DETERMINANTS OF CONTRACT PERFORMANCE IN SOCIAL SERVICES: LINKING IMPLEMENTATION GOVERNNACE TO INSTITUTIONAL DESIGN

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Key Messages:

- Though institutional design and implementation of social health insurance programs have received attention, but there is little understanding about the interaction between them in determining performance.
- Implementation governance needs to be aligned with the institutional designs in order to achieve the desired effect from the institutional design. If not aligned it accentuates weakness in institutional design.
- Other Social health insurance programs can learn from experience of RSBY in tailoring their implementation in order to be more effective, however there is a limit to which implementation governance can address gaps in institutional design.

Key Words: Social Health Insurance, Institutional Design, Implementation Governance, Opportunism, Rashtriya Swasthya Bima Yojana (RSBY)

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Abstract

Research on performance of social health insurance programs have either focused on institutional design - rules regarding revenue collection, pooling and purchasing or implementation- power imbalances, street level bureaucracy, inter organisational relationships, but rarely examined both factors simultaneously. As a result, we know very little about the dynamic relationship between institutional design and implementation governance and its consequent impact on performance. This paper explores the role implementation governance plays in relationship with institutional design in determining performance in case of National Health Insurance Program (RSBY) in India. RSBY, delivers medical insurance to around 41 million low income families in 28 states, through a conglomeration of private, public and non-profit agencies. Using a comparative case study approach, based on data from in-depth interviews (51), field observation (5), administrative records and documents, this study analyzed variation in the performance across three jurisdictions having similar institutional design but differences in implementation governance. The similar institutional design controlled for commonly known determinants of performance-contract design, administrative process, capacity and resource availability. This provided distinctive opportunity to examine the interaction between institutional design and implementation governance and resulting variation in performance. As institutional design always have some gaps, implementation governance is expected to address the opportunistic behavior arising from their incompleteness. In different contexts, similar institutional design poses different opportunities and threats and therefore requires an implementation governance that aligns with its need. An appropriate implementation governance addresses the gaps in institutional design, encouraging agents to capitalise on opportunities and manage threats during implementation leading to outcomes that are in line with a policy's objectives. But a dysfunctional implementation governance inflated even smaller weakness in institutional design leading to serious performance issues. Thus, social health insurance programs need to tailor implementation governance that aligns with institutional design in a given context.

INTRODUCTION

Globally with 150 million population facing catastrophic health expenditure and 100 million driven into poverty due to health expenditure has seen unprecedented attention to universal coverage and reforms of health financing systems in developing countries in last decade (Vega 2013). Many countries are reforming their existing health insurance programs, merging them and finding ways to move towards universal health coverage. Need to improve effectiveness of existing health insurance programs and coherence among various programs is receiving attention (Wagstaff 2010). In order to improve effectiveness, institutional design of the health insurance programs have been examined predominately (Reich et al 2015, McIntyre and Kutzin 2016; Liu et al 2014). Studies have specifically focused on - resource collection (Jowett et al 2016; Yates, 2016), benefit package design (Penteli & Ginneken 2017), purchasing (Hanson 2014) and payment mechanisms (Atuoye et al 2016). Policy implementation (Gilson et al 2014; Mathaeur and Carrin 2011) is also getting prominence as even the well-designed health financing arrangements fail to achieve their intended outcomes (Agyepong et al 2011) and lead to adverse effects (Ridde et al 2014). But studies have rarely examined both institutional design, policy implementation and interaction between them in determining effectiveness of health financing arrangements.

North defines institutions as "formal and informal rules, enforcement characteristics of rules and norms of behavior that structure repeated human interaction". Institutional design and their enforcement along with, actors, context, characteristics of goods and services and interactions between them finally shapes the incentives of actors (Ostrom 2005).The actors rationally pursue their interests, making strategic choices (Peng. et. al., 2009) and this pattern of interaction determines performance of governance system (Ostrom 2005). A given transaction between two agents is shaped by multiple layers of institutions (Williamson 2000). At most basic level is contract design –that is rules regarding task allocation, output specification, payment mechanisms, and residual rights allocations. These ex-ante incentive alignment may fail and therefore parties in contract frame set of ex-post governance rules. These rules regarding contract governance include – bilateral procedures for resolving disagreements, contractual safeguards, and supervision and coercion mechanisms. The rules related to contract design and contract governance are further influenced by the institutional environment- rules related to contract enforcement and dispute redresal system. These include web of public enforcement mechanisms-organization of courts, judiciary, the legal profession, enforcement services and process of law making (Hadfield 2005). Finally, informal institutions- social norms, customs and traditions either support \reinforce institutional environment or replace\undermine them (Grzymala-Busse, 2010)

Contracts are always incomplete as rules may missing, conflict with each other and interpreted differently. Unique characteristics of healthcare pose additional challenges in designing effective contracts. Information asymmetry, outcome uncertainty, and dependent outcomes limit measuring appropriate deliverables in healthcare contract and tying them with payment mechanisms that allocate risks appropriately (Robinson, 2001). Further contracts may not be enforceable completely specially in developing country context due to limited regulation in health sector and in-effectiveness of formal institutions. In developing countries health sector are generally under-regulated with limited or no regulation regarding entry, quality, price, distribution and competitive practices (Kumaranayake et al 1998; Sheikh et al 2015). In addition, Information asymmetry between consumers, providers and payers further limits enforcement of contracts as all stakeholders tend to exploit the information advantage which are difficult to detect and monitor by other parties. Agents in pursuit of self-interest violate either explicit or implicit norms of contract demonstrating opportunistic behavior. Opportunism reduces performance; increases transaction costs (bargaining, monitoring and mal-adaptation), reduces trust, satisfaction, motivation and increases conflict between parties

