Ecoles des Hautes Etudes en Santé Publique

Master of Public Health

Gender Equity in Access to Health Care

How social health protection can tackle access barriers for women and improve gender-related inequities

A case study on India's national health insurance scheme *Rashtriya Swasthya Bima Yojana* (RSBY)

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List of Acronyms

AABY	Aam Aadmi Bima Yojana (Life/Accident Insurance for BPL)
APL	Above Poverty Line
BPL	Below Poverty Line
ESIS	Employees' State Insurance Scheme
FGD	Focus Group Discussion
GHS	Government Health Scheme
GIZ	Gesellschaft fuer Internationale Zusammenarbeit (*German Technical Cooperation)*
GoI	Government of India
IGSSP	Indo-German Social Security Programme
IEC	Information and Education Campaign
ILO	International Labour Organization
INR	Indian Rupee
JBY	Janashree Bima Yojana (Life/Accident)
JSY	Janani Suraksha Yojana *(Cash transfer programme to promote institutional deliveries)*
LMIC	Low- and Middle Income Countries
MGD	Millenium Development Goals
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MoLE	Ministry of Labour and Employment
NFHS	National Family Health Survey
NSS	National Sample Survey
PDS	Public Distribution System
RSBY	Rasthriya Swastya Bima Yojana
SC	Scheduled Castes
SDH	Social Determinant of Health
SHP	Social Health Protection
SPYM	Society for the Promotion of Youth and Masses
SNA	State Nodal Agency *(implementing body of RSBY on state level)*
ST	Scheduled Tribes
STI	Sexual Transmitted Infection
UHC	Universal Health Coverage
UNDP	United Nations Development Programme
WB	World Bank
WHO	World Health Organization

Key terms

Universal Health Coverage (UHC) : The World Health Organization (WHO) defines UHC as providing "access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access".

Social Health Protection (SHP): According to the International Labour Organization (ILO), SHP includes "all public and private measures against the social distress and economic loss caused by the reduction of poverty, stoppage or reduction of earning or the cost of necessary treatment that can result from ill health" and is based on "the core values of equity, solidarity and social justice". (reported in Scheil-Adlung and Kuhl 2012).

Health inequality is a descriptive term used to designate differences, variations, and disparities in the health outcomes of individuals and groups and does not necessarily imply moral judgment. Gender inequalities in health outcomes may reflect biological differences and are not always be an indicator of gender injustice. (Kawachi 2006)

Health inequity refers to those inequalities considered as unjust and unfair because they emerge from socially derived processes (Kawachi et al 2006 and Balarajan 2011). In the context of this study, the equity term is preferred.

Empowerment has multiple facets: it refers to autonomy and decision making power over health, access to and control over resources (such as food, education, income and health care) and opportunities, self-confidence, mobility, domestic violence, political awareness and participation.

Abstract

Background: Gender is one of the major social determinants of health and negatively affects health and access to health care for millions of women worldwide. However, the specific health needs and vulnerabilities of women are rarely taken into account in the design and implementation of Social Health Protection (SHP). This study explores the role of SHP in tackling access barriers to health care for women and reducing gender inequities by taking the example of India's' flagship social security programme, the health insurance scheme *Rasthriya Swastya Bima Yojana* (RSBY).

Methods: The study used mainly a qualitative research approach. A total number of ten focus group discussions with female beneficiaries of RSBY (7), as well as male beneficiaries (2) and non-members (1) werecarried out in two different districts in the State of Haryana. Additionally, expert interviews captured the perceptions of key-stakeholders at local and national level. Secondary data from the RSBY database was used to provide a comprehensive analysis.

Results: The study found that RSBY has started to tackle women's access barriers to health care. The scheme enhances their decision making power and improves access to and control over financial resources in terms of seeking health care. Nevertheless, empowerment at the household level is not translated into an improved social position and bargaining power in the interaction with health care providers. Gender inequities and power imbalances prevail and hamper the access of women to the health care system.

Conclusion: The study identified the need for a greater dialogue on the design level on gender issues. Many barriers stem from the misalignment of incentives and insufficient regulation of different stakeholders. Recommendations include a closer monitoring in order to protect women from providers' ill-mannered behaviour, increased efforts on awareness raising, targeted specifically at women and the development of a gender-sensitive monitoring and evaluation system.

Résumé en français

Contexte: Le genre est l'un des déterminants sociaux de santé le plus important et affecte négativement la santé et l'accès aux soins de santé de millions de femmes dans le monde. Pourtant, les aspects de vulnérabilité et les besoins particuliers des femmes en matière de santé sont rarement pris en compte dans la conception et la mise en œuvre des systèmes de protection sociale en santé. Cette étude explore comment ces systèmes peuvent traiter le problème des barrières d'accès aux soins dont les femmes sont victimes et réduire les inégalités entre les sexes, à la lumière du programme phare de sécurité sociale indien, le système d'assurance santé *Rasthriya Swastya Bima Yojana* (RSBY).

Méthodes: L'étude se fonde principalement sur une approche de recherche qualitative, d'après les résultats de discussions ciblées de groupes organisées dans l'Etat indien du Haryana. Sur les dix groupes ayant participé, 7 étaient composés de femmes bénéficiaires du RSBY, 2 d'hommes bénéficiaires, et 1 de non-membres. Des entretiens d'experts ont également permis de rapporter le point de vue des acteurs clé, tant au niveau local qu'au niveau national. Des données secondaires provenant de la base de données du RSBY ont été utilisées pour approfondir l'analyse.

Résultats: L'étude a montré que RSBY a commencé à s'attaquer aux barrières d'accès aux soins dont sont victimes les femmes, en renforçant leur pouvoir de décision, et en améliorant leur emprise sur les ressources financières en matière d'aspiration aux soins de santé. Néanmoins, cette amélioration au niveau du foyer ne se traduit pas en termes de position sociale ou de renforcement dans le rapport aux fournisseurs de soins, domaines où persistent des inégalités liées au genre qui handicapent sensiblement les femmes dans leur accès au système de santé.

Conclusion: L'étude met l'accent sur le besoin, dans la conception des systèmes, d'une meilleure concertation sur les questions relatives aux différences entre les sexes. De nombreux obstacles proviennent de l'absence de régulation des différents acteurs. Les recommandations incluent un contrôle plus étroit dans ce domaine, qui permettrait de protéger les femmes des comportements discriminatoires, ainsi un effort sur la sensibilisation et l'information à destination spécifiquement des femmes, et enfin le développement d'un système de suivi et d'évaluation intégrant les facteurs de genre.

1. Introduction

In recent years, a growing international movement has been calling for the implementation of Universal Health Coverage (UHC). At the 65th World Health Assembly in May 2012, the Director-General of WHO, Dr. Margaret Chan, reiterated the importance of UHC as *"the single most powerful concept that public health has to offer"*. There is an increased awareness of the role that UHC and social health protection (SHP) can play in reducing health inequities, as Dr. Chan further emphasised: *"It is a powerful equalizer that abolishes distinctions between the rich and the poor, the privileged and the marginalized, the young and the old, ethnic groups, and women and men."*

However, so far, monitoring of gender equity and aspects of inclusion or empowerment of women as one of the most vulnerable groups are rarely taken into account in the design and implementation of SHP. Yet, women and men have different health needs and risks, some of them explained by biological differences (sex), others resulting from socially constructed norms and expectations (gender). There is evidence that women, although having a higher life expectancy than men across the world, bear a greater burden of disease and spend more years living with a disability (Payne 2010; Scheil-Adlung and Kuhl 2012). SHP can play a key role in reducing the health inequities between men and women and improving health care access for women. Furthermore, SHP might even exacerbate gender inequities when it fails to address different needs of men and women and therefore should take into account gender issues.

This study explores the role of social health protection in reducing gender inequities by taking the example of India's' flagship social security programme, the health insurance scheme *Rasthriya Swastya Bima Yojana* (RSBY).

Aim

The aim of this study is to analyze to what extent RSBY contributes to a more equitable access to quality health care forwomen.

Objectives

1. To explore the barriers in access to health care for women
2. To explore whether RSBY helps them to overcome the identified access barriers and contributes to their empowerment (through increased decision making power, access to/ control over resources and improved social position).
3. To explore the experiences of women in accessing benefits of RSBY at different stages (awareness of the scheme; enrolment; utilization of benefits)
4. To assess to what extent health needs and vulnerabilities of women are adequately reflected in the design of RSBY and to what extent the design fosters / hinders gender equity.

As a crosscutting objective, the study tries to pay special attention to intersections with other forms of inequalities related to vulnerabilities across the life cycle (i.e. age, marital status) or social and cultural factors (castes, religion).

Research questions

- What are the gender-related barriers in access to health care for women?
- What are the experiences of women with RSBY regarding awareness of the scheme, enrolment and utilization of benefits?
- Does RSBY provide effective support in overcoming the identified access barriers and improve women's access to health care?

The master thesis is structured as follows: After the introduction, chapter 2 presents the research methodology. Chapter 3 provides an overview of the key concepts underlying an equity approach to health care access and SHP in low- and middle income countries (LMIC). It outlines how gender as a social determinant affects health and results in various access barriers to health care for women. Furthermore, the role of SHP in mitigating these access barriers is analyzed. Chapter 4 applies the conceptual framework to the Indian context and describes gender inequities in health and access to health care in India. Subsequently, chapter 5 presents the key features of the design and implementation of RSBY. It also reviews the extent to which gender dimensions have been taken into account in the design of the scheme. Chapter 6 presents findings on gender issues regarding enrolment and utilization of the scheme by analysing the quantitative data. Chapter 7 presents the major findings from the qualitative research, i.e. focus group discussions and interviews, which are then discussed in chapter 8. Chapter 9 concludes and gives recommendations on the integration of gender aspects in RSBY.

2. Methods

2.1 Study design

The study used mainly a qualitative research approach. It was decided to opt for focus group discussions, as they are well suited for exploratory research into new domains and encourage the expression of different viewpoints on an issue (Greenbaum 1998).

Literature review

In a first step, a review of academic literature has been carried out. The most common databases and journals have been used for literature research (e.g. PubMed, Science Direct) as well as websites and databases of international organizations (e.g. ILO, WHO, WB).

Analysis of RSBY data

State- and district level enrolment and utilization data from the RSBY database has been analyzed to identify potential gender issues and to develop further research questions to be explored in the qualitative research part[1].

Focus Group Discussions

To better understand beneficiaries' perception of the value of RSBY, focus group discussions with female members of RSBY (seven FGDs) as well as male members (two FGDs) and non-members (one FGD) were conducted. The qualitative research part was designed not to measure the extent of gender inequalities within RSBY, but rather to explain how and why these inequalities occur and to learn more about the types of barriers women face when accessing the benefits of the scheme.

The discussions were organized around three themes: (1) Perception of gender roles and empowerment of women in the community, (2) Women's health problems, health seeking behaviour and barriers in access to health care, and (3) Experiences with RSBY and the role of RSBY in overcoming the identified barriers. Most of the time was spent on the latter two themes. However, the questions provided only guidelines, as the objective of FGDs was to obtain as much unknown information as possible. A detailed list with relative research questions for the FGDs can be found in the annex (I).

