Implementing Health Insurance: The Rollout of Rashtriya Swasthya Bima Yojana in Karnataka

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The National Health Insurance Scheme – Rashtriya Swasthya Bima Yojana – aims to improve poor people's access to quality healthcare. This paper looks at the implementation of the scheme in Karnataka, drawing on a large survey of eligible households and interviews with empanelled hospitals in the state. Six months after initiation in early 2010, an impressive 85% of eligible households in the sample were aware of the scheme, and 68% had been enrolled. However, the scheme was hardly operational and utilisation was virtually zero. A large proportion of beneficiaries were yet to receive their cards, and many did not know how and where to obtain treatment under the scheme. Moreover, hospitals were not ready to treat RSBY patients. Surveyed hospitals complained of a lack of training and delays in the reimbursement of their expenses. Many were refusing to treat patients until the issues were resolved, and others were asking cardholders to pay cash. As is typical for the implementation of a government scheme, many of the problems can be related to a misalignment of incentives.

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Poverty and ill-health are intimately related. The poor are often unable to smooth consumption across periods of ill-health (Gertler and Gruber 2002), and it has been argued that "catastrophic" health expenses are a major entry point into poverty across the world (Xu et al 2003). When asked, the poor confirm this: an extensive research programme undertaken across parts of India (Rajasthan, Gujarat and Andhra Pradesh) and Africa (Ghana, Uganda and Kenya) found that ill-health and health-related expenses were the most common reasons given by the poor for their own descent into, and inability to escape from, poverty (Krishna 2003, 2004; Krishna et al 2004, 2005).

Karnataka is no exception. Studies of informal-sector workers in the state show that health shocks are the most common form of household crisis (Rajasekhar et al 2006, Rajasekhar, Suchitra and Manjula 2007). These studies point out that across five categories of workers (agricultural labourers, construction workers, domestic workers, garment workers and incense stick rollers), 36-65% of households had experienced at least one emergency during a reference period of three years. Between 59% and 79% of the emergencies faced relate to health.

Government intervention seems warranted. But it is an open question whether the government should provide healthcare directly, empower the beneficiaries (e g, through vouchers) to obtain it from private providers, or enter into public-private partnerships with health providers and insurance companies. Designing and implementing large-scale public service delivery systems is notoriously difficult, as the Indian experience illustrates: after all, India is already supposed to have universal, free, publicly provided healthcare. In practice, the better-off pay for private health services, leaving the poor to live and die with the corrupt, low-quality and overburdened public hospitals. Research has shown that the poor spend considerable amounts of money on healthcare, both in the private sector and the supposedly free public sector. Private healthcare is not always high-quality: unregulated providers tend to offer low-quality care (Das and Hammer 2007).

Rashtriya Swasthya Bima Yojana (RSBY), an ambitious new public health insurance scheme for the poor, was conceived with these concerns in mind. It aims to improve the quality of health services available to the poor by making it attractive for private and public hospitals to provide care. By allowing the hospital to bill an insurance company for the cost of treatment, providing health services to the poor would be associated with hospital revenue. And by subsidising the annual premium, the government would make the scheme nearly free for beneficiaries.

Smart card technology would be employed for identification and control.

However, experience suggests that even the most carefully designed programme will encounter difficulties when implemented. Various actors will do their utmost to rig the scheme in their favour. Invariably there will be situations that have not been thought of in advance. And political forces may hinder the roll-out of any programme.

With a scheme on the scale and ambition of RSBY, it is clearly of great interest to monitor and evaluate its implementation. Large sums of money are being spent, and the health of enormous numbers of people is at stake.[1] Is the taxpayer getting value for money? What issues need to be addressed? What went well, and what lessons can be learnt?

This paper is motivated by such questions. It studies the implementation of RSBY in Karnataka, from the initial political and planning processes through the first six months of operation. The focus is on how the implementation was planned and to what extent the plan was successfully executed. The status of the programme after six months is evaluated by looking at three important measures of success: awareness of the scheme amongst the target population, enrolment in the scheme and utilisation.

These questions are addressed by analysing data collected from 3,647 eligible households across 222 villages in Karnataka. The households were randomly selected from the same list that was used to identify beneficiaries. The data were collected in the period June-August 2010. Later, in October 2010, key personnel from 39 RSBY-empanelled hospitals in the state were also interviewed.

