europe*. Buckingham, Philadelphia: Open University Press, pp. 1–30.
- Mott McDonald, 2011. Pilot Post-enrolment Survey of the RSBY Programme in Haryana. Available at: <http://www.rsby.gov.in/> [Accessed March 9, 2013].

- Mukherjee, P., 2013. Speech by the President of India, Shri Pranab Mukherjee at the inauguration of the golden jubilee celebrations of the Government T.D. Medical College, Alappuzha, Kerala: 16-03-2013. Available at: www.presidentofindia.nic.in [Accessed April 4, 2013].
- Nagpal, S., 2013. *Expanding health coverage for vulnerable groups in India*, Washington D.C.: World Bank. Available at: http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/01/31/000425962_20130131131817/Rendered/PDF/749450NWP0VIET00Box374316B00PUBLIC0.pdf [Accessed March 14, 2013].
- Nandi, S. et al., 2012. *The Emerging Experience of RSBY in Chhattisgarh: What can the Informal Sector Workers Expect? Background paper for MFC Annual Meet 2012*, Medico Friend Circle (MFC). Available at: <http://www.mfcindia.org> [Accessed March 9, 2013].
- Narayan, D. & Pritchett, L., 1999. Cents and sociability: Household income and social capital in rural Tanzania. *Economic Development and Cultural Change*, 47(4), pp.871–897.
- National Department of Health, 2011. Green Paper on National Health Insurance in South Africa.
- National Statistical Commission, 2012. *Report of the Committee on Unorganised Sector Statistics*, Government of India.
- Navarro, V., 1995. Why Congress did not enact health care reform. *Health policy: Crisis and reform in the US health care delivery system*, pp.391–396.
- NCEUS, 2006. *Report on Social Security for Unorganized Workers*, New Delhi: National Commission for Enterprises in the Unorganized Sector, Government of India.
- NCMH, 2005. *Report of the National Commission on Macroeconomics and Health*, New Delhi, India: National Commission on Macroeconomics and Health, Ministry of Health and Family welfare, Government of India, 2005.
- NCMP, 2004. *National Common Minimum Programme of the Government of India*, Available at: pmindia.nic.in/cmp.pdf [Accessed January 15, 2012].
- Ndiaye, P., Soors, W. & Criel, B., 2007. Editorial: A view from beneath: Community Health Insurance in Africa. *Tropical Medicine & International Health*, 12(2), pp.157–161.
- Newman, J. & Kuhlmann, E., 2007. Consumers enter the political stage? The modernization of health care in Britain and Germany. *Journal of European Social Policy*, 17(2), pp.99–111.
- NHA, 2009. *National Health Accounts India, 2004-05*, New Delhi: National Health Accounts Cell, Ministry of Health and Family Welfare, Government of India.

- Nicolle, E. & Mathauer, I., 2010. Administrative costs of health insurance schemes: Exploring the reasons for their variability. Discussion paper number 8.
- NIHFW, 2011. *A Rapid appraisal of Rashtriya Swasthya Bima Yojana in Delhi.*, New Delhi, India: National Institute of Health and Family Welfare/Indian Council of Medical Research.
- Normand, C. & Busse, R., 2002. Social health insurance financing. In *Funding health care: options for Europe*. Buckingham, U.K.: Open University Press.
- NRHM, 2005. *Report of Task Force on Exploring New Health Financing Mechanisms*, New Delhi: National Rural Health Mission, Ministry of Health & Family Welfare, Government of Karnataka. Available at: <http://stg2.kar.nic.in/healthnew/SAST/about-sastvas.pdf> [Accessed August 20, 2012].
- NRHM, 2010. *Draft Urban Health Framework for Implementation*, New Delhi, India: National Rural Health Mission, Ministry of Health & Family Welfare, Government of Karnataka.
- NSSO, 2006. *Morbidity, Health Care and the Condition of the Aged, Jan.-June,2004*, New Delhi: National Sample Survey Organisation, Ministry Of Statistics And Programme Implementation, Government Of India. Available at: http://mospi.gov.in/national_data_bank/pdf/NSS%2060th%20Round-507.pdf [Accessed February 12, 2012].
- O’Cathain, A. & Thomas, S., 2006. Combining qualitative and quantitative methods. In C. Pope & N. Mays, eds. *Qualitative research in health care [electronic resource]*. Malden, Mass: Blackwell Pub/BMJ Books, pp. 102–111.
- O’Toole, L.J., 1986. Policy Recommendations for Multi-Actor Implementation: An Assessment of the Field. *Journal of Public Policy*, 6(02), pp.181–210.
- OECD, 1994. *The reform of health care systems*, Paris: OECD Publishing.
- OECD, 2011. *Health at a Glance 2011: OECD Indicators*, OECD Publishing. Available at: http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2011_health_glance-2011-en [Accessed February 23, 2013].
- Office of the Registrar General and Census Commissioner, 2011. *Population Census India 2011*, New Delhi, India: Ministry of Home Affairs, Government of India.
- Okunzi, S.A. & Macrae, J., 1995. Whose policy is it anyway? International and national influences on health policy development in Uganda. *Health Policy and Planning*, 10(2), pp.122–132.
- Oliver, A., 2005. The English National Health Service: 1979-2005. *Health Economics*, 14(S1), pp.S75–S99.

