Information and Health Care

A Randomized Experiment in India

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Health and Development

- Improving health seen as key part of development
  - As a component of human capital
  - As an end in itself
- But the poor typically have limited access to health care
  - High-quality private care may be unaffordable
  - ‘Free’ public health services may be severely rationed, of low quality, or involve hidden costs

Research Question 1

- ‘Everybody’ is in favour of improving health care in developing countries
- But what is the cost of substandard public health care provision for the poor?
  - Difficult to draw lessons from comparisons with rich countries
  - And what is the right benchmark?
- An alternative is to ask: What would be the impact on health and income if the poor had free access to the private health care system in their own country?
  - This is the question we are attempting to answer

Health care in India

- Public and private sectors
- Public services are ‘free’ but have major problems
  - Cash constraints
  - Low staff motivation and incentives
  - Poor service delivery and quality
  - Excessive political interference in staff posting
- Pushes people towards private healthcare services

Health care in India

- Private services are high-quality but very expensive
- Greater out-of-pocket health expenditures for the poor
- This leads to greater impoverishment and indebtedness of the poor
  - Funds diverted from food and/or education
  - Work days lost due to illness
  - Borrow to fund cost of healthcare
- Deepens the poverty trap

RSBY

- In 2007 GoI introduced the National Health Insurance Scheme (RSBY) targeted at the BPL population
- First such national-level scheme for the poor in the country in the area of health
- RSBY will potentially impact around 450 million people in India who fall under the new poverty line of $1.25 per day (World Bank)
- Window of 5 years

RSBY

- Total cover of up to Rs.30,000 (~ £400) per BPL family of 5 per annum
- Pre-existing conditions to be covered
- Coverage of health services related to hospitalization and services of a surgical nature that can be provided on a daycare basis.
- Cashless coverage of all health services in the insured package

RSBY

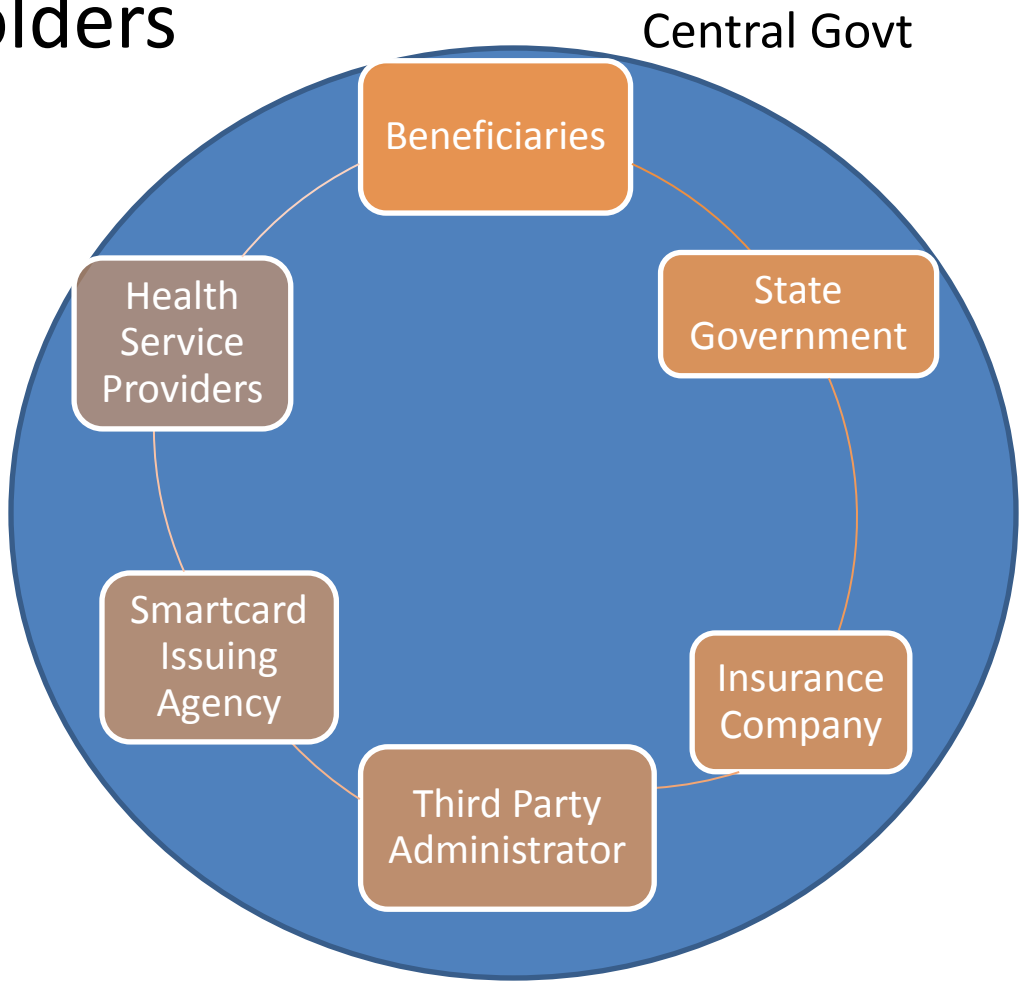
- Issuing of smartcards containing biometric information of all registered members for beneficiary identification
- Provision for reasonable pre and post-hospitalization expenses for one day prior and 5 days after hospitalization
- Provision for transport allowance (actual with limit of Rs.100 (~ £1.33) per visit) but subject to an annual ceiling of Rs.1000 (~ £13.33)

