"When the Government Changes, the Card Will Also Change": Questioning Identity in Biometric Smartcards for National Health Insurance (RSBY) in India

Stefan Ecks *Edinburgh University*

Abstract: Since the mid-2000s, government initiatives in India have been gripped by the idea that biometric identification is more efficient than any form of paper-based documentation. In this article, I explore how new health care schemes in India have adopted this technocratic promise. On the basis of ethnographic research in Karnataka, I describe how enrolments for biometric smartcards for RSBY insurance proceeds. These enrolments are meant to turn the rural poor into consumer citizens, yet the RSBY cards elicit unexpected responses from the beneficiaries. Instead of reproducing state authority, the new ID cards become a fulcrum for questioning the stability of government.

Keywords: biometric IDs, RSBY, India, health insurance, poverty, consumer citizens

Résumé : Depuis la moitié des années 2000, les initiatives du gouvernement indien ont été fascinées par l'idée que l'identification biométrique est plus efficace que les formes de documentation écrites (sur papier). Dans cet article, j'examine de nouveaux programmes relatifs aux services de santé en Inde qui ont adopté cette promesse technocratique. À partir d'une recherche ethnographique à Karnataka, je décris comment ont lieu les inscriptions pour les cartes biométriques intelligentes de l'assurance RSBY. Ces inscriptions visent à changer les pauvres des zones rurales en des citoyens consommateurs ; or les cartes RSBY suscitent des réactions imprévues de la part des bénéficiaires. Au lieu de reproduire l'autorité de l'état, les nouvelles cartes d'identité deviennent l'occasion de contester la stabilité du gouvernement.

Mots-clés : Identification biométrique, RSBY, Inde, assurance santé, pauvreté, citoyens consommateurs

The Promise of Biometric Health IDs

Identity cards are technologies of social, political and legal control (Das and Poole 2004, Hull 2012, Marx 2015). ID cards enforce asymmetries in how stable the identities of card issuers and card holders are taken to be. Whoever is legitimate to issue an ID card is assumed to be self-same and stable, whereas the identity of the card holder is up for scrutiny. The ID issuer questions and establishes the identity of the card receiver and not vice versa. Yet, as I will argue in the following, the issuing of ID cards can also make card receivers question this power asymmetry. Hence, receiving a card does not necessarily mean that the stability of the ID issuer goes unchallenged. The moment a card is issued can occasion doubts in the ID card recipient about the stable identity of the card issuer.

My example will be experiences of enrolling for a biometric smartcard issued under the Rashtriya Swasthya Bima Yojna (RSBY) program in southern Karnataka, India. RSBY, which translates to "National Health Insurance Program," is the world's largest health scheme that relies on biometric cards. People "below poverty line" (BPL) are eligible to receive a smartcard, which allows them to claim hospital expenses of up to ₹30,000 per family per year.

RSBY was first launched by the central government's Ministry of Labour and Employment in 2008. Policy-makers put all emphasis on RSBY's "smart" technology, which was portrayed as future-oriented and emblematic of a new, clean and technocratic India. Biometric smartcards epitomise India's post-reform "aesthetics of arrival" (Kaur & Hansen 2015) in cutting-edge modernity. Between 2008 and 2016, more than 41 million RSBY cards were issued (Government of India 2017). Anthropologists have asked why documents are often "invisible" forms of power and have highlighted "the denial of the mediating role of documents" as a technique of maintaining authority (Hull 2012, 253). By foregrounding the futuristic materiality of the smartcards, the RSBY

scheme does the opposite: it augments the mediating role of the document and makes new power relations visible.

There is a range of health insurance programs for poorer people in India, but RSBY is the largest and best known. RSBY uses a combination of photographic and fingerprint technologies to ensure that any one of the people on the card claiming health expenses is entitled to do so. These "paperless" and "smart" ways of storing and processing data are also meant to make sure that the hospitals that provide health services for card holders are not overcharging or making fraudulent claims. When going to hospitals to make claims, claimants have their fingerprints taken and compared to those stored on the card. This aims to make claiming and reimbursing benefits "safe and foolproof" for all participants.

Biometric identification has become common in industrialised countries, but it is also being introduced in lower- and middle-income countries. Biometric IDs are used in passports or bank cards. Health is another field of application, with IDs being issued both by governments and by public–private partnerships and non-governmental organisations. Multinational donor organisations, such as the World Bank or the Gates Foundation, are providing financial and technical support to IT systems that extend the reach of biometric cards in the health field. Biometric cards seem to be the best way of closing the "identity gap" that people in poor countries are experiencing. The assumption in the development sector is that reliable digital ID systems are the best method of administrating benefits because they provide both identification (who is the beneficiary?) and authentication (is the person claiming the benefit the person entitled to receive the benefit?). Closing identity gaps becomes closing development gaps (Gelb & Clark 2013).

Biometric ID systems look brand new, but they have a long history. One of the oldest recorded moments of using biometric data for ID purposes was the use of handprints in colonial India. In 1858, Sir William Herschel, of the Indian Civil Service, invented whole-hand printing with ink on the back of employment contracts with colonial subjects. Herschel wanted to make contracts more binding, but he also wanted to ensure that only people under contract would receive payments from the civil service (Sengoopta 2004; Komarinski 2005). Biometric identification technology emerged in a colonial encounter between administrators and largely illiterate locals. The introduction of RSBY cards 150 years later continues a long tradition of administering people who are deemed most reliably identifiable through stable bodily identifiers. ID systems based on writing held sway for most of the colonial and post-colonial period (see Gupta 2012, 204), but biometrics are now established as a superior form of verification.