- Oliver, A., 2009. The single-payer option: a reconsideration. *Journal of Health Politics, Policy and Law*, 34(4), pp.509–530.
- Oliver, A. & Mossialos, E., 2005. European health systems reforms: Looking backward to see forward? *Journal of Health Politics, Policy and Law*, 30(1-2), pp.7–28.
- Ostrom, E., 2000. Social capital: a fad or a fundamental concept. In *Social Capital: A Multifaceted Perspective*, P. Dasgupta and I. Seragilden, eds., Washington DC: World Bank, pp. 172-214.
- Otiso, K.M., 2003. State, voluntary and private sector partnerships for slum upgrading and basic service delivery in Nairobi City, Kenya. *Cities*, 20(4), pp.221–229.
- P4H, 2013. Providing for Health (P4H)-Social Health Protection Network A global network for Universal Health Coverage (UHC) and Social Health Protection (SHP). Available at: <http://www.who.int/providingforhealth/en/> [Accessed March 13, 2013].
- Palacios, R., Das, J. & Sun, C. eds., 2011. *India's Health Insurance Scheme for the Poor: Evidence from the Early Experience of the Rashtriya Swasthya Bima Yojana.*, New Delhi: Centre for Policy Research.
- Palumbo, D.J., Maynard-Moody, S. & Wright, P., 1984. Measuring degrees of successful implementation achieving policy versus statutory goals. *Evaluation Review*, 8(1), pp.45–74.
- Pappas, G. et al., 1997. Potentially avoidable hospitalizations: inequalities in rates between US socioeconomic groups. *American Journal of Public Health*, 87(5), pp.811–816.
- Patel, V. et al., 2011. Chronic diseases and injuries in India. *The Lancet*, 377(9763), pp.413–428.
- Patton, M.Q., 1999. Enhancing the quality and credibility of qualitative analysis. *Health Services Research*, 34(5 Pt 2), p.1189.
- Patton, M.Q., 2002. *Qualitative Research and Evaluation Methods*, 3rd Edition. Sage Publications Incorporated.
- Patton, M.Q., 2008. *Utilization-focused evaluation* 4th ed., Beverly Hills, CA: Sage Publications.
- Paul, S., 1998. *Making voice work: The report card on Bangalore's public service*, World Bank Publications. Available at: http://books.google.com/books?hl=en&lr=&id=DUSrtU37EjAC&oi=fnd&pg=PA1&dq=Making+Voice+Work:+The+Report+Card+on+Bangalore%E2%80%99s+Public+Services&ots=zLMT5r1Hs8&sig=ro4xFGRjkGBUGIYxhYxHTDF_c1U [Accessed April 6, 2013].

- Paul, V.K. et al., 2011. Reproductive health, and child health and nutrition in India: meeting the challenge. *The Lancet*, 377(9762), pp.332–349.
- Pearson, M., 2002. Allocating public resources for health: developing pro-poor approaches. Available at: <http://hdrc.dfid.gov.uk/wp-content/uploads/2012/10/Allocating-public-resources-for-health.pdf> [Accessed March 26, 2013].
- Pellissery, S., 2005. Local Determinants of Exclusion and Inclusion in Rural Public Works Programmes A Political Economy Approach. *International Journal of Rural Management*, 1(2), pp.167–184.
- Penchansky, R. & Thomas, J.W., 1981. The concept of access: definition and relationship to consumer satisfaction. *Medical Care*, Feb;19(2):127-40. pp.127–140.
- Peters, D.H. et al., 2002. *Better health systems for India's poor: findings, analysis, and options*, Washington, D.C.: World Bank Publications.
- Peters, D.H. et al., 2008. Poverty and Access to Health Care in Developing Countries. *Annals of the New York Academy of Sciences*, 1136(1), pp.161–171.
- Peters, D.H. & Muraleedharan, V.R., 2008. Regulating India's health services: To what end? What future? *Social Science & Medicine*, 66(10), pp.2133–2144.
- Peters, D.H., Rao, K.S. & Fryatt, R., 2003. Lumping and splitting: the health policy agenda in India. *Health Policy and Planning*, 18(3), pp.249–260.
- PHFI, 2011. *A Critical Assessment of the Existing Health Insurance Models in India.*, New Delhi: Public Health Foundation of India, Planning Commission of India. Available at: planningcommission.nic.in/reports/sereport/ser/ser_heal1305.pdf [Accessed February 4, 2012].
- PIB, 2008. Extension of Rashtriya Swasthya Bima Yojana to building and other construction workers. Available at: www.pib.nic.in [Accessed March 11, 2013].
- PIB, 2011a. Extension of Rashtriya Swasthya Bima Yojana to the Domestic Workers, Release ID :72827. Available at: <http://labour.nic.in/pib/PressRelease/LS-DomesticWorkersUnderRSBY.pdf>. [Accessed February 16, 2012].
- PIB, 2011b. Rashtriya Swasthya Bima Yojana Will be Extended to Workers in Hazardous Mining and Associated Industries. Available at: www.pib.nic.in [Accessed March 11, 2013].
- PIB, 2012a. India Supports Universal Health Coverage at 65th World Health Assembly, Geneva.