(Hawkins, 2008; Caniels et al., 2012). Even when the opportunistic behaviors are detected, litigation cost, ineffectiveness of contract law and poor third party verifiability limits use of legal dispute resolution mechanisms (Gow et al 2000). Further lack of trust in formal institutions, corruption further undermines effectiveness of formal institutions (Gryzmala-Busse, 2010). Thus ex-ante institutional arrangements are bound to provide prospects for opportunisms more so in case of healthcare context in emerging economies. Governance during implementation fills this gaps in ex-ante institutional design (Williamson 2005). Governance during implementation consists of formal governance mechanisms- monitoring, authority, penalty and informal governance mechanisms- reciprocity, trust and relational norms.

A number of empirical reviews have identified implementation governance as one of the key factors influencing performance in case of social services contracting (Fernandez, 2009; Romzek and Johnston, 2005; Amirkhanyan and Lambright, 2007, 2011). Studies in health financing arrangements have examined institutional design (Liu et al 2014; Bertone and Messen 2012; Reich et al 2015; Takian and Doshmangir 2015) and specific aspects of implementation (Agyepong 2011; Gilson et al 2014; Ridde et al 2013; Bertone and Witter 2015) but have rarely examined implementation governance, and its interaction with institutional design in determining effectiveness of these arrangements.

Controlling opportunism, a dimension of program performance in multi-organizational arrangements is considered as most importance function of Implementation governance (Williamson 2000; Hawkins et al 2008). Social Health Insurance programs are generally multi-agency effort and therefore this study uses control of partner opportunism as a measure to assess effectiveness of implementation governance. Generally implementation governance is designed before the start of the relationships, but "self-interested individuals with guile" (Williamson, 1985 P 47) will find creative ways to avoid fulfilling their contractual obligations. Also as implementation progress, risk of opportunism in a transaction may change due to environmental turbulence, increase in complexity of transaction and variation in context (Olander et al 2010). Therefore implementation governance need to be adapted in order to align them with the risk in transaction in order to effectively govern the transaction (Williamson 1985). However, organizations need to have ability to adapt governance and power imbalances may limit the ability of the organization to do so (Hart, 2003; Simon, 1995). Recently Matheur and Carrin 2011) has proposed a framework for assessing effectiveness of health financing arrangements which includes implementation governance along with institutional design. However Matheur and Carrin (2011) framework as well as studies based on that (Ahmed et al 2013; Annear et al 2013) consider implementation governance as a static concept wherein the organizational practices need not be adapted based on the changes in the nature of transaction to be effective. However this paper argues that as nature of transaction changes, it poses different set of opportunities and threats. Partners need to adapt governance matching with risks in transaction in order to mitigate conflict and realize mutual gain. If the adapted governance aligns with the needs of transaction, it fills the gap in the institutional design and induces order by empowering agents to capitalize the opportunity and overcome threats during implementation. On the other hand if governance is not aligned with the need of the transaction, this incongruence accentuates the gaps in the contracts, facilitating opportunistic behaviors by partners. An appropriate implementation governance reduces opportunism and thus increases performance in an inter-organizational context. Thus implementation governance mediates the effect of institutional design on program performance. This study demonstrates, this mediating role of implementation governance a case of social health insurance program in India-National Health Insurance Program also known as Rashtriya Swasthya Bima Yojana (RSBY).

RSBY: Institutional Design and Implementation Framework

Government of India launched RSBY in 2008 to address lack of health insurance coverage which drove around 40 million people in India to poverty every year due to catastrophic

healthcare expenditure (Selvaraj and Karan, 2009). As of March 2016, RSBY program covered around 41 million below poverty line (BPL) families earning less than one dollar per day and other vulnerable groups in unorganized sector, in 482 districts across 29 provinces, i.e. states. The program is primarily funded through general taxes and provides cashless hospitalization up to 460 USD per year, for families voluntarily enrolled in the program through a network of 12000 hospitals (both public and private) across India. The program is implemented through a conglomeration of agencies from both public and private sector with district as the unit of implementation.

Insert Table 1 & 2 Here

Table-1 provides the institutional design of the program based on Matheuer and Carrin (2013) framework whereas Table -2 lists various agencies involved in the program implementation and their roles. Both central and state government contribute to funding in the ratio of 75:25. The contribution by the beneficiary is limited to 0.5 USD as registration fee thus the program is 100% pre-paid. The premium per family for each district is decided through a competitive bidding process among technically qualified insurance companies (IC) and lowest quote is awarded the contract by State Nodal Agency (SNA) an agency dedicated to manage the scheme. The IC is expected to provide health insurance coverage up to 460 USD per annum for a family of five on a family floater basis.

