Gender equality in access to health care: The role of social health protection

A case study on India’s national health insurance scheme RSBY

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INTRODUCTION

Applying a gender lens to social health protection

Women and men face 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 around the world, bear a greater burden of disease and spend more years living with a disability (Payne 2010; Scheil-Adlung and Kuhl 2012). The socially constructed roles and expectations attributed to men and women lead to power imbalances and differential access to and control over resources related to health care.

An equity approach to health aims to ensure that both men and women have equal access to the resources they need in order to satisfy their respective health needs. 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’. Though social health protection policies cannot replace the need for broader policies that address gender inequalities in general, these policies have nevertheless the potential to contribute in closing gender gaps and tackling gender inequalities in access to health care (Scheil-Adlung and Kuhl 2012). Furthermore, health programmes are rarely gender neutral and can even reinforce existing inequalities if gender issues are not adequately addressed in the design and implementation (Luttrell and Moser 2004).

However, so far, surprisingly little attention has been put on ‘applying a gender lens’ to social health protection policies. Monitoring of gender equality and aspects of inclusion or empowerment of women are rarely taken into account in the design and implementation of social health protection policies.

This article explores the role of social health protection in tackling access barriers to health care for women and reducing gender inequalities. First, it outlines how gender affects health and results in various access barriers to health care for girls and women. Subsequently the role of social health protection in mitigating these access barriers is analysed by taking the example of India’s flagship social security programme, the health insurance scheme Rastriya Swasthya Bima Yojana (RSBY). Eventually, the article gives some recommendations for the design and implementation of inclusive social health protection programmes which take into account the specific health needs and risks of women.

The results stem from a study carried out under the umbrella of the Indo-German Social Security Programme of the Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH (GIZ) in March and April 2012. The study used mainly a qualitative approach in order to understand beneficiaries’ perception of the scheme and to learn more about the type of barriers women face when accessing the benefits of the scheme. Ten focus group discussions with female members as well as non-members of RSBY have been carried out in different districts of Haryana in northern India, which was the first state to implement RSBY. Additionally, expert interviews captured the perceptions of key-

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1 Gender equality refers to the equal access to resources, opportunities, socially-valued goods and decision making processes, without being dependent on or constraint by biological sex (UNFPA 2012). Gender equality does not mean that men and women shall become the same; as such, gender inequalities in health outcomes may reflect biological differences and are not necessarily an indicator of gender injustice. Therefore, in the context of this paper, the term gender equality refers to equal access for women and men to health care and health care related resources necessary to satisfy their respective health needs.

2 Gender equality is not only centred on women; however, as due to power imbalances in many cases women are disadvantaged in terms of decision-making and access to resources, this paper focuses on health needs of women.
stakeholders at local and national level. Secondary data from the RSBY database was also used for descriptive analysis.

**CONCEPTUAL FRAMEWORK: GENDER AND HEALTH**

The Gender Dimension of Health and Access to Health Care

In most societies, relations between men and women are largely unequal and hierarchical, often resulting in unequal access for women and girls to social goods and services. Lack of empowerment negatively influences the health and well-being of millions of girls and women all over the world (Doyal 2000; Kirts and Hatcher Roberts 1996; Scheil-Adlung and Kuhl 2012; WHO 2008). Empowerment in this context 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). Their lower educational status influences not only the health of women but also those of their children; 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.

Due to gender inequalities in access to formal employment and income, as well as a general lack of power and access to economic resources, women are more prone to poverty and insecurity. Poverty, in turn, is strongly interlinked with health. The unequal access to formal labour prevents many women from having access to health care or other social protection benefits, as entitlement to social health protection is often linked to specific eligibility criteria (e.g. formal employment) which exclude women.

**Barriers in access to health care for women**

The unequal access to resources, capabilities and rights also affects women’s ability to use health care services according to their needs. Especially in low- and middle income countries, this results in a lower utilization of health care by women (Scheil-Adlung and Kuhl 2012).