Expert interviews

In addition, guideline-based expert interviews with key stakeholders of RSBY on local and state level helped to get insights on RSBY design features and gain a better understanding of the implementation process. Subsequently to the FGDs, interviews with public and private health care providers, local heads of the villages (Sarpanch) and implementers of RSBY at local/regional level were conducted in order to compare beneficiaries' points of view with those of implementers and providers. A list of the persons interviewed can be found in the annex (II).

2.2 Data collection

Research setting

Qualitative research was carried out during the months of March and April 2012 in seven different villages of the two districts Palwal and Panipat in Haryana. Haryana is a State in Northern India with around 25.3 Million inhabitants (Census 2011). The majority of its inhabitants belong to Hinduism (84%), followed by Sikhs (15%) and Muslims (1%). The main source of income of this relatively wealthy state is the agricultural and manufacturing sector. The literacy rate is 76.6 %, with 66.8% of women being literate as compared to 76.6% of men (national average: 74%; Census 2011). The

[1] Access to the RSBY database at the Ministry of Labour and Employment (MoLE) was provided as part of the internship within the Indo German Social Security Programme (IGSSP)

child sex ratio, as an indicator of gender inequality (cf. chapter 4.2), is with 800 girls per 1000 boys aged 0-6 the lowest ratio on the national level. The overall infant mortality rate is 60, with substantially higher rates for girls (70) than for boys (51; Ramaiah et al 2011).

Haryana was the first state in India to roll out RSBY. For the insurance year 2011/2012, more than half a million households are enroled in RSBY. Around 600 hospitals have been empanelled across the State. The average utilization rate ranges between 2.24% (third round) and 2.79% (first round). The declining trend from the first round to the third round, which is reflected both in enrolment rate as well as utilization rate, is contrary to a generally positive trend in other states. The utilization rate is slightly higher for females than for males, with 2.52 % and 2.27% respectively in the second round. There is a gender bias in enrolment rates, with a male-female ratio of 144 males enroled for 100 females in the first round, though with a positive trend of129 males enroled for 100 females in the second round. More details can be found in the district report figures in annex (III).

Financial year	Households enroled (Million)	Number of Hospitalizations (Claims made)	Claims Amount (Million Rupees)	Empanelled hospitals
2008-09	0.40	3857	21.6	233
2009-10	0.55	46945	221.6	403
2010-11	0.63	47137	223.5	429
2011-12	0.57	61912	328.6	623

Table 1: RSBY in Haryana

Setting and sampling of Focus Group Discussions (FGD)

The state of Haryana was selected for its accessibility and yet rural setting, as well as its health indicators (such as unequal sex ratios) reflecting gender inequities. Two different districts were purposively selected in order to have a comparison for different implementation processes due to different insurance companies. The selection of the geographical areas for carrying out the FGDs was influenced by the availability of a local facilitator to gain access to the local communities. In Palwal district, support has been provided by the local branch of the NGO “Society for the Promotion of Youth & Masses (SPYM)”, which implements community development programs and self-help groups for women since 1995. In Panipat district, the responsible insurance company (ICICI Lombard) established the contact to local heads of villages called “*sarpanch*”, who are closely involved in the implementation of the RSBY scheme and identification of eligible households. Through the insurance company, villages were selected that had at least 5 claims of female members in the current insurance period. Once in the village, other participants for the focus groups were identified by using a snowball system.

A screening questionnaire has been used in order to ensure that participants suit the inclusion criteria. Only current members of the scheme were included in the discussions; an effort was made to include mainly members who had already benefited from the scheme, as the study was mainly interested in experiences within the health seeking process. Group homogeneity was a major concern; the greater the similarity between FGD participants, the more likely they are to relate to

each other and to express their opinions freely (Greenbaum 1998); therefore inclusion of both younger and older participants from the same household tried to be avoided.

A total number of 10 FGDs with 6 to 12 participants per group were carried out in different villages of rural and semi-urban areas of the two districts. In order to explore different experiences and vulnerabilities of women, discussions were held with different sub-groups of female RSBY members: 1 FGD with Muslim women, 1 FGD with women belonging to a scheduled caste, 1 FGD with widows and elderly women, 3 mixed groups with female members. To also capture men's perceptions on women's health issues, 2 FGDs were carried out with male members of RSBY. 1 FDG held with female non-members explored barriers towards the enrolment into the scheme. A first pilot discussion was carried out to test the methodology and adapt the guidelines.

Procedure

Initial meetings with the local NGO and local government officials for Palwal and Panipat were respectively conducted, mainly to gain entry into the communities, to describe the research focus and also to understand the social dynamics. Inputs had been given to the field workers of the organization to assemble each group of 6-10 participants in a quiet environment within the village itself (common community hall, home of one of the participants, etc.) on a designated day and time. Given the fact that the research period took place during harvesting season and that women could only allocate limited time, some group discussions were conducted in the field during lunch break to allow participation of women.

Each FGD has been facilitated by an experienced female interviewer. Initially, women in the FGDs did not feel comfortable to talk about women's specific health problems and reported not having any specific problem. This was especially the case in the pilot discussion, which was guided by a male moderator; it was therefore decided to conduct further FGDs only with female researchers. Culturally adapted moderation methods were used, such as picture cards with faceless line drawings of individuals performing several tasks related to economic activities, housework and childcare, to initiate discussions on gender roles and perceptions. All FGDs were conducted in the local language (Hindi) and audio-recorded. They were then translated into English and transcribed (simultaneously) by the interviewer. Intelligent verbatim transcription was used for this study; the informational content of data was given priority, unnecessary fillers were cut out and the rest left as it was spoken. Nonverbal information was included when considered as relevant for the understanding of the discussion. Transcriptions were checked by a second person to ensure its quality.

Ethical considerations

Written consent was taken from all participants during FGDs, dictated in the language that they could understand, with the right to participate voluntarily. For illiterate participants, signature was given by the local worker. During data discard, care was taken to ensure safe disposal.

2.3 Data analysis

Results of the focus group discussions were analyzed using N-Vivo 9 software. Thorough reading has been conducted to obtain a general sense of the information and to reflect its original meaning. Subsequently, a coding scheme has been developed and common themes that run across the data were coded. An inductive or deductive approach (Dey 1993) was chosen according to the topic: with regard to access barriers to health care, pre-set categories based upon the rich research literature (cf. chapter 3) were used, and new categories added as they became apparent. For experiences with RSBY and its effect on women's access to health care, categories were defined as they emerged from the data. Once coded, the data was rearranged according to the thematic context. Thereafter, concepts were defined, associations were identified and potential explanations developed.

Quantitative data was analyzed using STATA 11 software.

2.4 Limitations of the study

The use of smart card technology yields a rich and unique database, through which (in theory) each enrolment and hospital transaction of around 80 Million beneficiaries can be traced. Yet, the quality of available data has to be considered with a critical eye in terms of accuracy, completeness, consistency and reliability.

The origins of observed data flaws are various: first, flaws in the lists to identify eligible "Below Poverty Line (BPL)" households, provided by state governments, result in numerous errors in the enrolment data sets. Most BPL lists have not been updated since their elaboration in 2002/2003. Due to migration, death and birth the demographic details of the families are not correct any more, neither rectified by the field team during enrolment. Furthermore, confusion over usage of gender codes (gender codes applied in different states vary between 0-4) and manual errors in the enrolment process deteriorate the quality of enrolment data. Similarly, hospitalization data quality is reduced by errors in date of admission and discharge, as well as manual errors in transaction codes for benefit packages. Whether data errors – for example the maintained utilization of gynaecological packages by men, which account for 8% of the total utilization for male members aged from 21 to 30 - are caused intentionally or by data errors cannot be established with certainty. Precautions have now been taken to avoid these kind of problems in the future by using cross-checking methods, i.e. the entry of "sex=male" will not allow the entry of "relation= mother-in-law" afterwards.

However, these problems still exist in the current available data and jeopardize the scientific validity of any statistical analysis. Especially gender (due to confusion over usage of gender codes) and

age (due to lack of update of BPL data) inconsistencies are matters of concern and seriously compromise any attempt of analysis. Therefore, the initially planned “mixed-methods approach” could not be realized as intended.

With regard to the qualitative research methodology, organization of the FGD and gaining entry into the community was challenging. In some villages, unwelcoming attitude of Sarpanch and mistrust towards the insurance company hampered realization of FGDs. Additionally, timing of field research coincided with the harvesting season, where women could allocate less time for discussions. Targeting of different sub-groups turned out to be difficult, i.e. in case of younger women. Even though an important number of participants belonged to a scheduled caste (SC) or scheduled tribe (ST), this study failed to find any differences associated with caste. Such differences may exist, but discussing these sensitive issue has proven difficult.

Using the insurance company to identify FGD participants could have resulted in a selection bias, though, this has not been found to be of concern. However, a bias consists in having included almost only members of RSBY, thus only those women who successfully overcame the barrier to get enroled. Concerns associated with gender-bias in the enrolment process (i.e. problems related to BPL list) have therefore not been assessed. Unfortunately, participants of the non-members group turned out to be non-eligible to the scheme.

In a first step, FGD participants were asked to identify general access barriers to health care they had faced prior to their membership in RSBY. This could entail a recall bias; furthermore, it turned out to be difficult for participants to distinguish experiences prior / after enrolment.

A general concern with the methodology of FGDs is that participants may be influenced by the groups’ opinion and would not express their own opinion, especially on sensitive issues such as gender discrimination as well assexual and reproductive health issues.

3. Conceptual framework: The gender dimension of health

3.1 Gender as social determinant of health

The Global Commission on Social Determinants of Health (WHO 2008) argues conclusively that health is not only determined by “germs and genes” (Rohregger 2011, p.1), but is to a high extent influenced by social factors. The so-called social determinants of health are the structural determinants, social and economic conditions under which people live and which are responsible for a major part of health inequities. Gender is one of the most influential social determinants of health: the health of women and men is not only influenced by “sex” – biological differences – but also by “gender”. These socially constructed roles and expectations attributed to men and women lead to power imbalances, differential access to and control over resources, as well as a different social

position. Hence, an equity approach to health aims to ensure that both men and women[2] have equal access opportunities to the resources they need in order to satisfy their respective health needs, rather than equalizing health outcomes (Doyal 2000; PHO 2012; Sen and Oestlin 2009; Whitehead 2006).

In most societies, relations between men and women are largely unequal and hierarchical. Lack of empowerment negatively influences the health and well-being of millions of girls and women all over the world (Doyal 2000; Kitts and Hatcher Roberts 1996; Scheil-Adlung and Kuhl 2012; WHO 2008). Although women have a higher life expectancy than men all over the world, they bear the greater burden of disease and spend more years of life with disabilities (Scheil-Adlung and Kuhl 2012; Payne 2009). Empowerment has multiple facets: it refers to autonomy and decision making power over health, access to and control over resources (such as food, education, income and health care) and opportunities, self-confidence, mobility, domestic violence, political awareness and participation.

Over 580 million women worldwide are illiterate, twice as much as men (WHO 2009). Although many countries have achieved gender equality in primary education, secondary education is still more accessible for men than for women. Education influences not only the health of women but also those of their children. The relationship between mothers' education and child development and mortality is well documented; as such, women's lower educational status is the strongest contributor to child malnutrition (WHO 2008). The access to health related education and information increases the knowledge of women on disease prevention and treatment, improves their capacity to assimilate health messages and to take informed decisions. Educated women are also more likely to have access to employment and income. Women also participate less in political institutions and have less political power.