Insert Figure-1 here

Figure-1 provides the Implementation Framework of the program. The central government steers the scheme, and controls the design and implementation of the program primarily through the contract document between IC and SNA which is a principle implementation document. This contract includes terms of relationship between IC and SNA as well as all other agencies, IC may engage to deliver services. The contracted IC may further sub-contract Smart Card Services Providers to enroll the beneficiary and Third Party Administrators to create a network of qualified hospitals and manage claims. Though the IC may sub-contract with other agencies to deliver the services but ultimate responsibility lies on them. The State Government nominates department from District Administration (DA) and field level officers to support IC in during implementation.

The families who are in the state BPL lists or specific vocation groups can enroll in the program and receive a bio-metric smart card containing demographic details of family members and list of empanelled hospitals. Enrolled beneficiary, when falls sick can visits any of the empanelled hospital and access services using smart card. Providers at the network hospital provide cashless services as included in the benefit package. The benefit package covers all conditions including pre-existing disease and maternity cover categorized into 1500 packages. A package includes all expenditures during hospitalization, limited pre & post- hospitalization expenditure as well as transportation expenditure. The providers get paid on the basis of pre-defined fixed rate per package .Providers submit claims through an online claims database and IC is required to make decision on claims within 30 working days. On suspicion of fraudulent activity, IC can start an investigation and if found guilty can initiate process of dis-empanelment of concerned hospital after taking necessary approval from the DA. The inputs, process and role of various agencies in enrolment of beneficiary, empanelment\de-empanelment of hospitals and claims management has been explicitly defined. Monitoring is done based on data submitted by agencies.

Materials and Method:

All implementation units in RSBY have same contract design, administrative structure and implementation process. This unique design of program controlled the critical determinants of

program performance, allowing to tease out the mediating role of implementation governance using a case study methodology. Process tracing within a case was used to map out institutional design and implementation governance. Cross-validation and generalization was done using comparative case analysis.
The framework of Matheur and Carrin (2011) was used to map institutional design, identifying specific rules to health financing function. First the formal rules related to three health financing functions – resource collection, risk pooling and purchasing and governance mechanisms that in put in place to ensure compliance were mapped. For this, a series of documents were reviewed that outline the rules related to scheme. This was followed by a series of preliminary interviews with core team (5) and field level agencies (4) to get insight on how these rules work in practice. Mapping revealed incompleteness of institutional design- incomplete rules, Incompatible rules, missing supporting conditions\rules -, incentives\disincentives to organisations\individuals and various opportunistic behaviours they drive.

The second stage of analysis, focused on interaction between institutional design and implementation governance. As all jurisdiction have similar institutional design, there states were selected based on the variation in implementation governance (explanatory variable) to make causal inferences whether it leads to variation in performance that is extent of partner opportunism (dependent variable) as suggested by King Kohen and Verba (2004, Pg 140). In each of the states, a district, implementation unit of the program, was selected as all implementation units have the same institutional design. This made data collection manageable. Within the district, data was collected from all stakeholders through semi-structured interviews (42) and field observations (6) yielding data with high informational content so as to generate an in-depth understanding of the implementation governance from different perspectives. This qualitative data (interviews/observations) was complemented with secondary data which included data provided by agencies and ministries, reports, published and unpublished articles, data published on official websites and newspaper reports. For mapping implementation governance, implementation structure, contextual factors, inter-organizational relations were was mapped during four stages of the program implementation- planning, enrolment of beneficiary, empanelment of hospitals and claims management. In order to understand interaction between institutional design and implementation governance, study traced the governance mechanisms used by stakeholders for prevention and control of all instances of opportunism that resulted\could have resulted because of gaps in institutional design as identified earlier. This revealed how dynamics of implementation governance influences behaviour of agents who are trying to exploit the opportunities and constraints imposed by institutional design. Impact of governance mechanisms on each opportunism provided the information about extent to which governance dynamics were effective in filling the gaps in institutional design and thus aligned with the nature of transaction they governed.

In the third step a comparative case analysis across three states was done to map out similarities and differences in implementation governance and program performance allowing to infer about the role it plays in determining performance. Linking gaps in institutional design with variation in implementation governance, and variation in performance across three states allowed to infer about the mediating role of implementation governance.

Results & Discussion:

This section first provides gaps in institutional design and proposed governance mechanisms as given in the program design. Next, the paper describes how implementation governance varied in practice and how this impacted performance. This is followed by a comparative analysis of implementation governance and resultant impact on performance in three states -

Himachal Pradesh, Punjab, and Uttar Pradesh, linking variation in implementation governance with variation in performance.

Link between Institutional Design and Implementation Governance

Insert Table 3 Here

Table 3 present's various rules, threats they pose and governance mechanisms proposed to address them as per program design. IC is contracted through a competitive bidding, based on premium per family. Second this premium per family is tied to number of beneficiary enrolled rather than healthcare service utilization. Thus complete financial risk of health service utilization is on IC. Therefore IC have incentive to focus on enrolment of beneficiary and control healthcare utilization as it reduces their profit margins. Further there are no performance incentives in empanelment of hospitals, healthcare utilization, and claims management. Given strong incentive to reduce healthcare utilization, Insurance Company may not do quality enrolment\ making beneficiary aware about the program, empanel limited hospitals or hospitals of poor quality, and reject claims on trivial reasons. Thirdly profit oriented private hospitals given fixed price package rates may induce demand to increase revenues and provide low quality care to reduce cost.

