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RESEARCH REPORT

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List of Acronyms

ANC	Antenatal Care
BPL	Below Poverty Line
CAPI	Computer Assisted Personal Interviewing
CMO	Chief Medical Officer
FP	Family Planning
IDI	In-Depth Interview
IUD	Intra Uterine Device
MNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
NGO	Non-Governmental Organization
OPE	Out of Pocket Expenditure
RH	Reproductive Health
RSBY	Rastriya Swasth Bima Yojana (National Health Insurance Scheme)
SACHI	State Agency for Comprehensive Health Insurance
SMS	Short Message Service
TV	Television
UP	Uttar Pradesh

Executive Summary

In 2008, the Government of India launched the National Health Insurance Scheme, Rashtriya Swasthya Bima Yojana (RSBY), to enable families living below the poverty line (BPL) in both urban and rural areas to access a range of private health services. Enrolled families can avail a pre-specified package of health services from private hospitals empaneled under RSBY, including family planning (FP) and other reproductive health (RH) services.

Although RSBY has been in place for almost eight years, limited research among its potential beneficiaries shows that awareness and knowledge about the scheme and its benefits are low. Anecdotal evidence suggests that women seek antenatal care, delivery services, sterilization, and post-abortion care from public hospitals rather than private, RSBY empaneled hospitals. It is unclear if this is due to a lack of awareness of RSBY services or reflects women's preferences to not seek certain services from private hospitals. The available evidence suggests several limitations and barriers that may affect the utilization of RSBY services and warrants a more in-depth examination of the contexts of FP/RH services.

Due to these limitations in existing evidence, the Population Council, under the Evidence project, conducted a study among the urban poor to: (i) determine RSBY awareness and barriers to enrollment; (ii) identify barriers and facilitating factors to utilizing RSBY for FP/RH services; (iii) assess the concerns and limitations of administrators and providers at RSBY empaneled private hospitals for providing FP/RH services under RSBY; and (iv) provide programmatic recommendations to improve the delivery and utilization of RSBY for various FP/RH services.

A cross-sectional study, using both quantitative and qualitative data collection methods, was conducted in September and October, 2015. The study was conducted in three cities, located in three zones of Uttar Pradesh: Allahabad, Kanpur, and Lucknow. We interviewed 726 married women, ages 18 to 35 years, and 640 men from the same households. A bilingual computer-assisted personal interviewing (CAPI) program, developed by the researchers, was used for data collection with mini-laptops. We also collected data from the BPL families not enrolled in RSBY to assess reasons for non-enrollment. We interviewed 20 hospital heads and doctors of RSBY empaneled private hospitals to understand supply-side perspectives.

The results of the survey show that the most common reason BPL families did not enroll in RSBY was a lack of awareness about the scheme (94 percent). About two-thirds of both women and men enrolled in RSBY knew it can be used for general medical and surgical conditions, but only 20 to 40 percent knew RSBY can also be used for FP/RH services. Knowledge about RSBY entitlements among RSBY families was measured at about 60 percent. However, nearly 60 percent of families did not know which type of hospitals provide RSBY services. Less than 30 percent of women and men of RSBY families reported receiving the list of empaneled hospitals, and only 10 percent had the list available.

The utilization of RSBY for health services in empaneled private hospitals was very low (6 percent and 3 percent for women and men, respectively). The most commonly used RH service under RSBY was delivery services. Use of FP services, however, was negligible because of low levels of knowledge about the availability of FP services through RSBY and because FP services are available free of charge in public hospitals. Program reasons such as hospitals reporting that cards were out of date, mismatched fingerprints of care seekers, and lack of help at hospitals for the paperwork were the main reasons (90 percent of women and 84 of percent men) for not receiving RSBY services. Furthermore, the reasons for not utilizing empaneled private hospitals for RH services like pregnancy complications, delivery, or post-abortion care, were the perceived high costs of services at private hospitals and perceived better quality of RH services at public hospi-

tals. Those who availed health services from empaneled private hospitals, however, had a good opinion about their quality of care.

Health care providers reported that poor families generally choose FP services from public hospitals because they are available free of cost. They reported that RSBY card holders mainly use the card for medical emergencies such as major surgeries and accidents. The providers were primarily concerned about the low reimbursement rates for health services that are set by the State Agency for Comprehensive Health Insurance (SACHI), the nodal government agency responsible for implementation of RSBY. Health care providers also expressed concern over delays and denials of reimbursements by the insurance companies.

Based on the results of this study, we suggest the following programmatic recommendations to improve the supply-side and demand-side barriers of the RSBY program, including for FP/RH services.