The promise of making the body a stable and incorruptible source of unique personal identifiers to sidestep written documents is evident in all the programmatic statements about RSBY. According to Anil Swarup, the civil servant who is credited with designing the scope and shape of RSBY, this biometric data system is "paperless, cashless, and ageless" (Swarup 2013a). In corruption-prone countries such as India (Srivastava 2012; Roy 2016), services can be delivered transparently and fairly only with a robust personal identification system of beneficiaries and benefits in place. RSBY is superior to other schemes because it minimises the scope for fraud by both individuals and hospitals. The bodies of RSBY beneficiaries may be vulnerable to disease and decay, but their fingerprints and faces are meant to be so incorruptible as to make the administration of benefits incorruptible, too. "Paperless" biometrics work with the "ageless" parts of the body to make the system itself "ageless." In Max Weber's (1978, 957) classic formulation of bureaucracy, documents are handled by "a staff of subaltern officials and scribes of all sorts." In RSBY, all human intermediaries are foregrounded as potential points of corruption and resource leakage, which the smart new system promises to eliminate.

RSBY was designed by the Ministry of Labour with assistance from the German international development agency GIZ (Deutsche Gesellschaft für internationale Zusammenarbeit). For complex political reasons, the central Ministry of Health did not want to take up health insurance schemes. The Ministry of Labour took up the development of RSBY under its remit of dealing with informal labour. As Swarup (2013b) points out, 94 per cent of all labour in India is in the informal sector. "The problem is: defining this individual – because without defining him, you can't benefit him – then, locating him, registering him, and benefiting him." This is so difficult because the majority of people in India are poor, illiterate and often migratory. If people have no fixed or clearly identifiable address, then the technology has to take this into account. If people are to be reimbursed for health care costs, this has to happen directly in the hospital and not at some later stage through their home address. If people are largely illiterate, a successful scheme also has to be paperless (Swarup 2013b). If people are highly mobile, the smartcard has to be issued on the spot, instead of being printed elsewhere and then being sent to a home address (Swarup 2013b). The RSBY scheme is a key example of how "the software engineer," India's new archetypical citizen-subject, is helping to pull "the farmer," India's old archetype, into

the connected world of the twenty-first century (Philip 2016).

Initially, hopes were high that RSBY cards could be used for purposes beyond health coverage. Some pilot schemes used the RSBY system for the administration of other social benefits, such as life insurance or food rations, with a plan toward developing RSBY into a platform for an integrated social protection system (Swarup 2013a). The excitement about using RSBY-type smartcards for other services also reached beyond India, and delegations from other countries visited to see how the scheme was working and how it could be adapted elsewhere. For example, in 2012 a German delegation arrived in India to study how RSBY cards could be used to replace paper vouchers to administer free school meals. That Germany, the country with the "world's oldest social security system," would seek "India's help to provide social benefits to needy schoolchildren" was reported with pride in the news (*Economic Times* 2012).

An additional benefit of RSBY cards was, according to Swarup, the provision of a form of "smart" ID card to poor people. However, since RSBY cards identify groups of household members rather than individuals, the scope for using RSBY cards as proof of individual identity is limited. Moreover, eligibility for enrolling in RSBY is predicated on being identified and documented as the holder of another, non-biometric card, the "below poverty line" card. One of the benefits that comes with holding a BPL card is being entitled to food rations from government shops. BPL cards are issued by state governments to households earning less than ₹27,000 a year. By classifying people as BPL, the state "converts the many facts of someone's material deprivations into a category that can be enumerated and measured" to create "a class of people for whom programs are targeted" (Gupta 2012, 156). RSBY could never be a stand-alone ID system, because it has to rely on how Indian state bureaucracies are administering other social benefits.

Plans for making RSBY cards proxy IDs for poor people were pushed aside by a much more ambitious national ID card project called Aadhar. The Aadhar system is run by the Unique Identification Authority of India (UIDAI) and has been rolled out since 2009. With now more than 1.133 billion IDs issued, Aadhar is the world's largest biometric ID system, enrolling up to 99 per cent of the Indian population. Aadhar's mission is to "de-duplicate" (Cohen 2016) the entire population of India so that every individual person has one, and only one, unique identity. The goal is to eliminate all "incomplete, fake, or duplicate identities" (Rao 2013, 72). If any ID system is now in the running to be a platform for social benefits, it is Aadhar and not RSBY. In fact, it is likely that Aadhar is going to become the basis for RSBY enrolments in the future. Whenever someone enrols in Aadhar, they are going to be "preseeded" in the database for future RSBY enrolments (Gelb & Raghavan 2014). The central government minister for labour announced plans to move the administration of social benefits to Aadhar (*Economic Times* 2016).

Enrolments into RSBY cost ₹30 per card. Enrolments are run by private insurance companies. The companies are selected through a tendering process where the company making the best offer gets the contract from the state government. The insurance companies' incentive is to enrol as many people as possible in RSBY, because insurers get a premium for each person that joins. These private companies do not benefit from anyone making claims through RSBY. Hence the incentive structure for the private companies is to achieve high enrolment numbers and low claimant numbers. This design – high investment in getting people to enrol and low investment in explaining how the scheme works – goes some way to making sense of some of the beneficiaries' experiences that I will describe here. My main argument, that the issuing of the RSBY biometric smartcard occasions doubt about the stability and identity of "the state," can be understood only within the context of the political economy of health in India.

A Poor and Patchy State of Health

India has a poor history of protecting people from excessive health expenditures. Most health care expenses continue to be paid out of pocket by rich and poor people alike. Government institutions exist and are in theory supposed to cover all citizens' needs. But the public sector captures only around 30 per cent of all health expenditures, and the bulk of all expenses is in the private sector. Even by the standards of lower- and middle-income countries, national budgets allocated to health are extremely low in India (Organization for Economic Collaboration and Development 2015, 156). The share of the government has been hovering around 1 per cent of GDP since the 1990s (Rao & Choudhury 2012).

Even the Ministry of Health and Family Welfare (Government of India 2014, 8) has diagnosed a "failure of public investment in health to cover the entire spectrum of health care needs" and a "worsening situation in terms of costs of care and impoverishment due to health care costs." People's out-of-pocket (OOP) health expenditures are said to be "more impoverishing than ever," and even hospitalisation in a public hospital does not protect against "catastrophic health expenditures."

Indeed, hospitalisation costs almost tripled between 2004 and 2014. The average cost of hospitalisation was ₹24,436 in urban areas and ₹14,935 in rural areas. The ministry estimates that 63 million people in India fall deeper into poverty every year because of OOP health costs (see Peters et al. 2002; Shahrawat and Rao 2011). In 2011–12, 18 per cent of Indian households faced catastrophic health expenditures, up from 15 per cent in 2004–05.