To address the gaps in institutional design a number of governance mechanisms are included in the program design. Monitoring of the program is done through analysis of data on beneficiary enrollment, hospital empanelment and claims management, predominately in terms of quantity and to some extent on quality dimension. Apart from the data, the monitoring is done through regular meeting and field visits. At National level, a monthly meeting of national level nodal officers of the insurance companies is done and at state level review meetings (including Insurance companies) are held in each state once in six months to review progress and discuss issues in implementation. Field key officer and district administrators are required to monitor implementation through regular field visits. In addition, some states State nodal agencies have employed field level officers to monitor progress. Contract document includes set guidelines for each and every process and implementers are expected to adhere to the contract. Agencies are expected to work as a "team and facilitate and support each other in performing." In the case of problems, stakeholders are advised to "sit together discuss and seek a response from the agency" (Interview with Core Team). In case of dispute agencies are expected to use a three tiered internal grievance redressal mechanism rather than the formal judiciary. The defaulting agency may not be contracted again and can be debarred for bidding in the scheme. If a severe problem arises midway, the contract can also be cancelled.

Interaction between institutional design and Implementation Governance

Effective implementation requires compliance by the key stakeholders - IC, DA, SNA and hospitals. The incentive and constraints imposed by the institutional design are further shaped by context-informal norms, industry dynamics-, implementation dynamics-implementation structure, inter-organizational relationships- and interaction among them. A favorable implementation governance and contextual factors filled the gaps in institutional design leading to high performance whereas unfavorable implementation governance was found to have pernicious effect on the institutional design lowering performance.

The program deign describes inputs, and process in extensive details but as outputs, outcomes and quality is vaguely defined and not measured, process compliance is stressed during implementation. For processes compliance, program design entrusts DA and SNA to supervise and monitor activities of IC and hospitals and prevent adverse outcomes. The SNA and DA also chair the grievance committee at respective levels giving them authority to ensure the compliance. However, DA and SNA have limited incentives to perform. In fact they have

incentive to behave opportunistically because of uncompetitive public sector salaries, limited advancement and pressures from top to be corrupt (Vaishnav and Khosla 2016).

Though there is a three tiered grievance reddresal system but as these committees have no legal sanctity, "no legal power and legal sanctions can be put except non-renewal of the contract for defaulting private sector agencies."(Interview Core Team). In case of opportunism by public functionary, no penalty has identified so far. Further, the beneficiaries of the programs, given low literacy levels and high transaction cost in using the system have not aired their grievances so far either against hospital or IC.

Insert Figure 2 Here

One of the important aspect of implementation governance is implementation structure. As shown in the figure 2, the critical relationship at district level is between DA, IC, SNA and hospitals. Enrolment is critical for IC as their revenue depends on number of families enrolled. IC is needs support of DA for approval of enrolment plan and making Field Key Officers available without whom enrolment can't be done. IC also needs support of DA for managing disputes during enrolment due to poor quality enrolment lists. DA's role is to facilitate implementation activities but DA tends to exploit this dependence of IC and engages in rent seeking in various forms. DA's position as arbitrator for disputes at the district level further increases power imbalance between them.

One of the common forms of rent seeking by DA is to pressurize IC to empanel their favored hospitals. DA\ SNA can only suggest hospitals to IC but empanelling a particular hospital is ultimately prerogative of the IC. But due to dependence of IC they get veto power in empanelment of hospitals. A number of hospitals have sprung up in rural areas exclusively designed and customized for RSBY patients to capture the money coming from public purse (Reddy et al., 2011; La forgia and Nagpal, 2012). Anecdotal evidence suggests that many of these hospitals are either related to district administration or collude with DA to get empanelled in the program even if they do not qualify (Asher et al 2015; Maurya, 2015). Once empanelled, these hospitals engage in extensive fraudulent claims.

Subtle opportunistic behaviors by private hospitals are common in Indian health insurance market. Private hospitals deliver most of the care (around 60% of the all inpatient care as per National Sample Survey Organization, 2004),but have limited regulation in terms of infrastructure and almost no regulation when it comes to quality and cost of service delivery. Private hospitals have been found to exploit the information asymmetry in healthcare extensively by inducing demand more so especially in case of insured patients (Bhat 2005; Bearing Point, 2008) and in rural markets where the possibility of second opinion is limited (Desai,2009). In case of RSBY, hospitals are paid on basis of predetermined package rates. These packages are not well defined, not scientifically priced, priced much lower than market rates in general, and do not take into account co-morbidities and covers only hospitalization care (La Forgia and Nagpal 2012). This incentivizes providers to induce care which is further facilitated by lack of cost-consciousness among beneficiaries due to absence of co-payment. Providers turn ambulatory care into hospital based care, select higher paying packages (DRG Creep), and provide low quality care service and select low cost cases (cream-skimming). Providers also provide only part of package or engage in informal payments in order to cover the cost. Hospitals which are under immunity of DA, engage in more blatant fraudulent behaviors like ghost patients, colluding with beneficiary to make claims without providing services and claiming multiple packages.

