RESEARCH ARTICLE

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IMPLEMENTING NATIONAL HEALTH INSURANCE IN INDIA: LESSONS FOR POLICYMAKING AND PRACTICE IN LOW-INCOME COUNTRIES

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Abstract

While the drive for universal healthcare is high on the policy agenda of developing nations, the models and approaches vary. This study explores service-provider and user experiences of one such scheme - India's recent national health insurance programme, Rashtriya Swasthya Bima Yojana-RSBY. It examines how the policy's design affects healthcare delivery and service use. The findings show that despite improved hospital access for some, shortcomings in the RSBY resulted in perverse incentives for medical provision and large unmet healthcare needs amongst users. It suggests that a focus on hospital-based care and private provision will pose challenges to expanding healthcare access. Moreover, policy design exercises a powerful and steady influence over health care delivery processes and hence its conceptualisation and subsequent development needs to be evidence based.

Keywords: health policy, developing countries, implementation, clinicians, patients

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1 INTRODUCTION

Universal health coverage (UHC) is high on the policy agendas of governments in developing countries and global health organisations [53]. World Health Organization (WHO) Director-General, Margaret Chan, recently observed that in the past decade governments have come to realise that health is not a 'drain on resources…(but) a driver of socioeconomic progress' [10]. Universal health coverage implies access to good quality health care for all those who need it without impoverishing medical costs [61]. Marking an important shift in global health financing debates from the 1980-1990s (which typically recommended user fees in public facilities in developing countries), international organisations like the WHO and World Bank are now advocating that healthcare services be mostly free at the point-of-delivery and funded through pre-paid risk pooling mechanisms. In the context of universalising health coverage, there is growing consensus that developing countries should focus on their most deprived populations who generally face worse health and poorer access to health-care services compared to other groups. In several low and middle-income countries, pre-pooled financing arrangements including social health insurance and targeted health insurance programmes for vulnerable groups are emerging as popular strategies for expanding service access. Colombia and Mexico have long-standing subsidised health insurance programmes for disadvantaged groups, China presently runs three separate insurance programmes for its rural and urban working and non-working residents and Rwanda and Ghana have scaled-up and integrated multiple community-based health insurance schemes under a common national system [58]. Aiming to improve medical access and prevent 'catastrophic health spending', India launched the Rashtriya Swasthya Bima Yojana (RSBY), a national health insurance programme for poor and vulnerable families in 2008. Each country experience provides important lessons on the governance, financing and organisational arrangements that aid the transition to UHC. This research examines RSBY's operation in India's capital, Delhi in order to assess if it was enacted in ways that achieved its goals and whether it benefited its clients by improving their access to hospital treatments and protecting them from high medical costs.

It is now well understood that how a policy is implemented affects its outcomes in important ways and that many programmes are often not delivered as intended leading to unexpected or undesired consequences [6][26][59]. In under-resourced settings, implementation of health care programmes face numerous additional barriers. A classic problem is one of poor central government management with inadequate resources, weak communication of policy objectives, poor incentives, and regulatory controls causing ineffective implementation [45][54]. Equally, local-level factors operating at the frontlines are also significant for the quality of service provision [9][55]. Organisational norms may induce health care providers to treat service users in negative or disrespectful ways [20] or manage stressful rationing of scarce resources by denying benefits to clients [1].

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This paper examines some of these issues by investigating both service providers' and benefit recipients' experiences of medical delivery through the RSBY in Delhi. In doing so, it seeks to add to emerging scholarship on health policy processes in developing countries by generating evidence on the instruments and mechanisms for delivering health policies in such contexts.

The research is informed by Walt and Gilson's [55] four-pronged 'actor-content-context-process' policy analysis model and an actor-centred 'responsive' [49] or 'constructivist' [25] evaluation approach. Walt and Gilson encourage that alongside the technical content of policies, the policy context, processes (policymaking and implementation), and actors (individuals, groups, organisations) as well as their inter-linkages be taken into account in assessing programme impact. Guba and Lincoln's [25] actor-centred, responsive approach requires that evaluation criteria for policies be based on 'issues' raised by multiple actors in the evaluation setting. It incorporates multiple stakeholders and looks beyond stated policy goals in order to derive more locally relevant benchmarks of a programme's performance. It is vital for understanding the drivers, barriers and general conditions under which policies are successful.

