

URSULA RAO

Policy as Experimentation

Failing 'Forward' Towards Universal Health Coverage in India

Abstract: The article starts with puzzlement about the optimism of a new generation of (Indian) policy-makers who believe that investing in digitally managed publicly funded health insurance (PFHI) schemes can dramatically improve health security in India, provide poor people with seamless access to high-quality hospital care and contribute significantly towards achieving universal health coverage. In view of persistent high social inequality and dissatisfaction with the chronically underfunded medical system, this optimistic vision appears as a curious utopia, not least because it survives multiple failures and heavy critique. Fine-grained ethnography shows that in practice the ambitious transformation of health finance, via the operation of national health insurances projects, was slow to be established and plagued by myriad technical and administrative frictions, and its impact on wellbeing and sustainability has been heavily contested. By zooming into the nitty-gritty of the laborious roll-out of a project with dramatically new features, this article illustrates that hope for transformation emerges less from successful implementation than from the determination to keep trying – seeking improvement through tweaking the system and reforming policy. Welfare in this iteration is an experimental engagement with future-making. As such, it does not promise effective management *per se*; rather, it demands investment in an uncertain journey, cobbled together by tinkering, adjusting, reforming and re-regulating.

Keywords: digital governance, experimentation, India, policy, publicly funded health insurance (PFHI), PM-JAY, RSBY

It had just turned twelve noon, and as I stepped out of the air-conditioned car it took me a minute to adjust my eyes to the glaring sunshine. I had arrived in a small town called Alva, at the enrolment centre for a national health insurance scheme for poor people (Rashtriya Swasthya Bima Yojana, RSBY). Pradeep, the RSBY quality assurance officer from the Department of Health and Family Welfare of the Government of Chhattisgarh, had agreed to take me on a tour through several districts of the state so that I could better understand how, and whether, RSBY worked. In Alva, I found women waiting patiently in the hot sun. I walked up to number eight in the queue, a woman called Leena, introduced myself, and asked why she had come. 'To get the new health card', she said, predictably. 'They told me that you get a piece of paper to enrol. Do you have it?' I asked. She replied that she did not have one, but that her neighbour had told her about the enrol-



ment camp, and since she had a ration card for people living below the poverty line she expected that she would also be eligible for RSBY.

We continued our conversation. She spoke about her work as a housekeeper – how she left the house each morning after dropping the kids at school to clean in several middle-class homes, and thus had missed the health worker when she came by to deliver the enrolment slips for RSBY. She had decided to try regardless, and when she reached the table 30 minutes later, she confidently told the computer operator Manav that her name would be in the list. Annoyed by the missing slip, Manav somewhat reluctantly loaded the below-the-poverty-line (BPL) data. This took ten minutes. Manav cursed the computer; his was a high-pressure work environment in which payments depended on the number of issued health coverage smart cards, and while each station had a daily enrolment capacity of 60 families, operators usually managed to enrol no more than 40 families, being slowed by their overburdened computers and complicated communication with semi-informed customers. Loading databases was particularly time-consuming. Once the portal had finally come up, Manav checked for Leela's name and did not find it. He checked again and then said 'I can't waste more time on this. Go to the other table and fill in the form!' Leela did as she was told. The form was an application for MSBY (Mukhyamantri Swasthya Bima Yojana, 'Chief Minister's Health Insurance Programme'). MSBY is a state-funded non-targeted replica of RSBY that provides the exact same benefits to all residents of the state regardless of their economic status. For poor people, MSBY became a way to circumvent the BPL criteria, and in this case allowed Leela to sign up for the insurance despite the difficulties with the database.

This scenario took place in 2015, five years after the launch of RSBY. By that time the health insurance scheme had matured in some states and failed in others. Chhattisgarh had emerged as the model state, where RSBY had functioned for ten years before it was absorbed into the even more ambitious PM-JAY (Pradhan Mantri Jan Arogya Yojana) project.¹ RSBY provided people living below the poverty line with an annual insurance coverage of RS30,000 (about US\$400) for in-hospital treatment in all participating private and public hospitals. The publicly funded policy covered up to five family members, whose biometric and demographic data were stored on a smart card for secure identification at hospital receptions. Reading the card details would trigger a complex digital communication processes – facilitated by Third-Party Provider – that would link hospitals to insurance companies for the purpose of organising reimbursement and generating treatment statistics. In theory, the project provided poor people with a seamless service; in practice, everyone knew that the coverage was limited, the annual renewal would pose problems and the technical infrastructure was not yet in place. Leena's case reveals a typical complication of welfare projects as well as one workaround. In this case, the information campaign, despite much effort, was ineffective, since Leena's data could not be identified on the badly organised BLP database without the number on the enrolment slip. As an alternative, the

computer operator offered her enrolment in MSBY. Although meant to help the lower middle classes, the project also became a means to work around eligibility issues and provide pathways for people to overcome a common blockage. Such policy tweaks and their creative appreciation help to explain the longevity of RSBY in Chhattisgarh.

One of the controversial features of RSBY, and its successor PM-JAY, is their complex technical set-up, which is prone to failure and requires all stakeholders to possess a high degree of digital competence. Another more fundamental critique reveals rifts in the assessment of the private medical market and its ability to provide cost-efficient healthcare solutions. In policy circles many are convinced that government hospitals could never satisfy the growing and diverse health needs of India's huge population. Publicly funded health insurance (PFHI) schemes then appear as an important complement to the tax-financed health infrastructure, since they allow poor people to access high-quality private healthcare that they normally could not afford. In this reading, PFHI schemes liberate poor people from having to seek healthcare at underfunded and overcrowded government hospitals and enhance their health security by giving them a choice of healthcare provider (Dilip 2012; Swarup and Jain 2011; Reddy et al 2011). However, critics counter that subsidies for expensive care in private hospitals are unsustainable, weaken the public health system, and negatively impact preventive and primary care. For them, massive investment in PFHI is an ethically problematic subsidisation of an under-regulated private medical market that wastes much-needed state resources and traps poor people into paying more rather than less for necessary medical treatment (Devadasan et al 2013; Dasgupta et al 2013; Ecks 2018; Hooda 2020b; Nandi et al 2012).²

In this text, I do not seek to take sides in the debate on PFHI. Instead, I try to understand how they continue to survive in India despite the controversy that surrounds them and their limited success in reducing catastrophic health expenditure (Hooda 2020a). I report from a long-term research project³ that traces the emergence of ideas for alternative health finance in policy documents, studies cases of breakdown, improvisation and reform, and reflects on the role techno-optimism plays in keeping PFHI schemes afloat. In a country that possesses the largest biometric database of the world (Aadhaar),⁴ instated to grant citizens friction-free access to public and private services and make services interoperable, burgeoning investment in digital governance fosters the hope that reorganising the state in the image of a platform (Singh 2019) will solve key issues of social security (Cohen 2019). The evolution of PFHI schemes is a case in point. Adopting these schemes, the state acts in the role of an aggregator that organises access to medical care on the private market. Thereby, it is liberated from the role as sole provider of free healthcare. Such a reworking of the health system embodies the hope to strengthen social security through harvesting the benefits of market competition (see Prince, this issue). This new version of a public-private partnership in the health sector is linked to the assembly of a complex

digital infrastructure for the management and surveillance of all stakeholders that is supposed to enhance management capabilities of the state, thus delivering the benefits of health security while simultaneously taming the market and bending it towards the collective interests of the nation.