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 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 2004b):

- **Accessibility** refers to geographical barriers associated with long distances to the health facility, insufficient road infrastructure and lack of transport. Though geographical barriers affect both men and women, they may have a greater impact on women due to cost or lower safety of travelling, as well as cultural norms that may not allow a woman to travel on its own. Studies found that distance to health care facilities is a major determinant of delays in seeking health care for women (Vietnam; Ensor and Cooper 2004a) and represents a greater barrier for accessing health care for women than for men with a similar income (India; Vissandjee et al 1997).

- **Availability** refers to the disposability 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 travelling and additional costs. Moreover, in many cultures it is not appropriate for women to consult male doctors, though female providers are 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 in the literature (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 and 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 often 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). The health sector itself is a social institution upholding gender roles and norms and potentially exacerbating gender inequalities (WHO 2008). Acceptability is linked to a gender-biased priority setting, with studies showing a preferential access to health care for men over women (Ensor and Cooper 2004a): 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.
CASE STUDY: INDIA’S HEALTH INSURANCE FOR THE POOR (RSBY)

Gender, equality and health in India

India ranks very low in international comparisons of gender equality. It is the lowest ranking country in the South Asian region on the Gender Equality Index and ranks 114 out of 155 on the gender related development index. In terms of gender equality in health and survival, India is ranked 132 out of 134 in the World Economic Forum's ranking (Hausmann et al 2010).

Though health indicators in India have generally improved a lot over the last decades, strong inequalities in health outcomes persist. The child sex ratio 1 is one of the fundamental indicators of gender inequality in India. Strong preference for sons has led to a marked decline in the sex ratio over time, to 914 girls per 1000 boys (as per Census 2011, reported in Ramaiyah et al 2011). Furthermore, girl child mortality is 40 per cent higher than boy child mortality (ibid). The lower status of women in the Indian society and discriminatory socio-cultural norms are the source of various health risks and vulnerabilities; gender based violence is socially widely accepted (with 39 per cent of married Indian women having experienced domestic violence; Kishor and Gupta 2009). Early marriage, leading to interruption of education, teenage pregnancy and early motherhood remains very common (28 per cent of all Indian women aged 15 to 19 have already been married; OECD 2012).

Gender inequality has further important intersections with other bases of discrimination such as caste, ethnicity, religion, marital status and disability. For instance, the Muslim tradition of purdah persisting amongst both Muslim and Hindu communities in the northern part of India is concealing women from men and requires women to cover their bodies and faces, to avoid public appearance and usually not to speak to any men outside their families. As a consequence, purdah restrictions limit women’s mobility and ability of using health services outside home for themselves or their children (Vissandjee et al 1997).

In the traditional hierarchy of the Hindu castes system, scheduled castes (16 per cent of the population as per Census 2001) and scheduled tribes (8 per cent of the population) 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, scheduled castes and scheduled tribes have higher mortality rates and lower vaccination rates as compared to other castes (Subramanian 2008).

Due to stigmatization, a lower level of educational attainments, lesser employment opportunities and therefore a lower socio-economic status, disabled persons are among the most discriminated groups in India. Among them, children, women and elderly people are particularly vulnerable. Currently, little reliable data on health care access and social protection of disabled women is available in India.

Health Financing and Social Health Protection in India

One of the key factors affecting equitable access to health care in India is the insufficient public expenditures on health, with an estimated 4.2 per cent of the GDP for 2009 (WHO 2012). India has one of the highest proportions of private spending worldwide: 70 percent of health care costs are covered by private households, out of which 87 per cent are spend as out-of-pocket expenditure (WHO 2012).

Health care expenditures are leading to an estimated 39 million Indian people falling into poverty every year. 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).

Since India’s independence in 1947, equality 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. However, most of these 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.

Rashtriya Swasthya Bima Yojana (RSBY)

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.

RSBY aims at overcoming weaknesses of precedent schemes and contains several innovative features to correspond to the health needs of the targeted poor people. All transactions are completely cashless and do not require poor beneficiaries to pay in advance and get reimbursed later. To avoid complicated procedures, which are difficult to manage for the mainly illiterate target group, the scheme was de-

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1 defined as the number of female children per 1000 male children in the age group of 0—6 years
signed 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 private or public hospital throughout India.

The scheme uses a sophisticated technology system. The high-tech biometric smart card contains fingerprints and photographs of the up to 5 family members and allows identification in hospitals and is thus supposed to reduce options for fraud and abuse.