RSBY

- Registration fee of Rs. 30 (~ 40p) is paid by HH to insurance company per annum
- Annual premium of Rs. 750 (~ £10) is borne by the Central and State govts on a 75:25 ratio
- Cost of smartcards also borne by Central government @ Rs. 60 (~ 80p) per card
- Hence more of a subsidized health care scheme rather than health insurance in the strictest sense of the term

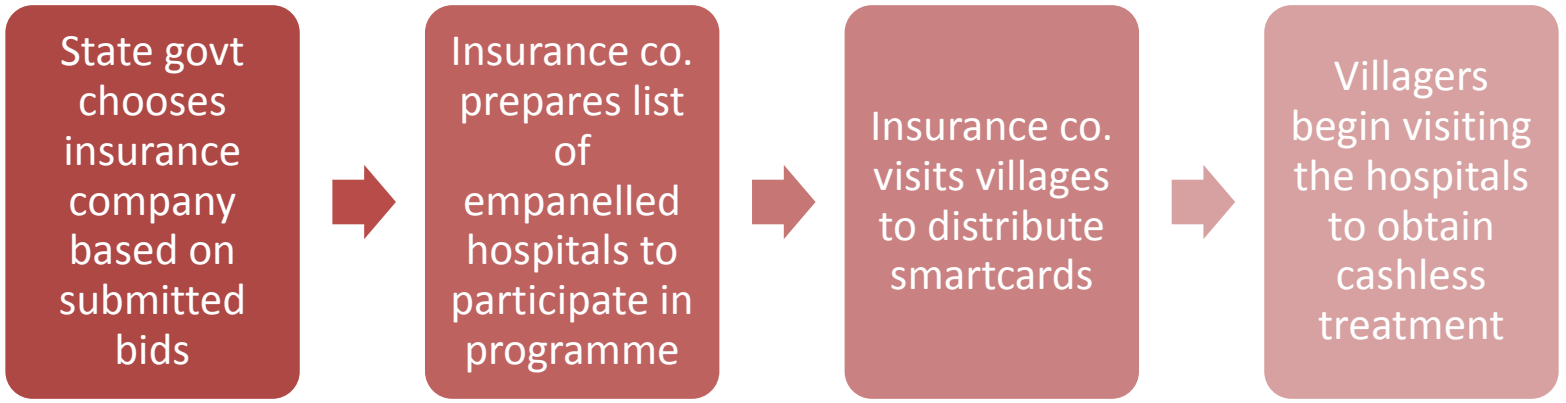
RSBY

- Stakeholders



RSBY

- Schematic timeline of RSBY



Our Intervention

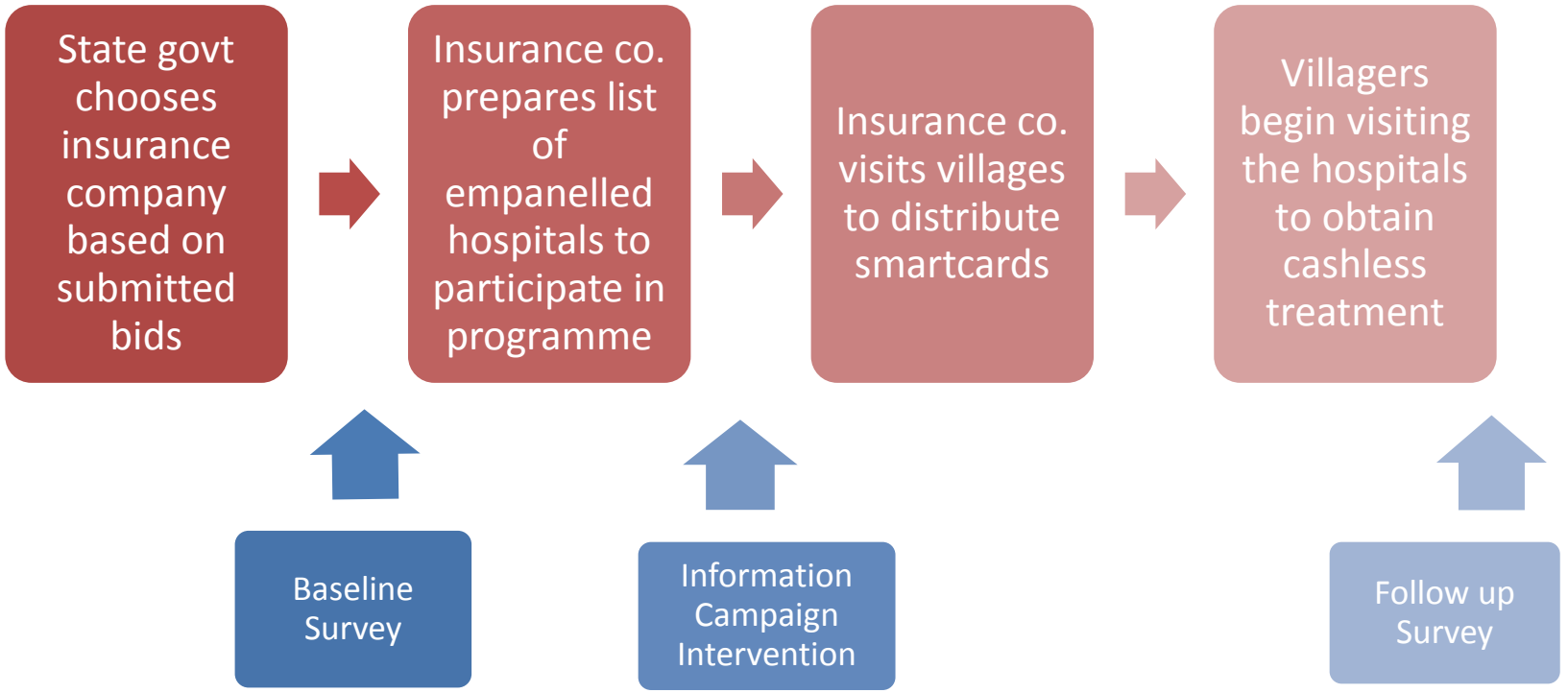
- RSBY will be rolled out in districts across Karnataka
  - Village-level randomisation of health care programme not possible
- Encouragement design
  - Provide high-quality information about the programme in treatment villages
  - Success of social programmes depends on spreading information about them effectively
    - Otherwise even ‘free lunch’ programmes may have low take-up rates. E.g. past poverty-eradication schemes in India
  - Our campaign will be an instrument for take-up and/or utilitization of the programme