Focusing on alternating moments of breakdown and reform, this article highlights the essentially experimental character of the digitising mission. Following the evolution of digitally enabled PFHI, their invention appears to be not so much a confident new project as an experimental engagement with the social, driven by the utopian desire to bring about fundamental change. It is a curious utopia, because there is no indication that the new system works better, nor a clear endpoint of convergence, when the social would resemble the ideal type utopian model. Instead, the motion 'forward' is marked by an ongoing flow of change – and communication about necessary, planned and desired change – that pulls actors in multiple directions. The contentious investment in trying to make a policy work despite the odds is stubbornly upheld amid the tedious labour of building really existing institutions. To develop this line of argumentation, in the next section, I introduce the hope policy-makers in India attach to experimentation with insurance schemes as a way to reform health finance. I reflect on this hope in view of an academic debate about the role of uncertainty and emergence as part of knowledge practices. The second, ethnographic, section spells out some key moments in the evolution of RSBY and their relevance for PM-JAY. I describe certain changes made in the course of the making of RSBY and PM-JAY, the circumstances that inspired the changes and their sometimes unexpected consequences. While things never ran smoothly, every change and new idea that altered the course of action rekindled the hope that, ultimately, PFHI could be made to provide sustainable and effective healthcare to the poor.

Experimental Engagement with Healthcare Finance

In the mid-twentieth century, following a comprehensive study of the epidemiological situation in India, the Bhore Committee (1946) developed a wide-ranging plan for a state-financed health system that would provide universal healthcare to all citizens of independent India. It defined the contours of India's subsequent tax-based national health infrastructure, which however never managed to satisfy the aspirations associated with it. All subsequent five-year plans have complained that the Indian health system suffers from under-funding and is in urgent need of reform (Duggal 2001). From the 1980s onwards,⁵ high-level policy papers have recommended health insurance companies as additional coverage for private treatment that would complement the overburdened government hospitals. This notion gained additional traction with the liberalisation of the economy in the 1990s, and was spurred on by the demands for structural adjustment programmes and fiscal discipline imposed by the World Bank. In 1997, the Ninth

Five Year Plan (Government of India 1997) emphasised the usefulness of PFHI as a means to protect families from catastrophic health expenditure, and it recommended that the government ‘evolve, test and implement’ affordable insurance models for poor people. By 2002, the government promised to launch a health insurance scheme for the unorganised sector and develop affordable health insurance solutions for different income groups (Government of India 2002: 83, 135–141). These documents strongly endorse the private medical market and suggest using digital technology to efficiently and transparently manage novel service solutions. Health finance is treated as an area ‘where many *experiments* need to be encouraged to discover what can work best for people’ (Government of India 2008: 105, my emphasis). The mantra is repeated five years later in the programme for Universal Health Care. The Twelfth Five Year Plan (2012–2017) quotes the recommendation of the High Level Expert Group: ‘State governments should consider *experimenting* with arrangements where the state and district purchase care from an integrated network of combined primary, secondary and tertiary care providers’ (Government of India 2012: 11, my emphasis).

In the 2010s the call for policy-makers to experiment manifests also as a willingness to test new technologies to calibrate a digitally mediated market for state-financed health services. RSBY is a key player at this time of rapid digitisation, and was assembled during a fairly hectic start (Shroff et al. 2015; Swarup 2019, 2020). In a matter of months, a task force, led by the Secretary of Labour Sudha Pillai and the IAS officer⁶ Anil Swarup, designed an entirely new approach to securing the health of the unorganised sector, using a complex and as yet untested digital set-up.

There were indeed many cashless health insurance schemes but at that time there wasn’t any paper-less scheme. Similarly, no scheme in the country was portable. All this required sophisticated technological interventions. . . . It was at this stage that an offer came from the local representative of the World Bank. Robert Palacios went out of his way to divert some funds available with the Bank This money was utilised to develop and test the software and also prove that the ideas that we were developing would work. (Swarup 2020: 139; see also Swarup 2019)

At every step of the way, building RSBY proved to be challenging. Insurance companies were initially reluctant to support a government project for poor people, stakeholders were not digitally literate and hospitals were of varying quality. During the roll-out, biometric technology proved to work poorly, beneficiaries lacked information, the scheme’s benefits were hard to communicate and reimbursement caused a huge amount of friction between hospitals and insurance companies. RSBY particularly struggled in rural India, where many places were off the grid. Over the course of RSBY’s ten-year existence, each of these problems was discussed, reflected on, mulled over – and some were solved by tweaking the system. Reforms created new ripple effects, leading to new cycles of failing and learning. When, after ten years in government, the UPA alliance lost power to the

BJP-headed coalition under Modi, RSBY no longer had the necessary backing of the national government. However, rather than disappearing, it was reimagined as PM-JAY, a similar project using the same infrastructure but provided with an increased budget. The annual insurance sum has now been raised to RS500,000 (about US\$6,700), the cap on family members lifted, and further groups of beneficiaries and medical packages added. Moreover, states have been given more flexibility to tailor the projects to their specific situations – importantly, state governments can now choose between ‘assurance’ and ‘insurance’ models. In the latter, claims are processed and paid by a contracted public or private health insurance provider; in the former, states form trusts that act as insurers and directly pay the medical bills. Like its predecessor, PM-JAY is advertised as a significant step toward greater health security. In five years, the mission statement promises, with a nod to Sustainable Development Goal 3.8,⁷ that India will ensure ‘financial protection against catastrophic health expenditure and access to affordable and quality healthcare for all’.⁸