- PIB, 2012b. Rashtriya Swasthya Bima Yojana, Release ID :87618. Available at: www.pib.nic.in [Accessed March 21, 2013].
- PIB, 2013a. Rashtriya Swasthya Bima Yojana(RSBY)-Highlights,Release ID:94269. Available at: www.pib.nic.in [Accessed April 4, 2013].
- PIB, 2013b. Union Budget 2013-14 Highlights: RSBY to be Extended to other Categories such as Rickshaw, auto-Rickshaw and Taxi Drivers, Sanitation Workers, Rag Pickers and Mine Workers. Available at: www.pib.nic.in [Accessed March 11, 2013].
- Pillay, T.D. & Skordis-Worrall, J., 2013. South African health financing reform 2000–2010: Understanding the agenda-setting process. *Health Policy*, 109(3), pp.321–331.
- Planning Commission, 2006. *Report of the Working Group on Labour Laws and Other Labour Regulations.*, New Delhi: Planning Commission of India, Government of India.
- Planning Commission, 2008a. *Eleventh Five Year Plan (2007–2012) Volume-1: Inclusive Growth & Volume II: Social Sector Services.* Planning Commission, Government of India., New Delhi: Oxford University Press India.
- Planning Commission, 2008b. *Eleventh Five Year Plan 2007-2012. Volume II: Social Sector.*, New Delhi: Oxford University Press India. Available at: <http://planningcommission.nic.in/plans/planrel/fiveyr/welcome.html> [Accessed February 9, 2012].
- Planning Commission, 2011a. *Faster, Sustainable and More Inclusive Growth: An Approach to the 12th Five Year Plan (2012-2017)*, New Delhi: Government of India.
- Planning Commission, 2011b. *High Level Expert Group Report on Universal Health Coverage for India*, New Delhi: Planning Commission of India, Government of India.
- Planning Commission, 2011c. *Mid-Term Appraisal for Eleventh Five Year Plan 2007-2012.*, New Delhi: Oxford University Press India.
- Planning Commission, 2012. *Report of the Expert Group to Recommend the Detailed Methodology for the Identification of Families Living Below Poverty Line in the Urban Areas*, New Delhi, India: Planning Commission of India, Government of India.
- Planning Commission, 2013a. State-wise Indicators of Poverty & Per-capita Expenditure. Available at: <http://planningcommission.nic.in/data/datatable/index.php?data=datatab> [Accessed March 29, 2013].

- Planning Commission, 2013b. *Twelfth Five Year Plan 2012-2017.*, New Delhi: Oxford University Press India. Available at: <http://planningcommission.nic.in/plans/planrel/fiveyr/welcome.html> [Accessed February 9, 2012].
- PMA Conference, 2012. Report on the Prince Mahidol Award Conference 2012: moving towards universal health coverage—health financing matters. In Prince Mahidol Award Conference. Bangkok, Thailand. Available at: www.pmaconference.mahidol.ac.th [Accessed March 8, 2013].
- PMO, 2005. PM addresses 40th Indian Labour Conference, December 9, 2005. Prime Minister's Office, India
- PMO, 2008. Prime Minister's speeches: PM launches Apollo Reach Hospitals. Available at: <http://pmindia.nic.in/speech-details.php?nodeid=687> [Accessed February 19, 2012].
- PMO, 2011. PM's Inaugural Address at the 56th Meeting of the National Development Council (NDC) at Vigyan Bhavan, New Delhi on 22nd October, 2011. Available at: <http://pmindia.nic.in/speeches.htm> [Accessed February 12, 2012].
- PMO, 2012a. Address by the Hon'ble President Of India, Shrimati Pratibha Devisingh Patil, to Parliament New Delhi, 12th March, 2012. Available at: www.pmindia.gov.in [Accessed March 11, 2013].
- PMO, 2012b. Health outlay to be increased to 2.5% of GDP, Press Release, 29 February 2012.
- PMO, 2012c. Prime Minister's speeches: PM's Independence Day Speech, 2012. Available at: <http://pmindia.nic.in/search.php?q=independence+day+speech&ln=> [Accessed September 7, 2012].
- Pope, C., Ziebland, S. & Mays, N., 2006. Analysing qualitative data. In C. Pope & N. Mays, eds. *Qualitative research in health care [electronic resource]*. Malden, Mass: Blackwell Pub/BMJ Books, pp. 82–111.
- Preker, A.S., 2003. *Private Participation in Health Services*, World Bank Publications.
- Pressman, J. & Wildavsky, A., 1973. *Implementation: how great expectations in Washington are dashed in Oakland; or, why it's amazing that federal programs work at all, this being a saga of the Economic Development Administration as told by two sympathetic observers who seek to build morals on a foundation of ruined hopes*, Berkeley: University of California Press.
- Prinja, S. et al., 2012. User charges in health care: Evidence of effect on service utilization & equity from north India. *The Indian Journal of Medical Research*, 136(5), p.868.

- Propper, C., 2010. *The operation of choice and competition in healthcare: A review of the evidence*, London: The 2020 Public Services Trust. Available at: http://clients.squareeye.net/uploads/2020/documents/0920TWE_ESRC_healthcare_050730%20C.pdf [Accessed September 7, 2013].
- Putnam, R.D., 2000. *Bowling alone: The collapse and revival of American community*, New York, U.S.A.: Simon and Schuster.
- Putzel, J., 1997. Accounting for the 'dark side' of social capital: reading Robert Putnam on democracy. *Journal of International Development*, 9(7), pp.939–949.
- QSR International, 2012. QSR International: NVivo 9. Available at: http://www.qsrinternational.com/products_nvivo.aspx [Accessed February 19, 2012].
- Ragin, C.C., 1999. The distinctiveness of case-oriented research. *Health Services Research*, 34(5 Pt 2), p.1137.
- Rajasekhar, D. et al., 2011. Implementing health insurance: the rollout of Rashtriya Swasthya Bima Yojana in Karnataka. *Economic & Political Weekly*, 46(20), p.57.
- Ram, F., Mohanty, S. & Ram, U., 2009. Understanding the distribution of BPL cards: All-India and selected states. *Economic and Political Weekly*, 44(7), pp.66–71.
- Rao, K.D., Bhatnagar, A. & Berman, P., 2009. India's health workforce: size, composition and distribution. *India Health Beat*, 1(3), p.19.
- Rao, K.D., Bhatnagar, A. & Berman, P., 2012. So many, yet few: Human resources for health in India. *Human Resources for Health*, 10(1), p.19.
- Rao, K.D., Peters, D.H. & Bandeen-Roche, K., 2006. Towards patient-centered health services in India—a scale to measure patient perceptions of quality. *International Journal for Quality in Health Care*, 18(6), pp.414–421.
- Rao, M. et al., 2011. Human resources for health in India. *The Lancet*, 377(9765), pp.587–598.
- Rao, Mohan et al., 2011. Human resources for health in India. *The Lancet*, 377(9765), pp.587–598.
- Rao, M.G. & Choudhury, M., 2012. *Health Care Financing Reforms in India*, New Delhi, India: National Institute of Public Finance and Policy. Available at: http://www.nipfp.org.in/newweb/sites/default/files/wp_2012_100.pdf [Accessed September 12, 2012].
- Reich, M.R., 1995. The politics of health sector reform in developing countries: three cases of pharmaceutical policy. *Health Policy*, 32(1), pp.47–77.