Supply-side Recommendations

1. The state government should update the list of BPL families in Uttar Pradesh at least once every five years to reduce the mismatch of home addresses and individual members' records provided at enrollment and verified subsequently at service delivery.
2. SACHI could consider revising the RSBY reimbursement rates for health services in consultation with representatives of empaneled private hospitals.
3. RSBY services should be expanded to include coverage of injectable contraceptives.
4. The state government should revise the bidding process to engage insurance companies for a longer period in a particular district, instead of annual bids.
5. The state government should revise the premium paid to the insurance companies, along with an assessment of BPL families' willingness to pay.
6. Empaneled hospitals should designate one person well versed in the rules and regulations of RSBY to assist enrolled clients as they seek services from the hospital.
7. In order to reduce denials of coverage at the point of service, the computer enrollment system should be improved to minimize errors in data and biometric entry. Linking the RSBY card to the national unique identification number should be explored by the government.
8. The reimbursement process should be studied to identify and mitigate barriers and delays in reimbursements faced by the empaneled hospitals.

Demand-side Recommendations

1. Implement intensive, multi-channel campaigns to raise awareness of RSBY and encourage enrollment among BPL families, and notify BPL families about venues and times of enrollment camps in advance. Community stakeholders such as ration shop owners, frontline workers, and non-governmental organizations (NGOs) could be involved in providing information about the RSBY scheme to BPL families to increase beneficiaries' knowledge and rights. Insurance companies should also investigate the potential for SMS and voice messages to mobile phones to increase awareness among BPL families about RSBY and upcoming insurance company enrollment camps.
2. Give special attention to raising awareness and facilitating utilization of RSBY for FP/RH services. The greatest use of FP/RH services by women was for delivery services. Information boards in delivery wards and recovery areas describing the FP/RH services offered under RSBY offer an opportunity to raise awareness of and increase utilization of other RH services, including FP.

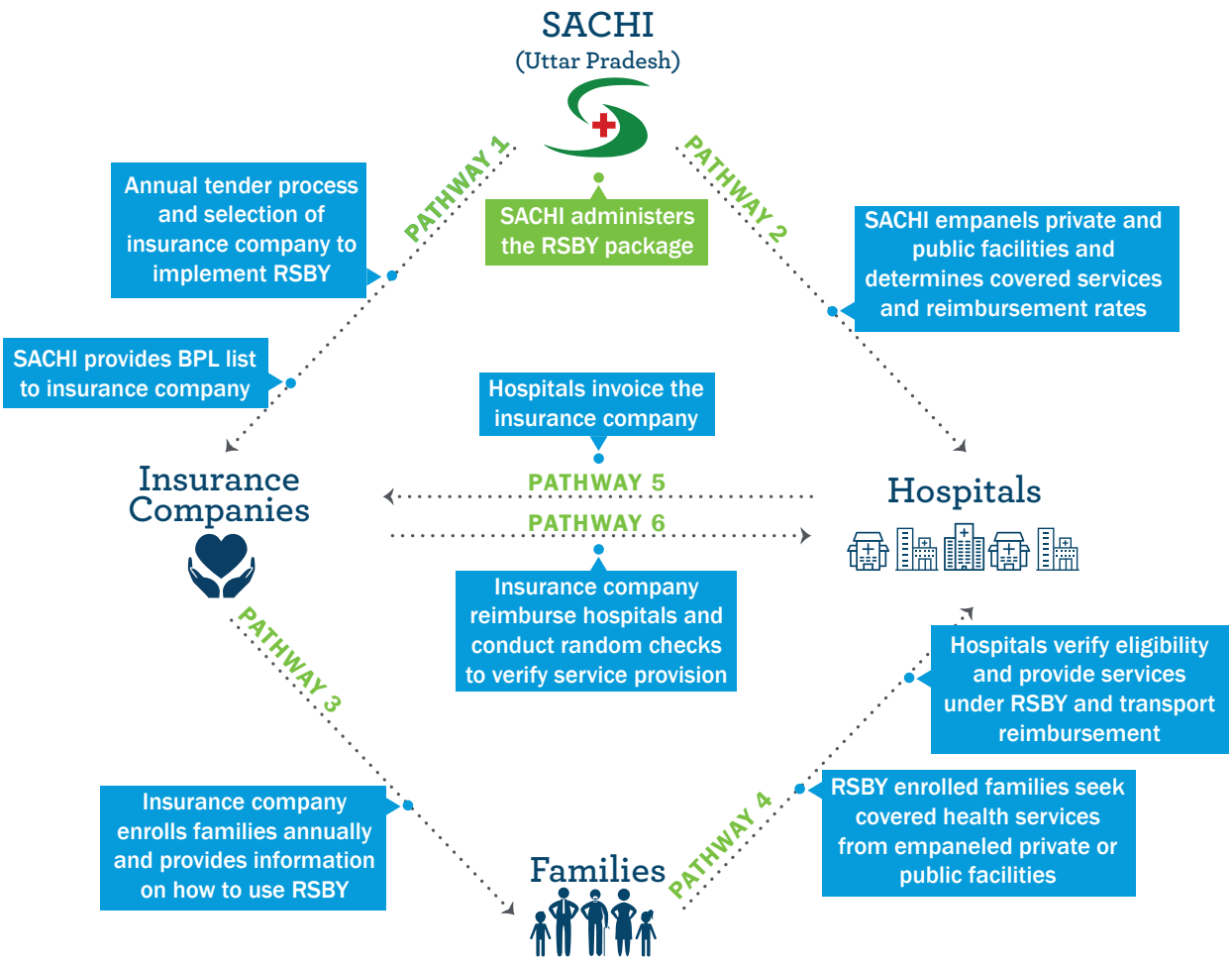
3. Educate RSBY families about services covered by RSBY and the process for utilizing services in empaneled facilities by providing easily understandable written/visual instructions, in addition to a verbal explanation, at the time of enrollment and through periodic community meetings. Empaneled hospitals can offer space for insurance company representatives to have an information/enrollment desk so those coming in for services can easily learn about the program and enroll during their visits.