In contrast to traditional government-led 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 making it attractive for private and public hospitals to provide health care to the poor.

The success in terms of enrolment figures is impressing; RSBY has become one of the largest health insurance schemes in the world within a few years, providing coverage for 32.6 million BPL households. The scheme has been introduced in 409 districts across 25 states and union territories of India so far. Around 4.8 million hospitalization cases in one of the 12 444 empaneled hospitals have been covered by RSBY since its inception (RSBY website, as by 11th Oct. 2012).

**RSBY through a gender lens**

This section gives an overview on gender issues in RSBY regarding enrolment and utilization by analyzing the available quantitative data. It then presents findings from the qualitative research, i.e. focus group discussions with female members and non-members, as well as interviews.

**Enrolment and hospitalization patterns (analysis of quantitative data)**

In terms of access to the scheme, male member enrolment is higher than female enrolment, with 60 per cent men against 40 per cent of women on the national level. Disaggregated enrolment ratios per state reveal important variations, with some states having reached almost equal enrolment (such as Jharkhand, with 49 per cent of members being female), whereas imbalances are marked in other states such as Chandigarh, where only 29 per cent of members are women. 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, against the dismal scenario in terms of enrolment of females, trends regarding hospitalization are encouraging. Female members tend to use services in hospitals more often than male members do. In absolute numbers, women are still outnumbered by men during the first insurance year. The difference becomes less significant during the second year. The female utilization rate (2.77 per cent) was higher than for males (2.56 per cent) even during the first year.

However, it would be premature to draw conclusions on the current status of gender equality within RSBY based on these data. Many issues regarding enrolment and utilization patterns remain unclear. The quality of currently available data has to be seen with a critical eye in terms of accuracy, completeness, consistency and reliability. Precautions have been taken to avoid gender and age inconsistencies in the database in the future, but these problems exist in the current available data and jeopardize the scientific validity of any statistical analysis.

**What are the gender related access barriers to health care for RSBY members?**

Participants were asked to identify the major barriers they face when seeking health care. Formulated problems were consistent with findings of other studies on health care utilization in similar context. Almost all 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. The most common barrier was geographical accessibility - reinforced by Purdah restrictions and limited mobility of women – as well as financial affordability, which prevents many women from seeking health care. Because women are economically dependent on their husbands, they report having less access to and control over financial resources of the household, and have fewer possibilities to purchase money for treatment.

Especially widows and elderly women rely on their social network; without external support, they are forced to delay or forgo treatment.

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4 For 314 districts that completed the first insurance year, called “round”. Data presented in this section is taken from the completed district records, Ministry of Labour and Employment, as per 31.03.2012

5 Female beneficiaries utilizing services as a proportion of total females enrolled
Others were directly related to the RSBY scheme. The main barriers to health care (reported in the previous sections), were also numerous. Some of them refer to general access

However, accounts on barriers in using the scheme benefits member

house to save my life. Otherwise, I would have left this world. (Female participant)

Many women such as gynecological problems. The cashless features give them the power to keep the utilization of the smart card:

To make use of 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 inequalities and power imbalances in the society.

Low level 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 empanelled hospitals. Yet, in this study none of the women has been exposed to any health related campaigns in

What are the experiences of women with RSBY - regarding awareness, enrolment and utilization of benefits?

General features of the scheme – eligibility of BPL households, coverage of hospitalization costs up to 30 000 INR (around 430 Euros) – are well known among respondents, whereas women seem to have less information than men about the details and functioning of RSBY, such as benefits covered under the scheme, empanelled hospitals etc. Information on empanelled hospitals is only given in written pamphlets, which is obviously not a way to reach illiterate women. None of the participants in the investigated districts has been exposed to one of the district wise Information and Education Campaigns. Either these campaigns have not been carried out, or the channels seem to be inappropriate to reach the target population. This might be 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.

Low enrolment rates of women reflect their disadvantaged position in decision making with regard to enrolment in the scheme. It became clear during the discussions that women have very little influence on the decision whether to become member of RSBY or not. In most cases, it is the husband as head of the household who takes this kind of decision.

However, 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 smart card with them 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 of their husband.