In the next section RSBY is briefly introduced, with an emphasis on the design features that are intended to encourage take-up and utilisation. In the following section, the local political process and RSBY implementation plan is discussed. Thereafter the findings of the surveys are presented, along with an analysis of the actual implementation of the scheme. The conclusion suggests that many of the problems can be understood in terms of the incentives.

1 Rashtriya Swasthya Bima Yojana

RSBY was announced by Prime Minister Manmohan Singh in August 2007. The aim of the scheme is to "improve access of below the poverty line (BPL) families to quality medical care for treatment of diseases involving hospitalisation and surgery through an identified network of healthcare providers" (RSBY 2009).

The scheme provides for annual cover of up to Rs 30,000 per household. The policy covers hospitalisation, day-care treatment and related tests, consultations and medicines, as well as pre- and post-hospitalisation expenses, for some 700 medical and surgical conditions and procedures. Pre-existing conditions are included, as is maternity care, and there is a provision for transport allowance subject to a cap of Rs 1,000 per year. However, expenses related to outpatient treatment are not covered.

An insurance company, selected in a tender process, receives an annual premium per enrolled household from the government. The premium, which cannot exceed Rs 750 per household, is wholly subsidised by the central (75%) and state (25%) governments. The beneficiary household only pays an annual registration fee of Rs 30.

Each BPL household can register up to five members under the scheme. The names, ages, photographs and thumb impressions of enrolled members are stored on a smart card which is issued to the household. Beneficiaries can obtain cashless treatment by presenting the smart card at any participating ("empanelled") hospital. Hospitals are issued with the technology required to access the data stored in the cards. Treatment costs are reimbursed to the hospital by the insurance company according to fixed rates.

The scheme aims to improve poor people's choice of care provider by empanelling both private and public hospitals. There is also a provision for "splitting" a card so that migrant workers can avail of RSBY benefits from any empanelled hospitals in the country.

RSBY aims to provide incentives for all stakeholders and to promote transparency and accountability. It also has a number of features that are aimed at achieving high take-up and utilisation rates. Some of the most salient features are discussed below.

Enrolment: Targeting has been a consistent problem in Indian poverty alleviation programmes. RSBY seeks to overcome this by asking the state governments to provide the insurance company with data on eligible (BPL) households. In earlier schemes, insufficient publicity and a lack of prior notice regarding the dates of enrolment have come in the way of widespread coverage. RSBY aims to overcome these problems by requiring that a road map for the enrolment campaign in all the villages in a taluk or district will be prepared in advance, and that advance notice of the enrolment team's visit should be given in each village.

A list of eligible households is to be posted prominently in the enrolment station or village by the insurer. The aim is to enable households to establish in advance whether they are eligible for the scheme, so that they can plan whether to be present when enrolment team visits the village. Smart cards should be issued on the day of enrolment. A local government official should be present in order to facilitate the identification of beneficiaries in the presence of the insurer. The Rs 30 annual registration fee is unlikely to deter many households from registering.

Utilisation: On-the-spot issue of smart cards allows the households to utilise the scheme right from the day of enrolment. The insurance company should provide the enrolled household with a pamphlet containing the following information: (a) a list of participating hospitals; (b) a summary of what is covered under the policy; and (c) a toll-free telephone number in each district from which information on hospitals and benefits is available.

The Rs 30,000 level of cover is likely to be sufficient for a majority of households in a given year. Primary studies from Karnataka show that, on average, a poor household spends Rs 20,000 on hospitalisation each year (Rajasekhar, Berg and Manjula 2009). The wide cover provided by RSBY should make it attractive to utilise it: most pre-existing conditions are covered, and there is a provision for reasonable pre- and post-hospitalisation expenses. The scheme is intended to be completely

"cashless" so that no outlay is required from the patient. A smart card based system facilitates identification of beneficiaries and processing of client transactions. Apart from the smart card, the beneficiary does not have to present any documents. There is a transport allowance of Rs 100 per event of hospitalisation, subject to an annual ceiling of Rs 1,000. A "split card" provision aims to encourage utilisation by the migrant workers and their families.

2 Implementing RSBY in Karnataka

In Karnataka, RSBY is administrated by the department of labour, while at the district level it is the responsibility of a committee under the deputy commissioner. The committee has members from the departments of rural development and panchayati raj (RDPR), health, education, women and child development, urban development and public information. The committee also consists of a high-ranking police official, a measure taken in anticipation of disputes over eligibility. The district's senior-most labour officer serves as the member-secretary of the committee and is referred to as the district key officer.