Accordingly, this paper focuses on the views and experiences of two key stakeholder groups: RSBY clinicians and RSBY patients. While patient satisfaction and fulfilment of needs and expectations are increasingly established as key criteria for evaluating the service quality in developed economies [19][37], user-driven assessments of healthcare quality are largely neglected research in the global South [2][43]. This is especially true for clients of social programmes like the RSBY who also happen to be poorer and detached from formal channels to relay their feedback to policymakers. Even as the number of formal evaluations and independent research on the RSBY grow, surprisingly few studies assess its performance from the standpoint of its users.

The following sub-sections provide a background on the RSBY programme, which is followed by Section 2 on the study's methods. Section 3 presents the Results and the paper concludes with a Discussion and Conclusion in Section 4.

1.1 Rashtriya Swasthya Bima Yojana (RSBY)

The RSBY is a government-sponsored quasi health insurance scheme targeted to India's designated below poverty line (BPL) population. Estimated to constitute 60 million, these are individuals living below a centrally determined income threshold that varies regionally. Aiming to protect recipients from 'major health shocks', the RSBY offers a 5-member household insurance coverage worth INR 30,000 (about $460) annually for hospital-based medical and surgical treatments. Outpatient treatments are not available through RSBY membership.

Designed as a classic money-follows-patients model, users can patronise any RSBY listed hospital of their choice. Private medical facilities are encouraged to participate alongside government hospitals, both of which

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stand to gain additional revenue from RSBY clients. Policy makers anticipate improvements in both the availability and quality of medical provision as facilities compete for RSBY patients [38] as well as a widening of patient choice [44].