- Reid, M., 2011. Behind the 'Glasgow effect'. *Bulletin of the World Health Organization*, 89(10), p.706.
- Rein, M., 1976. *Social science and public policy*, Penguin Books New York. Available at: <http://library.wur.nl/WebQuery/clc/300096> [Accessed February 8, 2013].
- Reiser, S.J., 2005. Research Compensation and the Monetization of Medicine. *JAMA: The Journal of the American Medical Association*, 293(5), pp.613–614.
- Remesh, B.P., 2009. Rethinking Social Protection for India's Working Poor in Unorganised Sector. In *Health Care 2. Asian Social Protection in Comparative Perspective*. Singapore: Welfare Reform Academy, University of Maryland, USA. Available at: http://www.welfareacademy.org/pubs/international/policy_exchanges/as_p_papers/index.shtml [Accessed August 20, 2012].
- Richards, D., 1996. Elite interviewing: approaches and pitfalls. *Politics*, 16(3), pp.199–204.
- Ridde, V. & Morestin, F., 2011. A scoping review of the literature on the abolition of user fees in health care services in Africa. *Health Policy and Planning*, 26(1), pp.1–11.
- Roy, I., 2011. 'New'Lists for 'Old':(Re-) constructing the Poor in the BPL Census. *Economic & Political Weekly*, 46(22), p.83.
- RSBY, 2011a. Providing Outpatient Healthcare to complement Rashtriya Swasthya Bima Yojana (RSBY), India's National Health Insurance Scheme. Available at: <http://rsby.gov.in/> [Accessed March 21, 2013].
- RSBY, 2011b. RSBY Guidelines for Merging MNREGA and BPL data to extend RSBY cover to MNREGA Beneficiaries. 9 Aug. Available at: <http://www.rsby.gov.in/Documents.aspx?id=1> [Accessed February 16, 2012].
- RSBY, 2012a. Rashtriya Swasthya Bima Yojana: About the Scheme. http://www.rsby.gov.in/about_rsby.aspx. Available at: http://www.rsby.gov.in/about_rsby.aspx [Accessed February 14, 2012].
- RSBY, 2012b. Tender Document-Implementation of Rashtriya Swasthya Bima Yojana in [Name of the State] 2011-12. Available at: <http://rsby.gov.in/tender.html> [Accessed February 12, 2012].
- RSBY, 2013. Tender Document-Implementation of Rashtriya Swasthya Bima Yojana in [Name of the State] 2013. Available at: <http://rsby.gov.in/tender.html> [Accessed March 21, 2013].
- RSBY Connect, 2013. RSBY Connect March 2013, Issue 14. Available at: www.rsby.gov.in [Accessed April 1, 2013].

- RSBY National Workshops, 2009. In RSBY National Workshop. Trivandrum, Kerala, India: Ministry of Labour & Employment, Government of India. Available at: www.rsby.gov.in [Accessed December 14, 2011].
- RSBY National Workshops, 2010. In RSBY National Workshop. Chandigarh, India.: Ministry of Labour & Employment, Government of India. Available at: www.rsby.gov.in [Accessed February 4, 2012].
- RSBY National Workshops, 2011. RSBY National Workshop at Raipur, Chhattisgarh. 3rd, 4th & 5th May, 2011. In RSBY National Workshop at Raipur, Chhattisgarh. 3rd, 4th & 5th May, 2011. Raipur, Chhattisgarh: Ministry of Labour & Employment, Government of India. Available at: www.rsby.gov.in [Accessed February 16, 2012].
- Rudra, N., 2007. Welfare states in developing countries: unique or universal? *Journal of Politics*, 69(2), pp.378–396.
- Russell, S., 2005. Treatment-seeking behaviour in urban Sri Lanka: Trusting the state, trusting private providers. *Social Science & Medicine*, 61(7), pp.1396–1407.
- Sabatier, P. & Mazmanian, D., 1979. The conditions of effective implementation: a guide to accomplishing policy objectives. *Policy Analysis*, 5(4), p.481.
- Sachs, J.D., 2012. Achieving universal health coverage in low-income settings. *The Lancet*, 380(9845), pp.944–947.
- Saltman, R.B., 2002. The Western European experience with health care reform. *Copenhagen: European Observatory on Health Care Systems*. Available at: <http://www.teamgrant.ca/M-THAC%20Greatest%20Hits/M-THAC%20Projects/All%20info/mthac%20lectures/Saltman%20Paper.pdf> [Accessed September 5, 2012].
- Saltman, R.B., Busse, R. & Figueras, J. eds., 2004. *Social Health Insurance Systems in Western Europe*, Berkshire, U.K.: Open University Press.
- Samajik Suvidha Sangam, 2012. Samajik Suvidha Sangam, Mission Convergence: Implementation Support. *Samajik Suvidha Sangam, Mission Convergence*. Available at: www.missionconvergence.org/implementation-support.html [Accessed February 19, 2012].
- Sandelowski, M., 1995. Triangles and crystals: On the geometry of qualitative research. *Research in Nursing & Health*, 18(6), pp.569–574.
- SAS, 2009. Vajpayee Arogya Shree scheme. Available at: <http://stg2.kar.nic.in/healthnew/SAST/about-sastvas.pdf> [Accessed August 20, 2012].
- Schmidt, J.D., 2006. Flexicurity, casualisation and informalisation of global labour markets. *Globalization and Conflicts*, Macmillan, London. Available at:

http://vbn.aau.dk/files/33967493/workingpaper_133.pdf [Accessed January 24, 2013].

- Schneider, A. & Sidney, M., 2009. What Is Next for Policy Design and Social Construction Theory? *Policy Studies Journal*, 37(1), pp.103–119.
- Schoen, C. et al., 2010. How health insurance design affects access to care and costs, by income, in eleven countries. *Health Affairs*, 29(12), pp.2323–2334.
- Schoen, C. et al., 2006. U.S. Health System Performance: A National Scorecard. *Health Affairs*, 25(6), pp.w457–w475.
- Schwandt, T.A., 2007. *The SAGE Dictionary of Qualitative Inquiry* 3rd ed., Sage Publications, Inc.
- Selvaraj, S. & Karan, A.K., 2009. Deepening health insecurity in India: evidence from national sample surveys since 1980s. *Economic and Political Weekly*, 44, pp.55–60.
- Sen, A., 1992. *The political economy of targeting*, Washington: World Bank.
- Sen, A., 2010. India's health cover for poor attracts world. *The Economic Times*. 15 October.
- Sen, G., Iyer, A. & George, A., 2002. Structural Reforms and Health Equity: A Comparison of NSS Surveys, 1986-87 and 1995-96. *Economic and Political Weekly*, pp.1342–1352.
- Seshadri, T. et al., 2012. Impact of RSBY on enrolled households: lessons from Gujarat. *BMC Proceedings*, 6(Suppl 5), p.09.
- SEWA, 2012. Vimo SEWA Insurance. Available at: www.sewainsurance.org [Accessed August 15, 2012].
- Shahrawat, R. & Rao, K.D., 2011. Insured yet vulnerable: out-of-pocket payments and India's poor. *Health Policy and Planning*. Available at: <http://heapol.oxfordjournals.org/content/early/2011/04/12/heapol.czr029.short> [Accessed September 15, 2012].
- Silverman, D., 2005. *Doing qualitative research: a practical handbook* 2nd ed., London: Sage.
- Singh, A., 2008. The Past, Present and Future of Industrial Policy in India: Adapting to the Changing Domestic and International Environment, Working Paper No. 376. Available at: <http://www.cbr.cam.ac.uk/pdf/WP376.pdf> [Accessed August 16, 2012].
- Smith, O., 2013. *Georgia's Medical Insurance Program for the Poor*, Washington D.C.: World Bank. Available at: <http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/>

02/01/000425962_20130201162852/Rendered/PDF/749980NWP0Box30Program0for0the0Poor.pdf [Accessed March 14, 2013].

Somanathan, A., Dao, H.L. & Van Tien, T., 2013. *Integrating the Poor into Universal Health Coverage in Vietnam*, Washington D.C.: World Bank. Available at: http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/01/31/000425962_20130131131817/Rendered/PDF/749450NWP0VIET00Box374316B00PUBLIC0.pdf [Accessed March 14, 2013].

Spaan, E. et al., 2012. The impact of health insurance in Africa and Asia: a systematic review. *Bulletin of the WHO*. Available at: http://www.who.int/entity/bulletin/online_first/12-102301.pdf [Accessed November 30, 2012].

Spratt, K., 2009. *Policy Implementation Barriers Analysis: Conceptual Framework and Pilot Test in Three Countries.*, Washington, DC: Futures Group, USAID Health Policy Initiative, Task Order 1. U.S. Agency for International Development.

Sridhar, D. & Gómez, E.J., 2011. Health financing in Brazil, Russia and India: what role does the international community play? *Health Policy and Planning*, 26(1), pp.12–24.

Srivastava, R., 2012. Changing employment conditions of the indian workforce and implications for decent work. *Global Labour Journal*, 3(1), pp.63–90.

Stake, R.E., 1975a. Program evaluation particularly responsive evaluation. *Center for Instructional Research and Curriculum Evaluation. University of Illinois at Urbana-Champaign*. Available at: <http://globalhivmeinfo.com/CapacityBuilding/Occasional%20Papers/05%20Program%20Evaluation,%20Particularly%20Responsive%20Evaluation.pdf> [Accessed March 10, 2013].

Stake, R.E., 1975b. To evaluate an arts program. In *Evaluating the Arts in Education: A Responsive Approach*. Columbus, Ohio: Merrill.

Stake, R.E., 1995. *The art of case study research*, Thousand Oaks, CA:SAGE.

Starfield, B., 2000. Is US health really the best in the world? *JAMA*, 284(4), pp.483–485.

Starfield, B., 2011. Primary care: an increasingly important contributor to effectiveness, equity, and efficiency of health services. *SESPAS report 2012. Gaceta Sanitaria*. Available at: <http://www.sciencedirect.com/science/article/pii/S0213911111003876> [Accessed February 5, 2013].