Rising care costs led to calls for publicly financed health insurance schemes. A range of new schemes have been introduced since the mid-2000s (Devadasan et al. 2006). All these schemes share the idea that catastrophic household debt caused by health expenditures is bad for both individual households and for the wider economy. All these schemes also assume either that existing public sector health facilities are unable to cope with the demand for affordable care, or that they themselves can be expensive enough to put people into poverty. Everyone, including poor people in both rural and urban areas, consult private practitioners more often than government practitioners (Bhatia and Cleland 2001; Narasimhan et al. 2014).

The new policies are designed to allow poorer people to access costly and mostly private health care without having to pay out of pocket. In the language of the policy-makers, "supply-side financing" in the sense of putting money into government infrastructures was unable to reduce household OOP expenditures. Hence a new type of "demand-side financing" was designed, which puts "freedom of choice" about where to spend money into the hands of people.

For those who designed RSBY, this freedom of choice was the scheme's "unique selling point" (Swarup 2013a, 2013b): the shifting of decision making about health care spending from the government to the individual citizen. Instead of the government providing a consistent and reliable public health care infrastructure, citizens are told to seek services in the private sector. Given the costs of private health care, prior to these new schemes, one could opt out of government health care only if one was rich enough to pay for private providers. The "unique selling point" of RSBY is that it empowers people living below the poverty line to choose between public and private hospitals just like the rich. But most other health schemes available in India, even those available to people below the poverty line, work on the same set of demand-driven assumptions. In this way, RSBY is in line with wider neoliberal transformations of health care in India over the past decades. I will return to this gap between neoliberal policy and people's experiences of what these policies mean in my ethnography of RSBY enrolments in Karnataka below.

RSBY was meant to be a "national" health care scheme that would transcend the many differences between states and districts. One of the projected benefits of the smartcard technology was that it would allow people to travel to different hospitals within districts and states, and even across different Indian states, and to be able to use the same card in all locations. As a "national" system, the RSBY card should work like a passport that allows movement within India. However, this promise has never been fulfilled because the RSBY scheme has been very unevenly implemented across India. Some federal states in India are providing continuous support for RSBY, whereas others, such as Andhra Pradesh, have never participated in RSBY. Some states participated only for limited periods or never committed a lot of resources to it. By 2016, roughly 57 per cent of eligible households across India had been enrolled but with a huge variation across districts, ranging from only 3 per cent enrolment in Kannauj in Uttar Pradesh to nearly 90 per cent in several districts of Chattisgarh and Kerala (Karan, Yip, and Mahal 2017).

This checkered implementation is even evident at the highest level of government in terms of which agency should be responsible for RSBY. The scheme was initiated by the Ministry of Labour, but control was shifted to the Ministry of Health in 2015, and its long-term future is not secured.

The task of implementing RSBY was conferred to state-level ministries. This resulted in a highly uneven implementation and of RSBY being constantly subjected to the vicissitudes of political conditions. A patchy rollout of RSBY is evident district by district and even village by village (Rajasekhar et al. 2011; Sun 2011; Palacios 2010). In the state of Karnataka, for example, RSBY ground to a halt in 2013. The Karnataka Ministry of Labour stopped organising further enrolments for a host of political reasons, one of them being the uncertain outcomes of the Indian general elections of 2014. In the run-up to the elections, there was fear that promoting RSBY enrolments would be seen as a form of political campaigning on behalf of the ruling Congress Party. In Karnataka, RSBY is associated with Congress politics because it was introduced during the reign of the United Progressive Alliance (UPA), of which Congress is the dominant force, which ruled India from 2004 until 2014. A host of new social welfare schemes were introduced by the UPA, RSBY being an exemplary one among them. The Congress Party maintained its hold on the Karnataka legislative assembly elections in 2013 but in 2014 lost the national elections for the Lok Sabha (the lower

house of the Indian parliament in Delhi). A new wave of enrolments in RSBY commenced only in 2014, but the change-over between ministries put another damper on the rollout of the program. Meanwhile the central government has announced that the implementation of RSBY is also going to change in the future, but it is not yet clear how.

RSBY card holders can take their card to a hospital that is "empanelled" in RSBY. Both private and public hospitals can become empanelled. Hospitals bill patients at their usual rates but can recover parts of the costs not from patients but from RSBY. Hospitals have an incentive to admit BPL patients who might not be able to afford their services out of pocket, and they also have an incentive to charge for services covered by RSBY. Many costs that come with hospitalisation are not covered by RSBY. Also, RSBY reimburses inpatient procedures, but neither outpatient treatments nor medications are covered – the two main sources of household health expenditures (Garg and Karan 2009; Shahrawat and Rao 2011).

The extent to which hospitals get themselves empanelled as RSBY providers has been limited and haphazard. For example, the largest hospital in Mysore district, the JSS charitable hospital, never became empanelled in RSBY. With 1,800 beds, the JSS hospital is one of the largest hospitals in India and is by far the biggest in the city of Mysore. Up to one thousand patients are treated every day in the outpatient departments. Around three thousand surgeries are performed in the hospital's 27 operation theatres every month. Every month, more than twenty thousand inpatients and more than sixteen thousand outpatients are treated. JSS is a charitable hospital with a mission to provide "affordable healthcare with human values." JSS explicitly welcomes poorer people and those from the rural areas. RSBY would be expected to be part of the accepted insurance schemes, but it is not. A host of other health care schemes, catering to a wide range of beneficiaries from the poorest to the richest, are administered at JSS. However, RSBY is entirely absent. When I spoke with the hospital's director about health insurance and asked why RSBY is not on its list of approved programs, he said that RSBY was not reliably available in the region and that other schemes were in place and doing a better job at providing access to care than RSBY.