Gender inequalities in employment are manifested by occupational segregation, gender-based wage gaps and women's disproportionate representation in informal employment, unpaid work and higher unemployment rates. In many LMIC, women represent the majority of agricultural workers and are often unpaid (WHO 2009). Even for equivalent work, women are paid 20-30% less than men (WHO 2008). The unequal access to the formal labour market also prevents many women from having access to health or other social protection benefits. Due to gender inequalities in access to formal employment and income, as well as a general lack of power, social status in society and access to economic resources, women are more prone to poverty. Female-headed households account for about one-quarter of the households in the world and are especially vulnerable and disadvantaged (WB 2012).

[2] Gender equity is not only centred on women; however, as in many cases women are disadvantaged as compared to men, this study focuses on health needs of women.

Violence against women - including sexual violence as well as other forms of abuse and exploitation - affects the health of women in a complex way, i.e. harm through injuries, unwanted pregnancies and abortions, mental trauma and depression, anxiety and higher risk for STIs.

3.2 The impact of gender on access to health care

The unequal access to resources, capabilities and rights also affect women's ability to use health care services according to their needs. Especially in LMIC, unmet need results in a lower utilization of health care by women (Scheil-Adlung and Kuhl 2012).

There is a conceptual need to distinguish between constraints limiting the opportunities of men and women that result in gender disparities in access to health care: According to the typology of Kabeer (reported in Thakur et al 2009), constraints can be *gender-specific* (barriers women or men face *because* they are women/men) or *gender-intensified*. The latter are 'gender-neutral', but are exacerbated by gender and have a differential impact on men and women (Thakur et al 2009).

The access to health care depends on a number of supply- and demand side factors. Demand side factors at the individual, intra-household or community level influence the ability of users to avail health services. Supply side factors are those aspects inherent to the health system that influence the use of health care services by consumers. In the literature, most attempts in framing access to health care in low-income countries include four dimensions of access and health seeking behaviour, each having a supply and demand element (Jacobs et al 2011; Peters et al 2008; Ensor and Cooper 2004). No framework in each of these dimensions could be identified that takes into account how gender affects access to health care.

Accessibility refers to equal access to available care for equal need, including geographical access associated with distances to the hospital facility, road infrastructure and means of transport. On the supply side, accessibility is closely linked to the fair allocation of resources (urban- rural bias in resource allocation and health care infrastructure). The inverse relationship between the distance to a health facility and the use of services has been widely documented (i.e. Peters et al 2008). Though geographical barriers affect both men and women, they have a greater impact on women due to cost and safety of travelling, as well as cultural norms that may not allow a woman to travel on her own. A study in Vietnam found that distance to health care facilities is the major determinant of delays in seeking health care for women (Ensor and Cooper 2004). A study in India found that distance is a greater barrier for accessing health care for women than it is for men with a similar income (Vissandjee et al 1997).

Availability refers to the availability of the right type of care when needed. This includes availability of skilled health care service providers, medicines and laboratory services. It may be more difficult for women to cope with non-availability of services, as returning to the health care facility entails

repeated travel and additional costs. Moreover, in many cultures it is not appropriate for women to consult male doctors, though female providers are often not available (Rashid et al. in Ensor and Cooper 2004b). Consulting hours are often not sensitive to gender division of work and women's time constraints during the day**.**

The availability of education is also mentioned as a demand-side barrier for healthcare (Jacobs et al 2011; Ensor and Cooper 2004b); women's limited access to education deprives them from knowledge on providers and treatments available as well as tools to make informed decisions (Paruzzolo 2010; Michielsen et al 2011).

Affordability is one of the most important determinants of access to health care. Financial accessibility includes not only direct costs of treatment, but also indirect costs of seeking health care, such as transportation, expenses on food and lodging, as well as opportunity costs through loss of productivity. Women have less access to and control over financial household resources and participate less in decision making with regard to health care.

Acceptability refers to the responsiveness of the health care system to social and cultural expectations of users and communities (Peters et al. 2008), including trust in the provider, perceptions of health and illness etc.

Health systems often lack responsiveness towards the health needs of women; social and cultural reasons are at the source of pronounced gender inequities in this dimension (ibid). Moreover, the health sector itself is a social institution upholding gender roles and norms and potentially exacerbating gender inequalities (WHO 2008). As mentioned before, it may not be appropriate for women to see a male provider; consequently, the lack of female providers makes it impossible for women to seek medical advice, especially with regard to sexual and reproductive health matters. Acceptability is further linked to a gender-biased priority setting, with studies showing a preferential access to health care for men over women (Ensor and Cooper 2004): women seem to be less likely than men to consult modern health care services, more likely to postpone or forgo treatment, giving priority to needs of other family members rather than to themselves. Moreover, women face important time constraints and other competing demands, such as household responsibilities, child care, food production, subsistence agriculture and other income-generating activities which hamper health seeking behaviour.

Adequacy or **quality** refers to the technical ability of the health care system to provide quality of care for all. The mentioned frameworks consider quality of care as an integral component of each of the four described access dimensions.

The table below shows a summary of the barriers found in the literature along the four dimensions with an indication of gender-specific and -intensified barriers.

Dimension of access barrier	Supply–side barriers	Demand-side barriers	Examples how gender affects these barriers
Accessibility	- Distance of health care facilities	- Indirect costs to consumers (transport, opportunity costs) - Availability of transport means	- Restricted mobility of women
Availability	- Qualified health workers, adequate infrastructure - Convenience of opening hours - Waiting time - Staff motivation - Price and quality of drugs and other consumables - Referral mechanisms	- Information on health care choices and provider - Education (general education and health knowledge)	- Availability of female health care provider - Lower education associated with low ability to assimilate health care messages and make informed decisions - Convenience of opening hours with regard to women's time constraints and competing demands
Affordability	- Direct price of services, including informal payments	- Household resources and willingness to pay - Opportunity costs - Cash flow within society	- Asymmetric access to and control over household resources
Acceptability	- Characteristics of health services / responsiveness - Complexity of billing system and inability for patients to know prices before - Unwelcoming staff attitude, including trust of population; opportunistic behaviour	- Households expectations towards health care provider - Low self-esteem and little assertiveness - Community and cultural preferences of treatment - Beliefs and expectations towards health and illness - Stigma - Lack of health awareness, unfelt need	- Reluctance of women to seek health care outside community - Priority setting - Decision making over treatment by husband / family - Stigma of gynaecological and sexual health problems - Health system unresponsive to women's need

Table 2: Access barriers to health care
Source: Adapted from Ensor and Cooper 2004; Peters et al 2008; Jacobs et al 2011; Michielsen et al 2011

3.3 Applying a gender lens to Social Health Protection

The aim of SHP is to overcome access barriers to health care by protecting against the risk of ill health and alleviating the financial burden related to health care treatment. SHP encompasses various financing and organizational options. Financing mechanisms range from tax-funded national health service delivery systems, social health insurance, private insurance to micro- and community-based insurance schemes[3].There are also important variations in the organisation of SHP with regard to purchasing and provision of services as well as benefits covered (ILO 2007).

SHP is mainly concerned with financial access barriers. However, this may not be sufficient to guarantee access to health care for women. In addition, SHP has to tackle socio-cultural and other (gender-related) barriers that prevent individuals to benefit from the services they are entitled to receive, as pointed out by a newly released UNICEF study (UNICEF 2012). Devereux and Sabates-Wheeler (2004) outline that social health protection should also address concerns of social equity and inclusion in order to become 'socially transformative'. SHP doesn't replace the need for broader policies that address gender inequalities in general, but it has nevertheless the potential to address

[3] Health Insurance is a major component of social health protection policies designed to achieve UHC. This study focuses specifically on health insurance and takes the example of RSBY. However, results are believed to be applicable to the analysis of other forms of SHP as well

these structural factors as well as tackle gender inequities in access to health care (Scheil-Adlung and Kuhl 2012). Furthermore, as pointed out by Luttrell and Moser (2004), SHP programmes are rarely gender neutral and can even reinforce existing inequities if poorly designed.

Nonetheless, surprisingly little attention has been put on 'applying a gender lens' to SHP, by analyzing SHP with regard to the equitable access and use of benefits by women. Studies in Senegal (Asfaw 2004) and Ghana (reported in Scheil-Adlung 2012) found women more likely to be enrolled than men, whereas other studies could not determine any differences (ibid). None of the studies which had identified gender inequalities in enrolment have explored the underlying factors. There is also very limited data available regarding gender inequalities in utilization of SHP benefits. A study on the NHIS Ghana (Mensah et al 2009) found female members were more likely to receive antenatal care, have institutional deliveries assisted by trained health professionals and experience less birth complications.

According to Scheil-Adlung and Kuhl (2012), the following structural factors within the design and financing of social health protection may constitute barriers for women and hinder their equitable access to SHP:

- Gaps in population coverage, as entitlement to SHP is often linked to specific eligibility criteria (i.e. formal employment) which exclude women.
- Deficits in financial protection with persisting out-of-pocket expenditures in form of co-payments, user fees and other expenditures and lack of income loss compensation through illness or maternity
- Provided benefits do not always correspond to the needs of women.

4. Setting the context: Gender, health and social health protection in India

4.1 Gender and equity in India

Gender equity is anchored in the Indian Constitution and has been strengthened by a number of laws to protect women's rights. Despite this strong legal framework, the gap between policy and practice is huge. Cultural and religious norms and values seem to be more influential for women's rights than the legal framework (OECD 2012).

India is the lowest ranking country in the South Asian region on the Gender Equality Index, measuring economic participation, education and empowerment and ranks 114 out of 155 on the gender related development index (GDI). In terms of gender equity in health and survival, India is ranked 132 out of 134 in the World Economic Forum's ranking (Hausmann et al 2010).

Literacy rates are substantially lower for women than for men (65% and 82% respectively, Census 2011). Fewer women participate in the informal or formal labour market (35% compared to 85% of men; Hausmann et al 2010). The lower status of women and discriminatory socio-cultural norms are

the source of various risks and vulnerabilities: gender based violence is widely socially accepted, 39% of married Indian women (age 15-49) have experienced domestic violence (National Family Health Survey NFHS-3; Kishor and Gupta 2009). More than half of both men (51%) and women (54%) think that certain reasons justify a husband beating his wife (i.e. showing disrespect for in-laws, neglecting the house and children, going out without permission; ibid). Early marriage, leading to interruption of education, teenage pregnancy and early motherhood, remains very common in India: 28% of all Indian women between 15 and 19 are married, divorced or widowed (OECD 2012).

Gender inequity has further important intersections with other bases of discrimination such as caste, ethnicity, religion, age and marital status. In the traditional hierarchy of the Hindu castes system, scheduled castes and scheduled tribes (SC: 16% and ST:8% of the population as per Census 2001) are the socially and economically most disadvantaged groups in the Indian society (Balarajan 2011). Even though public legitimacy of caste has decreased, segregation persists and affects health and access to health care. For example, SC and ST have higher odds of mortality (Subramanian 2008) and lower vaccination rates as compared to other castes (39.7%, 31.3% and 53.8% respectively). There is evidence that members of SC, especially *Dalits* (Untouchables) are victims of violence on the part of Non-*Dalits* (Holmes et al 2010). In terms of religion, Muslims (13.4% of the population as per Census 2001) suffer from widespread rejection from the Hindu society. The muslim tradition of *purdah* (segregation of women and men) is persistent amongst both Muslim and Hindu communities in the northern part of India and limits women's mobility and ability of using health services outside the home for themselves or their children (Vissandjee et al 1997). As women live longer than men and because their life expectancy has increased more than that of men, women form the majority of elderly people in the world and are more likely to be left as widows. Widows are more prone to poverty due to their lower economic and social status in India, as well as lack of eligibility to social protection benefits (Sen and Oestlin 2009).