If reading high-profile policy documents draws attention to the growing demand for experiments in health finance, then studying the development and implementation of RSBY close up – its operation and slow decline as well as its later re-imagining as PM-JAY – draws attention to the malleability of policy. Institutions, such as healthcare infrastructures, are always in a process of emergence and continuously update their operations in reaction to fiscal demands, historical challenges and emerging realities. Many of these activities of recalibrating operations stay below the radar of public attention. In turn, dynamic adjustment is easily observable at a time of proliferating silver-bullet ideas that quickly travel and are adopted, transmuted, changed and eventually folded into the next project. It is the time of ‘fast policy’ as a form of ‘experimental statecraft’ (Peck and Theodore 2015). Policy under these conditions must adapt quickly to constantly changing market conditions under neoliberal capitalism. Like Peck and Theodore, Jessop (2008) links experimentation to policy’s new short-windedness. Without sufficient time for planning, consultation and testing, there is ‘rapid programme rollout, continuing policy experimentation, institutional and policy Darwinism, and relentless revision of guidelines and benchmarks’ (Jessop 2008: 193). Such a description draws attention to the provisional character of policy; yet it also risks romanticising earlier periods as times of proper planning. The well-documented history of failed projects (e.g. Scott 1998; Ferguson 1990; Ssorin-Chaikov 2016) should act as a reminder that there was never a time when rational planning superseded the need for adaptation and change. Knowledge has never been secure, and policy roll-out is always an uncertain process of learning-by-doing.

Policy as a mode of experimentation extends beyond the archetypal laboratory. Here, ‘experimentation’ does not denote a highly controlled and replicable study that grounds scientific findings; rather, it demarcates a social process that unfolds in real life, one that often reacts to dramatic occurrences in the world.

In view of global food crises, the UN deems the risky roll-out of gene-modified seeds preferable to a predicable future of food shortage (Phillips and Ilcan 2007).⁹ Similarly, health emergencies such as HIV/AIDS or Ebola regularly trigger hasty interventions in the form of risky medical experiments that are administered in heavily affected areas and are justified as necessary exceptions (Nguyen 2007). With a view to global power dynamics, Petryna (2007) castigates such experimentations as de-humanising. Multinational corporations gain arbitrage by exploiting the bioavailability of people in poor countries who are used to test technologies that will eventually deliver safe solutions to the rich. Such experiments put the lives of some people at risk in order to save the lives of others, and thus are criticised as forms of neo-imperialism. The establishment of PFHI schemes is of a different order, however, and concerns not dramatic exceptions but the quotidian reality of bureaucratic processes. There are some general similarities, since the reform is underscored by a deep sense of crisis within the Indian health-care system, and is driven by an enthusiastic embrace of the capitalist market and fuelled by the financial interests of health insurance companies, private medical providers and technology providers. To harvest the resources of the private medical market for an integrated system for universal health coverage, policy-makers seek to develop a system that will supplement the health infrastructure with a popular health insurance scheme for the poor. This radical idea would be implemented through testing a brand new technology that enabled reimagining the relationship between state and market (Nilekani and Shah 2015).

To comprehend the process of trial and error that accompanies making new institutions, a broad notion of 'experiment' is required. Here, experiment describes an open-ended social process characterised by a high degree of reflexivity and self-observation. Matthias Gross and Wolfgang Krohn (2005) map the history of a sociological debate that started with the hope that human society could be improved through controlled social experiments and social engineering. The idea that society could be manufactured according to an overarching plan, widespread in the first half of the twentieth century, was gradually replaced by a recognition that social relations are highly complex, human interaction contingent, and the future unpredictable. Reform, then, increasingly became a process of reflective engagement with an emerging reality, and development a cautious process of trial and error (Rottenburg 2009; Ssorin-Chaikov 2016). For example, Pritchett and Woolcock suggest experimentation as a remedy for the failure of earlier solutions: 'Development professionals need to help create the conditions under which genuine experiments to discern the most appropriate local solutions to local problems can be nurtured and sustained' (2004: 207).

The study of experimentation as a key component of modern statecraft requires recovering the history of a long-drawn-out process of twists and turns. States change continuously as new projects are introduced. They might begin as pilot projects that should 'prove the concept', yet in practice the test phase and

actual implementation bleed into one another, not least because scaling up poses its own set of problems, so that, at every stage, tweaks are introduced that alter the system with the goal of making it function better, or differently. These minor and major changes are often spoken about in the language of ‘improvement’, evoking the modernist imagination of linear time, the time of development, which presents the future in aspirational terms, as providing a pathway towards continuous betterment. In this framing ‘failure’ is the opposite of improvement, and yet at the same time it is integral to its working. The perceived failures of previous developments provide the impetus for new initiatives, and insofar as they provide the necessary lessons to be learnt for future success, they figure as the necessary stepping stones for improvement (Appadurai and Alexander 2020; Malpas and Wickham 1995; Maxwell 2007; Prince and Neumark, this issue, Pritchett and Woolcock 2004). Scholars have pointed to the ideological underpinnings of these narratives of improvement and shown that their various iterations – as imperialism, rational planning or market reform – produce debris and ruins (Ssorin-Chaikov 2016; Stoler 2013), act as anti-politics machines and occlude the disempowering effects of development projects (Ferguson 1990), or responsabilise citizens while hiding the structural violence of market regimes (Rose 1999). Some failures become endpoints and lead to systems being abandoned (Miyazaki and Riles 2007). Yet, major policy reforms, that introduce new expensive systems, are hard to abandon, not least because every system will be seen to have advantages, along with producing many failings and disappointments. The latter are approached through further reforms, leading to new innovations and learnings. The outcome of this process of learning by doing is uncertain and it is unclear who will, in the end, consider the ongoing development a success (see also Prince, Cross and Street, Redfield, this issue).

PFHI schemes provide an excellent case in point. While they are gradually made increasingly functional and also provide poor people (selectively) with access to high-quality (expensive) hospital treatment, their ability to improve health security in the long run is put in doubt. Can investment in the private medical market be a sustainable alternative to care provided by state institutions? Should all treatment be free, or should India prioritise universal *primary* healthcare, and leave it up to individual families to decide if they want to invest in expensive curative care? These are only some of the issues raised by critical observers of a medical market in which aspirations will forever exceed the financial possibilities of families, states and economies. However, ideological disputes and the sobering experience of the inefficiencies of the everyday state do not obliterate the belief in improvement or the hope for a better future (Li 2007). They provide fuel for a constant process of re-imagining the social. And critique from inside and outside the operation of power is the starting point for novel imaginations of, and impulses towards, reform.