The RSBY Enrolment Process

Fieldwork for this article was carried out in 2015 at three rural enrolment posts in central Mysore district. The ethnography of RSBY enrolments formed part of a research collaboration called Indian Health Insurance Experiments (2017), which evaluates the uptake of new insurance schemes among poorer people in India (for example, Nandi et al. 2015). The observations and interviews were conducted with 26 families directly at the enrolment stations. RSBY had been rolled out in Karnataka since 2008. There were no active RSBY smartcards in southern Karnataka in 2014, and people's memories of earlier phases of RSBY were fuzzy. What I could observe was a new wave of enrolments that began in late 2014. The enrolments took place in public sites, such as primary schools, and it turned out to be easy to contact people and ask them for an interview after they had received their smartcards. RSBY cards enrol families of up to five people and not individuals. The enrolment identifies male household heads as the primary card holder. This patriarchal bias of the bureaucratic process was mirrored in my interviews: the main respondent to my questions was always the male household head, with only occasional interventions from other family members. The field research was carried out by me and my Kannada-speaking research assistant and interpreter, Chanappa Kapli. Interviews were based on a semi-structured questionnaire. Audio recordings of the interviews were transcribed and translated from Kannada to English. My presence as a European researcher did not have any discernible response effects, neither among the officials carrying out the enrolments nor among the families interviewed.

Enrolments into RSBY were done by mobile teams of insurance company employees. The teams consisted of three to four people who travelled from village to village. Prior to their arrival, the companies identified who should enrol in RSBY through a list of BPL card holders provided to them by the state government. The companies liaised with local panchayats (village councils) to let them know when they were coming and what kind of setup was required to carry out the enrolments. The RSBY teams moved into primary schools and village halls for a day or two, depending on the size of the catchment population. The panchayats were active in informing people about the upcoming enrolments and in mobilising them to make the effort to come. In Mysore district, panchayats linked up with local health workers to distribute "tokens" to BPL households, slips of paper containing information about where to go and what to bring. People were also alerted to the need to arrive in person with every household member who should be included on the card. In case of anyone being absent from the enrolment, it was possible to add a name and biometric data at a later stage through a district office, but this was cumbersome. At all the posts we observed, enrolments in this wave proceeded smoothly. Times spent queuing to be seen ranged from a few minutes to

two hours. The full enrolment, from arrival to handover of the card, took about ten minutes per family. To get the card issued, family members gave their names to the enrolment team. A representative from the panchayat confirmed that the family was on the BPL register. In the RSBY database, information about beneficiaries is ordered by unique registration number (URN), name of the "head of family," age, insurance policy number, start and end dates of the policy (one year from day of enrolment), the available amount in the account (maximum ₹30,000), how much money is "blocked" (spent) from the card, and finally codes for district and state where the registration was done. A photo of all the household members was taken, as well as fingerprints from both hands. The RSBY cards were handed over to the household heads a few minutes later. In Mysore district, most of the time the enrolment teams also gave out leaflets explaining how the RSBY card could be used, with lists of hospitals that were part of the scheme. However, this was not done consistently, and in many cases people walked out with a card but without any information on how to use it. People's negative experiences, such as not understanding what the biometric card is for, can explain why the issuing of the card undermines rather than builds trust in the state. The following two sections provide a detailed ethnography of these experiences.

Experiencing the RSBY Card: What Is It For?

Among the 26 families interviewed after their enrolments, the most common sources of information about the event were panchayat workers, primary health care nurses, neighbours and family members. The panchayats did an awareness drive, distributing leaflets informing them of the time, place and purpose of the enrolments, as well as making announcements via loudspeakers carried through villages on autorickshaws. Such drives are a common way of spreading information about elections, public health camps and other relevant events. The second source of information was nurses from primary health care centres under the Ministry of Health who went door to door in some areas, trying to mobilise as many potential beneficiaries as possible. Both panchayats and nurses handed out tokens (*chiti*) that people should bring with them to the enrolment station: "Some girl came from a hospital to inform us. She was visiting all houses and giving token. She informed that this is a health card and if there are any problem then the government will give up to 30 thousand, the rest of the amount you have to pay" (family #26). Some families complained that not all relevant people had received tokens for the event in this way. A third and equally important source of information about the enrolment events came from neighbours and extended family members. Several families said that they had not received any information about the enrolments but were simply following behind neighbours who said that they should come along.

All the families that we talked to said that the awareness drives for RSBY had happened only a few days before the actual enrolments and that this was the first time that they had ever heard of RSBY. Since RSBY is meant to be the leading health scheme for people below the poverty line in India and has been running since 2008, to find that most people interviewed had no prior awareness of it was surprising (see Madhukumar et al. 2012; Reshmi et al. 2007; Narasimhan et al. 2014).

There were only three families who had prior experiences of using RSBY. One household head (#6) had faint memories of having enrolled in RSBY seven years earlier, but said that they did not have any health problems that year and did not use it. After one year the card expired, and they had not heard anything else about renewals until now. Another man (#7) said that RSBY has been around for the past "seven years" but that this was the first time that his family had enrolled. During another enrolment drive some years earlier, he remembered being out of the village and missing the occasion. Srinivas, a lorry driver in his early 40s, had had a kidney operation three years ago at a government hospital and ongoing problems with his kidneys. He remembered enrolling in RSBY for years earlier and of going to the hospital with the card two times, but in each case the card was declined and he was told that RSBY did not cover the particular problem diagnosed.

All of the families interviewed said that health care costs were too high. All of them were able to recall previous episodes of a family member being hospitalised with serious consequences for the household's financial situation. For example, Chandru, a 42-year-old day labourer, was trying to find money for his mother's brain tumour operation. The cost was ₹100,000; ₹10,000 was covered through a central government scheme, but the remaining ₹90,000 had to be paid from a loan. They are still repaying to this day. The father of a 35-year-old tailor (#25) had to be taken to hospital eight years ago with liver problems. He was admitted to the JSS hospital and treated there. The total cost was ₹45,000, but he had only ₹10,000 available, so the rest had to be covered by a loan of ₹35,000 at a 5 per cent interest rate. This loan was still being paid off all these years later. His son then got tuberculosis. They took him to the government hospital in Mysore, but when they did

not receive good treatment there, they shifted to a private clinic where each visit cost ₹500, about ₹10,000 over six months. TB treatments have a dedicated public infrastructure of clinics that supposedly cover 100 per cent of all treatment needs, yet this is one among many examples that show that OOP expenses can be high even when treatments are, allegedly, free and easily available (Ecks and Harper 2013). OOP health care expenses add to other major expenses. In the case of an elderly couple (#9) who had to find the money for dowries for three daughters, they had to sell their two hectares of land. After selling the land, the husband started working as a cleaner in a private hospital.