In India health insurance industry is still very small (health insurance comprises around 6.1 percent of total insurance business) and a loss making segment (net insurance claim ratio was 102 percent in 2015 (IRDAI 2015). Lack of regulation, absence of standard treatment

guidelines, and limited penetration of health insurance limits control on hospitals. ICs have not build their capacity to manage claims and have traditionally relied on unethical approaches to control cost (Bearing Point 2008). Further in RSBY because of high volume of claims, and lower fees (as explained later) , claims monitoring system is more geared towards detecting blatant cases-fraudulent claims- rather than subtle opportunistic behaviors- like DRG creep and supply induced demand, expected to be more common. Even if the fraud is detected and brought to the notice of district grievance committee, DA being chair of district grievance committee interferes in their dis-empanelment providing immunity to errant hospitals.

According to the program design, IC has no formal contract with DA but the roles of both agencies are well defined. Due to lack of formal contract, IC cannot exercise any direct influence on DA. However, in case of non-compliance by DA, IC could approach SNA responsible to ensure compliance by DA. SNA vary in their motivation to control DA and ability to exercise hierarchical control on DA. In some states DA is under direct hierarchical authority of SNA but in others DA could be from different department and SNA may lack any control whatsoever on them. In case of non-reddresal of their grievances, IC can approach higher authorities like National Nodal Agency, which can exercise indirect hierarchical control on DA through SNA or State level government. However relationship between SNA and National Nodal Agency varies across state from very collaborative to a hands off approach. State governments also vary in their support towards RSBY implementation, from very active support in some states to very lackadaisical approach in others. Further DA being public servants, cannot be fired, in case of non-performance, limiting effectiveness of control exercised by SNA and\or State Government.

The induced demand by private hospitals have significantly contributed to claims ratio and in many states the claims ratios have surpassed 100% (Ministry of Labor and Employment 2014). Districts with hospitals under immunity of DA have witnessed claims ratio to the extent of 700%. Unable to control fraudulent hospitals, IC resort to counter opportunistic behaviors to control claims ratio. These include suspending hospitals so that they cannot file claims, delaying claims payment and paying lower than the claimed amount. Therefore genuine hospitals which already have high client load, due to lower package price, claim rejection due to frivolous reasons and delayed claims payment leave, leaving predominately fraudulent hospitals in the hospital network. The fraudulent hospitals anticipating opportunistic behaviors by IC submit inflated and fraudulent claims. Foreseeing possibility of opportunism these hospitals even collude with enrolment agencies and audit agencies to get smart cards of enrolled beneficiaries even before they reach beneficiaries. This leads to a vicious cycle of opportunism and counter-opportunism.

As engaged in fraudulent behavior, DA do not monitor and complain opportunistic behaviors of IC or Hospitals during enrolment and claims management. Also if IC anticipates fraudulent behavior by DA (as commonly expected in states with high corruption in public services) they behave opportunistically during enrolment and claims management to control hospitalization. During enrolment, they may not include details of all family members, do not distribute cards on the spot, and provide incomplete information about accessing benefits\ network hospitals. However adverse selection and cream skimming was not found during enrollment (Das and Leino 2011). During empanelment, they empanel few hospitals, avoid facilities that are popular among beneficiaries or located in remote places. In claims management, they reject claims on trivial reasons, delay payment of claims and dis-empanel hospitals without proper investigations. Thus fraudulent behavior by DA induces other agencies to behave opportunistically. This breakdown of implementation governance accentuated weakness of institutional design leading to extensive opportunism and reduced effectiveness of the program.

Variation in Implementation Governance leading to variation in performance.

Most of the factors that influence implementation for example competition between agencies , population characteristics, incentive structure in the contract, characteristics of the agencies, implementation process, institutional environment, resource allocation are controlled because of the unique design of the program. Thus, based on the design, limited variation in performance is expected though extensive variation in performance was observed. Table 4 presents comparison of performance in three selected states. A comparative analysis of illustrates implementation governance as a critical determinant of variation in performance.

Insert Table 4 Here

Table-4 presents the overview of the three states. On one extreme is Himachal Pradesh, a high performing state with lowest level of frauds in RSBY, received awards for enrolment of beneficiaries and utilization of services. The state is also economically developed with low corruption in public service, and high level of human development. One the other extreme is Uttar Pradesh, low performer with extensive frauds observed in the scheme. The state is economically less developed with low level of human development and high corruption in public service delivery (Paul *et al*., 2004). Between these two extremes is Punjab, a moderate performer in program with some frauds. The state is economically developed but lags in social development. In the following paragraphs we discuss how the variation in implementation governance determined the performance of the program in respective states.

In Himachal Pradesh, the program is managed by an autonomous agency under department of health with very few staff. IC being from inception of the program shares a close relationship with state government. State government keen to improve performance, actively participated in the planning and implementation of the program. There was considerable pressure on DA to facilitate implementation resulting in limited dependency of IC on them. DA being from department of rural development, had limited connection with private hospitals. State government ensured full autonomy to IC in hospital empanelment. Thus DA lacked any veto power in hospital empanelment. State government strongly favours public hospitals and more than 90% empanelled hospitals were from public sector providing limited opportunity for collusion to DA as public hospitals did not pay any rent to get empanelled. Also in order to keep the program clean, state government severally punished fraudulent agencies. No opportunistic behavior was observed in the studied district either in hospital empanelment or enrollment. Opportunistic behaviors in Himachal Pradesh was lowest compared to other states. Lower fraudulent activities and involvement of same set of stakeholders (same hospitals and IC) has ensured continuity of care resulting in higher utilization. Utilization of the program has increased considerably from a hospitalization ratio of 2% in the first year to 5% in the second year.