Following a tender process, the National Insurance Company was selected as the RSBY insurance provider in Karnataka with an annual premium per household of Rs 475.28. The tender document lists the procedures and conditions covered under the scheme.

Several issues needed to be resolved before RSBY could be implemented in the state. One of them was the question of eligibility. Since the lists of BPL households in urban areas were not readily available, it was decided to implement RSBY only in the rural parts of the selected districts in the first phase. The central government asked the state government to use the list of households obtained from the BPL survey undertaken by the RDPR in 2003. However, it was feared that this might lead to problems for two reasons: First, households identified by the food and civil supplies department for the distribution of ration cards are also widely referred to as BPL households in rural areas, and this might lead to confusion about eligibility. Second, the RDPR list is widely perceived to be rife with false positives (inclusion of non-poor households) and false negatives (exclusion of poor households). It was feared that offering free health insurance to apparently non-poor households would result in loud and even violent protests by the excluded poor. For this reason, the state initially wanted to provide RSBY benefits to all BPL ration cardholders, accounting for a much higher proportion of the population than those included in RDPR list. However, it became clear that the central government would only subsidise the insurance premium for BPL households identified by the RDPR. The issue caused significant delays. Only after the return of the United Progressive Alliance government in Delhi did the state government agree to implement RSBY using the RDPR list.

A second hurdle was a "turf war" between government departments in Karnataka. The health department objected to the assignment of the programme to the labour department.

A third issue was that the state government was keen to implement its own brand of health insurance scheme for the poor, called Vajpayee Arogyashree. It was argued that implementing both programmes would lead to wasteful duplication. However, the central government argued that since RSBY provides for secondary healthcare, whereas the focus of Vajpayee Arogyashree is on tertiary healthcare, there would be no significant duplication. In the end it was decided to implement Vajpayee Arogyashree only in northern districts, while RSBY was implemented in five districts located in other parts of the state.[2]

Before the launch of the programme, three third party administrators[3] were appointed between the five districts, and a smart card provider was chosen for each district. The process of empanelling private and government hospitals was also started. However, the number of hospitals empanelled by the end of 2009 was small, and initial interest came mainly from private hospitals.

In December 2009, a state-level workshop was held in which key stakeholders and district-level officials (deputy commissioners and labour officers) discussed the scheme and its implementation. District-level workshops were also held in December 2009 and January 2010 with the purpose of finalising district implementation plans including enrolment road maps.

In the state-level workshop, the understanding was that the insurance company would conduct and bear the cost of awareness campaigns. It would provide wide publicity about the scheme by distributing leaflets, placing posters at prominent places in the villages and so on. Hospitals would be requested to conduct health camps once the enrolment process was complete. While some participants in the state-level workshop argued that district administrations should engage local non-governmental organisations (NGOs) in creating awareness of the scheme, others suggested the use of village-level government staff such as anganwadi teachers, gram panchayat secretaries and school-teachers. Some participants argued that anganwadi teachers were already overburdened, but others suggested that they might be willing to help if provided with a monetary incentive. In the end, the question of how to create awareness was left to each district administration.

Households would be enrolled as follows. A road map would be drawn up with the date and venue of enrolment camps for each village, and the details would be communicated through gram panchayat secretaries, anganwadi teachers, etc. On the day, an enrolment camp would be set up at a prominent place such as a school building or the gram panchayat office. A village-level official (called field key officer), a representative of the insurance company and a representative of the third party administrator would be present. The village-level official would identify the beneficiary household, after which photographs and fingerprints were to be taken of the household head and up to four other household members. In order to overcome problems posed by power shutdowns and computer/printer breakdowns, a backup computer, printer and power supply would be available at each camp. Smart cards were to be distributed to beneficiaries on the day of enrolment, along with a pamphlet containing details of the programme and a list of empanelled hospitals.