Starfield, B., Shi, L. & Macinko, J., 2005. Contribution of Primary Care to Health Systems and Health. *Milbank Quarterly*, 83(3), pp.457–502.

- Stenberg, K. et al., 2010. Responding to the challenge of resource mobilization-mechanisms for raising additional domestic resources for health. *World Health Report (2010), Background paper 13*. Available at: <http://wwwlive.who.int/entity/healthsystems/topics/financing/healthreport/13Innovatedomfinancing.pdf> [Accessed February 23, 2013].
- Stone, D., 2004. Transfer agents and global networks in the 'transnationalization' of policy. *Journal of European Public Policy*, 11(3), pp.545–566.
- Stuckler, D., Basu, S. & McKee, M., 2011. Health care capacity and allocations among South Africa's provinces: infrastructure-inequality traps after the end of apartheid. *American Journal of Public Health*, 101(1), pp.165–172.
- Sun, C., 2011. Hospitalization patterns in RSBY: Preliminary evidence from the MIS. In *India's Health Insurance Scheme for the Poor: Evidence from the Early Experience of the Rashtriya Swasthya Bima Yojana*. New Delhi: Centre for Policy Research, pp. 84–116.
- Surender, R., Fitzpatrick, R. & Brown, S., 1998. The patient's view of general practice fundholding: results of a cross-sectional survey. *Health & Social Care in the Community*, 6(5), pp.370–377.
- Surender, R. & Walker, R., 2013. *Social Policy in a Developing World*, Edward Elgar Publishing.
- Tapay, N. & Colombo, F., 2004. Private health insurance in OECD countries: the benefits and costs for individuals and health systems. In *The OECD Health Project Towards High-Performing Health Systems Policy Studies: Policy Studies*. OECD Publishing, p. 265. Available at: http://books.google.com/books?hl=en&lr=&id=DJ9OogHo0J0C&oi=fnd&pg=PA265&dq=tapay+and+colombo&ots=EWAX0c2_Eb&sig=tvo-dsrKaBjMntsw2Z915dZi5u8 [Accessed February 23, 2013].
- Tendler, J., 2004. Why social policy is condemned to a residual category of safety nets and what to do about it. In *Social Policy in a Development Context*. Basingstoke: Palgrave.
- Thampi, G.K., 2002. Corruption in South Asia, Insights & Benchmarks from Citizen Feedback Surveys in Five Countries. Transparency International Monograph, December.
- The Economic Times, 2012. Direct Plan Panel to give more money for Rashtriya Swasthya Bima Yojana: Mallikarjun Kharge to PMO. *The Economic Times*. 25 January.
- The Hindu, 2012. Activists to approach PMO on universal healthcare. *The Hindu*. 31 May.
- The Lancet, 2011. India: Towards Universal Health Coverage. *The Lancet*, 377(9761). Available at:

<http://www.sciencedirect.com/science/article/pii/S0140673612614858>
[Accessed March 8, 2013].

- The Lancet, 2012. The struggle for universal health coverage. *The Lancet*, 380(9845), p.859.
- The National Archives, 2013. Origins of the NHS. Available at: <http://www.nationalarchives.gov.uk/cabinetpapers/alevelstudies/origins-nhs.htm> [Accessed March 8, 2013].
- The Research Institute, 2012. RSBY–CHIS Evaluation Survey (Facility Level Survey to Assess Quality of Hospitals in RSBY Network & Post Utilization Survey of RSBY Patient Experience at Empanelled Hospitals in Kerala). Available at: <http://www.rsby.gov.in/> [Accessed March 9, 2013].
- Thomas, J.W. & Grindle, M.S., 1990. After the decision: Implementing policy reforms in developing countries. *World development*, 18(8), pp.1163–1181.
- Thomson, S., Foubister, T. & Mossialos, E., 2009. *Financing health care in the European Union: challenges and policy responses.*, World Health Organization. Available at: <http://www.cabdirect.org/abstracts/20093282958.html> [Accessed March 25, 2013].
- Tishler, C.L. & Bartholomae, S., 2002. The recruitment of normal healthy volunteers: a review of the literature on the use of financial incentives. *The Journal of Clinical Pharmacology*, 42(4), pp.365–375.
- TNHSP, 2009. Chief Minister Kalaingar Insurance Scheme for life saving treatments. Available at: <http://www.tnhsp.org/chief-ministers-comprehensive-health-insurance-scheme> [Accessed August 20, 2012].
- Tobin, G.A. & Begley, C.M., 2004. Methodological rigour within a qualitative framework. *Journal of Advanced Nursing*, 48(4), pp.388–396.
- Tsai, T.C., 2010. Second chance for health reform in Colombia. *The Lancet*, 375(9709), pp.109–110.
- UHC Forward, 2013. UHC Forward: Towards Universal Health Coverage. *UHC Forward: Towards Universal Health Coverage*. Available at: <http://uhcforward.org/about/uhc-forward> [Accessed March 6, 2013].
- UNDP, 2011. *Human Development Report 2011 Sustainability and Equity: A Better Future for All*, New York, U.S.A.: United Nations Development Programme. Available at: <http://hdr.undp.org/en/reports/global/hdr2011/download/> [Accessed September 7, 2012].
- UNDP, Global South-South Development Academy & ILO, 2011. *Sharing Innovative Experiences: Successful Social Protection Floor Experiences, (vol 18)*, UNDP, ILO, Special Unit for South-South Cooperation. Available at: [301](http://south-</p></div><div data-bbox=)

south.ipc-undp.org/library/successful-social-protection-floor-experiences.html [Accessed March 6, 2013].