The description of policy as experimentation, or continuous learning-by-doing, seemingly contradicts public announcements that are often steeped in

development optimism. It also exceeds the intention of the planning moment, when stakeholders might indeed be convinced that a new policy will fix the identified problem, only to realise later that the intervention has multiple ripple effects that must be dealt with in order to save the project or reach the defined target. However, rather than dismiss the hope associated with market dynamics and digital governance as mere political propaganda, misguided ideology or blind techno-optimism, I treat them as crucial drivers of reform. In the spirit of this special issue, I ponder the significance of utopian imaginings and study the work techno-optimism performs to keep engaged an army of people who seek to improve access to healthcare through flexible solutions and a spirit of reform. Here, the curious utopia manifests as the insistence that access to high-quality care for all is possible, a goal that is stubbornly upheld while dealing with multiple challenges of an expensive and unevenly implemented project (see, for example, Beckert 2016). A return to the case study serves to illustrate instances of practical innovations that accompany the making of nationwide PFHI schemes, in their iterations as RSBY and PM-JAY.

Making RSBY Inclusive

Two key concerns haunt a health insurance scheme for the BPL population, namely the problems of inclusiveness and cost efficiency. Here, I deal with them in turn. From the beginning, RSBY suffered from massive exclusion errors, a fate it shared with most Indian welfare projects. Across a whole spectrum of projects, people living below the poverty line were unable to access government subsidies due to a lack of knowledge, missing ID documents, slow processing of applications, caps on beneficiaries, corruption and fraud. It was hoped that the roll-out of biometric identities would solve these persistent access issues, allowing for a fraud-free, instantaneous identification of beneficiaries (Nilekani and Shah 2015). RSBY was founded on this positive evaluation of the capability of modern fingerprinting technology and was the first project to scale up biometric identification procedures for the purpose of welfare delivery, even before Aadhaar was fully functional. However, fingerprinting technology proved to work poorly among members of the working class, leading to a rejection rate of up to 70% at hospital receptions in the first year. The result was worrying, and led to a three-year process of consultation and tinkering. Eventually, a sustainable solution was negotiated and the identification requirement was relaxed. Rather than mandating a positive match from the patient during the biometric identity check, the hospital could accept any person as a patient under RSBY who was listed on a valid smart card. If they could not prove their personal entitlement, the person could bring a relative also listed on the same card who would pass the biometric verification test and assure the hospital that the patient was indeed their relative and among the people listed on the card (Rao 2018). The changed verification

procedure smoothened the admission procedures, but it certainly did not eliminate all inclusion issues (Rao 2019).

Lack of awareness and database issues were other crucial roadblocks. In the first year of the policy, enrolment figures in all participating states were dismally low, mainly because beneficiaries had not heard of RSBY, did not comprehend the meaning of insurance or failed to prove their eligibility. The initial slow uptake posed a severe threat to the project as a whole, not just because few people benefited from the additional funding, but because insurance companies threatened to desert a project whose feasibility fundamentally depended on risk pooling among a large population. On the day I met Leena, I received a first glimpse of the factors that had turned Chhattisgarh into an RSBY model state. Over the course of several years, the state has built an increasingly elaborate system that fed an ongoing process of reflection and reform. Enrolment is a case in point. Dissatisfied with the uptake in the first year, the state rethought its information campaign, and when the new approach proved to be promising, the government became even bolder: in the third year it extended coverage to potentially the entire population of Chhattisgarh by starting MSBY. Together, these two reforms improved awareness and circumvented the issue of faulty BPL-data (Rao and Nair 2019).

The day of our visit to the enrolment centre in Alva had begun in the office of the District Medical Officer (DMO). On entering the building, we were greeted by a long table with an endless line of neatly arranged piles of paper-slips. I was startled and, asking a nearby bureaucrat what this was for, learned that there was one piece of paper for each household eligible to receive the RSBY smart card. They all had to be distributed. The work would be done by contracted field-workers, who would come later, collect the piles, and distribute the slips during house-to-house visits in their catchment areas. They had the task of explaining the programme and encouraging their interlocutors to take advantage of this offer. The DMO was proud of this system: by creating awareness, showing the way to the station, explaining the project and encouraging people to make the investment, it addressed several problems that usually plagued RSBY's roll-out. Accustomed to seeking healthcare for free or a small contribution in government hospitals, poor people were unfamiliar with the mechanisms of an insurance scheme and found it hard to understand why the government gave them a plastic card rather than money. The social worker took time to explain the mechanics of insurance companies and their usefulness. As the years progressed and people had had various (bad) experiences, beneficiaries were updated about changes to the programme and new grievance mechanisms, and were encouraged to continue trusting this resource. The campaigning helped push up the number of interested beneficiaries, yet it did not resolve the issue of faulty BPL-data. A solution to this latter issue arrived in 2015, when the state decided to expand the reach of the project by starting MSBY, the open-for-all duplicate of RSBY. By effectively abandoning targeting, the state gave a massive impetus for growth and

tackled false exclusions. Leena was among the beneficiaries of this change. When it was her time to sign up, the enroller could not verify her economic status and could not enrol her in RSBY, but instead could offer her the same benefit via the alternative route of MSBY.

The change was applauded by insurance companies. They earned more from the inclusive policy while keeping expenditure steady and potentially reducing their financial risk. However, this was only half of the story: now hospitals were furious and threatened to leave the project. Not all of them had been happy with RSBY in the first place, since it upset their finance model. While the government had argued that hospitals could now tap into new markets by counting poor people as paying customers, hospital administrations countered that the ministry-defined treatment rates for RSBY were paltry, did not meet their expenses and led to dilemmas if they had to treat a person for several illnesses at the same time. What should they do: treat RSBY patients poorly or charge them additional fees on top of the amount taken from the insurance policy? Either of these actions would get them into trouble, ruin their reputation and scare-off paying customers. Eventually, the dust settled and different hospitals made their respective compromises, often by including RSBY in their charity programme, which allowed for cross-subsidising. However, the introduction of MSBY threatened to upset their financial planning once again. During an extensive tour of hospitals in three districts of Chhattisgarh, I found that simple rural hospitals were content since RSBY and MSBY benefited their institutions, while the financial managers of upmarket urban facilities reacted furiously whenever I mentioned MSBY. The fact that the middle class, too, would now stop paying appropriate bills and rely on the cheaper RSBY package rates threatened the financial feasibility of their institutions.¹⁰ Protesting noisily, the hospitals entered several rounds of tough negotiations with the state government until package rates were adjusted, after which MSBY became a firm part of the insurance landscape in Chhattisgarh. Confrontations with hospitals continue and are underscored by a suspicion that MSBY might offer substandard services or be involved in fraud or deliberate attempts to drive up costs. The control of unethical behaviour in the medical market is a key element of new strict surveillance regimes of PM-JAY (Furtado et al 2020).