In Uttar Pradesh, implementation governance was in complete contrast to what has been observed in Himachal Pradesh. In Uttar Pradesh an autonomous agency, was established with adequate staff to monitor implementation. Disputes due to poor quality BPL lists, non-availability of FKOs, has made insurance companies considerably dependent on DA. Further rules were restructured giving district administration complete decision making power in hospital empanelment resulting into extensive veto power of DA. State government favored private hospitals due to pathetic status of public hospitals, and more than 90% of the empanelled hospitals were from private sector, providing extensive opportunity for district administration to seek rent and abuse their veto power. Further this veto power of DA was unchecked as SNA's had no direct hierarchical authority on DA. DA and chief Executive officer of SNA were at the same level of administrative hierarchy therefore any instruction for DA had to be routed through the highest level of bureaucracy in the state. As a result SNA couldn't exercise any hierarchical authority on DA. IC with very little autonomy and

subordinate position had to bow down to the demands of the DA. Because of the high veto power, perverse incentives, and lack of accountability, DA abused their veto power extensively, leading to counter-opportunism by other agencies. Collusion, rent seeking and bribe payments were reported in almost all activities- awarding of contracts, field implementation, and empanelment of hospitals and audit of the hospitals. In many districts claims ratio was more than 200% which is difficult to explain merely on the basis of pent up demand.

In Punjab, the program is managed by a corporatized SNA-Punjab Health System Corporation (PHSC)-with a team under their direct hierarchical authority in each of the district providing them in-depth information and control over field operations. SNA because of their judicious governance has earned trust of all stakeholders and won award for effectively managing relationship with stakeholders. Given the limited beneficiary size, IC is considerably dependent on support of DA in enrollment. DA have been instructed by SNA to not interfere in issues related to private hospitals empanelment and keep them informed in all of their communication with IC. Thus SNA has tried to constrain the veto power of DA in hospital empanelment and provided complete autonomy to IC. The SNA also actively promotes empanelment of public hospitals and around half of the empanelled hospitals are from the public sector even though population prefers private hospitals. But DA being from health department have close linkages with private hospitals that provided them opportunity to collude. DA in spite of instructions and direct hierarchical authority of SNA, continued colluding with private hospitals given their guaranteed job tenure as public servant. This led to opportunistic behaviors of hospitals and counter opportunism by IC though the extent has been limited due to repeated intervention by SNA.

Thus all there states varied in terms of veto power of agencies, opportunity to abuse the veto power and performance as given in table 5. Thus there was a concordant relationship between veto power of district administration, opportunity to abuse the veto power and opportunistic behaviors observed. Uttar Pradesh had extensive fraudulent behavior, in Punjab moderate whereas in Himachal Pradesh least. In implementation governance, most critical dimension was veto power of DA in hospital empanelment. If DA had veto power and if there were rent seeking opportunities available, they abused their veto power, leading to counter opportunism by other parties, making implementation governance dysfunctional in plugging the gaps in institutional design. An implementation governance aligned with nature of transaction adequately addressed the risks in transaction increasing performance as seen in Himachal Pradesh, whereas if not aligned it lead to extensive opportunism and low performance as observed in case of Uttar Pradesh. Figure 5 presents the relationship between the risk in transaction as determined by gaps in institutional design, context and industry dynamics with the implementation governance.

Conclusion

As institutional designs are always incomplete more so in case of emerging economies, governance mechanisms during implementation are designed to address these risks in transaction. However variation in context may alter risks in transaction making designed implementation governance in-appropriate. In addition desired governance mechanisms could not be deployed due to variation in implementation structure. This leads to implementation governance dynamics that not only fails to address the gaps in institutional design bur rather inflate even small weakness to serious performance issues. However an appropriate implementation governance dynamics effectively controlled partner opportunism and improved performance. Variation in implementation governance dynamics across three states resulting in variation in performance illustrated the role implementation governance plays in determining performance.

Implementation governance and their interaction with institutional design in determining performance of social health programs has received limited attention and thus this study contributes to existing literature on implementation of social health insurance program. Using a qualitative study to unearth contextual issues that determine the dynamic variation in implementation governance, the study extends theorization on inter-organizational practices which are considered as static in the existing literature. This study also contributes to scant literature on governance of PPPs which have proliferated in the emerging economies context to deliver healthcare programs. Though contracts design and institutional environment in these arrangements has been extensively emphasized, governance during implementation is largely ignored.

Limitations of this study include possibility of under-reporting bias due sensitive nature of data related to opportunistic behavior in public health insurance program. Further examination of implementation governance in other social health insurance programs in different context is needed to validate the dynamic nature of implementation governance and its interaction with institutional design.