- UNGA, 2011. Sustainable Health Financing Structures and Universal Coverage, Sixty-Fourth World Health Assembly, Agenda item 13.4.
- UNGA, 2012. United Nations General Assembly, Sixty-seventh session, Agenda item 123, Global Health and Foreign Policy. Available at: <http://www.un.org/News/Press/docs//2012/ga11326.doc.htm> [Accessed February 27, 2013].
- UNICEF, 2012. *Levels & Trends in Child Mortality, Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation*, New York, U.S.A.: United Nations Children's Fund (UNICEF).
- UNICEF, 2013. Picture in India: Nutrition. *UNICEF*. Available at: http://www.unicef.org/india/children_2356.htm [Accessed January 23, 2013].
- Van der Zee, J. & Kroneman, M.W., 2007. Bismarck or Beveridge: a beauty contest between dinosaurs. *BMC Health Services Research*, 7(1), p.94.
- Van Doorslaer, E. et al., 2007. Catastrophic payments for health care in Asia. *Health Economics*, 16(11), pp.1159–1184.
- Van Doorslaer, E. et al., 2005. Paying out-of-pocket for health care in Asia: Catastrophic and poverty impact. *Proyecto Equitap: Documento de trabajo*, 2.
- Van Doorslaer, E., Masseria, C. & Koolman, X., 2006. Inequalities in access to medical care by income in developed countries. *Canadian Medical Association Journal*, 174(2), pp.177–183.
- Van Meter, D.S. & Van Horn, C.E., 1975. The Policy Implementation Process A Conceptual Framework. *Administration & Society*, 6(4), pp.445–488.
- Vashisht, N. & Puliyeel, J., 2012. Polio programme: let us declare victory and move on. *Indian Journal of Medical Ethics*, 9(2), pp.114–117.
- Wagstaff, A. et al., 1999. Equity in the finance of health care: some further international comparisons. *Journal of Health Economics*, 18(3), pp.263–290.
- Wagstaff, A., 2002. Poverty and health sector inequalities. *Bulletin of the World Health Organization*, 80(2), p.97.
- Wagstaff, A., 2009. *Social Health Insurance Vs. Tax-financed Health Systems: Evidence from the OECD*, World Bank. Available at: <http://papers.ssrn.com/sol3/Delivery.cfm?abstractid=1331880> [Accessed August 26, 2012].

- Wagstaff, A., 2010. Social health insurance reexamined. *Health Economics*, 19(5), pp.503–517.
- Wagstaff, A. & Doorslaer, E.V., 2003. Catastrophe and impoverishment in paying for health care: with applications to Vietnam 1993–1998. *Health Economics*, 12(11), pp.921–933.
- Wagstaff, A. & Moreno-Serra, R., 2009. Europe and central Asia's great post-communist social health insurance experiment: Aggregate impacts on health sector outcomes. *Journal of Health Economics*, 28(2), pp.322–340.
- Waldron, H., 2007. Trends in Mortality Differentials and Life Expectancy for Male Social Security-Covered Workers, by Socioeconomic Status. *Social Security Bulletin*, 67(3), pp.1–28.
- Walker, L. & Gilson, L., 2004. 'We are bitter but we are satisfied': nurses as street-level bureaucrats in South Africa. *Social Science & Medicine*, 59(6), pp.1251–1261.
- Walt, G. & Gilson, L., 1994. Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy and Planning*, 9(4), pp.353–370.
- Ware, J.E. et al., 1986. Comparison of health outcomes at a health maintenance organisation with those of fee-for-service care. *The Lancet*, 327(8488), pp.1017–1022.
- Weiss, C.H., 1998. *Evaluation: Methods for studying programmes and policies* 2nd ed., New Jersey, U.S.A.: Prentice Hall.
- Weiss, L., 2000. Developmental states in transition: adapting, dismantling, innovating, not 'normalizing'. *The Pacific Review*, 13(1), pp.21–55.
- Westat India Social Sciences, 2010. *RSBY Beneficiary Experience Survey: Summary of Findings from the Feasibility Study*, New Delhi, India: Westat India Social Sciences. Available at: <http://www.rsby.gov.in/> [Accessed March 9, 2013].
- Whitehead, M., 1990. *The concepts and principles of equity and health*. Copenhagen: World Health Organization
- WHO, 1948. *Constitution of the World Health Organization*., Available at: http://www.searo.who.int/LinkFiles/About_SEARO_const.pdf [Accessed March 4, 2012].
- WHO, 1999. *The World Health Report 1999*., Geneva: World Health Organization.
- WHO, 2000a. *The world health report 2000 - Health systems: improving performance*, Geneva: World Health Organization. Available at: <http://www.who.int/whr/2000/en/index.html> [Accessed February 29, 2012].