4.2 Health and access to health care in India

Though health indicators in India have generally improved a lot over the last decades, strong inequities in health outcomes persist. The largest part of the burden of disease lies on India's poor population and vulnerable groups: the poorest 20 percent have mortality and malnutrition rates twice as high as the richest quintile (Peters et al 2002).

The child sex ratio[4] is one of the fundamental indicators of gender inequity. A strong preference for sons has led to a marked decline in the sex ratio over time, slipping from 962 in 1981 to 914 as per Census 2011 (reported in Ramaiah et al 2011). Sex ratios are lowest in the states of Haryana and Punjab, with 800 and 846 respectively, and highest in Mizoram with 971 (ibid). The decline can be explained by the increasing availability of ultrasound technology allowing for sex-related abortions

[4] defined as the number of female children per 1000 male children in the age group of 0—6 years

and an unchanged preference for sons while fertility rates decreased (WB 2012). Furthermore, girl child mortality is 40% higher than boy child mortality (Ramaiah et al 2011).

Though there has been a positive trend over the last decades, maternal mortality remains high with 200 maternal deaths per 100 000 live births (WHO 2012). Women's access to health care during pregnancy and childbirth remains limited, with stark patterns of inequality. Women in the richest quintile are three times more likely to have a delivery assisted by skilled health personnel than those of the lowest wealth quintile (89% and 19% respectively; WHO 2012). Only half of mothers (50.2%) received antenatal care from a doctor, and one quarter (22.85%) didn't receive any prenatal care (NFHS-3, Kishor and Gupta 2009).

Barriers in access to health care for women in India

The table summarizes findings of the NFHS-3 and shows that women in India face a number of barriers in accessing health care.

	All women	Lowest wealth quintile	Highest wealth quintile
Hurdles to health care *(% of women age 15-49 who say the specified hurdle is a big problem in accessing health care, by wealth quintile, NFHS-3)*			
Getting permission to go	6.7	10.9	2.3
Getting money needed for treatment	17.3	34.8	3.0
Distance to health facility	25.3	47.4	5.9
Having to take transport	22.9	45.4	4.5
Finding someone to go with you	11.7	21.4	3.3
Concern of availability of female doctors	18.7	30.1	8.2
Concerns of availability of any provider	22.7	35.4	10.8
Concerns of availability of drugs	22.9	36.8	9.9

Table 3: Access barriers for Indian women, NFHS-3

The most common barrier is geographical accessibility, which may be reinforced by *Purdah* restrictions and limited mobility. Only one-third of 15-49 year old women in India are allowed to go unaccompanied to the market, to the health center or elsewhere outside the community (Holmes et al 2010). According to NFHS-3, financial affordability also prevents many women from seeking care. Unavailability of health care providers or drugs are supply driven barriers which are more difficult to tackle for women than for men, as women find it more difficult to come back to the hospital twice if services are not immediately available. Notably, one-fifth of all women report the inavailability of a female health care provider as a concern.

4.3 Social health protection in India

Health financing in India

One of the key factors affecting equitable access to health care in India is the insufficient public expenditure on health, with an estimated 4.2 % of the GDP for 2009 (WHO 2012). India has one of the highest proportions of private spendings worldwide: 70% of health care is paid by private households, out of which 87% is spent as out-of-pocket expenditure (WHO 2012). Health care expenditures are leading to an estimated 39 million Indian people falling into poverty every year. Furthermore, there is a lack of comprehensive methods of risk pooling. However, there has been a

tremendous increase in coverage during the past years, from around 75 million people covered in 2007 to 302 million people in 2010, which is almost one fourth of the population (Reddy et al 2011). Underfunding has resulted in a poor performance of public health facilities and pushes many Indians towards the private sector. India has one of the most privatized healthcare markets worldwide, both in provision and financing of healthcare. However, due to a virtual lack of regulation and poor monitoring of the latter, quality of care is not always better (Miechelsen 2012).

Social Health Protection in India

Since India's independence in 1947, equity in health and access to health care has been a guiding principle of India's health policies, resulting in a number of measures towards social protection in health. In 2008, the Government of India legislated the *Unorganized Workers' Social Security Act* to provide a framework for social protection to its estimated 430 million working population in the informal sector (Swarup and Jain 2011). Furthermore, the rapid economic growth of the country provides a unique opportunity to increase financial commitments towards the health sector.

Various schemes to provide health insurance coverage have been introduced in the past, i.e. the Employees' State Insurance Scheme (ESIS) and the Central Government Health Scheme (CGHS) for employees of the formal sector, as well as numerous programmes on state level to cover the informal sector (Swarup and Jain 2011). India has one of the World's largest conditional cash transfer programmes to promote institutional deliveries among poor women (Janani Suraksha Yojana, JSY); its internationally lauded health insurance scheme RSBY is considered one of the most innovative social security schemes (ILO/ UNDP, in Swarup and Jain 2011) and recently a High Level Expert Group on UHC has been appointed to develop a strategy towards UHC.

However, most of the ambitious government funded schemes encountered massive implementation problems due to poor policy design, lack of clear accountability, failure to reach out to beneficiaries resulting in low awareness and high confusion about the multitude of different and often concurrent schemes. The previously mentioned flagship programme to improve access to health care for the poor, RSBY aims to overcome these weaknesses and will be described in the next chapter.

5. India's national health insurance scheme for the poor- Rashtriya Swasthya Bima Yojana (RSBY)

Rasthriya Swasthya Bima Yojana (RSBY), the health insurance scheme for the population below the poverty line (BPL), has been launched by the Ministry of Labour and Employment in 2008. The primary objective of RSBY is to provide financial protection against catastrophic health expenditures and health related impoverishment by providing cashless hospitalization coverage for BPL families.

Additionally, the scheme intends to improve the quality of care through demand-side financing and consumer-directed empowerment.

5.1 Design of RSBY

RSBY provides hospitalization coverage for up to five members of a household with an annual ceiling of 30 000 INR. The table below provides a summary of the most important elements of the scheme:

Rasthriya Swathya Bima Yojana (RSBY)	
Target group	Initially: Population below the poverty line Specific groups above poverty line, such as workers under the National Rural Employment Guarantee Act (NREGA), domestic workers, construction workers, rickshaw pullers and other vulnerable groups are added gradually
Target population	60 million BPL households (300 million individuals) by 2012
Type of enrolment	Voluntary. States provides electronic lists of eligible BPL households. Insurance companies visit villages to enrol eligible families and issue smart cards on the spot Enrolment unit: Family (max. five members per family). Active enrolment strategy, where insurance companies visit villages to enrol BPL families in each district and issue smart cards on the spot.
Benefit package	Comprehensive hospitalization coverage with an annual ceiling of INR 30 000; 1-day pre-hospitalization and 5-days post-hospitalization covered; Transportation costs of 1000 INR per year (lump sum of 100 INR per hospitalization); Pre-existing diseases covered from day one; No age limit for eligibility under the scheme
Funding	Nominal registration fee of INR 30 per household/year Premiums are subsidized by the central (75%) and state governments (25%) through general tax revenue. Insurers are selected at the state level through a competitive tendering process.
Delivery process	Enroled households receive a biometric smart card, which can be used in any of the empanelled hospitals across India to receive cashless treatment. Hospitals submit paperless claims to the insurance company online.
Institutional Structure	Business model, with primary stakeholders in the scheme: The Central Government, State Governments, State Nodal Agencies, Insurance Companies, Hospitals and NGOs
Providers	Public and private providers empanelled by insurance company. Empanelment based on infrastructure and quality standards Provider Payment Mechanisms: Fee-for-service, Diagnosis-related groups (fixed packages rates defined for each of the covered procedures and interventions)

Table 4: Design Features of RSBY

Innovative design features

RSBY contains several innovative features to correspond to the health needs of the targeted poor people. All transactions are completely *cashless* and don't require poor beneficiaries to pay in advance and get reimbursement later. To avoid complicated procedures which may be difficult to manage for the mainly illiterate target group, the scheme was designed to have *paperless* transactions. To take into account the migration worker phenomenon, the smart card is *portable* and benefits can be availed in every empaneled hospital throughout India.

Use of technology

The high-tech biometric smart card contains fingerprints and photographs of the family members and allows identification in hospitals, thus is supposed to reduce options of fraud and abuse. All hospitals are IT enabled and connected to the common server, allowing smooth data flow regarding utilization periodically. Smart cards should be issued on the spot during the enrolment process.

Provision of health insurance services through public-private partnership

In contrast to traditional government-lead schemes, RSBY is created as a public-private partnership model and involves a number of various stakeholders from the public and private sector, such as state level governments, private-for-profit insurers, public and private health care service providers. Quality of care shall be improved by providing incentives to all stakeholders and by making it attractive for private and public hospitals to provide health care to the poor.

5.2 Implementation of RSBY

Implementation of RSBY: a success story

The success in terms of enrolment figures is impressive; RSBY has become one of the largest health insurance schemes in the world within a few years, providing coverage for 29.7 million BPL households (approximately 80 million individuals).The scheme has been introduced in 409 districts across 25 states and union territories of India so far. Around 3.5 million hospitalization cases have been covered by RSBY since its inception. 10 862 hospitals, of which 7 576 private and 3 286 public facilities have been empanelled (RSBY website, as per May 23, 2012).

The average hospitalization rates for RSBY are comparably higher than the national average: the hospitalization rate for the 314 districts having completed the first round has been 2.6% for RSBY members[5] compared to a national average of 2.4% and 1.7 % for the poorest-of-the poor population (according to the 60th round of the National Sample Survey Organization, NSS-60). However, RSBY performance varies across states and districts, with significant variations in take-up and hospitalization rates across geographical areas and across households. As an example,

[5] Data presented in this section is taken from the completed district records, MoLE, as per March 31, 2012

hospitalization rates vary from 0.02% in Arunachal Pradesh to 5.21% in Kerala (round 1). This suggests the presence of local demand and supply side constraints (Hou and Palacios 2011).

Criticisms of RSBY

Critical voices have raised doubts on the design and implementation process of RSBY (Michielsen 2012; Rajasekhar et al 2011) as well as its financial sustainability (Dror and Vellakkal 2012) and ability to provide financial protection to its beneficiaries (Selvaraj 2012). First, critics point out that RSBY has not been integrated into the national health policy and co-exists / competes with a number of other health programmes on national and state level. Coordination with other sectors, primarily the (not involved at all) Ministry of Health and Family Welfare, is very weak.

An important weakness of the scheme is its hierarchical top-down model which doesn't allow for adequate participation of the community. Currently, the role of NGOs and other grassroot level organizations is, if involved at all, reduced to the promotion of RSBY (Michielsen 2012). Furthermore, targeting - as it has always been in India's social welfare programmes – is a problem. Flaws in the BPL lists' quality, used to identify eligibility of households to the scheme are well documented (Sun 2011, Rajasekhar et al 2011), with a presumed high number of false positives (inclusion of non-poor households on the list) and false negatives (exclusion of poor households from the list). Other implementation challenges include problems with the smart card technology and invalidity of the cards; low awareness among beneficiaries on how and where to use the smart card; delays in reimbursement of empaneled hospitals.