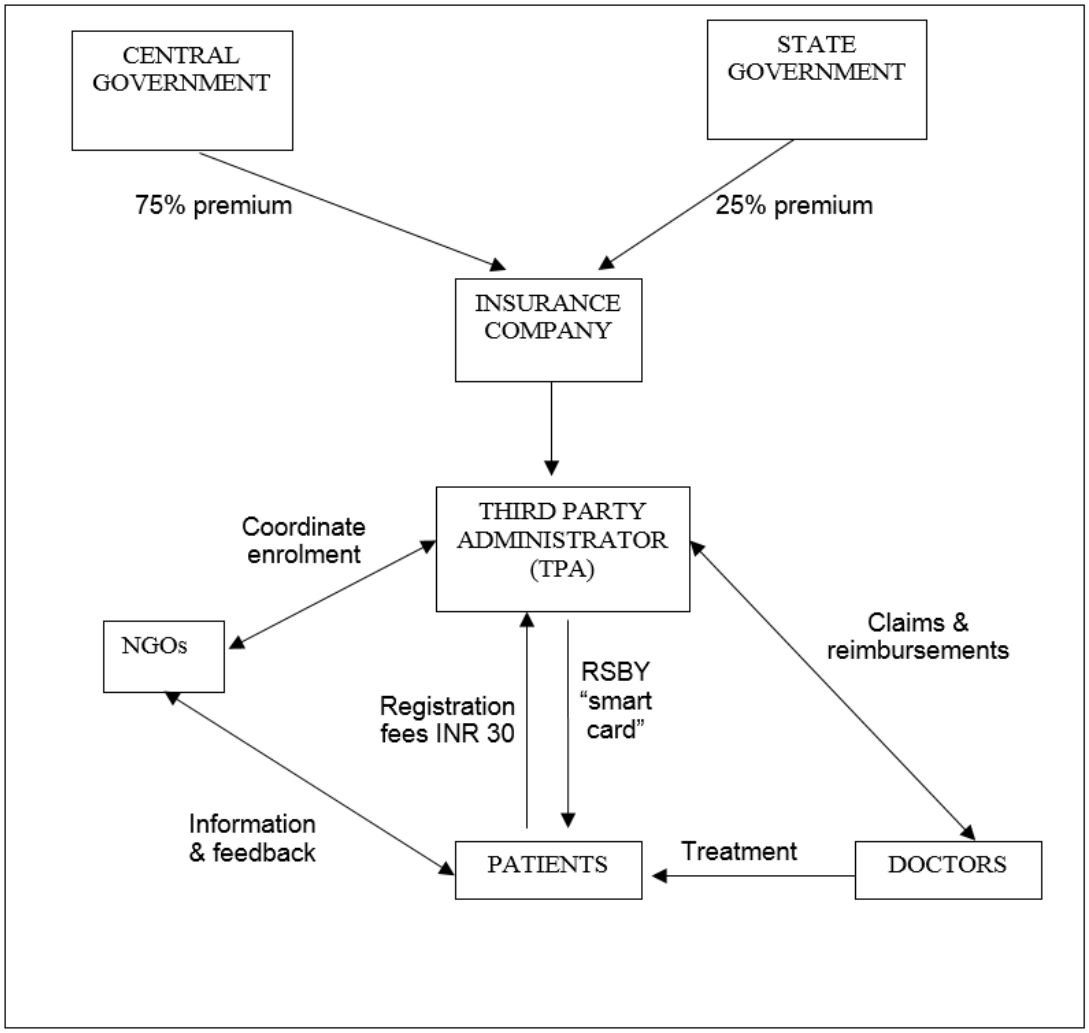

Figure 1 Key actors and processes in the RSBY.

Nationally, over 10,000 hospitals participate in the RSBY; about two-thirds of them private-sector facilities, over 36 million families are estimated to have RSBY coverage and over 9 million people are estimated to have utilised hospital treatments since the scheme began [38]. The RSBY is operational across 23 of India's 36 states and union territories.

1.2 How is the RSBY run?

A federal government programme, RSBY is managed by the national Ministry of Labour and Employment and its administration decentralised to local state governments. It is important to note that RSBY was couched in the context of a development strategy that justified social investment in health in

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terms of long-term productivity of the workforce, and was therefore located within the Labour Ministry rather than Ministry of Health. For their part, state governments contract an insurance company to run the RSBY and manage enrolments, hospital enlistments, transaction records and claim settlements (Figure 1). NGOs and grassroots organisations often assist insurance companies with benefit recipient identification and community outreach. The national government pays 75% of the RSBY premium and state governments contribute the remaining quarter. RSBY members pay an administrative fee of INR 30 (about 50 cents).

The initiative was intended to mitigate catastrophic health-related expenditure assumed to result largely from tertiary level hospital-based care [38] and designed therefore to specifically provide only hospital-based care to recipients. State authorities stipulated a medical package listing individual procedures and fixed tariffs. In Delhi, at the time of fieldwork, doctors were paid a per-diem allowance of INR 500 ($7.5) for non-surgical inpatient treatments, INR 750 ($11.5) for intensive care treatments (respectively, $20 and $40 in 2013) and different pre-fixed prices for individual surgeries. Eligible applicants are issued an ATM-like, RSBY 'smartcard' with their biometric details in order to 'pay' for treatment, thereby making it a cashless transaction for the patient.

Delhi was among the first three states in India to rollout the RSBY in April 2008. The state-contracted insurance company had in turn outsourced all RSBY operations to an authorised intermediary Third Party Administrator (TPA) agency. In 2009-10, the period studied, about 6 million families in Delhi's nine districts were targeted for RSBY membership. Although membership grew to over 200,000 registrations in 2009-2010 from 41,990 enrolees the previous year, over 60% of the target population in Delhi remained without RSBY coverage [47]. While national directives support the participation of both public and private medical providers, in the last five years only private sector facilities have enrolled with the RSBY in Delhi. According to discussions with state government officials during fieldwork, the omission of government hospitals in Delhi seemed partly to do with their lack of institutional capacity for managing RSBY funding as well their own reluctance to participate claiming to provide free services to the poor anyway [23].

2 METHODS

This study adopted a qualitative case design in order to better understand the processes and dynamics involved in the early stage of implementation and programme roll out. As with all qualitative research the concern was with identifying the contextual conditions favourable to certain policy outcomes rather than establishing causality between variables [33]. Although documentary analysis and observation were also employed, the findings mainly come from in-depth interviews with medical providers and users.