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Table 1: Institutional Design and Contextual Factors in RSBY

Type of Rules	Rules in RSBY	Contextual Factors
Revenue collection		
Insurance Enrolment Rules	Funded through general tax ; Population having BPL Cards and selected population groups, Family as unit of enrollment – Maximum five members, Voluntary Membership, Enrolment on selected date at a specified location , renewed every year, 30 INR contribution per family collected at the time of enrolment, Central government pays 75% of the premium per family contingent after paid by state government, Premium ceiling of 700 INR	Accuracy of BPL List and Verification of beneficiary Dispersed population Limited awareness and literacy
Co-payment\User fee	No copayment	Limited affordability
Pooling		
Pooling and Risk equalization rules	State and central government funds, Risk pooling at district level; No risk equalization between districts. All districts have the same coverage of 30,000 INR per family per year	Districts differ in epidemiological and health service utilization rates but there is limited data
Purchasing and Provision of Services		
Purchasing and Provision Rules	Awarding of contract through a competitive bidding among technically qualified Insurance company based on lowest cost bid Premium price decided after competitive bidding Purchasing from both –public and private providers Eligibility of Providers defined though provider accreditation not needed Purchasing defined at national level	Limited number of Insurance Companies No scientific method of pricing the premiums. Premiums are based on past utilization rates Public providers have low service quality Limited number of qualified providers in rural areas
Provider Payment Rules	1200 Packages defined; Payment based on package rates ; Medical Care payment based on per diem rates ;Same Package rates across all geographies ; Prospective price setting ; Retrospective payment Insurance company liable to make decision on claims within 30 days ; Claims made online by a dedicated computer and server ; Payment transferred to the hospital account	No standard treatment guidelines Extensive variation in treatment procedures
Rules related to Benefit Package	Only in-patient care included ; Includes all pre-existing diseases except few ; 1200 packages defined –surgical packages dominate ;Medical Care included ; Co-morbidities and co-existing disease are not included; Packages also include pre hospitalization and post-hospitalization expenditure up to certain days in addition to hospitalization; Package includes drugs , food and (travel up to a certain level); Limited definition of packages; No referral system in place; No costing of procedures and benefit package done	OPD care contributes significantly to healthcare expenditure. Input costs are vary extensively across geographies. Social status and power of doctors is difficult to be challenged because of information asymmetry and illiteracy in rural areas

Rules related to benefit package utilization	No co-payment ; Patient can appeal against hospital and insurance company at district grievance committee; Patient rights not defined	Limited awareness and literary
Rule Monitoring and Enforcement	Limited Impact monitoring	

Table 2 RSBY scheme Implementation Structure: Role of Different Stakeholders

Decision Maker	**State Level**			**District Level**			
	Central Government	State Government	State Nodal Agency	District Administration	Insurer\TPA	NGOs	Providers of care
Oversight of the Scheme	√						
Design of The Scheme	√						
Financial Management\Planning	√						
Benefit Package Design	√	√					
Target Beneficiary Selection		√					
Contract with Insurer		√	√				
Actuarial Analysis					√		
Selection of providers				(√)	√		
Awareness of the scheme				√	√	√	
Enrolment				√	√	√	
Provision of Healthcare Services							√
Claims Processing and Payment					√		
Monitoring	√		√	√	√		
Dispute Redressal	√		√	√			

(Source: Adapted by the authors from Reddy et al., 2011)

Table 3: Incompleteness of Institutional Design and Governance Mechanisms used to address them in RSBY

Specific Rules	Threats due to incompatibility, incompleteness of rules and missing supporting conditions	Governance mechanisms to address risks
Competitive Bidding for contracts	Limited quality measures in Bidding & therefore IC will not provide quality of services (incompleteness)	DA and SNA monitors quality of services delivered by IC
Contract Duration	Too short contract that prevents ex-ante investments, investments in preventive care, capability in claims management (missing supporting conditions)	None
Insurance company receives premium on enrolment of beneficiary	Insurance company has incentive to lower utilization (hospitalization) as it directs impacts their profitability. (incompleteness)	SNA and National Nodal agency monitor the claims and hospitalization. Hospitals can approach district grievance addressal system for any grievances against IC.
Performance Monitoring System	Lack of performance incentives & penalty clauses during the contract period may lead to limited motivation to perform. Opportunistic behavior in areas which are difficult to monitor. (incompleteness)	SNA and DA needs to ensure accountability to performance.
Family as a unit of enrolment	IC may not enroll all family members (Incompleteness)	Field level monitoring by DA
Validation of BPL family by field key officers	IC is dependent on DA to make FKOs available (missing supporting condition)	SNA controls functioning of DA
IC responsible for awareness of the beneficiary about the scheme	IC has incentive lower the utilization by beneficiary and therefore may not provide adequate information about the how to utilize the scheme. (Incompatibility)	FKOs and DA monitor the enrolment process
Empanelment of Both private and public hospitals	Private providers can induce demand given their profit incentives and package based pricing. (missing supporting conditions)	DA recommends private hospitals. Quality standards for empanelling hospitals
Empanelment of hospitals is prerogative of IC	IC has incentive to keep utilization low and therefore may empanel hospitals that reduce utilization	DA can recommends the hospitals from the district.
Fixed price treatment packages to hospitals	Incentive to reduce quality & Induce demand (missing supporting conditions)	Monitoring by IC

Table 4: Performance across three states

	Himachal Pradesh	**Uttar Pradesh**	**Punjab**
Number of families enrolled in the program (as on February 2017)	480588	1464242	232352
Corruption in Public Services	Moderate	High	Moderate
GDP Per Capita	$1520	$551	$1333
% of Population Below Poverty line	8.4	32.8	10
Human Development Index (2011-12)	0.122	0.538	0.647
Infant Mortality Rate (2011)	38	57	30
Enrolment Ratio	79.9	31.11 (2011-12)	46% (2011-12)
Hospitalization Ratio	5.1	2.7 (0.2- 2.5)	2.3
Percentage of Hospitals from Private sector	10	90	50
Claims Ratio	234	128	94
Source: Based on data provided by Ministry of Labour, Government of India and various secondary reports.			