The case opens a window onto a suite of problems and the lessons that have been taken from them. These are changes to the regime of biometric identification, the relaxation of the BPL criteria, the need for information campaigns, and the balancing out of the fiscal interests of governments, insurance companies and hospitals. Tough negotiation, fiscal analysis, recourse to established means of mobilising the poor, together with techno-optimism and a spirit of learning-by-doing had turned the various issues into problems to be solved. Feedback about the myriad challenges reached decision-makers via a patient helpline, social media, feedback sessions with local workers and various stakeholders, India-wide workshops, real-time data, their own analysis and academic

publications. Software updates, new regulations or laws, financial adjustments or alternative surveillance mechanisms fixed some of the problems – and created new ones in a never-ending process of testing, tinkering and reform. The settling of RSBY/MSBY in place is not a linear story of success or improvement but an attempt to find an acceptable compromise between different economic interests, without ever fully succeeding, as a continuous trickle of critical studies show (Fan et al 2012; Hooda 2017, 2020a; Khetrapal 2019). To provide further evidence for the experimental character of growing with a policy, the next section discusses issues with insurance companies and the shift from an insurance to an ‘assurance’ model under PM-JAY.

From Insurance to Assurance

Along with questions of inclusiveness and reach, problems of sustainability and utilisation have dogged the implementation of RSBY and its successor. From its inception, the national PFHI schemes faced vociferous opposition from proponents of an integrated nationally financed health infrastructure. Subsidising health insurance companies seemed an unnecessary expense that threatened to escalate costs without benefiting the target group. The topic was also hotly debated among representatives of the RSBY in Delhi and Raipur. The first year saw everyone looking closely at enrolment figures, and for a while the continuously growing number of issued smart cards was trumpeted as proof of concept, since they were assumed to indicate the number of people who had access to free hospital care. Very soon though, the naivety of this position became clear, and by now many studies have shown that because hospitals cluster in cities, rural beneficiaries do not necessarily have easy access to quality care. Moreover, not all beneficiaries know how to use the card, can convince hospitals to treat them under the scheme or experience full recovery within the scope of the policy. The moments in the evolution of RSBY/PM-JAY illustrate the changes undertaken to address one specific set of issues, namely to prevent state funds from being syphoned-off by insurance companies that failed to deliver the agreed services.

Soon after the launch of RSBY, the first scandals broke, some of which involved insurance companies. Journalists exposed unscrupulous companies that issued cards and collected the premium without passing on the cards to the beneficiaries. In one case, a whole stack of issued cards was found dumped in a village well, leading to a major investigation of the insurance company in question. Such spectacular cases were only the tip of the iceberg. There were other subtler forms of manipulation, as I learned on board a flight to Raipur, on my way to conduct follow-up fieldwork in Chhattisgarh. During the flight, my seat neighbour made a friendly inquiry, asking why I was flying to Raipur, a city not known for attracting white foreigners. Filled with anticipation, I broke into an animated speech

about RSBY, the plans for paperless health insurance and the energetic Raipur team. When I finally paused, a beaming smile on my face, my seat neighbour replied dryly: 'I worked for them as representative of the GIZ.'¹¹ Recovering from my momentary shock and realising that fieldwork had already started, I quickly asked for more details. The man had been part of an IT team dealing with a major problem: enrolment agencies that were using substandard software and low-resolution biometric capture. Registering a fingerprint on a smart card takes a few minutes because of the amount of visual data required. With two fingerprints of up to five persons per card, even the most motivated enrollers rarely managed to register more than five families an hour. And because their income depended on the number of cards issued, insurance companies had an interest in increasing registration rates. To maximise the income from each enrolment station, some companies had set the resolution of the digital capture very low. This sped up enrolment but also caused issues during identity verification, when fingers were rejected because the fingerprint's master copy lacked sufficient granularity. Here was another issue hindering utilisation. Realising that uniform standards were needed, the ministry deviated from the original plan, developed the software for managing enrolment and usage of the health insurance itself, and mandated that all participants use it.

This moment also underscored that there were innumerable opportunities for manipulation, more than anyone could imagine, and since it was impossible to foresee the next 'creative' act of tinkering and its damaging effects, the ministry in Chhattisgarh used statistics as a proxy for measuring success. 'In the beginning, we did not understand anything, but now we master the digital technology', explained the data analyst in Raipur. By showing me the tables for the treatment periods of 2013 and 2014, he could demonstrate that the utilisation rate had improved but not quite reached the level they had expected. 'We want to see a convergent rate of no less than 98%.' He insisted that a government-funded project must limit the profit private insurance companies could earn from welfare budgets. Accordingly, the ministry preferred state-owned insurance providers over private players, since they would be content with a smaller profit margin. Utilisation data defended the ministry against critics, who saw RSBY as an illegitimate subsidy for private insurance companies that would boost their profits without improving the health status of the population. A conversion rate of 98% would leave insurance companies with a marginal gain of only 2% from the total sum of premiums paid. Pointing to this figure, the government could argue that this was a small price to pay for mobilising the help of experienced insurance providers to tackle the mountainous task of providing tailor-made hospital care to poor people.

Nevertheless, the concern over profits for insurances continued to linger, not least because the High Level Expert Group on Universal Health had cautioned the government against the insurance model in its 2011 report:

Recommendation 3.1.9: Do not use insurance companies or any other independent agents to purchase health care services on behalf of the government. (Planning Commission of India 2011: 12)

Recommendation 3.2.1: All government funded insurance schemes should, over time, be integrated with the UHC system. All health insurance cards should, in due course, be replaced by National Health Entitlement Cards. The technical and other capacities developed by the Ministry of Labour for the RSBY should be leveraged as the core of UHC operations – and transferred to the Ministry of Health and Family Welfare. (Planning Commission of India 2011: 14)

When he announced his reform, Modi honoured this recommendation. He promised India a ‘health assurance project’ that would move the country in the direction of securing universal health coverage. PM-JAY, advertised as the largest health insurance scheme in the world,¹² continued the path taken by RSBY, but with a twist. The government recommended handing over the task of claim reimbursement to a government trust that would pool the risk instead of outsourcing reimbursement processes to insurance companies. Today, of thirty-three participating states, twenty-two use the trust model, while seven states subcontract claim management to insurance companies, and four states have adopted a hybrid model.¹³ During an interview with the founding CEO of PM-JAY, Indus Bhushan, I asked about the advantages and disadvantages of the trust model. He replied that the insurance model was better suited for states with weak management capacity, while strong states could save costs by directly processing claims. As we continued the conversation, it became obvious that the shift had become possible due to years of experience with PFHI schemes, and had benefited from the accumulation of technical knowledge gathered during RSBY’s implementation. Today, many state governments are better equipped to run an insurance project of such scale, understand insurance mathematics and build the necessary digital infrastructure for claim management.