Some families said that they would rather die than pay too much for health care. It was possible to spend money within limits, but there was no point in ruining an entire household's finances for a single episode of ill health. Devanna (#24), a day labourer with just a small patch of agricultural land, said that for "big problems" they would not seek treatment but "stay at home," because they were unable to repay big loans, even if they could take them out. Nagasundara (#11), a casual worker in his mid-30s who said his family earned less than ₹5,000 a month, said that any health problem costing more than ₹100,000 to treat would not be taken to a hospital "because we cannot pay that much; just we would like to die, that is the only option." Ravi (#17) and his wife also worked as day labourers. Whatever money they earned, maybe ₹200 in a day, was just about sufficient to feed themselves and put their three children through school, but not for other expenses: "If any big problem occurs, we will not go to the hospital for consultation. We will try tablets [self-medication]. Otherwise we will commit suicide."

Every family said that they "did not know much" or "did not really understand" RSBY. Lacking information about how to use the RSBY card right after it had been issued is striking, because receiving a freshly printed biometric ID card should be the one moment when people know best what it is good for. Some guessed that the card was "like a ration card" (#12) that could be used to get health services, but the details were fuzzy. Some said the card was for "use in hospitals" (#20), but the difference between empanelled and not-empanelled hospitals seemed mysterious. In all cases, people understood that the card entitled them to ₹30,000 per year and that any excess costs had to be paid for out of pocket, even though they did not always grasp if this amount could be spent on several occasions or only on one occasion. Despite having been handed the RSBY card only minutes earlier, some people said that this card was valid "for life" and there was no need for renewal. Indeed, several people pointed out that one of the advantages of the RSBY card was that it did not need annual renewals, as opposed to other health care schemes. One of the people who said that no annual renewal was necessary also said that he was illiterate and unable to read the pamphlet that had been handed to him along with the card: "I am uneducated. I cannot read anything. I just look at pictures" (#26). Sadly, there were no informative pictures on the leaflets. Another said, "We do not know about RSBY, it's just that all people are enrolling, so we also came for enrolment" (#11).

The most critical voices compared the lack of information about the uses of RSBY to an act of "cheating" because "they give no clear information to the people" (#11). It was typical that even when benefits were available, the government failed to provide proper information on how to access them. When approached if it was possible to ask government officials about RSBY, some felt that poor people were routinely treated with disdain. Ravi (#17) said that he did not understand what RSBY was all about, but that there was no point in asking government people about it: "We will not ask anybody about this. If we ask anybody, they will not respond clearly. They will tell us: 'You are uneducated, why do you need this information,' like this they will scold, so I do not want to ask anybody."

Experiencing the RSBY Card: "What's the Use?"

In our interviews with enrolling families, we asked about their awareness of other "health cards" and that they compare the advantages and disadvantages of RSBY to these other cards. In southern Karnataka, another card is far more widely known and more widely used than RSBY: the Yeshasvini card. This card is available to people in rural areas as well as informal sector workers in urban areas. It is administered through workers' cooperatives across the state of Karnataka, and it covers card-holding families for private health care of up to ₹150,000 per year. Enrolment costs for Yeshasvini vary depending on several criteria, but come in on average at ₹200 per person. Enrolment in Yeshasvini started at 1.6 million members in 2003 and increased to 3.4 million members in 2013. This represents about 15 per cent of all target beneficiaries and 9 per cent of the rural population of Karnataka (Aggarwal 2010, 6).

About a quarter of the families we talked to during RSBY enrolments also had Yeshasvini cards and could compare the benefits of the two cards to each other. Most of the other families had also heard of Yeshasvini

even if they were not members of the scheme. The two features that allowed the easiest comparisons between RSBY and Yeshasvini were the enrolment fees and the available annual allowances. At only ₹30 per family, RSBY was clearly more affordable and therefore seen as more favourable than Yeshasvini. In fact, a few people pointed out that they had paid for the Yeshasvini annual membership in the past but had not renewed their cards because of the comparatively high cost of enrolment. One household head (#8) who has held a Yeshasvini card for several successive years summed up this opinion: "RSBY is a good scheme, as far as I know. One card contains the whole family and all their information. And we pay just ₹30 for enrolment. Yeshasvini is also good, but we need to pay ₹250 a person."

Everyone agreed, however, that ₹30,000 from RSBY is far too little, not only when it is compared to Yeshasvini's ₹150,000, but by any standard. Almost everyone said that the costs for health care are so high that ₹30,000 will not get you anywhere. Perhaps a few minor problems could be covered with this amount, but any actual hospitalisation case could not be financed with the amount provided under RSBY. For this reason, many questioned if RSBY should exist at all: "₹30,000? What's the use?" Chandru (#10) asked bitterly. Even if RSBY covered outpatient department (OPD) treatments and medication costs – which it currently does not – the amount was painfully inadequate.

Of course, being promised ₹30,000 was better than being promised nothing at all. For a small enrolment fee of ₹30 per family, there was no visible drawback in taking advantage of a potential source of health care funding: "We are poor people. Thirty thousand rupees is a good amount, if they will give when problems arise. Only if problems occur, that time we will know" (#18). Some said that they were happy that anything at all is given to them to help cover health costs. One said, "I am very happy about this because they [the government] are paying *that* much money" (#6). However, these expressions of gratefulness were rare, and even those who were grateful for some financial aid did not say that ₹30,000 was in any way adequate.