These findings form part of a larger study which focused on several features including the reasons for the choice and design of this particular model by policy makers and the practical challenges to rolling it out by

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government administrators/TPAs/insurance companies and NGOs. This paper reports the findings mainly from interviews with clinicians and service users. In late 2010, 38 clinicians, senior hospital administrators and TPA executives in Delhi selected through purposive and snowballing techniques, were interviewed. Situated across Delhi's nine districts, the majority of facilities in this study were small clinics or nursing homes with fewer than 20 beds 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. Facilities were generally located in residential areas, smaller clinics in both slum areas as well as richer neighbourhoods while both hospitals in this sample were located in middle-class Delhi areas.

Eighty-four benefit recipients (55 women and 29 men, over 18 years) most of whom had recently accessed RSBY hospitals for personal care or a family member's treatment were also interviewed. The sample for this study was purposively selected from across Delhi's nine districts. The typical criteria to be eligible for RSBY benefits in Delhi included both an income threshold in the case of below poverty line families as well as an additional set of non-income measures such as old age, disability, and insecure employment identifying those considered "vulnerable". Respondents, most of whom were married with children, 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.

Local NGO workers and occasionally doctors facilitated initial meetings with RSBY users, who in turn identified other recipients to interview. Interviewing ceased once 'saturation' was reached and no new information was forthcoming [8]. The majority of patient participants in this sample were married with children, lived in state-allocated public housing and slum colonies, and aged between early twenties to over 70. Similar to national trends on RSBY utilisation, commonly reported RSBY treatments among users in Delhi included routine treatments for fever, localised pain, gastrointestinal problems, ophthalmic procedures, and surgery for gall-bladder stones and gynaecological problems.

Study sites included 32 private hospitals, clinics, and nursing homes. Almost all were for-profit facilities, many of them small establishments with between 10-20 beds and owned by individual doctors. The two largest hospitals in the sample had over 50 beds and included a multi-speciality hospital and a charitable eye hospital. Facilities were identified from the official list of RSBY providers available from leaflets provided to new members during enrolment.

English and Hindi language topic guides were developed for providers and service users. Interviews with doctors examined their reasons for participating in the scheme, the anticipated impact on them personally (volume and nature of work, clinical autonomy, remuneration) and their general experiences of the RSBY. Service users were asked their views on

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RSBY benefits, experiences at enrolment centres and RSBY hospitals, observations about the program and satisfaction with its functioning. Interviews were tape-recorded, transcribed and when necessary, translated into English.

Data analysis was carried out iteratively, with concurrent data collection and analysis. Responses were categorised and coded using the NVivo 9 software programme and themes were developed in relation to the key research questions and constructivist evaluation framework. Service access and affordability for patients were key criteria to assess programme effectiveness given RSBY aims [38]. As fundamental health system goals, patient satisfaction and service quality were other important benchmarks for RSBY performance [4][28][60]. Quality was understood to include the infrastructure (structure), interpersonal procedures (processes) and self-reported treatment outcomes [17].

This study was approved by the authors' institute. Informed consent was obtained from all participants and all names have been anonymised.

Delhi was chosen as the case study site since it had relatively longer experience implementing the RSBY and was broadly representative of RSBY institutions, administrative arrangements, and delivery processes that are standardised nationally. However, as with qualitative research generally, the findings are specific to the time, place and individual respondents in this study [12][39]. Circumstances in Delhi may not represent events in other (especially non-urban) regions with a different public-private provider mix and patient demand patterns. This study focused on current RSBY recipients and not on eligible non-members who could not or did not join the RSBY. Their viewpoints will present a fuller assessment of the RSBY. Finally, since the focus of the study was on early programme delivery and utilisation experiences, further longitudinal research is needed to evaluate longer-term outcomes of service quality, health status and economic outcomes.

3 RESULTS

3.1 Private medical delivery: Who participated and why?

As indicated earlier, currently RSBY participation has not yet been taken up by any public hospital in Delhi but only available at private medical facilities. When asked to comment, TPA executives explained that since, in their judgment, state-prescribed RSBY tariffs and remuneration rates were unlikely to appeal to larger hospitals, they had only focused on enlisting smaller establishments in Delhi.