- WHO, 2000b. WHO | The world health report 2000 - Health systems: improving performance. *WHO*. Available at: <http://www.who.int/whr/2000/en/> [Accessed February 29, 2012].
- WHO, 2005. Sustainable health financing, universal coverage and social health insurance. Available at: http://www.who.int/health_financing/documents/cov-wharesolution5833/en/index.html [Accessed February 10, 2012].
- WHO, 2006. *The World Health Report 2006 - working together for health*, Geneva: World Health Organization. Available at: <http://www.who.int/whr/2006/en/> [Accessed February 10, 2012].
- WHO, 2007a. Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action.
- WHO, 2007b. Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: World Health Organization
- WHO, 2007c. WHO Fact Sheet: Paying for Health Services, Fact sheet No. 320 / Social Health Protection. Available at: www.who.int/mediacentre/factsheets/fs320.pdf [Accessed February 23, 2013].
- WHO, 2010. *World Health Report 2010 - Health systems financing: the path to universal coverage*, Geneva: World Health Organization. Available at: <http://www.who.int/whr/2010/en/index.html>. [Accessed February 29, 2012].
- WHO, 2012a. Fact file on health inequities, World Conference on Social Determinants of Health. World Health Organization (WHO).
- WHO, 2012b. Mexico City Political Declaration on Universal Health Coverage: Sustaining universal health coverage: sharing experiences and promoting progress. World Health Organization
- WHO, 2012c. Process of translation and adaptation of instruments. Management of substance abuse. Research Tools. *World Health Organization*. Available at: http://www.who.int/substance_abuse/research_tools/translation/en/ [Accessed February 26, 2012].
- WHO, 2012d. Trends in maternal mortality: 1990 to 2010, WHO, UNICEF, UNFPA and The World Bank estimates. World Health Organization
- WHO, 2012e. *WHO Global Health Expenditure Atlas 2012*, Geneva: World Health Organization. Available at: <http://www.who.int/nha/atlas.pdf> [Accessed April 15, 2013].
- WHO, 2012f. *World Health Statistics 2012*, Geneva, Switzerland: World Health Organization. Available at:

http://www.who.int/gho/publications/world_health_statistics/2012/en/
[Accessed September 12, 2012].

- WHO-Europe, 2001. Poverty and health — Evidence and action in WHO's European Region. Available at: http://www.euro.who.int/_data/assets/pdf_file/0008/117476/edoc8.pdf [Accessed February 29, 2012].
- WHO-SEARO, 2004. *Regional Overview of Social Health Insurance in South-East Asia; (Annex 2: Health Insurance in India)*, New Delhi: World Health Organization, Regional Office for South East Asia.
- Wibulpolprasert, S. & Pengpaibon, P., 2003. Integrated strategies to tackle the inequitable distribution of doctors in Thailand: four decades of experience. *Human Resources for Health*, 1(1), p.12.
- Wilding, P., 2000. Exploring the East Asian welfare model. *Public Administration and Policy*, 9(2), pp.71–82.
- Wilkinson, M. & Moore, A., 1997. Inducement in Research. *Bioethics*, 11(5), pp.373–389.
- Wilkinson, R.G. & Marmot, M., 1998. *Social determinants of health: the solid facts*. Geneva: World Health Organization.
- Wilkinson, S.E. & Callister, L.C., 2010. Giving Birth: The Voices of Ghanaian Women. *Health Care for Women International*, 31(3), pp.201–220.
- Williams, B., 1994. Patient satisfaction: a valid concept? *Social Science & Medicine*, 38(4), pp.509–516.
- Wilsford, D., 1994. Path dependency, or why history makes it difficult but not impossible to reform health care systems in a big way. *Journal of Public Policy*, 14, pp.251–251.
- Woods, N., 2006. *The globalizers: the IMF, the World Bank, and their borrowers*, Cornell University Press. Available at: http://books.google.com/books?hl=en&lr=&id=hbE24GEtcl8C&oi=fnd&pg=PR9&dq=Woods,+Ngaire,+&ots=R-cXE3Ctff&sig=F_r9rp_Mx_oTulsWvvgg2hKZKB9s [Accessed March 23, 2013].
- World Bank, 1993. *World Development Report 1993: Investing in Health.*, New York: Oxford University Press. Available at: http://www-wds.worldbank.org/external/default/main?pagePK=64193027&piPK=64187937&theSitePK=523679&menuPK=64187510&searchMenuPK=64187283&siteName=WDS&entityID=000009265_3970716142319 [Accessed February 18, 2012].
- World Bank, 2004. *World Development Report 2004: Making services work for poor people*, Washinton D.C.: World Bank.

- World Bank, 2009. *World Development Indicators.*, Washington, D.C.: International Bank for Reconstruction and Development/World Bank. Available at: <http://data.worldbank.org/indicator> [Accessed February 9, 2012].
- World Bank, 2011. *Atlas of Global Development*, World Bank Publications.
- World Bank, 2012a. World Bank, Data & Statistics, Country Classification. *World Bank*. Available at: <http://go.worldbank.org/47F97HK2P0> [Accessed July 29, 2012].
- World Bank, 2012b. *World Development Indicators.*, Washington, D.C.: International Bank for Reconstruction and Development/World Bank. Available at: <http://data.worldbank.org/indicator> [Accessed February 9, 2012].
- World Bank, 2013a. Health Systems and Financing. *The World Bank*. Available at: www.worldbank.org [Accessed February 23, 2013].
- World Bank, 2013b. Universal Health Coverage Study Series. *The World Bank*. Available at: www.worldbank.org [Accessed April 15, 2013].
- Xu, K. et al., 2007. Protecting Households From Catastrophic Health Spending. *Health Affairs*, 26(4), pp.972–983.
- Yeates, N., 2002. Social politics and policy in an era of globalization: critical reflections. *Social Policy & Administration*, 33(4), pp.372–393.
- Yeates, N., 2008. *Understanding Global Social Policy*, Bristol: Policy Press.
- Yin, R., 2003. *Case study research: Design and methods*, Thousand Oaks, California, U.S.A.: Sage Publications, Inc.
- Yip, W. & Hsiao, W.C., 2009. Non-evidence-based policy: How effective is China's new cooperative medical scheme in reducing medical impoverishment? *Social Science & Medicine*, 68(2), pp.201–209.
- Zhou, Z. et al., 2011. New estimates of elasticity of demand for healthcare in rural China. *Health Policy*, 103(2–3), pp.255–265.