There is also anecdotal evidence of frauds and abuse from insurance companies and health care providers (Rajasekhar 2011). The most well-known fraud example is a health insurance scam in the state of Uttar Pradesh, where claims have been falsified: hundreds of men seem to have their uterus removed, and women had hydrocele testis procedures done (Khan 2010).

Critics also claim that political pressure on the Government to succeed has led to a one-sided emphasis on rolling out the scheme as quickly as possible, by enroling as many eligible BPL-households as possible, with much less attention put on the quality of services. Lack of regulation, monitoring and accountability in the system has been brought up by various authors, especially with regard to the over prominent role of the private sector (Selvaraj 2012, Rajasekhar 2011, Michielsen 2012).

5.3 Integration of gender dimensions in the design of RSBY

To tackle gender-related discrimination and to ensure an equal enrolment of women, RSBY has included a security mechanism in the software which makes enrolment of the spouse mandatory when her name appears on the BPL list. However, inclusion of other female family members won't be influenced by this measure. With regard to the benefits provided, the reproductive health needs of women have been taken into account by the inclusion of maternal health care (normal delivery

and caesarean section, miscarriage or abortion induced by accident or other medical emergency). Antenatal and postnatal care are not included, nor are family planning methods. The links and potential competing aspects with JSY, a cash transfer programme to foster institutional deliveries, are not clearly set out.

Beyond these isolated measures, little attention has been given to explicitly encourage take-up and utilization of the scheme by women. Despite a robust body of evidence on gender-related health inequities in India, tackling gender issues doesn't feature as a programme objective. In interviews with RSBY advisors, the low prioritisation of gender issues is explained by the fact that the scheme is both open to female as well as male BPL card holders and therefore specific considerations to foster the inclusion of women would not be necessary. Moreover, it is assumed that "health need is same for both genders" (Jain 2011, page 56).

5.4 Hypothesis on the potential of RSBY to improve access to health care for women

With regard to the formulated research questions, the following hypotheses are proposed on how RSBY provides effective support in overcoming access barriers (cf. 3.2) to improve women's access to health care:

Accessibility: Barriers related to transport are removed, as these costs are covered by RSBY.
Availability: Through the provision of information on health care facilities and associated services RSBY would tackle demand-side barriers related to information gaps, therefore reducing the power gap between patients and providers linked to asymmetry of information. Furthermore, the SNA and insurance companies are called upon organizing Information and Education Campaigns (IEC), which are supposed to improve general health literacy of women. On the supply-side, RSBY offers incentives to empaneled hospitals to provide quality treatment to the poor and shall act positively on the availability of drugs (specific channels of drug procurement for empaneled hospitals).
Affordability: Unlike the majority of other health insurance schemes, RSBY does not operate on a reimbursement system, and thus does not constitute financial barriers at the point of accessing care. This would increase the autonomy of women, who would not rely any more on their husband to organize money for treatment. The smart card is expected to increasewomen's access to and control over financial resources, thus mitigating asymmetric control over household resources and increasing the decision making power with regard to their own health.
Acceptability: Through RSBY, health care service providers get financial incentives to provide good quality services to the poor. Women's bargaining power and social position towards health care providers shall be improved in the sense of a "consumer directed empowerment". The smartcard has been designed especially for a target group with low level of education; paperless

features shall avoid complex administration and billing systems and facilitate the process of seeking health care for low educated women.

6. Does RSBY improve women's health care access? Results of the quantitative analysis

In terms of access to the scheme, male member enrolment is higher than female enrolment, with 60% men against 40%women (for 314 districts that completed the first insurance year, called "round")[6]. Disaggregated enrolment ratios on state level (see annex IV for details) reveal important variations, with some states having reached almost equal enrolment (such as Jharkhand, with 49% of members being female), whereas imbalances are marked in other states such as Chandigarh, where only 29% of members are women. However, enrolment ratios have improved from round 1 to round 2, with 44% of women enroled in the 154 districts having completed two rounds. A study on enrolment patterns (Sun 2011) did not find a strong gender bias in enrolment, but found that the limit of five members per family has negative effects on the enrolment of daughters as compared to sons when the family counts more than five members.

Interestingly, in contrast to the dismal scenario in terms of enrolment of females, trends regarding hospitalization are very encouraging. Women tend to use services in hospitals more often than men. In absolute numbers, females are still outnumbered by men during the first round: in contrast to 404 951 males that went to the hospital, the number of females was only 263 989 (sex ratio in hospital utilization: 65.1). However, the difference becomes less significant during the second round, when 509 421 males compared to429 651 females used the RSBY services (sex ratio in hospital utilization: 84.3).The female utilization rate[7] (2.77%); was higher than for males (2.56%) even during the first round (for 154 districts having completed two rounds). This trend is also reflected in the state level disaggregated figures (details in the annex IV).

However, it would be premature to draw conclusions on the current status of gender equity within RSBY based on these data. Many issues regarding enrolment and utilization patterns remain unclear, and it has been argued in the sections on data limitations (cf 2.4) that currently available data do not allow for definitive analyses on gender issues within RSBY. More information, i.e. on what kind of services are availed, by which age groups etc. is necessary. As an example, gynecological procedures alone account for 9.6% of overall male and female utilization. Thus, the overall utilization rates could hide substantial gender variations, i.e. a lower utilization of general medical procedures by women. Also, hysterectomy appears as one of the most often used

[6] Data presented in this section is taken from the completed district records, MoLE, as per 31.03.2012

[7] Female beneficiaries utilizing services as a proportion of total females enroled

packages. This should be monitored carefully, as higher prevalence of hysterectomy among insurance members has been reported from other studies in a similar context (Desai et al 2011); and had been shown to be motivated more often by the financial profitability for the doctor than by medical indication (supplier induced demand). This indicates that higher utilization among women cannot necessarily be interpreted as equitable.

7. Does RSBY improve women's health care access? Results of the qualitative research

This chapter presents the major findings from the qualitative research, i.e. focus group discussions with female as well as male members and interviews with key stakeholder at local and regional level.

Profile of Participants

In total, 66 women participated in the 8 female FGDs. Respondents were aged between 22 and 65, with an average age of 41. The level of education was low, with a majority (73%) of women being illiterate or having completed only elementary education (until grade 8; 24%). 76% of the participating women were married; the remaining 24% were widows. Almost all participants – except in the group of non-members – were BPL-card holders. The majority of women are members of a self-help group (64%). A total number of 18 men participated in the 2 remaining group discussions. A detailed list with socio-demographic information on the participants can be found in the annex (V). Information on the key-stakeholders interviewed can be derived from the annex (III).

7.1 Perception of gender roles and the relation between gender and health

The group discussions started with an exchange on gender related tasks in the community in order to stimulate the reflection on culturally shaped gender perceptions and assess the level of women's empowerment in the community. The extent to which women had access to and control over resources and participated in major decisions varied across the participants of FGDs, though overall empowerment as defined in chapter 3. was found to be very low. The most pronounced gender inequities were found among Muslim women, who were much less empowered, had no access to- and control over financial resources, limited freedom of movement and no say in decision making related to health. Though the majority of Muslim women were members of a self-help group (SHG) this had no positive influence on their empowerment. Members of SHG in the other FGDs seemed to be more self-confident, had more control over financial resources and appeared to be generally more empowered. Together with Muslim women, widows and elder women turned out to be the most vulnerable groups, facing significant problems in their daily life as well as in seeking health

care. Generally, the socially attributed gender roles are accepted by the women, even though some women wish to have a greater autonomy.

> What can we do? If men decided, it is done. What can we say. Even if we say something they might simply deny it. *(Female participant, FGD 4)*
>
> We are not interested [in participating in meetings]. Already we have enough work to do, take care of house, children, cooking, laundry, working in the field. Poor woman. What can she do? (…). We all have just one option, work in the field. *(Female participant, FGD 7).*
>
> Let alone cooking. Our men beat us up if we refuse to work in fields. *(Female participant, FGD9)*

It is a general perception among both men and women that women bear the greater burden of responsibilities, work harder and have less time for leisure activities as compared to men. In many villages, women are not only engaged in reproductive activities (child bearing and care) and activities related to household organization, but also have to bear the burden of productive activities and generate income through field work.

Women agree unanimously that gender specific tasks and roles affect their health negatively: hard work and less time for recreation is associated with a number of health problems women have to face. Stress and tension are important factors held responsible for the perceived greater vulnerability of women - reported especially from the group discussions with widows, muslim women and women whose partners drink excessively. The greater vulnerability of women due to unequal repartition of work is also recognized by men:

> Women are more susceptible to illness. (…) The main reason could be water. The quality of water is very poor in this village. (…) Another reason could be heat. Women work in the fields all day long and exposed to sun and heat. That makes them weaker. *(Male participant, FDG 2)*

7.2 Health and health seeking behaviour of women

Unsurprisingly, the morbidity patterns of women reflect a higher prevalence of infectious diseases (with typhoid, malaria and waterborne disease most frequently mentioned) as compared to chronical diseases. Interestingly, participants in the male FGDs were well aware of the specific health problems faced by women and talked openly about the issue. Frequently reported specific health problems of women were anemia, problems related to pregnancy and leucorrhea (vaginal discharge, a common symptom for vaginal infections or STIs).

Health seeking behaviour is influenced by the perception of illness severity and the persistence of symptoms. Only when symptoms persisted, progressed over a longer time period or were really severe, women were likely to seek medical assistance. Especially “women’s” problems are considered as normal, and women usually do not seek treatment.

In terms of provider choice, there is a clear preference for private providers. The quality of care is perceived to be very poor in public health care facilities, and rude attitude of health care providers towards patients results in a general preference for private facilities.

> Public hospitals provide free care but we need to get all expensive medicines from outside. They give only a bed and few cheap injections and medicines. *(Female Participant, FGD 1)*

7.3 Barriers in access to health care for women

Participants were asked to identify the major barriers they face when seeking health care, emphasizing the time period prior to their RSBY enrolment. Problems formulated by the participants were consistent with findings of other studies on health care utilization in similar contexts. In accordance to Kabeer's typology (cf. 3.2), almost each of the identified barriers were exacerbated by gender and had a differential impact on men and women, with women generally facing greater difficulties in accessing adequate care due to their lower social status.

Accessibility: Geographical access as a common problem in rural areas has been mentioned frequently by participating women, even though it was not found to be a reason to postpone or forgo treatment. Some women face difficulties in finding a person to accompany them to the hospital. Women do not feel comfortable when travelling alone, as they would have no one to assist them and give information in the hospital. Therefore, women mainly rely on men to accompany them in case of health problems.

> I cannot go alone [to the hospital]. First of all, I don't know which bus goes to where. I wait for my husband to take me. But we have permission from men to travel alone. *(Muslim women, FDG4)*

Availability: Lack of information with regard to the location of health care facilities and treatment options were found to be a major hurdle on the demand-side when accessing care. Low levels of health literacy may also lead to an unfelt need for treatment or a postponement reported by women for conditions such as antenatal care, childbirth or gynecological problems. As women have no access to information on what kind of treatment is available, they rely on their husband, family members or neighbors.