Many respondents were quick to offer suggestions about how much RSBY should pay. *Ondu lakh*, which is ₹100,000, was a figure that several people mentioned as the minimum amount any health scheme should offer. This amount was not even to be used in several installments for a variety of episodes – in the way that the policy-makers envisaged RSBY should be used – but simply for a single episode of hospitalisation. Another suggestion focused on percentages of total costs to be covered. Several people said that, whatever the amount may be, 50 per cent should be reimbursed; others said that a 70 per cent reimbursement would be adequate (#20).

People had many suggestions for how RSBY could be better organised in other ways. One common suggestion was that RSBY should not only cover hospitalisation costs, but also OPD treatments and medications. For OPD procedures and drugs, ₹30,000 seemed more plausible than for large-scale surgeries. Another idea was that RSBY would only succeed if it secured quality care. Some felt that the hospitals treating under RSBY would be bad hospitals and that all the good hospitals must be paid for out of pocket (#26). Another suggestion was that government money should be spent to cover whatever procedure is necessary and that the scheme should not work based on a fixed rupee amount. If someone requires a particular surgery and is unable to pay for it out of household resources, the operation should be free:

> I am giving an important suggestion to the government: they have to identify the poor people [*karag badava*]. Depending on how much they have to spend, if it is ₹10,000 they should pay ₹10,000. If it is ₹100,000, they should give ₹100,000. The full amount. Anyone who is a labourer can earn up to ₹300 a day. That goes into food and living – how can he pay any more money? Any big operation that costs more than ₹100,000, a poor person will have to die (#10).

Other people made proposals for how the money should be allocated, with some people saying that medicines should be given directly to poor people when they need them, and others saying that funds should be allocated from the government to private hospitals for them to have a budget to treat poor people in need.

The question of social inequality and the fair allocation of limited public resources reappeared when we asked if families who are classified as "APL" (above poverty line) should also be entitled to receive an RSBY card. Most people said that APL households should also get some financial protection because they were almost as poor as households below the poverty line. Given that the RSBY amount of ₹30,000 was so low anyway, making it available to others did not seem too problematic. However, several also said that social benefits such as RSBY should be strictly limited to those who needed them most, and those people were the BPL households. This was sometimes coupled with complaints about APL households obtaining BPL cards through bribing panchayat workers to get access to benefits

reserved for BPL households (#23). Richer people also managed to get better treatment at government hospitals because they were better educated and could harangue hospital staff more effectively than BPL people (#10): "In the government hospital, if you see the educated people, they will question them and get free benefits, but if any uneducated person goes to the hospital, then he must pay the full amount. He will be sent around, from one ward to another, from one hospital to another."

Just as there was little disagreement about ₹30,000 being insufficient, there was also little disagreement about the government being responsible for providing some level of help to poorer citizens. Yet there were a few people who said that ₹30,000 may not be enough money, but that the government should not give away more than that. If the government puts too much into health, then the country suffers in other ways: either funds are deducted from other areas or the government finds ways of extracting funds from elsewhere. A day labourer from a village outside of Mysore was clear about this when asked if ₹30,000 was enough. He thought that the government was not able to provide health care to everyone: "If the government pays for all Indian people, how much money would that take? But even if the government pays for everything, people will not be satisfied. But however much money we get, we should get satisfaction" (#7). Health expenditures were just one item among many other areas where government spending was necessary, and allocating too much for health simply meant that other welfare and development areas got neglected. Baire Gowda (#26), a man in his mid-50s who had been a deputy member of the local panchayat for 15 years, said that people should not expect more than ₹30,000, "because the government should provide all the people, so the government cannot give to a single person too much. The government can help with some amount, but not with the full amount." For the sake of social fairness, people should not expect to get all their costs covered, just some costs (#25).

Receiving an RSBY card does not have any immediate benefit; the card is only a promise for the future. Many people doubted that this promise would ever be kept. There was a sense that a lot of benefit schemes were first introduced and then never properly implemented or maintained. Some people compared the RSBY card to the empty promises of politicians, who vowed anything to get elected but then forgot all about those promises. Several people said that there had been many policies but maintaining them properly was where the difficulties lay: "Maintenance is the big problem in these schemes" (#25). The current government may introduce a scheme, but then another government comes in and throws it all out of the window: "The government is providing this scheme, but the next government has to follow the same rules. If they stop, that means there is no use to this card" (#14).

Conclusion

Scholars working on welfare, citizenship and the state in India have noticed a shift from a Nehruvian model that wants to smooth social inequalities through targeted handouts to a neoliberal governmentality that stresses self-reliance and individual agency. This ideological shift is meant to make the poor become proactive consumers and wean themselves off government provisions. The RSBY smartcard is a prime example of this shift in its emphasis on citizen empowerment, demand-driven choice, and belief in markets producing optimal care.

The question is if these neoliberal imaginations of health citizenship are grounded in real experience. Recent scholarship on neoliberal health insurance schemes casts doubts on whether neoliberal reforms have been as thorough as policy-makers imagined they would be. For example, Anjaria and Rao (2014) argue that the RSBY scheme was introduced as a top-down neoliberal policy of mobilising rationally choosing citizens, yet "they have not produced unilateral outcomes of making citizens responsible for their own self-management or promoting a particular unequivocal class politics" (Anjaria and Rao 2014, 424–425).

New health care schemes such as RSBY are part of a liberalisation agenda that proposes a demand-driven restructuring of access to health care even for the poor. But the ethnography of RSBY card enrolments engender a different experience of being a citizen. From a policy point of view, RSBY is not meant to *create* a rationally choosing consumer citizen; rather it assumes that the scheme can find, and work with, consumer citizens who are already there. The smartcards are not making people "smart"; instead they are meant to unleash the smart potentials that consumer citizens already have. This makes sense because the existential burden to choose carefully between different health care options and the weight of having to take on full responsibility for how to spend limited resources have always already been with people, because India had never had a comprehensive welfare system that could then become neoliberalised (Gupta 2012). Those who designed RSBY might claim that they have introduced demand-side decision making, but instead they have introduced only another layer of complexity to what was already a complex set of decisions that individual households were facing all along. In turn, the lack of proper information

about how the scheme is to be used does not produce calculating, self-managing citizen-consumers. Instead decision making about spending scarce resources on health care remains as obscure and as risky as it has always been. RSBY does not make the poor take the initiative and mobilise market competition by being canny consumers. The scheme appears to people as just another promised state benefit that may, or may not, materialise. And even if the services materialise fully, ₹30,000 was clearly seen as insufficient to cover the real costs of a serious illness event.