3 The Status of RSBY in Karnataka

The process of enrolling households began in four of the districts in February 2010 and in the fifth district in March 2010. By early 2011, the total number of households enrolled in Karnataka was

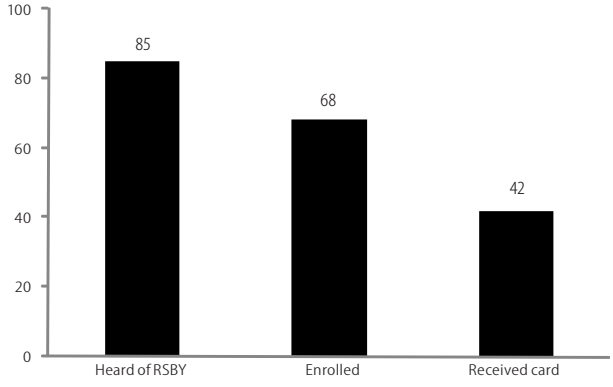
1,57,405. In all, 179 hospitals had been empanelled, out of which 63% were private.[4]

In this section, the status of RSBY in Karnataka is examined based on a survey of a randomly selected sample of 3,647 eligible households in Karnataka as well as a separate survey of 39 empanelled hospitals in the state. The analysis focuses on three aspects of the scheme's implementation: awareness, enrolment and utilisation.

3.1 Awareness

In response to the question "Have you heard of RSBY – national health insurance for poor people?" 85% of eligible households in the sample answered that they had (Figure 1). This may be considered quite an impressive result.[5]

Figure 1: Awareness and Enrolment (Proportion of eligible households, in %)



Still, complete awareness was not achieved, and this may be related to varying degrees of coordination at the district and taluk level. Several departments including revenue, rural development and panchayati raj, women and child development and health were all directly or indirectly involved in the awareness campaign, in addition to the insurance company, the third party administrator and the smart card provider. Generally, it is our observation that good coordination between these departments and actors in a given district resulted in smooth provision of information, while poor coordination in a district would result in confusion.

Inadequate awareness amongst intended beneficiaries is a problem common to many government initiatives. Creating awareness has often been given low priority in past programmes, leading to low uptake and poor utilisation. Recently, however, more emphasis has been given to information, education and communication (IEC) activities in the design of such schemes in India. This was the case with RSBY, for which it is explicit that the "state government should take necessary steps for improving the awareness level by organising different activities like health camps, etc, through state nodal agency (SNA) or authorising the SNA to hire civil society organisations/NGOs/experts to improve awareness and to facilitate access to health services".[6]

The aggregate level of awareness hides substantial variation across the districts, and this is plausibly related to the different approaches taken in creating awareness. At least two different models were in operation. One was to use anganwadi teachers.[7] These were invited to a meeting and briefly informed of the scheme. Each teacher was given a village-wise list of eligible BPL households and was asked to provide these with information about RSBY benefits and encourage them to sign up. The anganwadi teacher was asked to tell them when and where enrolment would take place. In order to speed up identification and enrolment, she was also asked to give each eligible household a preprinted slip with the names of all household members, which the household should in turn submit to enrolment officers on the day of enrolment. She would be paid Rs 2 per enrolled household. Although it appears that the anganwadi teacher did not in practice provide very good information on objectives and range of benefits to eligible households, the system of spreading the information on who is eligible, and the date and place of enrolment worked very well. There are several reasons for this: First, the anganwadi teachers with their regular activities relating to Integrated Child Development Services and self-help groups often already knew the eligible households and had won their trust, especially the women. Second, the incentive of Rs 2 per household is likely to have been a significant motivator for anganwadi teachers whose salaries are around Rs 2,500 per month.

The other main type of awareness-creating arrangement was to ask the secretary or bill collector of the gram panchayat to inform eligible households of the scheme. In some villages, information was provided through "tom tom".[8] This appears to have worked less well, for several reasons: First, in these villages the households were not given slips with their names. Second, the enrolment date and venue was not always determined in advance. Even where it was planned ahead of time, the dates were in many cases subsequently changed without notifying the households. Third, the gram panchayat secretary did not have as good a network as anganwadi teachers for the purposes of providing information.

3.2 Enrolment

In the survey, 68% of eligible households report having registered for RSBY (Figure 1). Although one might have expected an even higher enrolment rate given the apparent attractiveness of the benefits and low cost to the household (Rs 30 per year), this still seems like quite an achievement for a new programme of this kind.