On the supply side, availability of health care staff and doctors has been reported as a barrier only by a few participants. Availability of female health care providers is not a major hurdle for women when seeking care for general health problems. However, women feel embarrassed to talk about gender-specific health concerns with male doctors.

> Participant: It is so embarrassing to disclose such [sexual health] matters. (…)
> Moderator: When you have such problems do you expect to be seen only by female doctor?
> Participants: [Chorus] Yes. Only by female doctor. We need to talk about it and that cannot be done with a male doctor. *(Female participants, widows, FGD 6)*

Affordability: Financial constraints are the most frequently mentioned hurdle when seeking health care for women. Thereby, the gender dimension of access barriers became particularly apparent: because women are economically dependent on their husbands, they report having less access to and control over financial resources of the household, and have less possibilities to attain money for treatment.

Although most women can take decisions on small household expenditures or health care related treatments on their own, men take major financial decisions with the ultimate control over household resources and demand women to account for expenditures.

They manage all the expenses. We do not question them until we find them extravagant.
(Male participant, FGD 2)
It is good they don't give money to us. Then they would ask us to keep accounts. Now there is no tension: 'You keep the money. You take care of the expenditure. Give money when we need'.
(Muslim women, FGD4)

Women rely on their husbands for attaining money for treatment.

Moderator: Who pays for your medical expense?
Participant: Husband. He might borrow from his friends, relatives and moneylenders. But it is his job.
Moderator: Can't you borrow from someone?
Participant: Who will lend money to a woman? Poor woman! Only her husband has to spend money for her.
(Female participants, Scheduled Caste, FGD 1)

Being dependent on their husband's willingness to pay for medical expenditures, women are often denied from health care access. Widows and elderly women rely on their social network: without external support, they are forced to delay or forgo treatment.

If men feel the treatment is going to be expensive they refuse the treatment. *(Female participant, FGD 7)*

My husband keeps money. He is a heavy smoker and alcoholic. He goes to hospital for his health problems. But I have gallstone that needs surgery. I also get severe, intermittent pain and vomiting due to this. But my husband is still procrastinating surgery. He buys me medicine for pain and vomiting from local [RMP/quack]. I have left to God. *(Female participant, FGD 7)*

Moderator: What do women do for that [health problem]? Participant: Nothing. We leave it to God.
Moderator: Why is that? Participant: We don't have husband. What else can we do? You tell us. If we spend on these things how do we feed our children? How to manage other household expenses? (*Female participant, widow, FGD 6*)

Women seem to be more sensitive to indirect costs of treatment (such as waiting time, loss of productivity and concurrent responsibilities) compared to direct costs related to health care (*see acceptability barriers*).

Under-the-table payments were not found to be a major issue and are not very frequent according to participants. Moreover, they are not perceived as such, but more as a form of tipping. This is the case for joyful events such as deliveries. One participant reported that bribes are different with regard to the newborn sex: when the mother gives birth to a girl child, the family offers INR 100 to the care givers. In case of a boy child, INR 500 are considered as appropriate. This clearly shows the perceived lower value of girls, and could be an indicator that, from their birth on, females and males may be treated differently by the health system.

Acceptability: Gender-related barriers in access to health care become particularly evident within the dimension of acceptability, revealing the unresponsiveness of the health care system towards the needs of women. Women experience a high level of discrimination from health care providers, with unresponsive and rude attitudes towards female patients.

They don't care whether we recover from disease or die. Staff is very rude. They ask us to get out if we ask more questions. *(Female participants, FGD 9)*

Even though these barriers are not exclusively gender-specific and also affect male patients, they are clearly gender-intensified: the discussions with women show that discrimination affects especially the less educated, illiterate ones, who have fewer possibilities to protect themselves

against providers' abuse. They feel helpless about experienced discrimination, and seem to accept neglect and abuse as a kind predicament. Also, some women lack the social support from family members and feel abandoned with their health needs. Priority setting is an important acceptability barrier on the demand side: concurrent duties of women for child care and household responsibilities have been found as one of the reasons for non-utilization of health care:

> We should not be asked to come again and again. There is nobody in our family to share my responsibility. If I fall sick and keep running between hospitals and home who will do my job?
> *Female participant, widow, FGD 6)*

7.4 Experiences with RSBY

Awareness: have women been adequately informed about RSBY and its benefits?

General features of the scheme – eligibility of BPL households, coverage of hospitalization costs up to 30 000 INR – are well known among respondents, whereas women have almost no information about the details and functioning of RSBY, such as benefits covered under the scheme, empaneled hospitals etc. At the time of enrolment, the insurance company should provide a pamphlet with information on the empaneled hospitals, a summary of included benefits and the number of the toll-free information hotline. However, in Palwal district, none of the RSBY members had received this information. None of the FGD participants in the two investigated districts have been exposed to one of the district wise Information and Education Campaigns (IEC) of the SNA. Either these campaigns have not been carried out, or the channels seem to be inappropriate to reach the target population. This is especially true for women, who have less access to media, are less likely to leave the village and to get exposed to health information, and rely to a great extent on their husband for further information on hospital facilities.

Awareness raising and promotion of the scheme in the studied area is the sole responsibility of the insurance company and depends mainly on willingness to cooperate of Sarpanch and practices at the *gram panchayat*[8] level, which are difficult to control for RSBY. The majority of participants have become aware of the scheme through the *Sarpanch*[9] of their village who, in turn, has been approached by the insurance company to facilitate the enrolment process and identify eligible BPL households. In none of the investigated villages have NGOs or other grassroots level organizations been involved. The third source of information mentioned beyond *Sarpanch* and insurance companies is "word of mouth".

> Insurer organizes *panch sarpanch sammelan* to inform us about RSBY. But they give us some information and do something else in practice. I don't have any control over this matter. *(Sarpanch of Barbail village, Panipat)*
>
> Nobody told us anything. They took photographs and fingerprints and said we will send the card later trough which you can avail free treatment up to 30 000 Rupees. That's all. They didn't come back after that. (*Female participant, FGD 4)*

[8] Gram Panchayat are the local government on village level
[9] Sarpanch are the elected heads of the Gram Panchayat

Enrolment: What are the experiences of women with the enrolment process?

It became clear in the discussions that the decision to enrol under the scheme is taken by men. Only in cases where men are not present at the time of enrolment can women decide whether and which members to enrol. The dominant role of the *Sarpanch* becomes evident once more in the enrolment process: many women report that it is the decision of the *Sarpanch* whether a family is eligible and which family members get enroled in the scheme. Participants reported that names on the BPL lists are frequently changed by the *Sarpanch*, and that some villagers lost their eligibility to the scheme. None of the participants were aware that elderly people can also be enroled.

> None of us have included our parents or parents-in-law. Our sarpanch told us the scheme is meant only for husband, wife and up to three children. *(Female participant, FGD 1)*

Utilization: What are the experiences of women in using the smart card?

The disadvantaged position of women with regard to the enrolment into the scheme changes when it comes to the utilization of the smart card: All participating women keep the card and can use it as per requirement. The cashless features give them the power to avail health care services when they need it and take independent health decisions without asking permission from their husbands.

> We don't have to wait for anyone for our treatment. We can go to hospital on our own. No need to ask anybody's permission. Our men do not take any serious responsibility. *(Female participant, FGD 7)*
>
> [With the smart card] A woman can decide on her own to go to hospital and get the treatment. She doesn't need to be dependent on anybody's help or permission. Nobody will question her as long as she doesn't bring a financial burden into the family. *(Female Participant, FGD 8)*

The power related to the smart card was especially appreciated by women who beforehand had less influence on how household resources were spent.

Experiences with the utilization of benefits are mixed. Many women had positive experiences with the use of the smart card, reported quick admission procedures and simplified administrative procedures.

> Had we not had this card, we would have sold all our belongings and house to save my life. Otherwise, I would have left this world. *(Female participant, FGD 0)*
>
> This card has been very helpful to me. We went to Pant hospital in Delhi. I said I do not have money. But I had this card. Then everything was free. *(Female participant, FGD 0)*

Providers report that health care service utilization by women is increasing within the scheme, especially for health problems that women usually tend to neglect, such as gynecological problems.

However, accounts on barriers towards using the scheme benefits were also numerous. Some of them refer to general access barriers to health care (reported in the previous sections), others were directly related to the RSBY scheme. The main barrier in Palwal district was a lack of information on the empaneled hospitals. After having approached different hospitals without getting their smart care accepted, members ended up paying hospitalization costs out of their own pocket.

I didn't use this card when my wife was sick. She was admitted for few days. When she fell sick we didn't know which hospitals would accept this card and neither we had time to search for one. I came to know about those hospitals only later. *(Male participant, FGD 2, Palwal district)*

Those members who had received a list of empanelled hospitals encountered a number of barriers when approaching these establishments. Female respondents in the discussions reported feeling "lost" in hospitals and perceived staff behavior as unfriendly and rude, especially towards illiterate women. Women do not know how to cope with providers' opportunistic behavior, thus accept it passively as the normal experience of poor and uneducated women, or rely on their husband to solve the problem, by accompanying them and interacting with the provider.

Mostly, women are less educated. So they can't go alone. When they go to hospital doctors give out wrong information about the facilities. (…) For example, we have this old woman here. (…) If she goes to hospital doctor will confuse her by saying, 'this card is not accepted; this service is not included' etc. She will be left in the lurch.*(Female participant, Scheduled Caste, FGD 1)*

And look, in this Mewat district women are mostly illiterate. How can an illiterate woman go to hospital and make her own decision? Obviously, she waits for husband to take her to hospital. .*(Female participant, FGD 1)*

Moderator: Do you think a woman is treated more respectfully when she goes with a men?
Participant: That is always the case. I miss him everywhere, when I go to the hospital, in the village and when I struggle alone. *(Female participant, widow, FGD 6)*

The paperless features of RSBY, initially intended to make the health seeking process easier for illiterate patients, also have the unintended effect of hindering accountability and transparency. Doctors no longer mention the amount and debit the card without informing patients on the actual costs. Patients argue that they try to inflate the bills by increasing costs. Especially women do not dare to ask for clarification or to question the doctors.

Moderator: How much was the cost of the whole procedure?
Parti: They didn't tell us. They didn't take extra charge from us. That's all we know *(Female participant FGD1)*

When we use this card, doctors try to make the bill of Rs.30000, even though the treatment costs much less than that. Anyway, they don't tell us what was the total cost of the treatment and how much money is remaining in this card. We don't know if it is appropriate to ask them. *(Female participant FGD 1)*

Frequently, empaneled hospitals refuse patients and do not accept the smart card. Hence, members feel confused and get the impression that the scheme is not useful to them. Complaints about providers' negative behavior and abuse were frequent: patients report that doctors try to use the maximum amount on the smart card by inflating bills or unnecessarily extending admission time. If the amount for treatment exceeds the limit of the card, patients are discharged, even if the treatment is not completed. On the other hand, interviews with providers showed that these are under the double pressure of patients - to provide a treatment perceived as necessary from the patients' point of view - and insurance companies, that threaten with de-empanelment hospitals having high utilization rates. Furthermore, providers perceive interactions with RSBY members as difficult: Members show their card only at the time of discharge, are not aware of the services included and are very demanding.