PM-JAY continues a path that began with recommendations by the Planning Commission of India in the 1980s. The call for experiments with insurance-financed health services found takers from the mid-1990s onwards, leading to a series of projects. The discussion about the value of different insurance/assurance models is far from over. Along with its supporters, PM-JAY also has detractors who argue that it fails many poor people, drains state resources and is haunted by the fear of future cost explosion. Despite such critique, PFHI schemes have survived in India, not least because they cater to politicians’ desires for grand announcements and are supported by institutions of global governance and development funds. They are pushed by market ideology and techno-optimism, and as I have shown in this article, their survival is due not least to investment in feedback loops and reform, the activity of learning from failure, and the gradual accumulation of the knowhow of state governments in digital governance, new public management, and ultimately their capacity to create excitement

and expectations, and draw in all stakeholders into new forms of state–market interactions.

Conclusions

The durability of the vision to advance towards universal health coverage by adding PFHI schemes into the mix of free healthcare offerings emerges against the background of a long, drawn-out process of micro-reform. While experts debate the benefits and dangers of a health insurance-based finance model, its effects and position are contingent not just on ideological positionings and political decision-making but on optimising the day-to-day operations of a policy born digital. Because RSBY was the first nationwide biometrically enabled project, the learning curve for participants in the scheme was huge. The project survived in states that gradually built capabilities, invested in technology and human resources, and settled for workable compromises that tamed the exaggerated expectations of all stakeholders.

In this article, I have presented moments of reflection and reform as critical to the survival of PFHI schemes, specifically those that concern inclusion and cost–benefit calculations. Here, I am not arguing for or against this particular approach to health security; rather, I seek to reflect on the conditions that allow a utopian longing to survive in the face of the grinding reality of everyday bureaucratic regimes (see also Prince, this issue). RSBY entered a field unprepared for the comprehensive re-organisation of the health market and experimented with new means of digital management and surveillance. The experiment was far from contained in a pilot, an established method to test a concept before rolling out a new programme. Its pathway more clearly resembles the trajectory of a Gartner Hype Cycle¹⁴ (Fenn and Raskino 2008) – exaggerated expectations led to widespread disappointment, which in turn mutated into a new more stable and less ambitious project. Yet even then, for many reasons, the story of PFHI schemes remains open-ended. The technology continues to evolve rapidly, with a constant flow of new software and hardware updates. The balance between stakeholders is forever contested, and actors constantly find new irregular ways to profit. The medical market is highly dynamic, as are the concerns of public health. And then, as Ecks (2018) points out, it is always possible that a change of government will alter the trajectory entirely. Taking all this into account, the matter is unlikely to be settled soon, not least because the goal of universal health care is nearly impossible to realise with limited funds available.

The study of the unending struggle against the odds during the implementation of a radical idea draws attention to the multiple sites affected by the reform, and highlights plasticity as a key feature of policy in practice. I have treated RSBY/PM-JAY as examples that provide insights into the recursive adjustment of

policy, which has been noted to have accelerated in a contemporary environment characterised by transnational communication, enhanced speed of exchange between stakeholders, high reflexivity (Peck and Theodore 2015) and, in the specific case of a digital ecosystem, the production of real-time data that permits consistent monitoring of a policy's effects. Thus magnified, the experimental character of policy is thrown into sharp relief in projects born digital. By the gradual establishment of new solutions, nationwide PFHI schemes have opened up horizons for thinking differently about healthcare, but there are reasons to doubt that this amounts to 'progress'. Poor people now seek treatment more often in the high-quality settings of private hospitals; however, they also experience the catastrophic health expenditure that often accompanies these choices (Hooda 2020a). As welfare projects, RSBY and PM-JAY come with a disclaimer: the insurance schemes provide privileged access to high-quality care at the cost of imposing new disciplines on all stakeholders and forcing beneficiaries to make difficult choices between seeking the best possible treatment and protecting their families' finances (Ecks 2021). Such an approach defuses responsibility. While governments use projects as evidence of their efficacy during voting season, responsibility for failure is passed around: fingers are pointed at inefficient bureaucracies, at profit-hungry private markets or at uneducated poor people who are unwilling to learn. Failure can be glossed over through announcements of reforms that will fix a problem, this time for good. The notions of 'development' or 'progress' appear flawed labels for such a multi-directional, contested process.

Acknowledgements

Research for this article was conducted over a period of eight years from 2013 to 2021. It was supported financially by the Australian Research Council and the Deutsche Forschungsgemeinschaft. I am grateful for the support of all members of Ankur: Alternatives in Education. The article developed over a long period of time and many friends and colleagues supported me in this process. I would like to thank in particular Ruth Prince and Tom Neumark as well as Andrew McDowell for their time and thoughtful input in the final stages. Finally, I am indebted to the anonymous reviewers and the editor of the journal for their incredibly useful comments.

URSULA RAO is Director of the Department of Anthropology of Politics and Governance at the Max Planck Institut for Social Anthropology in Halle and Honorary Professor of Anthropology at the University of Leipzig. Her research focuses on e-governance and the social consequences of biometric technology in India, and she has recently co-edited the volume *Bodies as Evidence. Power, Knowl-*

edge, Security (Duke University Press, 2018) together with Mark Maguire and Nils Zurawski. Other publications cover topics such as urban space, Hindi and English journalism and ritual theory. email: rao@eth.mpg.de