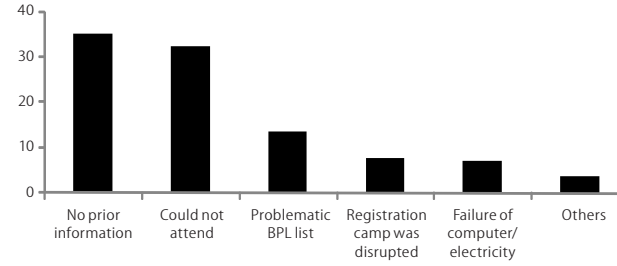
In almost all villages, enrolment took place either at the government school building or gram panchayat office, typically depending upon the distance of the village from the gram panchayat office. However, the location seems to have been determined with a view to a target number of households to be covered per enrolment session, rather than the convenience of beneficiary households. Households often needed to go to another village in order to enrol. In some cases, households were asked to attend an enrolment camp located in a neighbouring gram panchayat. Another problem was that local festivals or cultural events were not considered when fixing the date.

A road map should have been prepared in advance for each taluk. The plan was to be communicated to village-level officials for onward communication to eligible households. However, in many taluks this did not happen. In some cases there was a road map, but it was not communicated to the village-level officials.

There were cases where local officials began informing eligible households about the scheme only after the enrolment officers had arrived in the village.

The survey shows that 17% of eligible households did not enrol even though they had heard of the scheme. The contributing factors (Figure 2) were as follows:

Figure 2: Reasons for Non-Registration (% households)



No Prior Information: An important reason for not registering was a lack of advance notice on the date, time and venue of registration. Insufficient information was a problem in a significant proportion of the sample villages. As per the design of the scheme, households that failed to register during their local enrolment camp would have two other ways of doing so. The first is a taluk-level registration camp. The second is at the district RSBY office,[9] where the registration should be possible at any time. However, these measures were often not available or communicated despite repeated enquiries about late enrolment from eligible households.

Inability to Attend the Enrolment Session: An important reason for failing to register into the scheme was being unable to attend the enrolment camp. Some households were away on wage work or in the fields. This does not seem to be because they perceived that the foregone income from wage labour was higher than the likely benefits from the RSBY. The qualitative evidence shows that these households were under the impression that they would be able to enrol in the late afternoon or the following day, which was not the case. Others were unable to enrol because they were away from home on the day of enrolment for reasons such as the death of relative, hospitalisation or attending a wedding.

Problematic BPL List: There were problems with the enrolment team's list of eligible households, such as: (i) Erroneous names of household members. (ii) The head of the household was missing from the list, resulting in the whole household being refused. This is in spite of the fact that there is a provision to enrol households by registering another member as the head. (iii) In some cases the head of the household was ill or deceased, resulting in the whole household being prevented from registering.

Computer or Power Failure: As per the guidelines, the enrolment team should bring back-up computers and power supply so that the enrolment process would not be held up or disrupted because of computer breakdown or power failure. This did not always happen, with the result that some were unable to register. In these cases it was promised that the enrolment team would return in order to complete the registration process, but this did not happen.

Disruption at the Registration Camp: As noted earlier, the RDPR list suffers from both exclusion of poor households and inclusion of non-poor households. The government was aware of this and made a provision to include the superintendent of police into the implementation committee at the district level to ensure that the enrolment process would proceed without disruption. Whenever the local administration suspected that disruption might occur, it called for police support and completed the process.

Our survey team found that in practically every village, some people were provoked by the inclusion in the list of individuals generally perceived not to be poor. Angry residents approached enrolment officers to question the provision of benefits meant for the poor to the relatively wealthy. In several cases, the officers attempted to pacify residents by telling them that the list was constructed in 2002-03, that the government is aware of its deficiencies, and that there would soon be a new survey to identify the poor. In some cases, there were clashes, sometimes preventing enrolment from taking place on the scheduled day. The enrolment teams did not return to these villages to complete the enrolment process.

In several villages, it was reported that names of some of the household members appearing on the slip handed to the anganwadi teacher, were missing from the enrolment team's list of household members. Our team was able to verify that, in many cases, individual names appearing under a household in the original RDPR BPL list were not on the enrolment team's list. It should be noted that this is advantageous to the insurance company since the premium paid by the government is entirely based on the number of household cards issued, irrespective of the number of individuals enrolled per household, whereas only individuals listed on the card can obtain treatment under the scheme.