Treating RSBY patients is always a tiring job for us. *(Private health care provider, Gurunanak hospital, Palwal)*

Worryingly, many participants reported remaining user fees and often spent significant amounts on the purchase of medicines from outside – this despite the fact that medicines should be included in the benefit package, and that special purchasing arrangements have been set up for empaneled hospitals to avoid stock outs. In interviews with the health care providers, it became obvious that evenproviders are not always clear on which benefits are included (i.e. costs related to blood transfusions). A few respondents reported being asked to advance money. Discrimination was a concern in some cases; respondents felt that they received lower quality of care than non-BPL patients.

> When we use this card, if our treatment costs only 3-5000 and needs only 2 days of admission, doctors make us stay for more days and try to increase the cost to the limit of this card.(…) If the cost exceeds the limit, they ask us to vacate the bed, no matter the patient is completely cured or not.(…). They ask us to get expensive medicines and injections from outside. They don't give blood. We have to arrange it from outside and pay for it. *(Female participants, FGD 1)*
>
> When I went for my eye problem, they didn't accept the card for my surgery and asked to pay money. Card was valid. When I said I am poor and I don't have money they asked me to pay the money first and I could later get it reimbursed from the card. *(Female participant, FGD 6)*

However, even though participants reported a number of barriers and often found the smart card not very useful in the past, almost all of them would renew the card and remain convinced of the potential benefits the scheme could offer them. Accounts of members who had used the scheme successfully play an important role in convincing beneficiaries and raising awareness where and how to use the smart card.

8. Discussion

The strength of this study lies in the use of qualitative methods, which allowed exploring barriers in access to health care from the perspective of the female beneficiaries. Targeting different sub-groups of women allowed the capturing of heterogeneous life realities and vulnerabilities of women. Though it is not possible to draw representative conclusions from a study on this limited scale, the frequency with which respondents raised the same issues and concerns suggests that the findings about the range of access barriers and experiences with RSBY are fairly comprehensive.

The aim of this study was to provide an insight into access barriers to health care for women, and to explore the role of RSBY in overcoming these barriers and reducing gender-based inequities in health. The discussions with female members of RSBY show that women face a variety of different barriers when seeking health care, which are consistent with the results of similar studies in India (Vissandjee 1997; Nandraj et al 2001; Sinha et al 2005; Michielsen et al 2012; Shukla 2012). In addition, the study could identify a number of gender-specific and gender-intensified barriers.

The results of the qualitative research help to explain the quantitative data analysis: low enrolment rates of women reflect their disadvantaged position in decision making with regard to enrolment in the scheme. However, once this barrier has been overcome, the findings suggest that certain

design features of RSBY foster the access of women to health care and are translated in positive trends in terms of utilization. The scheme enhances women's decision making power and improves their access to and control over financial resources in terms of seeking health care. Nevertheless, this empowerment at the household level is not translated in an improved social position and bargaining power in the interaction with health care providers. Gender inequities and power imbalances prevail and hamper the access of women in the health care system. As argued in the first part of this paper, the health system is a social institution reflecting - and sometimes even intensifying - social inequities and power imbalances in the society.

Low levels of health literacy and lack of information on RSBY are among the most important barriers towards health care access for women within RSBY. To make use of their increased decision making power at household level, women need - as a first step - information on covered benefits and empaneled hospitals. Yet, in this study none of the women have been exposed to any health related campaigns in the scope of RSBY. Information on empaneled hospitals is only given in written pamphlets, which is obviously not a way to reach illiterate women. Secondly, a certain level of health literacy is fundamental for being able to assimilate information and decide on health care utilization. Women continue to rely on information obtained by their husband, and thus are not able to make independent use of the card.

Many of the problems women encounter when accessing benefits of RSBY are related to the design of RSBY and stem from a misalignment of incentives and lack of regulation. The absence of appropriate control of the different actors has led to the abuse of the system by certain stakeholders, very often at the expense of women as a particularly vulnerable group. Some design features of the scheme have led to unintended negative consequences, such as decreased transparency and accountability through the paperless features of the smart card.

As a demand-side financing mechanism, RSBY is based on the concept of consumer directed empowerment through financial power, assuming that "money follows the patients" (Hsio 2007, in Selvaraj 2012). However, besides the fact that availability of alternative choices is required to opt out of low quality care (which was often not the case in the investigated, mostly rural areas, where only few hospitals are empaneled), the results of this study show that financial power of the smart card alone is not sufficient for women to claim their right to quality health care. Lack of adequate information on health care options hinders female patients to take informed decisions. Furthermore, their social position and lower educational status makes women more vulnerable to supplier-induced demand and abuse from providers. Information asymmetry and supplier induced demand are key elements of health care market failure and affect women all the more.

9. Conclusions and policy recommendations

The study has identified the need for a greater dialogue on the importance of "applying a gender lens" to RSBY. Despite a robust body of evidence on gender-related health inequities in India, tackling gender issues does not feature as a programme objective and seems to rank very low on implementers' priority list. A more explicit approach in promoting gender equity and women's empowerment based on a *twin-track approach* (Thakur et al 2009) should be adopted: *Gender mainstreaming* requires the systematic and coherent integration of the gender perspective in the design and implementation of RSBY. Furthermore, targeted *gender-specific measures* can enhance women's empowerment and transform inequalities identified in the gender mainstreaming.
The following recommendations emerge from this study:

Develop gender-sensitive communication strategies to promote awareness about RSBY

Additional efforts should be made in order to promote awareness among women about the exact rights and benefits attached to RSBY. Periodically organized IEC campaigns should target women in particular, by using appropriate channels that also reach out to illiterate women. Additionally, women's health literacy could be improved through these campaigns, enhancing knowledge on symptoms that require treatment and health seeking behaviour. Furthermore, awareness raising campaigns should encourage active inclusion of vulnerable groups, i.e. elder women and widows.

Strengthen the role of civil society organizations (CSOs) in promotion and advocacy

Currently, local communities and CSOs are not appropriately involved in the scheme. Awareness raising in the studied area is the sole responsibility of the insurer. This raises serious concerns, as insurance companies have no incentive to inform beneficiaries properly and foster the scheme's utilization. Furthermore, risk selection could be an issue (indicated by the information on non-eligibility of elderly by the insurer).
Community based approaches, i.e. by involving traditional *Angawadi* and *Asha* health workers, self-help groups, NGOs and other grassroots level organizations could be an effective way of reaching out to potential beneficiaries of RSBY. However, their role must not be limited to the narrow task of transmitting information on the scheme. It is particularly important to involve stakeholders who can advocate for women and help them achieve their rights, reducing the power gap and asymmetry of information between the consumer and the health system.

Focus on the specific health needs of women in the benefit package of RSBY

In line with the MDGs (Universal access to reproductive health by 2015), RSBY could explore the potential of enlarging the benefits beyond deliveries and include further packages of sexual and reproductive health, such as antenatal and postnatal care, family planning or STIs treatment for the following reasons: antenatal and postnatal care are important determinants of maternal health;

access to family planning methods gives women more control over their bodies and autonomy over their reproductive life (WHO 2008), thus enhances their empowerment. The potential synergies and overlapping with similar programmes such as JSY should be carefully assessed.

As emerged from the group discussions, transport for women's accompanying person is one of the access barriers. Therefore, RSBY could consider the possibility of paying transport costs to an accompanying relative.

Enhance regulation of the different stakeholder

In a SHP scheme such as RSBY, which has shifted to a more outcome-focused "steer-and-channel" approach by introducing competitive mechanisms and entrepreneurial activities within a private-public partnership, regulation of market forces is particularly important. Entrepreneurial activities of insurers and private health care providers are one of the major catalytic elements to stimulate innovation within RSBY, but such a business model needs a careful control of possibly negative impacts of providers' behaviors on quality of care, in order to provide equitable access to health care for the whole population (Selvaraj 2012; Saltman et al 2002). Specific competences and additional allocation of resources to governments on the national and state level is needed to allow them to fulfill their regulatory roll properly. There are various steer-and-channel options (e.g. decentralization, enforced self-regulation, independent regulatory agencies, accreditation etc.) and ways of regulating entrepreneurial behavior (Saltman et al 2002). Within the scope of this paper, it is not possible to address this huge issue and give a comprehensive set of recommendations in terms of enhanced regulation. Since the 1990s, many European countries have seen a similar increase in entrepreneurial initiatives and have consequently put an emphasis on the regulation tools; the respective literature is extensive (e.g. Saltman et al 2002; Saltman 2002).

Improve quality management of empaneled hospitals

Following up on the previous recommendation, the responsiveness of the health care system to the needs and vulnerabilities of women has to be assured. Therefore, gender-sensitive criteria should be included in the quality management and empanelment process of hospitals, i.e. availability of female health care providers; evaluating thesatisfaction of female users with treatment; convenience of opening hours; gender trainings of health care staff etc.

Develop a gender sensitive monitoring and evaluation system

The close monitoring of intended and unintended effects of RSBY on gender equity and access barriers is important to improve the programme design and ensure equal participation of women. Therefore, more robust gender-disaggregated data is necessary to accurately identify gender disparities in health service access and utilization. Setting gender targets and monitoring them closely should be an integral part of the monitoring system.

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Annex

I. Research Questions of FGDs

(1) Perception of gender roles and empowerment of women in the community

- What are the specific culturally shared perceptions of gender-appropriate behaviour and what are the reasons behind?
- How do gender specific tasks and roles affect health and access to health care for women in the community?
- How "empowered" are women in the community in terms of access to resources, decision making power?

(2) Women's health problems, health seeking behaviour and barriers in access to health care

- What are the most common and distressing acute health problems faced by women?
- In case of health problems, what are the coping strategies?
- What are the encountered gender-related barriers women face when seeking health care at different levels?

(3) Experiences with RSBY and the role of RSBY in overcoming barriers in access to health care

- According to women's perception, does RSBY provide specific support to overcome mentioned gender-related barriers?
- Are there groups who are especially excluded / face higher difficulties to access benefits of RSBY (related to age, marital status, castes etc.)?
- Does RSBY contribute to the empowerment of women with regard to
    - Allocation of decision making power within the household: Are there any changes in decision making power in the family about health care utilization through RSBY? (independent health decisions of women, changing confidence in negotiation process)
    - Allocation of resources: Can women access more independently to health care due to RSBY and its cashless features?
    - Improved social position towards service provider: How are the relations with health care staff and medical institutions? Has the bargaining position of women improved through RSBY? Are there any changes in attitudes of staff during treatment since being member of RSBY?