Our Intervention

- Key outcome variables
- Health outcomes - morbidity in terms of days of sickness, mortality as well as subjective health status
- Economic outcomes - expenditure patterns, household indebtedness, income loss due to illness
- Labour supply outcomes - days lost due to illness for the person as well as other HH members caring for him, child labour

Our Intervention

- Schematic timeline of our intervention



Our Intervention

- Currently designing the intervention
  - Village-level meeting?
  - Intervention to take place before or after roll-out?
  - Research question 2
- Programme roll-out expected in May
- Follow-up survey 12 months later

Sample

- We are focusing on two districts of Karnataka
  - Bangalore Rural (it really is rural!)
  - Shimoga
- 75 treatment and 75 control villages in each of the districts
- Household and village questionnaires
- Health facility sheets to capture absenteeism
- Total sample: 300 villages, ~4250 households

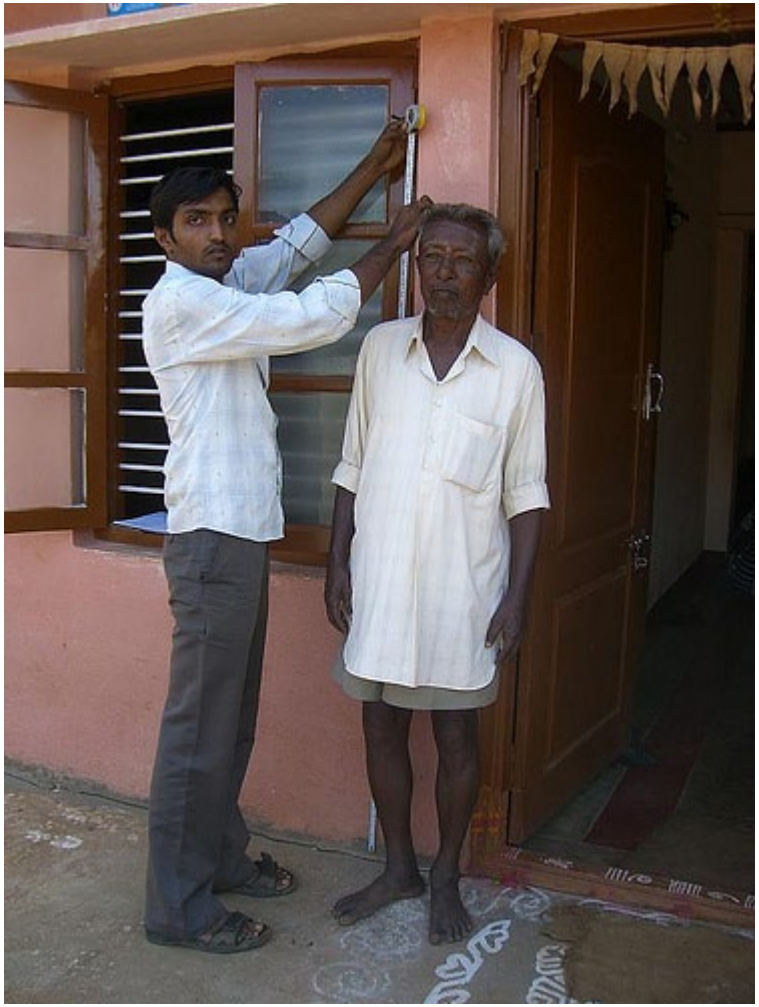
Pilot Survey

- Piloted the household questionnaire in October 2008 on 33 households in Tumkur district in south-east Karnataka
- Incidence of hospitalization is quite high – 25%
- Average household hospitalization expenditure of around Rs. 2260 (~ £30) per annum. Maximum is Rs.40,000
- Average household debt around Rs. 8495 (~ £113) of which around 19% were taken out for health reasons

Pilot Survey

- Problems with the BPL list
- Evidence of substantial mis-targeting
- Poor families are often not in the list while households with obvious visual indicators of prosperity are!
- BPL listing is an intensely political issue in India