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 participant)

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 member)

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

Many women have made positive experiences while availing benefits and using the smart card, report 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 member)

However, accounts on barriers in 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 was a lack of information on the empaneled hospitals. After having approached different hospitals without getting their smart card accepted, members ended up paying hospitalization costs out of their own pocket. Those members who had received a list of empaneled 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.

On the other hand, interviews with providers showed that there 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-empaneling hospitals having high utilization rates. Worryingly, many participants reported remaining user fees and often spent significant amounts on the purchase of medicines from outside. In interviews with the health care providers, it became obvious that also providers are not always clear on which benefits are included (such as costs related to blood transfusions).

Nonetheless, even though participants reported a number of barriers, 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.

Discussion: Does RSBY improve access to health care for women?

Low enrolment rates of women reflect their disadvantaged position in decision taking 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, the discussions with women also pointed out that empowerment at the household level is not translated in an improved social position and bargaining power in the interaction with health care providers. Gender inequalities 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 inequalities and power imbalances in the society.
the scope of RSBY. 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 sometimes 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 to the expense of women as a particularly vulnerable group.

Some design features of the scheme have led to unintended negative consequences. The paperless features of RSBY, initially supposed to make health seeking process easier for illiterate patients, also have the unintended effect to hinder 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 and question the doctors.

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, 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). Moreover, the results of this study show that financial power of the smart card alone is not sufficient for women to claim their right on 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.

CONCLUSIONS AND POLICY RECOMMENDATIONS

The study has identified the general 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 inequalities in India, tackling gender issues does not yet feature as a programme objective and still seems to rank relatively low on implementers’ priority list.

In order to reach its full potential, a more explicit approach in promoting gender equality and women’s empowerment based on a twin-track approach could 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 that have been identified in the gender mainstreaming.

The following recommendations for the design, implementation and monitoring of gender-sensitive social health protection programmes emerge from this study and may also be useful for other health insurance schemes.

Design

1. Integrate 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 wife mandatory when her name appears on the BPL list. However, inclusion of other female family members won’t be influenced by this measure. Beyond directives and quotas for including women, more attention should be given to explicitly encourage take-up and utilization of the scheme by women, especially the most vulnerable (widows, older women, disabled women).

2. Take into account specific health needs and gender-specific constraints of women in the benefit package.

Social health protection should be adapted to the specific needs of women, for example by ensuring the availability of female health care provider and culturally acceptable conditions in hospitals. RSBY may 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.

3. Consider specific vulnerabilities and sources of double discrimination.

Due to multiple identities, women may also face multiple vulnerabilities. As such, disabled women are prone to a double discrimination due to the fact of being female and living with disability. The different and overlapping dimensions of social exclusion should be adequately reflected in the design of the scheme.

Implementation

4. 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 information and education campaigns should target specifically women, by using appropriate channels that also reach out to illiterate women and increase their participation in the scheme. 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, widows and women with disabilities.

5. Strengthen the role of civil society organizations in promotion and advocacy for women.

Currently, local communities and civil society organizations 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 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 community 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 stakeholder who can advocate for women and help them achieve their rights, reducing the power gap and asymmetry of information between the female consumer and the health system.

6. Enhance regulation of the different stakeholders.
In a public-private partnership such as RSBY, which has shifted to a more outcome-focused “steer-and-channel” approach by introducing competitive mechanisms and entrepreneurial activities, regulation of market forces is particularly important in order to provide equitable access to health care for the whole population (Selvaraj 2012; Saltman et al 2002). A closer monitoring could help to protect women from providers’ ill-mannered behavior.

7. 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 ensured. Therefore, gender-sensitive criteria should be included in the quality management and empanelment process of hospitals, i.e. availability of female health care providers; evaluation of satisfaction of female users with treatment; convenience of opening hours; gender trainings of health care staff etc.

Monitoring
8. Develop a gender sensitive monitoring and evaluation system.
The close monitoring of intended and unintended effects of RSBY on gender equality 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 by using quantitative and qualitative approaches should be integral part of a social health protection monitoring system.

RSBY has started to tackle access barriers to health care for women. Thereby, the scheme has demonstrated that social health protection can play a key role in reducing health inequities between men and women and improving health care access.

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