"In Delhi, there are 350 hospitals approximately…(We) contacted about 200 …small and medium kind… Costly hospitals will not easily agree with the package rate because they have higher luxury charges… air conditioners… the staff …is well-educated and well-trained…" (TPA Manager)

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Interviews with doctors suggested that they had primarily joined the RSBY hoping to boost their earnings through increased 'custom' from poorer clients and their extended families.

"... relatives of poor patients may be (sic) richer. I mean they can pay money... They pay me full amount. So I get indirect business also." (Doctor-1, Central Delhi)

Some doctors also welcomed the potential of a more diverse and interesting clinical case mix, citing that atypical cases with more complex medical problems were more prevalent among less affluent and disadvantaged communities as illnesses were left untreated for longer.

"It is giving us good exposure to different kinds of patients... This being a poor class since they were [previously] unable to go to a hospital ... we are [now] also getting an opportunity to see certain kind of unusual cases…" (Doctor-7, North Delhi)

3.2 Medical providers' views of RSBY benefits and payment system

Doctors universally felt that RSBY rates were unreasonably low and did not reflect the actual monetary costs of treating patients. They were especially frustrated with RSBY's INR 500 (about $8) per diem rate for treating general ward patients. Many doctors argued that as small establishments they often ended up having to spend personal resources hiring specialist consultants and accessing diagnostic services from outside.

"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 Delhi)

"... If you have a big, large set up…then you can definitely treat them at this price. But we are taking so many things on rent… so it adds to cost factor." (Doctor-4, South Delhi)

Although surgical procedures were reimbursed at a higher and fixed package price for each procedure, most providers were still frustrated about the extra costs and medical risks involved.

"We have a gall bladder surgery…for 10,000 rupees…There'll be a surgeon involved… an anaesthetist…1500, 2000 (rupees). Nobody is going to come at that rate!" (Doctor-3, Southwest Delhi)

RSBY doctors also felt it was unrealistic to have fixed package pricing for treatments because medical practice was not formulaic and based on quick, ready-made diagnosis. They argued that pre-set tariffs left little room for treating more complex cases requiring extra resources.

"Medical science does not go by one plus one equals two! There can be lots of variations... patient can have complications...They are comparing medical sciences with...vegetable buying..." (Doctor-5, North Delhi)

Doctors were also quick to point out that contrary to assumptions, they were not necessarily able to maximise patient volumes in order to make up for RSBY's low remuneration rates. Several providers highlighted their limited capacity to serve more RSBY patients based on their personal expertise and infrastructural resources.

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"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 Delhi)

Though doctors generally appreciated not having to undergo elaborate pre-authorisation processes with the insurer/TPA for treating RSBY patients (unlike other private insurance schemes) and found its transaction software easy to manage, nevertheless, many reported long delays in being 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.

"… 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 …this is the dark part of the scheme." (Doctor-4, South Delhi)

3.3 Doctors' response strategies and impact on treatment quality

Doctors discussed frankly the negative impact of low compensation rates on their treatment practices. Faced with low tariffs for RSBY treatments, several providers felt conflicted between matters of personal economy and patients' interests. However, they expressed their inability to frequently provide the best available care for RSBY users.

"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...how can you provide this? You cannot provide good services to the patient." (Doctor-2, West Delhi)

A sizeable number of medical providers also followed a firm pay-or-leave policy for patients needing outpatient services since RSBY recipients were only eligible for hospital-based 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, we'll ask him either to pay or allow him to go away (to) another hospital which can cater to this kind of problem." (Doctor-5, North Delhi)

Doctors also reported turning down non-surgery RSBY patients for whom they received a daily allowance of INR 500, protesting their inability to effectively treat patients within the pre-set per diem amount. Other providers adopted an approach of making a case-to-case assessment for treating RSBY patients. Depending on the reimbursement rate and their estimated transaction and overhead costs, they decided whether a patient was 'worthwhile' to treat.