The introduction of biometric IDs is meant to close the "identity gap" between the disadvantaged and the well-off. The biometric ID card has thus become a promise of demarginalisation (Ecks 2005). It is supposed to use the individual body as an incorruptible source of stable identifiers to give ageless definition to the citizen, who can then become a fully benefit-maximising health care consumer.

However, the ethnography of RSBY enrolments does not provide evidence that anyone in Mysore district perceived the card as a moment when their identity as a full health citizen was validated. The common assumption in the anthropological literature on bureaucratic procedures is that the issuing of an ID document is a moment when authority becomes reproduced "across time and space" (Sharma and Gupta 2006, 13). Instead, I argue that the issuing of RSBY cards does not seamlessly reproduce authority and that the card issuing becomes a moment when citizens question the reproduction of authority across time and space. In Mysore district, nobody seemed to be particularly impressed by the biometric technologies or by the logistical accomplishments of receiving a card within a few minutes. Not a single person walked out of the enrolment station proudly waving the newly minted card, declaring themselves a new kind of person with a new range of exciting opportunities. If anything, they bemoaned that they had not received any paper leaflets that could explain what they should do with the shiny new plastic card. There was no sense that the card receivers were elated by having their identities confirmed by the card issuer. There was no sense that the card-issuing process enacted a power differential between card issuer and card recipients. On the contrary, the card recipients questioned the stability and identity of the card issuer: "When the government changes, the card will also change." At stake were not the identities of RSBY card holders, but the identity, across time and space, of the authorities behind RSBY.

Stefan Ecks, *School of Social and Political Science, University of Edinburgh, Edinburgh, UK.*
Email: stefan.ecks@ed.ac.uk.

References

Aggarwal, Aradhna. 2010. "Impact Evaluation of India's 'Yeshasvini' Community-Based Health Insurance Programme." *Health Economics* (19): 5–35. https://doi.org/10.1002/hec.1605.

Anjaria, J. S., & Rao, U. (2014). Talking back to the state: citizens' engagement after neoliberal reform in India. Social Anthropology, 22(4), 410–427.

Bhatia, Jagdish C., and John Cleland. 2001. "Health-Care Seeking and Expenditure by Young Indian Mothers in the Public and Private Sectors." *Health Policy and Planning* 16(1): 55–61. https://doi.org/10.1093/heapol/16.1.55.

Cohen, Lawrence. 2016. "Duplicate, Leak, Deity." *Limn* 6. http://limn.it/duplicate-leak-deity/.

Das, Veena, and Deborah Poole, eds. 2004. *Anthropology in the Margins of the State*. Santa Fe: School of American Research Press.

Devadasan, Narayanan, Kent Ranson, Wim Van Damme, Akash Acharya, and Bart Criel. 2006. "The Landscape of Community Health Insurance in India: An Overview Based on 10 Case Studies." *Health Policy* [Amsterdam] 78(2–3): 224–234. https://doi.org/10.1016/j.healthpol.2005.10.005.

Ecks, Stefan. 2005. "Pharmaceutical Citizenship: Antidepressant Marketing and the Promise of Demarginalization in India." *Anthropology & Medicine* 12(3): 239–254. https://doi.org/10.1080/13648470500291360.

Ecks, Stefan, and Ian Harper. 2013. "Public-Private Mixes: The Market for Anti-tuberculosis Drugs in India." In *When People Come First: Critical Studies in Global Health*, ed. João Biehl and Adriana Petryna, 252–275. Durham, NC: Duke University Press. https://doi.org/10.1515/9781400846801-013.

Economic Times. 2012. "German Delegation Coming to India to Take Rashtriya Swasthya Bima Yojana Lessons." 12 August. http://economictimes.indiatimes.com/news/economy/policy/german-delegation-coming-to-india-to-take-rashtriya-swasthya-bima-yojana-lessons/articleshow/15367929.cms?intenttarget=no.

—— 2016. "Government to Use Aaadhar to Deliver Benefits to Unorganized Workers." 2 May. http://economictimes.indiatimes.com/news/economy/policy/government-to-use-aadhaar-to-deliver-benefits-to-unorganised-workers/articleshow/52077509.cms

Garg, C. C, and A. K. Karan. 2009. "Reducing Out-of-pocket Expenditures to Reduce Poverty: A Disaggregated Analysis at Rural-urban and State Level in India." *Health Policy and Planning* 24 (2): 116–128. doi: 10.1093/heapol/czn046.

Gelb, Alan, and Julia Clark. 2013. "Identification for Development: The Biometrics Revolution." Working Paper 315, Center for Global Development. https://www.cgdev.org/publication/identification-development-biometrics-revolution-working-paper-315. https://doi.org/10.2139/ssrn.2226594.

Gelb, Alan, and Sneha Raghavan. 2014. "Rolling Out the Aadhar." Center for Global Development, March 6. https://www.cgdev.org/blog/rolling-out-aadhaar.

Government of India. 2017. Rashtriya Swasthya Bima Yojana. http://www.rsby.gov.in/

Government of India. Ministry of Health & Family Welfare. 2014. National Health Policy 2015 Draft. http://www.mohfw.nic.in/showfile.php?lid=3014

Gupta, Akhil. 2012. *Red Tape: Bureaucracy, Structural Violence, and Poverty in India*. Durham, NC: Duke University Press. https://doi.org/10.1215/9780822394709.

Hull, Matthew S. 2012. "Documents and Bureaucracy." *Annual Review of Anthropology* 41(1): 251–267. https://doi.org/10.1146/annurev.anthro.012809.104953.

Komarinski, Peer. 2005. *Automated Fingerprint Identification Systems (AFIS)*. Amsterdam: Elsevier Academic.

Indian Health Insurance Experiments. 2017. Indian Health Insurance Experiments. University of Chicago. https://indiahie-sites.uchicago.edu/.