3.3 Possession of Smart Cards

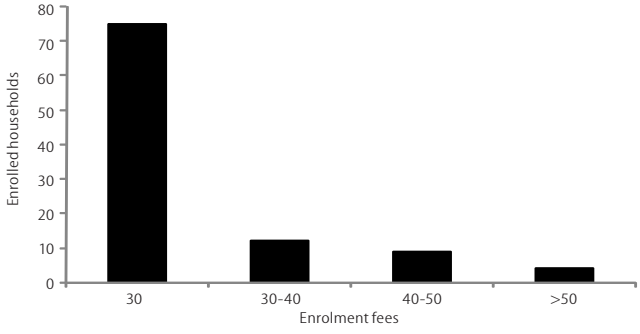
There were extreme delays in the issue of smart cards. According to RSBY guidelines, smart cards should be issued on the spot, immediately after registration. In most places this did not happen, and a full 38% of enrolled households had still not received their cards at the time of the survey conducted during the period of June to August 2010 – about five to six months after the policy has commenced.

Therefore, at least 38% of registered households did not benefit from RSBY in the first six months. Given that the insurance period is only one year, the effective policy period is, therefore, reduced by half or more, depending on when the cards actually arrive. The insurance company stands to gain from households that are enrolled without being able to obtain treatment, because it collects the premium without incurring any treatment costs. Following the initial failure to issue cards on the day of enrolment, nodal agencies do not appear to have followed up to see whether the delayed cards were in fact issued later.

In a large majority of these cases, it appears that the cards had not been issued by the provider. However, there were also reports that some gram panchayats had received smart cards, but did not distribute them to the households. In some cases, gram panchayat officials linked the delivery of cards to the payment of house tax, water user fees, etc. In other cases, local officials had asked for money for giving out the cards and the households had decided that getting the card was not worth the extra cost.

This is further corroborated by Figure 3. Only about 74% of the enrolled households paid the exact amount of Rs 30 as the registration fees. The remaining households paid something in addition, ranging from Rs 5 to as much as Rs 250. The qualitative data show that smaller additional amounts (Rs 5-20) were typically paid to anganwadi teachers or gram panchayat secretaries, while larger sums of about Rs 100-200 were typically paid to rectify minor mistakes such as erroneous names of household members in the list.

Figure 3: Distribution of Enrolled Households (%) by Amounts (Rs) Paid for the Enrolment



3.4 Utilisation of the Scheme

Six months after enrolment and the start of the policy period, only 10 out 3,647 sample households (0.4% of enrolled households) had utilised the card to obtain treatment. We will never know how many would have used the scheme if it had been implemented fully as intended, but the inclusion of pre-existing conditions may in itself have warranted a much higher rate. There are several factors behind this low utilisation rate, including non-delivery of smart cards and insufficient knowledge about how and where to obtain treatment under scheme.

Another reason was the low number of health camps. The evidence shows that the number of health camps conducted by the insurance company or the nodal department was low until about September 2010. Moreover, these camps were mainly organised at taluk headquarters. Naturally, health camps conducted only at the taluk headquarters would not have been able to attract the majority of cardholders.

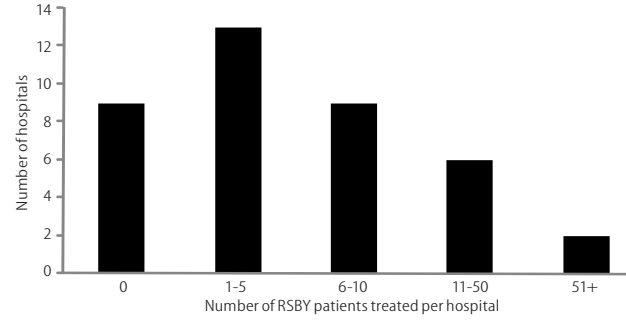
Another important determinant of utilisation is the level of preparedness of the network of empanelled hospitals. Since some of the card-holding respondents reported that they had tried to obtain treatment under RSBY at an empanelled hospital, but had been rejected, further investigation was warranted.

How Ready Are the Empanelled Hospitals? RSBY beneficiaries cannot utilise the scheme unless hospitals are ready to receive them. In October 2010, data was collected from 39 empanelled hospitals in Karnataka to assess the situation.

Participation Period: Of the surveyed hospitals, 15 had been empanelled for less than four months (since June 2010 or later), and a further 16 hospitals had been empanelled for less than six months (since April 2010 or later). Thus, nearly 80% of the hospitals in the sample were empanelled well after the enrolment of households. When enrolment took place in February-March 2010, only very incomplete information on participating hospitals could have been made available to the beneficiaries. In many areas the realistic choice of RSBY hospitals at the time of enrolment would have been very meagre.