"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 Delhi)

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At the same time, doctors also 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 reportedly made do with RSBY prices by persuading external consultants to subsidise their fees for users. However some hospital administrators also 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…But when it comes down to such type of patients… then the staff indirectly tell the doctors (that) this is a RSBY patient…" (Hospital Administrator-8, West Delhi)

Prompted by low remuneration rates, several doctors confirmed using fewer procedures and less-expensive, generic drugs and materials on RSBY patients.

"(For) a cash- paying patient I'd like to use the best available antibiotic in the market which is definitely a costlier one… (For) the BPL …I'd go for ...nominal or the normal antibiotic... which is also working…" (Doctor-4, North Delhi)

Some facilities rationed services by having a fixed quota of beds for RSBY-sponsored patients, rejecting additional patients if they turned up.

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

Respondents also stated that in order to economise on costs they would often arrange RSBY-related consultations and surgeries alongside scheduled appointments for other private patients. However, it was apparent that RSBY patients were typically not prioritised for treatment and could wait to be 'fitted in' between non-RSBY surgeries. Perversely, while rationing or diluting care on the one hand, doctors also at the same time acknowledged the pressures to 'over treat'. Some doctors candidly discussed hospitalising patients for longer in order to recover treatment costs, and others acknowledged having needlessly admitted ambulatory patients in order to treat them through the RSBY.

"Fifty % patients come for OPD (outpatient) purposes. I tell them, 'Look I'll only get paid if you're hospitalised'. So they get admitted…" (Doctor-1, South Delhi)

While there was evidence of 'mis-use' of hospitalisation by doctors and 'gaming the system', some of the pressure to over treat also came as a result of pressure from patients themselves. Some doctors admitted acquiescing to patient pressure and reported that when faced with patients' pleas or threats, they took recourse to hospitalising them. While accepting the undesirability of such actions, some felt this kind of flexibility was needed in order to be able to deliver on the RSBY.

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"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)

3.4 Patients' experience of RSBY services

In contrast to the many criticisms and shortcomings of the scheme articulated by providers, overall, patients reported quite high levels of satisfaction with RSBY membership, in particular with better availability of curative treatments and surgery. Several who had earlier experienced long delays at public hospitals found RSBY facilities by comparison quick to admit and treat them.

"Government hospitals... are always saying, 'Come back tomorrow. Come back in 15 days…' Then when I went again, they'd say they now had 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" (Male user-71)

Some patients welcomed spending less money at RSBY facilities than when previously admitted in local public hospitals where they had to purchase medical drugs and devices from outside.

"... We get medicines here [RSBY facility]. At [public hospital] we are told to buy medicines from outside... 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 paisa." (Male user-77)

Nevertheless, paralleling doctors' accounts of rationed services, some patients confirmed the feeling of 'diluted' care and often complained about the low quality of medicines given to them that had little effect on their ailment.

"What's there to say about their treatment! ... all that treatment involved was a saline drip with some vitamin…One pill in the morning and another in the afternoon…That's it!" (Female user-31)

The strongest complaint however centred on the perverse requirement that only hospital care was covered. Several patients reported that RSBY doctors had ignored their more routine health problems of fever, physical pain, and minor injuries and were deeply frustrated when doctors had said they could only treat RSBY patients for 'serious' or medical 'emergencies', or that they were asked to pay for outpatient services or refused treatment altogether.

"I've come for the second time. The first time… they said it couldn't be done…I was bitten by a dog… They said that this injury on my foot would get okay… (The nurses) said get 150 rupees then we will do an X-ray…So I came away quietly." (Female user-40)

Patients frequently reported having personally avoiding or foregoing RSBY services despite having needed medical attention since they were aware that it only provided hospital-based care.

"It's been many days since the card was made but I'm yet to use it. Once, I was terribly sick and bought medicines from outside… The biggest problem is that one doesn't get medicines (through RSBY) and has to be hospitalised." (Female user-28)

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Patient accounts also confirmed doctors' reports about needlessly extending hospital stays or substituting outpatient treatments with inpatient services by hospitalising patients for tests and investigations.