Notes

1. RSBY has lost political patronage under the new BJP-led national government. Yet, rather than being abandoned, a new similar project was launched and built on prior knowledge and experiences. For a critique of the ephemerality of policy in India, see Ecks (2018).
2. Some critiques identify issues in the spirit of recommending further reform of these projects (Ahuja 2004; Khetrpal 2019; Michielsen et al 2011; Ramprakash and Lingam 2018).
3. This project started in 2013 as a case study of RSBY, first in Delhi and later in Chhattisgarh, and now continues to follow the development of PM-JAY. The study involves participant observation and interviews with beneficiaries, planners and bureaucrats, and the staff of insurance companies, hospitals and third-party administrators.
4. <https://uidai.gov.in/>.
5. See, for a first mention in a high-level document, the first National Health Plan (Government of India 1983).
6. Indian Administrative Service (IAS).
7. <https://sdgs.un.org/goals/goal3>, accessed on 10.11.2021.
8. <https://pmjay.gov.in/vision-mission>, accessed on 07.02.2021.
9. The unequal distribution of risk has a long history and has been integral to imperial projects in which the colonies were used for experiments that produced 'universal knowledge' (Bonneuil 2000; Sengoopta 2003; Tilley 2011).
10. The topic of packages remains contentious also for PM-JAY. Moving on from the RSBY experience, PM-JAY has a more flexible rate allowing for higher rates of metropolitan hospitals. There is an added bonus when certain quality control measures are in place and implementing ministry thinking of a star rating system for hospitals (personal communication Indus Bhushan).
11. The GIZ (Deutsche Gesellschaft für Internationale Zusammenarbeit) is a German development institution that played a major role in getting RSBY off the ground (Khetrpal and Acharya 2019; Swarup 2019; Virk and Atun 2015).
12. <https://pmjay.gov.in/about/pmjay>, accessed on 07.02.2021.
13. <https://pmjay.gov.in/states/states-glance>, accessed on 07.02.2021.
14. <https://www.gartner.com/smarterwithgartner/top-trends-in-the-gartner-hype-cycle-for-emerging-technologies-2017>, accessed 15.11.2021.

References

- Ahuja, R. 2004. 'Health insurance for the poor', *Economic and Political Weekly* 39: 3171–3178.
- Appadurai, A. and N. Alexander 2020. *Failure*. Cambridge: Polity Press.
- Beckert, J. 2016. *Imagined futures: fictional expectations and capitalist dynamics*. Cambridge, MA: Harvard University Press.
- Bonneuil, C. 2000. 'Development as experiment: science and state building in late colonial and postcolonial Africa, 1930–1970', *Osiris* 15: 258–281.
- Cohen, L. 2019. 'The 'social' de-duplicated: on the Aadhaar Platform and the engineering of service', *South Asia: Journal of South Asian Studies* 42: 482–500.

- Dasgupta, R., S. Nandi, K. Kanungo, M. Nundy, G. Murugan and R. Neog 2013. 'What the good doctor said. A critical examination of design issues of the RSBY through provider perspectives in Chhattisgarh, India', *Social Change* 43: 227–243.
- Devadasan, N., T. Seshadri, M. Trivedi and B. Criel 2013. 'Promoting universal financial protection: evidence from the Rashtriya Swasthya Bima Yojana (RSBY) in Gujarat, India', *Health Research Policy and Systems* 11: 29.
- Dilip, T. R. 2012. 'On publicly-financed health insurance schemes. Is the analysis premature?', *Economic and Political Weekly* 47: 79–80.
- Duggal, R. 2001. *Evolution of health policy in India*. Mumbai: Cehat.
- Ecks, S. 2018. 'When the government changes, the card will also change: questioning identity in biometric smartcards for national health insurance (RSBY) in India', *Anthropologica* 60: 190–200.
- Ecks, S. 2021. "'Demand side" health insurance in India: the price of obfuscation', *Medical Anthropology* 40: 404–416.
- Fan, V. Y., A. Karan and A. Mahal 2012. 'State health insurance and out-of-pocket health expenditures in Andhra Pradesh, India', *International Journal of Health Care Finance Economics* 12: 189–215.
- Fenn, J. and M. Raskino 2008. *Mastering the hype cycle: how to choose the right innovation at the right time*. Cambridge, MA: Harvard Business Press.
- Ferguson, J. 1990. *The anti-politics machine. 'Development', depoliticization and bureaucratic power in Lesotho*. Cambridge: Cambridge University Press.
- Furtado, K. M., A. Raza, D. Mathurs and N. Vaz 2020. 'An assessment of the trust and insurance model of healthcare purchasing under PMJAY: examining two states', *PM-JAY Working Paper No. 008*. National Health Authority, Government of India, Ministry of Health and Family Welfare, 1983. National Health Policy, available at https://www.nhp.gov.in/sites/default/files/pdf/nhp_1983.pdf.
- Government of India, Planning Commission 1997. *Ninth five year plan 1997–2001 (Vol. 2)* (<https://niti.gov.in/planningcommission.gov.in/docs/plans/planrel/fiveyr/9th/vol2/welcome.html>) Government of India.
- Government of India, Planning Commission 2002. *Tenth five year plan 2002–2007. Volume II: Sectoral policies and programmes*. Delhi: Government of India.
- Government of India, Planning Commission 2008. *Eleventh five year plan 2007–2012. Volume II: Social sector*. Delhi: Oxford University Press.
- Government of India, Planning Commission 2012. *Twelfth five year plan 2012–2017. Social sectors. Vol. III*. Delhi: Sage.
- Gross, M. and W. Krohn 2005. 'Society as experiment: sociological foundations for a self-experimental society', *History of the Human Sciences* 18: 63–86.
- Hooda, S. K. 2017. 'Out-of-pocket payments for healthcare in India. Who have affected the most and why?', *Journal of Health Management* 19: 1–15.
- Hooda, S. K. 2020a. 'Decoding Ayushman Bharat: a political economy perspective', *Economic and Political Weekly* LV: 107–115.
- Hooda, S. K. 2020b. 'Health systems in transition in India. Journey from state provision to privatization', *World Review of Political Economy* 11: 506–532.
- Jessop, B. 2008. *State power*. Cambridge: Polity.
- Khetrapal, S. 2019. *Healthcare for India's poor. The health insurance way*. Delhi: Academic Foundation.
- Khetrapal, S. and A. Acharya 2019. 'Expanding healthcare coverage: an experience from Rashtriya Swasthya Bima Yojna', *The Indian Journal of Medical Research* 149: 369–375.