Number of Patients Treated: The picture of a scheme that is hardly operational is confirmed by interviews with the empanelled hospitals. Nine out of 39 hospitals surveyed (23%) had not treated any patients under RSBY at all (Figure 4). In a further 22 hospitals, the total number of RSBY patients treated since empanelment was less than 10 each. Only two surveyed hospitals reported having treated more than 50 patients each under the RSBY scheme by the end of September 2010.

Figure 4: Distribution of Empanelled Hospitals by Number of Patients Treated



It does not appear that recent hospital empanelment is the main reason for low utilisation: When the 39 hospitals are split into those that have been part of RSBY for at least six months and those that are more recent, the pattern for both groups is similar to that of Figure 4. Except for the "zero patients" category, where there are more newly empanelled hospitals, it does not appear that longer experience with scheme is associated with a higher number of RSBY patients treated.

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It may be that there is simply no demand for RSBY, due to problems on the beneficiary side as described above. But even if there was a demand, many hospitals admitted that they would not treat patients under RSBY. The reasons fall in two categories: technology-related and reimbursement-related. Both are made worse by an inadequate communication between the hospitals, the third party administrator and the insurance company.

Problems with Smart Card Technology: All the surveyed hospitals reported that the required technology to operate RSBY (computers with internet connection, card readers and software) was present. However, most of them reported problems with using it. The most commonly cited problems were: (a) Training in the operation of the technology had been insufficient or not provided at all. (b) The technology was not properly installed or malfunctioning. According to one hospital, repeated requests to look into this matter did not yield any response from the third party administrator in the district. (c) The information stored on some smart cards was incorrect or of low quality, including incorrect fingerprints, photographs of such low quality that they could not be used for identification and errors in personal data. One hospital reported that a pregnant middle-aged woman approached them for RSBY treatment, but according to her card she was 13 years old.

Problems with the Reimbursement System: The intention behind RSBY was that it should provide treatment that is not only free, but also "cashless", meaning that the patient should not have to make any outlays to be refunded later. The cost of the treatment should be booked directly onto the card, and the insurer would pay the hospital accordingly. The reimbursable rates are fixed for a large number of individual procedures, and for many common procedures there are "package rates" which gives a single overall rate for the total hospital bill including treatment, medicines and tests.

The hospitals reported serious problems with the reimbursement system.

Delays: Hospitals reported delays of up to *six months* in settling the submitted bills. One doctor said that his hospital has withdrawn from the scheme due to these irregularities. A staff member from another hospital noted that "we have not yet (October 2010) received payment for the treatment provided in May 2010".

Reduced Amounts: In some cases the hospitals were reimbursed only a fraction of the submitted bill.

Non-contracted Caps on Duration and Cost of Treatment: A doctor from one hospital noted that "[we] are being instruc ted that the patients should not be admitted for more than one day. They are also indicating the maximum cost that can be booked".

Many hospitals argued that contracted treatment rates are too low. However, the rates should have been known to them when they signed up for RSBY.

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The breathtakingly rapid economic growth in China since 1978 has attracted world-wide attention. But the condition of more than 350 million workers is abysmal, especially that of the migrants among them. Why do the migrants put up with so much hardship in the urban factories? Has post-reform China forsaken the earlier goal of "socialist equality"? What has been the contribution of rural industries to regional development, alleviation of poverty and spatial inequality, and in relieving the grim employment situation? How has the meltdown in the global economy in the second half of 2008 affected the domestic economy? What of the current leadership's call for a "harmonious society"? Does it signal an important "course correction"?
A collection of essays from the *Economic & Political Weekly* seeks to find tentative answers to these questions, and more.

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Windows of Opportunity

By K S KRISHNASWAMY

A ruminative memoir by one who saw much happen, and not happen, at a time when everything seemed possible and promising in India.
K S Krishnaswamy was a leading light in the Reserve Bank of India and the Planning Commission between the 1950s and 1970s. He offers a ringside view of the pulls and pressures within the administration and outside it, the hopes that sustained a majority in the bureaucracy and the lasting ties he formed with the many he came in contact with. Even more relevant is what he has to say about political agendas eroding the Reserve Bank's autonomy and degrading the numerous democratic institutions since the late 1960s.