"I was hospitalised for two days but they had to make a discharge slip showing five days of hospitalisation… They keep the card to signify that the patient is still in hospital." (Female user-12)

Users discussed their desire to preserve and prioritise RSBY funds for 'big' and 'serious' illnesses. Hence, as the RSBY intended, such patients independently managed their need for ambulatory services and drugs.

"…why use the (RSBY) card for a small illness...one can always get better by having a 20-25 rupee pill…best not to use our 30,000 rupees… a major problem can occur in the future…" (Female user-54)

The distinction in treatment between surgery and general ward RSBY patients outlined earlier by clinicians was confirmed by users whom hospital authorities had told that higher-value surgery cases were entitled to more services than other RSBY patients were.

"… one does not get food, medicines, or transport… Only surgery patients get all this… When we asked, they said it is different for surgery patients and for our patient." (Male user-44)

Patients also highlighted the limited capacity within RSBY facilities. Some surgical patients were asked to obtain advanced diagnostic tests and CT scans from external providers, and other users reported treatment delays caused by hospitals needing to procure external specialists.

"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)…" (Male user-34)

4 Discussion & conclusion

As the linkages between improving population health and economic development become increasingly well established and health reform becomes a significant policy priority in the developing world [14][24][51], so lessons about the utility and workability of existing programs become more important for health policy makers in low resource settings. While there are no ready-made or 'best' solutions for universalising health care whether in India or another developing country, this study highlights the importance of critically engaging with key stakeholder groups such as healthcare providers and users when rolling out health reforms in order to better align programme design with policy goals.

The findings suggest that even at an early stage of roll out, RSBY had some positive effects on treatment availability and service quality for its users. According to patients, RSBY facilities in Delhi were quicker to treat and often more cost-effective than government hospitals had been. However, the RSBY's exclusive focus on inpatient care induced negative practices among participating doctors and users that effectively weakened RSBY effectiveness in reaching its goals. Not only did it incentivise needless or extended hospital

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stays for some patients, it also left a huge health care need unmet among several recipients who required only basic primary care medical treatments, medicines, and diagnostic tests and could not obtain these services through the RSBY. Besides the cost-inefficiencies induced by needless hospitalisation illustrated here, lack of early primary care treatment by RSBY patients also has negative financial implications for the health system more generally as many early-stage medical problems may have gone undetected, forcing patients to return to hospitals sicker and costlier to treat – as shown in the wider literature [50]. This finding is especially significant because contrary to the underlying assumptions of RSBY programme designers, there is evidence that frequent outpatient spending and not hospital-based care causes most medical impoverishment in India [7]. Given the relative recency of the initiative, little data yet exists about the medium-long term economic impact of the programme. However, a recent study shows that government-run schemes including the RSBY tend to encourage relatively higher spending on inpatient care by poorer beneficiaries with an increasing proportion of them now experiencing catastrophic spending on hospital-based care. Hence, in areas running the schemes not only did hospitalisation expenses rise much faster than outpatient spending overall (9.2% versus 4.5% from 2004-2012) but also 7.7% of poor households suffered catastrophic consequences as compared to 7.4% earlier (ibid.).

By making primary care facilities available to poorer patients, policies can help them find a regular source of care, which is related to better prevention/ detection, lower hospitalisations and costs. A recent review of global health systems and policies concluded that 'many disease can be treated at a primary care level' and that robust primary care clinics…have proven to be an effective platform for most interventions including reproductive, maternal and child health, infectious diseases and chronic conditions such as diabetes [51]. Research in another emerging economy, China, has similarly revealed the limited impact of policies offering hospital-based benefits in a context where people spend more on obtaining outpatient treatments for chronic problems [62]. Primary care oriented health systems also report higher user satisfaction and better health outcomes [3][15][32]. Recognising this, governments in other emerging economies such as Thailand, South Africa, and Brazil are (re)fashioning health policies so as to prioritise primary and preventative care for vulnerable groups in their bid to universalise health care.

Furthermore, RSBY's remuneration structure was such that it attracted mostly smaller and less equipped facilities in Delhi to participate whose strong commercial ethos acted as a further potential barrier to patient centred care. Providers were unwilling or unable to treat all eligible patients and medical problems and among RSBY clients, were more inclined to treat higher-value surgery patients over those needing general medical care. 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 [16][34][36]. 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

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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 [27][40].