- Li, T. M. 2007. *The will to improve. Governmentality, development, and the practice of politics*. Durham, NC: Duke University Press.
- Malpas, J. and G. Wickham 1995. 'Governance and failure: on the limits of sociology', *The Australian and New Zealand Journal of Sociology* 31: 37–50.
- Maxwell, J. C. 2007. *Failing forward: turning mistakes into stepping stones for success*. New York: HarperCollins.
- Michielsens, J., B. Criel, N. Devadasan, W. Soors, E. Wouters and H. Meulemans 2011. 'Can health insurance improve access to quality care for the Indian poor?', *International Journal for Quality in Health Care* 23: 471–486.
- Miyazaki, H. and A. Riles 2007. Failure as an endpoint, in A. Ong and S. J. Collier (eds.), *Global assemblages: technology, politics, and ethics as anthropological problems*, 320–331. Malden, MA: Blackwell.
- Nandi, S., K. Kanungo, H. Khan, H. Soibam, T. Mishra and S. Garg 2012. 'A study of Rashtriya Swasthya Bima Yojana in Chhattisgarh, India', *BMC Proceedings* 6: OS.
- Nguyen, V.-K. 2007. Antiretroviral globalism, biopolitics, and therapeutic citizenship, in A. Ong and S. J. Collier (eds.), *Global assemblages: technology, politics, and ethics as anthropological problems*, 124–144. Malden, MA: Blackwell.
- Nilekani, N. and V. Shah 2015. *Rebooting India. Realizing a billion aspirations*. Delhi: Penguin.
- Peck, J. and N. Theodore 2015. *Fast policy: experimental statecraft at the thresholds of neoliberalism*. Minneapolis, MN: University of Minnesota Press.
- Petryna, A. 2007. 'Experimentality: on the global mobility and regulation of human subjects research', *PoLAR: Political and Legal Anthropology Review* 30: 288–304.
- Phillips, L. and S. Ilcan 2007. 'Responsible expertise: governing the uncertain subjects of biotechnology', *Critique of Anthropology* 27: 103–126.
- Planning Commission of India 2011. *High level expert group report on universal health coverage for India*. New Delhi: Government of India.
- Pritchett, L. and M. Woolcock 2004. 'Solutions when the solution is the problem: arraying the disarray in development', *World Development* 32: 191–212.
- Ramprakash, R. and L. Lingam 2018. 'Publicly Funded Health Insurance Schemes (PFHIS): a systematic and interpretive review of studies: does gender equity matter?', *eSocialSciences & Humanities* 59–79.
- Rao, U. 2018. 'Biometric bodies, or how to make fingerprinting technology work in India', *Body & Society* 24: 68–94.
- Rao, U. 2019. Re-spatializing security in India. Spaces of security, in S. Low and M. Maguire (eds.), *Ethnographies of securitescapes, surveillance, and control*, 231–252. New York: New York University Press.
- Rao, U. and V. Nair 2019. 'Aadhaar: governing with biometrics', *South Asia: Journal of South Asian Studies* 42: 469–481.
- Reddy, K. S., V. Patel, P. Jha, V. K. Paul, A. K. S. Kuman and L. Dandona 2011. 'Towards achievement of universal health care in India by 2020: a call to action', *Lancet* 377: 760–768.
- Rose, N. 1999. *Powers of Freedom. Reframing political thought*. Cambridge, Cambridge University Press.
- Rottenburg, R. 2009. 'Social and public experiments and new figurations of science and politics in postcolonial Africa', *Postcolonial Studies* 12: 423–440.
- Scott, J. C. 1998. *Seeing like a state*. New Haven, CT: Yale University Press.
- Sengoopta, C. 2003. *Imprint of the Raj. How fingerprinting was born in colonial India*. London: Macmillan.

- Shroff, Z. C., M. J. Roberts and M. R. Reich 2015. 'Agenda setting and policy adoption of India's National Health Insurance Scheme: Rashtriya Swasthya Bima Yojana', *Health Systems & Reform* 1: 107–118.
- Singh, R. 2019. 'Give me a database and I will raise the nation-state', *South Asia: Journal of South Asian Studies* 42: 501–518.
- Ssorin-Chaikov, N. 2016. 'Soviet debris: failure and the poetics of unfinished construction in northern Siberia', *Social Research: An International Quarterly* 83: 689–721.
- Stoler, A. L. 2013. *Imperial debris: on ruins and ruination*. Durham, NC: Duke University Press.
- Swarup, A. 2019. *Not just a civil servant*. Delhi: Unicorn Books.
- Swarup, A. 2020. *Ethical dilemmas of a civil servant*. Delhi: Unique Publishers India.
- Swarup, A. and N. Jain 2011. India: Rashtriya Swasthya Bima Yojana, in *Sharing innovative experiences. Successful social protection floor experiences* Vol. 18, 259–268. UNDP, ILO: Special Unit for South–South Cooperation.
- Tilley, H. 2011. *Africa as a living laboratory. Empire, development, and the problem of scientific knowledge, 1870–1950*. Chicago, IL: University of Chicago Press.
- Virk, A. K. and R. Atun 2015. 'Towards universal health coverage in India: a historical examination of the genesis of Rashtriya Swasthya Bima Yojana – the health insurance scheme for low-income groups', *Public Health* 129: 810–817.

La politique comme expérimentation : l'échec à l'avance vers la couverture santé universelle en Inde

Cet article commence par une certaine perplexité face à l'optimisme d'une nouvelle génération de décideurs politiques qui pensent qu'investir dans des régimes d'assurance maladie à financement public (PFHI) gérés numériquement peut améliorer considérablement la sécurité sanitaire en Inde, peut offrir aux pauvres un accès transparent à des soins hospitaliers de qualité, et peut contribuer de manière significative à la réalisation de la couverture sanitaire universelle (CSU). Compte tenu de la persistance de fortes inégalités sociales et du mécontentement à l'égard du système médical chroniquement sous-financé, cette vision optimiste apparaît comme une curieuse utopie, notamment parce qu'elle survit à de multiples échecs et à de lourdes critiques. Une ethnographie fine montre que, dans la pratique, la transformation ambitieuse du financement de la santé a été lente à se mettre en place, qu'elle a été en proie à une myriade de frictions techniques et que son impact sur le bien-être et la durabilité a été fortement contesté. En s'attardant sur les détails du déploiement laborieux d'un projet aux caractéristiques radicalement nouvelles, l'article montre que l'espoir d'une transformation naît moins d'une mise en œuvre réussie que de la détermination à continuer d'essayer – en cherchant à améliorer le système et à réformer la politique. L'aide sociale, dans cette itération, est un engagement expérimental dans la construction de l'avenir. En tant que tel, il ne promet pas une gestion efficace en soi ; il exige plutôt un investissement dans un voyage incertain, bricolé en bricolant, en ajustant et en réformant.

Mots clés : assurance maladie publique, expérimentation, gouvernance numérique, Inde, politique.