Karan, Anup, Wnnie Yip, and Ajay Mahal. 2017. "Extending health insurance to the poor in India: An impact evaluation of Rashtriya Swasthya Bima Yojana on Out of Pocket Spending for Healthcare." *Social Science & Medicine* 181: 83–92. https://doi.org/10.1016/j.socscimed.2017.03.053.

Kaur, Ravinder, and Thomas Blom Hansen. 2015. "Aesthetics of Arrival: Spectacle, Capital, Novelty in Post-reform India." *Identities* [Yverdon] 23(3): 265–275. https://doi.org/10.1080/1070289X.2015.1034135.

Madhukumar, Suwarna, D. Sudeepa, and Vaishali Gaikwad. 2012. "Awareness and Perception Regarding Health Insurance in Bangalore Rural Population." *International Journal of Medicine and Public Health* 22(2): 18–22. https://doi.org/10.4103/2230-8598.108390.

Marx, Gary T. 2015. "Technology and Social Control." In *International Encyclopedia of the Social & Behavioral Sciences*, 2nd ed., vol. 24, 117–124.

Nandi, Arindam, E. Phoebe Holtzman, Anup Malani, and Ramanan Laxminarayan. 2015. "The Need for Better Evidence to Evaluate the Health & Economic Benefits of India's Rashtriya Swasthya Bima Yojana." *Indian Journal of Medical Research* 142(4): 383–390. https://doi.org/10.4103/0971-5916.169194.

Narasimhan, H., V. Boddu, P.V. Singh, A. Katyal, S. Bergkvist, and M. Rao. 2014. "The Best Laid Plans: Access to the Rajiv Aarogyasri Community Health Insurance Scheme of Andhra Pradesh." *Health, Culture and Society* [Pittsburgh, PA] 6(1): 85–97. https://doi.org/10.5195/HCS.2014.163.

Organization for Economic Collaboration and Development. 2015. *Health at a Glance: OECD Indicators*. Paris: OECD Publishing.

Palacios, R. 2010. "A New Approach to Providing Health Insurance to the Poor in India: The Early Experience of Rashtriya Swasthya Bima Yojna." RSBY Working Paper 1. http://www.rsby.gov.in/documents.aspx?ID=14.

Peters, David H., Abdo S. Yazbeck, Rashmi R. Sharma, G.N.V. Ramana, Lant H. Pritchett, and Adam Wagstaff. 2002. *Better Health Systems for India's Poor*. Washington, DC: World Bank. https://doi.org/10.1596/0-8213-5029-3.

Philip, Kavita. 2016. "Telling Histories of the Future: The Imaginaries of Indian Technoscience." *Identities* [Yverdon] 23(3): 276–293. https://doi.org/10.1080/1070289X.2015.1034129.

Rajasekhar, D., Erlend Berg, Maitreesh Ghatak, R. Manjula, and Sanchari Roy. 2011. "Implementing Health Insurance for the Poor: The Rollout of RSBY in Karnataka." Research Paper, Suntory Centre, Suntory and Toyota International Centres for Economics and Related Disciplines, London School of Economics and Political Science. sticerd.lse.ac.uk/dps/eopp/eopp25.pdf.

Rao, Ursula. 2013. "Biometric Marginality." *Economic and Political Weekly* 4813: 71–77.

Rao, M. Govinda, and Mita Choudhury. 2012. "Health Care Financing Reforms in India." Working Paper 2012–100, National Institute of Public Finance and Policy. http://www.nipfp.org.in/media/medialibrary/2013/04/wp_2012_100.pdf.

Reshmi, B., N. Sreekumaran Nair, K. M. Sabu, and B. Unnikrishnan. 2007. "Awareness of Health Insurance in a South Indian Population – A Community-based Study." *Health and Population: Perspectives and Issues* 30 (3):177–188. doi: 10.4103/0970-0218.69288.

Roy, S. 2016. "Angry Citizens: Civic Anger and the Politics of Curative Democracy in India." *Identities* [Yverdon] 23(3): 362–377. https://doi.org/10.1080/1070289X.2015.1034131.

Sengoopta, Chandak. 2004. *Imprint of the Raj: How Fingerprinting Was Born in Colonial India*. London: Pan Books.

Shahrawat, Renu, and Krishna D. Rao. 2011. "Insured Yet Vulnerable: Out-of-Pocket Payments and India's Poor." *Health Policy and Planning* 27(3): 213–221. https://doi.org/10.1093/heapol/czr029.

Sharma, Aradhana, and Akhil Gupta. 2006. "Introduction: Rethinking Theories of the State in an Age of Globalization." In *The Anthropology of the State: A Reader*, ed. Aradhana Sharma and Akhil Gupta, 1–42. Oxford: Blackwell. https://doi.org/10.1385/CBB:44:01.

Srivastava, Sanjay. 2012. "Duplicity, Intimacy, Community: An Ethnography of ID cards, Permits and Other Fake Documents in Delhi." *Thesis Eleven* 1131: 78–93. https://doi.org/10.1177/0725513612456686.

Sun, Changqing. 2011. "An Analysis of RSBY Enrolment Patterns: Preliminary Evidence and Lessons from the Early Experience." In *India's Health Insurance Scheme for the Poor: Evidence from the Early Experience of the Rashtriya Swasthya Bima Yojana*, ed. Robert Palacios, Jishnu Das, and Changqing Sun. New Delhi: Centre for Policy Research.

Swarup, Anil. 2013a. "Interview with Anil Swarup on India's RSBY scheme." YouTube video, 3:04, posted by Social Protection Floor in Asia, 18 March 2014. https://www.youtube.com/watch?v=KY1k5d6FG2o&t=9s.

Swarup, A. 2013b. "Smart card system of India's RSBY scheme." YouTube video, 6:42, posted by Social Protection Floor in Asia, 18 March 2014. https://www.youtube.com/watch?v=fm5FmLLKwQo

Weber, Max. 1978. *Economy and Society: An Outline of Interpretive Sociology*. Berkeley: University of California Press.