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The problems with technology and reimbursements are so severe that many of the interviewed hospitals threatened to leave the scheme. Some have already formally withdrawn, while others simply refuse to treat patients under RSBY. Amongst those that do treat patients, it is common to charge the patients on top of what is booked on the card. It appears to be a common practice to ask patients to pay upfront and tell them that (some of) the outlay will be repaid to them if and when the hospital is reimbursed by the insurer.

One doctor observed that shortcuts are being made without regard to the consequences for the scheme as a whole. This is compounded by a lack of communication; hospitals do not know where to turn to resolve the questions and problems they have.

Conclusions

It is clear that RSBY has some attractive features and the potential to make a big difference to the lives of the poor. Awareness and take-up of the scheme have reached impressive levels in Karnataka.

But the scheme's implementation in the state is marred by serious problems, to the point where it was hardly operational halfway into the first policy period. The most important problems discussed in this paper are: delays of several months in the issue of smart cards; poor knowledge of how and where to utilise the scheme; hospitals not trained to use card-reading technology; and month-long delays and arbitrary caps in the reimbursement of treatment expenses to hospitals. These problems had led many hospitals to stop accepting patients under the scheme.

Based on the evidence presented in this paper we make the following observations:

First, coordination between the various departments entrusted with the implementation of RSBY needs to be improved. It appears that the level of organisation was much greater in districts where the district collector took an active personal interest in the scheme and its rollout.

Second, hospitals were recruited (empanelled) late in the process. The attention paid to proper installation and training of hospital staff in the use of the necessary technology has been inadequate. There is an urgent need to improve communication between hospitals and the other actors.

Third, many of the problems discussed can be related to misaligned incentives. The insurance company is clearly incentivised to enrol as many households as possible into the scheme in order to collect the premium from the government. Enrolment represents revenue for the insurer. Hence, making the insurer responsible for scheme enrolment was a good idea, and this may explain high levels of awareness and take-up.[10] However, the insurer is *not* currently incentivised to encourage utilisation in any way, since that only leads to costs from its point of view. Thus, the insurance company is not incentivised to ensure that card details are correct, that cards are issued without delay, that beneficiaries know how and where to obtain treatment or that hospitals are prepared and ready to receive patients. Ideally, these tasks should be overseen by actors who stand to benefit directly from high utilisation. If the treatment rates (i e, package rates) are high enough to be attractive, the hospitals themselves are the obvious candidates for these tasks. Ultimately, the challenge is find a mechanism that allows beneficiaries to achieve some control. A choice of alternative insurance companies and the resulting competitive pressure is one option. Alternatively, the payment of premium to the insurance company could be withheld until the beneficiaries have received their card and have successfully used it to pay for an initial health check at a participating hospital. The role of local governments and NGOs would be important given that the beneficiaries are poor and often uneducated.

RSBY has great potential to improve the welfare of the poor and help fulfil the vision of an inclusive development path for India. However, in the present situation we fear that many current beneficiaries in Karnataka will find that renewing the card, even at Rs 30 per year, is not worth the cost.

NOTES

1 As on 9 February 2011, RSBY is active in 60% of Indian districts, covering 22.8 million households.

2 The five RSBY districts are Bangalore rural, Belgaum, Dakshina Kannada, Mysore and Shimoga. The original plan was to include Gulbarga, too. However, in this northern district RSBY was eventually dropped in favour of Vajpayee Arogyasree.

3 Third party administrators are responsible for enrolling beneficiaries, issuing smart cards, liaising with hospitals, settling claims of healthcare providers and creating awareness.

4 These figures were obtained from the official website of RSBY (http://www.rsby.gov.in/ accessed on 5 January 2011).

5 These are self-reported figures, but it is unlikely that respondents had anything to gain from not telling the truth.

6 http://www.rsby.gov.in, accessed on 23 December 2010.

7 Anganwadi teachers, linked to the Department of Women and Child Development, combine roles of health worker and preschool teacher.

8 A musical instrument used in villages to pass on information to people.

9 According to the RSBY guidelines, "the enrolment process shall continue at designated centres agreed by the government/nodal agency after the enrolment period is over to provide the smart card for remaining beneficiaries".

10 Note, however, that since the premium is paid per household rather than per individual, the insurer is *not* incentivised to ensure that as many household members as possible are included in the scheme.

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