Furthermore, these findings underscore the importance of an actor-centred approach to policy analysis for better understanding policy implementation processes and emerging outcomes [22][52][55]. The dynamics of RSBY implementation reveal that frontline actors shape policies in crucial ways, leaving some stated policy goals unfulfilled or causing negative side effects through their actions. The findings conform to existing literature on discretionary behaviours by 'street-level' frontline implementers when faced with institutional and environmental constraints during policy implementation [35][31]. As demonstrated, local-level implementers will often be in a position to affect 'who gets what, when and how' [18][29] and hence policies need to incorporate measures to minimise negative outcomes during programme delivery. Political pragmatism may have dictated that RSBY utilise the vast private health sector to deliver RSBY services although this was not intended to bypass either public hospitals or better-equipped private facilities. RSBY policy was short-sighted in not foreseeing such perverse outcomes when operating within a marketised system. Equally, the findings suggest that it will be important for policy makers to address the concerns of front line clinicians if it is to ensure successful implementation - not least given that all participating facilities in Delhi and nearly two-thirds of its approximately 10,000 hospitals nation-wide belong to the private sector [38]. Given the likely reliance on the private-sector providers to meet healthcare needs in the immediate term, Indian policy-makers will need to identify strategies to meaningfully engage and incentivise them to achieve the desired outcomes – a key challenge given the entrenched and deep-rooted market culture which encourages profit maximising behaviour.

Overall however it is clear that problems emerging in the RSBY resulted not only from the way that it was implemented but also stemmed from the programme's design – namely the emphasis on hospital rather than primary or community based care. While attention is increasingly paid to implementation as a key factor in successful policy outcomes, especially in low-and middle-income countries where human resource and infrastructure capacities are limited, it is important to recognise equally, that policy design exercises a powerful and steady influence over resulting outcomes and hence its conceptualisation and subsequent development needs to be evidence-based. Moreover, these findings are important since they contradict the methodological perspective that privileges certain voices or has concerns about the reliability of subjective views of a health service [5][56]. Our results demonstrate that programme recipients were well placed to identify important gaps in RSBY policy that limited its effectiveness. Service users revealed weaknesses in policy implementation and delivery of services and were in an especially good position to reveal various perverse incentives for doctors resulting from the RSBY's exclusive focus on hospital-based treatments. In a

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context of relatively less focus on the patient voice, these results assume greater methodological significance.

Finally, though completed at an early stage of roll out, the results here continue to be borne out by more recent, albeit limited, state-level studies of the RSBY which report similar problems including patient refusals or out-of-pocket expenditure on medicines [13][42] and limited provider capacity [11]. Formal evaluations also acknowledge the need to involve more public providers in the RSBY [21]. These findings also concur with the last government's Five-Year Plan (2012-17) noting problems with the RSBY's functioning including unchecked provider-induced demand, lack of primary and outpatient services, needless hospitalisations, and inattention to local health care needs, particularly regional differences in disease patterns [41]. While proposals to reform RSBY's benefit package by pilot-testing outpatient programs and extend outpatient benefits to select occupational groups (weavers) are therefore welcome steps, nevertheless, any future scale-up of this initiative still appears to be some way off. Hence, even as the present PM Modi led government announced a plan to allow better off groups to opt-into the scheme, an immediate focus is to again to raise the hospitalisation coverage from 30,000 INR to 100,000 rather than a more substantive shift to primary and first-level care [48]. It is important therefore that the results from studies such as this as well as further evaluation of the various pilot-programmes currently underway inform the future direction of this policy. In terms of medical provision, this study found that some private doctors in Delhi were open and willing to respond to RSBY's monetary incentives. While its remuneration structure at the time attracted mostly smaller facilities, recent upward revisions in doctor per-diems in Delhi may prove a draw for larger and better-equipped private hospitals. However, whether current increments and contracts will give providers sufficient incentive to attract more providers and to achieve a spirit of cooperation with system and patient centred values remains to be seen.

COMPETING INTERESTS STATEMENT

No competing interests.

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