Figure 1: Implementation Structure RSBY Scheme

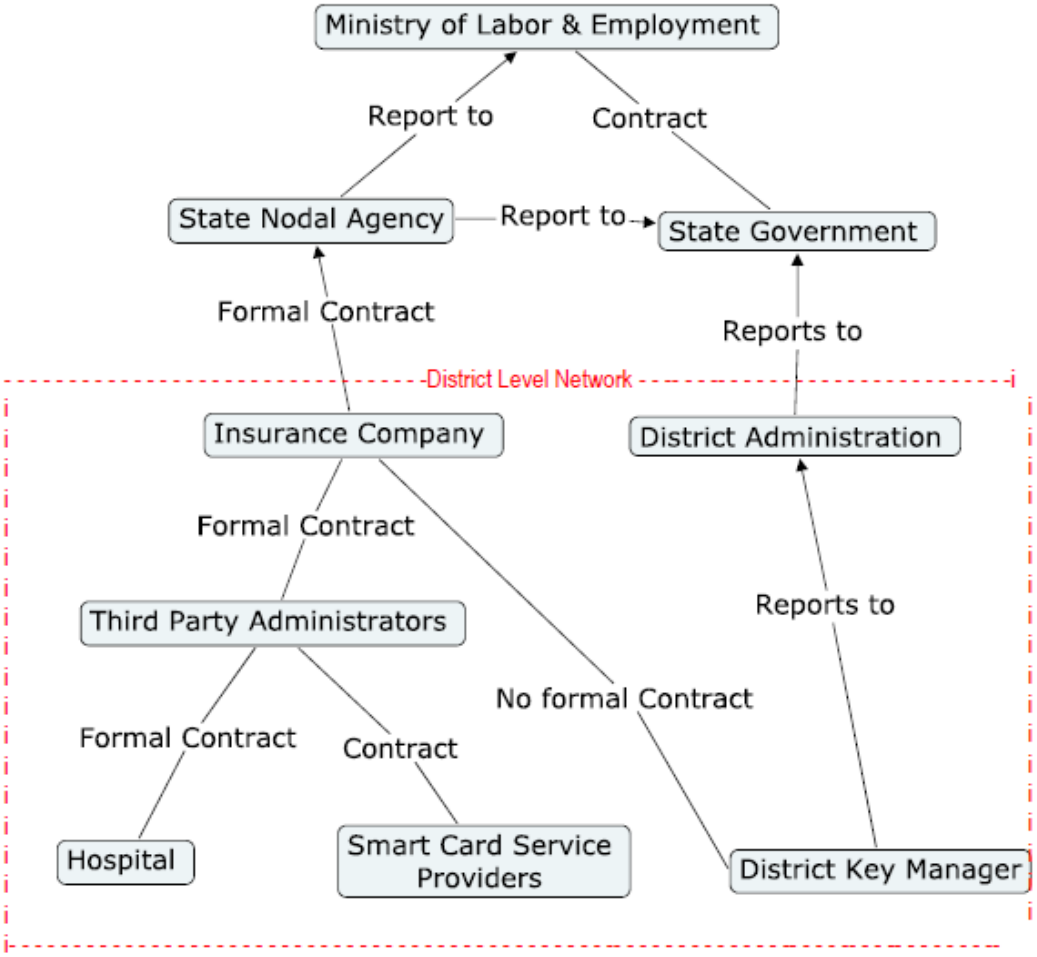

Fig 3: Critical Relationships in RSBY

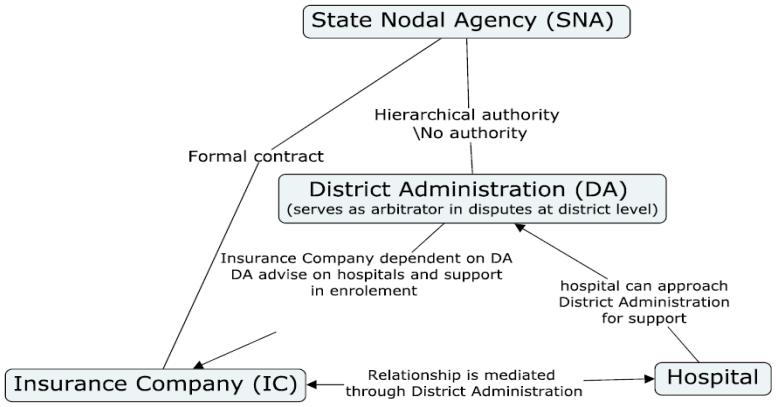

Table 5: Variation in Implementation Governance and performance:

		Veto Power of District Administration		
		Low	Moderate	*High Control*
Prospect of Opportunism administration (Share of Private Hospitals	*Low*	Himachal Pradesh (No Opportunism)		
	Moderate		Punjab (Moderate Opportunism)	
	High			Uttar Pradesh (High Opportunism)

Figure 4: Institutional Design & Implementation Governance: A conceptual Framework