Pilot Survey



Pilot Survey

Baseline Survey

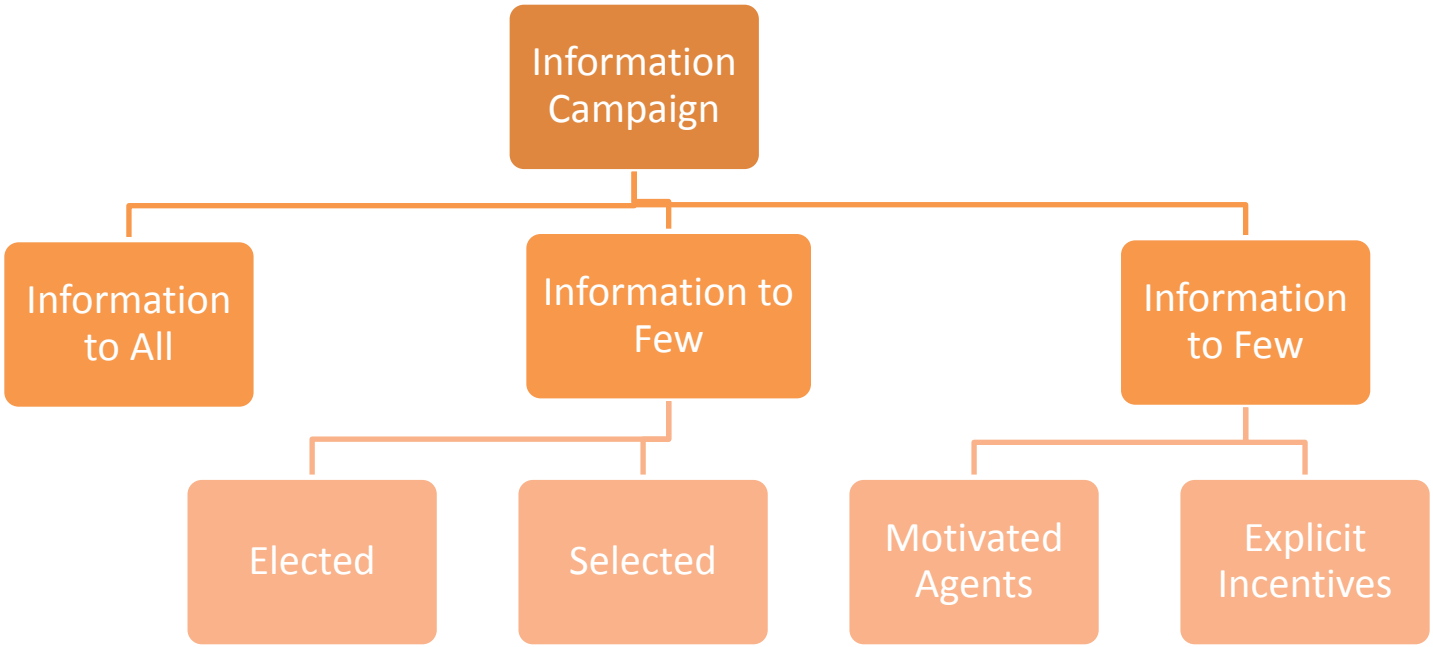
- Began in December 2008
- Nearly complete, but we don't have any data yet
- Team of 20 field investigators recruited and personally supervised by our colleagues at ISEC
- Data checkers to ensure strict quality control

Research Question 2

- Question 1 focuses on program evaluation of an information campaign that will be an instrument for subsidized healthcare
- But what is the best way to spread news?
  - Print media / posters
  - Village meetings
  - Through health workers
  - Elected village representatives
  - Agents paid on commission
- Question 2 thus looks at the mechanisms of effective information delivery and diffusion

Research Question 2

- We may be able to shed some light on this by introducing variation in our campaign



- Open to suggestions

Research Question 2

- Still brainstorming on this
- Only one other variation possible given our sample size and power considerations?
- Possible options:
  - Diffusion of information: information to all versus information to few
    - Relevant policy implication
  - Elected representatives versus financial incentives
  - Motivated agents versus financial incentives

Thank You