II. List of interview partners

National level

- UNICEF, Dr. Abilore Gore (Programme Officer, Maternal health)
- Center for Social Research CRS, Ms. Manasi (Research Director)
- Micro Insurance Academy MIA, Mr. Denny John (Deputy Director)
- NGO Society for the Promotion of Youth and Masses SPYM, Dr. Rajesh Kumar (Nationale Executive Director)
- GIZ-IGSSP, Dr. Rolf Schmachtenberg (Director of IGSSP)
- GIZ-IGSSP, Dr. Nishant Jain (Deputy Director of IGSSP)
- GIZ-IGSSP, Dr. Madan Gopal (Senior Advisor, RSBY Quality Management)
- GIZ-IGSSP, Henna Dhawan (Technical Advisor, RSBY Data Management)

State and Local level

- Public health care provider (ESI Hospital, Panipat)
- Private health care provider (Director, Gurunanak Hospital Palwal)
- Private health care provider (Medical Officer, Ravindra Hospital Panipat)
- RSBY District Nodal Officer, Panipat
- Local government official (Sarpanch of Babail Village, Panipat)
- Local government official (Sarpanch of Sewa Village, Panipat)
- NGO (SPYM, manager of local branch Mewat)
- Insurance company (ICICI Lombard New Delhi/ and Haryana branch)

III. Factsheet: RSBY in Haryana

As on 31.03.2012; Source: Ministry of Labour and Employment Data base

State	District	Round	BPL families	Male-female ratio in beneficiaries	Average family size in enrolment	Male-female ratio in hospitalization	Enrolment ratio (BPL families enroled,compared to total eligible BPL families)	Male hospitalization ratio	Female hospitalization ratio	Hospitalization ratio, both sexes
Haryana District										
Haryana	Mewat	1	53270	124.85	2.67	107.44	67.42	1.49	1.73	1.60
Haryana	Mewat	2	61452	124.84	2.70	96.18	57.70	0.95	1.23	1.07
Haryana	Mewat	3	61432	118.76	3.72	103.28	50.62	0.10	0.12	0.11
Haryana	Panipat	1	59388	154.43	2.47	114.45	60.03	1.49	2.02	1.70
Haryana	Panipat	2	74845	117.71	4.63	96.74	27.56	2.18	2.65	2.40
Haryana	Panipat	3	74817	135.79	3.16	106.71	29.38	2.07	2.63	2.31
Haryana Sub Total Round 1			**1163768**	**144.00**	**2.86**	**123.30**	**60.37**	**2.61**	**3.05**	**2.79**
Haryana Sub Total Round 2			**1298595**	**128.99**	**3.39**	**116.20**	**48.00**	**2.27**	**2.52**	**2.38**
Haryana Sub Total Round 3			**648518**	**118.21**	**3.25**	**101.68**	**42.09**	**2.09**	**2.43**	**2.24**
RSBY, all districts										
RSBY Total Round 1- 314 Districts			**42948127**	**151.93**	**2.76**	**137.94**	**54.33**	**1.75**	**1.92**	**1.82**
RSBY Total Round 2- 154 Districts			**20424200**	**127.35**	**3.05**	**118.57**	**51.77**	**2.82**	**3.03**	**2.92**
RSBY Total Round 3- 26 Districts			**5234015**	**103.78**	**3.27**	**80.58**	**62.24**	**5.79**	**7.45**	**6.60**

IV. State level disaggregated enrolment and utilization data

As on 31.03.2012, Ministry of Labour and Employment Data base; for 314 districts having completed the first round

Name of the State	Male Enrolment Ratio	Female Enrolment Ratio	Male Hospitalization Rate	Female Hospitalization Rate
Assam	62%	38%	0.11	0.08
Arunachal Pradesh	54%	46%	0.02	0.02
Bihar	59%	41%	0.98	1.60
Chhattisgarh	61%	39%	0.95	0.87
Delhi	57%	43%	2.88	4.36
Goa	61%	39%	0.05	0.21
Gujarat	58%	42%	2.33	2.17
Haryana	59%	41%	2.61	3.05
Himachal Pradesh	58%	42%	1.36	2.19
Jharkhand	51%	49%	0.83	1.15
Karanataka	59%	41%	0.97	0.86
Kerala	60%	40%	4.92	5.64
Maharashtra	64%	36%	1.55	1.94
Manipur	51%	49%	2.24	2.91
Mizoram	46%	54%	3.14	3.45
Meghalaya	45%	55%	0.84	1.09
Nagaland	62%	38%	2.89	2.13
Orissa	61%	39%	0.68	0.71
Punjab	63%	36%	0.99	0.86
Tamil Nadu	68%	32%	2.36	3.20
Tripura	53%	47%	3.11	2.22
UP	62%	38%	3.62	2.88
Uttarakhand	51%	49%	0.91	0.60
West Bengal	63%	37%	0.70	1.13
Chandigarh	71%	29%	0.10	0.02
Average	**60%**	**40%**	**1.75**	**1.92**

V. Socio-demographic profile of participants, Focus Group Discussions

	Date FGD	Place	RSBY affiliation/sub-group	Age	Education	Marital status	SHG member /years	SC / Religion	BPL
FGDs, FEMALE PARTICIPANTS									
0	31.03.2012	Palwal, Hathin (rural)	Female members, mixed (12)*	around 40	low level / illiterate	married	SHG member	na	BPL
				na	no	married	yes	na	BPL
				na	no	married	yes	na	BPL
				na	no	married	yes	na	BPL
				na	no	married	yes	na	BPL
				na	5th	married	yes	na	BPL
				na	no	married	yes	na	BPL
				na	8th	married	yes	na	BPL
				na	8th	married	yes	na	BPL
				na	5th	married	yes	na	BPL
				na	no	married	yes	na	BPL
				na	5th	married	yes	na	BPL
				na	5th	married	yes	na	BPL
1	05.04.2012	Palwal, Hathin, Firozpur-Rajput (rural)	Female members (9)	41	low level / illiterate	married	SHG member	SC	BPL
				55	no	married	8	SC	BPL
				58	no	married	10	SC	BPL
				35	no	married	5	SC	BPL
				36	no	married	8	SC	BPL
				27	8th	married	8	SC	BPL
				30	no	married	8	SC	BPL
				65	no	married	10	SC	BPL
				35	no	married	5	SC	BPL
				26	no	married	4	SC	BPL
3	05.04.2012	Palwal, Hathin	Female non-members (8)	34	mixed level education	married	SHG member	general	Non BPL
				26	12th	married	7	general	Non
				28	no	married	7	general	Non
				35	8th	married	10	general	Non
				35	no	married	8	general	Non
				40	no	married	8	general	Non
				40	no	married	8	general	Non
				27	8th	married	5	general	Non
				40	no	married	4	general	Non
4	06.04.2012	Palwal, Hathin Block, Malokhara Village (rural)	Female members - Muslim (9)	38	no education/ illiterate	married	SHG members	muslim	BPL
				38	no	married	no	muslim	BPL
				60	no	married	yes	muslim	BPL
				30	no	married	yes	muslim	BPL
				30	no	married	yes	muslim	BPL
				45	no	married	yes	muslim	BPL

				25	no	married	yes	muslim	BPL
				40	no	married	yes	muslim	BPL
6	16.04.2012	Panipat, Sewah Village (semi-urban)	Female members - widows (6)	46	mixed level of education	widow	mostly SHG member	Mixed	BPL
				45	7th	widow	8	general	BPL
				33	7th	widow	6	SC	BPL
				55	5th	widow	8	general	BPL
				40	no	widow	no	SC	BPL
				50	no	widow	8	BC	BPL
				55	no	widow	no	SC	BPL
7	17.04.2012	Panipat, Mathlauda Block, Rair Kalan Village(rural)	Female members, SC (7)	47	low level	widow / married	No SHG member	SC	BPL
				32	10th	widow	no	SC	BPL
				68	no	widow	no	SC	BPL
				35	no	married	no	SC	BPL
				40	5th	widow	no	SC	BPL
				65	no	widow	no	SC	BPL
				40	no	married	no	SC	BPL
				50	no	married	no	SC	BPL
8	09.05.2012	Panipat, Panipat Block, Babail Village (rural)	Female members, Mixed/Young (8) 22-35years	28	mixed level	married	No SHG member	SC/BC	BPL
				35	8th	married	1	SC	BPL
				25	5th	married	no	BC	BPL
				25	no	married	no	BC	BPL
				30	8th	married	no	BC	BPL
				30	no	married	no	SC	BPL
				22	no	married	no	SC	BPL
				35	no	married	no	BC	BPL
				25	no	married	no	BC	BPL
9	09.05.2012	Panipat, Samalkha Block, Manana Village (rural)	Female members Mixed / old (7) 40-65years	54	No education/ illiterate	Widow		BC	BPL
				40	no	married	no	BC	BPL
				60	no	widow	no	BC	BPL
				50	no	widow	no	BC	BPL
				65	no	widow	no	BC	BPL
				42	no	widow	no	BC	BPL
				62	no	widow	no	BC	BPL
				62	no	widow	no	BC	BPL
N.B.: only women were included that assisted until the end of the FGDs and signed written consents ; due to high turnover in some FGDs, the actual number of participants was thus much higher much higher than indicated									
FGD, MALE PARTICIPANTS									
2	05.04.2012	Palwal, Hathin, Firozpur-Rajput (rural)*	Male members (9)	34					
				20	10th	married	na	SC	BPL
				42	10th	married	na	SC	BPL
				38	8th	married	na	SC	BPL
				52	no	married	na	SC	BPL
				36	no	married	na	SC	BPL
				19	9th	non-married	na	SC	BPL

				40	6th	married	na	SC	BPL
				16	9th	non-married	na	SC	BPL
				40	8th	married	na	SC	BPL
	16.04.2012	Panipat, Sewah Village (semi-urban)	Male members (9)	around 45	na	na			
				na	na	na	na	na	na
				na	na	na	na	na	na
				na	na	na	na	na	na
				na	na	na	na	na	na
				na	na	na	na	na	na
				na	na	na	na	na	na
				na	na	na	na	na	na
				na	na	na	na	na	na
				na	na	na	na	na	na
* Missing information : data has not been collected by Moderator									

VI. Internship placement

As an international cooperation enterprise for sustainable development, the federally owned *Gesellschaft fuer Internationale Zusammenarbeit* (GIZ) is the implementing body of the German bilateral development cooperation and works on behalf of the *German Federal Ministry of Economic Cooperation and Development* (BMZ) with projects in more than 128 countries.

In India, through its Indo-German Social Security Programme (IGSSP), GIZ provides strategy and process consultancy to the Indian Ministry of Labour and Employment (MoLE) in implementing the "Unorganized Sector Workers' Act" (UWSSA). The act seeks to introduce social security system for the informal sector. The IGSSP focuses on three core areas: health insurance, old age protection as well as life and accident cover. Within the health insurance component, the focus is on strengthening the implementation of the national health insurance scheme RSBY at the national and state level. Main activities comprise i.e. providing personnel and technical support to the IT system of the RSBY smart cards and supporting the supervision of information flow and data management of RSBY, hospital quality management, marketing and information system for RSBY, advisory assistance for research projects (i.e. outpatient department pilot research). The MoLE has also expressed its interest in assistance from IGSSP in preparing and implementing a programme of coherent evaluation studies of the scheme on national and state level and setting-up a monitoring system.

In the context of the internship, the main focus was put on supporting the evaluation activities of IGSSP by developing comprehensive monitoring and evaluation strategies, including:

- Conducting a literature review and qualitative appraisal of existing evaluations on RSBY on national and state level
- Planning and coordinating an evaluation study on the implementation process of RSBY (developing methodologies, writing the ToR, coordinating the tendering process)
- Planning and conducting a qualitative research study on gender equality in RSBY

Furthermore, the intern deputized a team member and coordinated the design and implementation of the "GIZ- RSBY Young Professional Programme", a nation-wide capacity building programme of human resources for RSBY.

The intern participated in all relevant internal and external programme activities (meetings, field visits, seminars) to get an insight in the different components. She provided administrative support to ongoing activities (preparation of seminars, reporting). The intern was allowed to designate a part of her working time to her research project, when the other activities allowed this.

IGSSP-GIZ provided technical support to the research project by enabling access to RSBY enrolment and utilization data bases, establishing contacts with relevant key-stakeholders as well as financial support to the field work and costs related to translation and transcription of the focus group discussions and interviews.