Introduction

The national health insurance scheme, Rashtriya Swasthya Bima Yojana (RSBY), was launched by the Ministry of Labor and Employment of the Government of India in 2008 to promote equitable access to health services through both the private and public sectors. This scheme is intended to cover economically disadvantaged families living below the poverty line (BPL) in urban and rural areas to provide access to a pre-specified package of health services including general surgery, general medical care, pediatric care, gynecological care, family planning (FP) and other reproductive health (RH) services (Box 2), as well as dentistry, ophthalmology, urology, neurosurgery, and oncology (RSBY 2015a; RSBY 2015b). Though the RSBY program includes a range of services provided through both the public and private sectors, this study focuses only on FP/RH services provided through participating private hospitals.

The RSBY program has multiple pathways that comprise the system **(Figure 1)**. The operational process can be divided into two main domains: the supply-side (steps 1, 4 & 5) and the demand-side (steps 2 and 3).

FIGURE 1. SCHEMATIC DIAGRAM OF THE OPERATIONAL PATHWAYS OF RSBY



Pathways 1 and 2: In Uttar Pradesh, the State Agency for Comprehensive Health Insurance (SACHI) is responsible for implementing RSBY. SACHI has three main responsibilities:

1. **Selection of insurance company to implement RSBY:** SACHI selects an insurance company to work in each district, through an annual competitive tender process. This annual tender process means insurance companies who manage the RSBY program can potentially change every year. The families also have to enroll themselves in RSBY every year, even if the managing insurance company does not change; but their annual premium remains the same.
2. **Selection of empaneled hospitals to provide RSBY services:** SACHI empanels private and public hospitals into the scheme based on certain criteria, including: presence of a resident doctor who can be available to provide services at any time, a complete and functional operating theater, 24-hour ambulance service, onsite drug dispensary, and a canteen within the boundaries of the hospital.
3. **Selection of services and determination of reimbursement rates:** SACHI is responsible for preparing a list of health services covered by RSBY insurance and setting the reimbursement rates for each service, applicable to both private and public hospitals.

Pathway 3: The selected insurance companies are responsible for enrolling BPL families into the RSBY insurance scheme. The insurance companies use lists of BPL families in their districts provided by SACHI and prepared by the state government through a periodic census, with financial and technical support from the national Ministry of Rural Development. Each insurance company adopts its own strategy for publicizing RSBY to increase enrollment of eligible groups. The enrollment process is the same across all districts and includes receipt of one identification card per family (for enrollment of up to five family members) containing the name and photograph of the household head and information of the other enrolled family members (including biometric information consisting of a fingerprint). Since the insurance companies are selected annually by SACHI, BPL families are expected to enroll annually with the selected insurance company managing the RSBY scheme, even if the insurance company does not change. The insurance company is also responsible for ensuring participants know the names and locations of the empaneled hospitals and services covered under the insurance program.

Pathway 4: RSBY enrolled individuals seek health services from empaneled hospitals. In order to use subsidies offered under RSBY, enrolled individuals must first present their families' RSBY identification card at the hospital before receiving services. Once their biometric data are confirmed, they are told whether the services they are seeking on the visit day will be subsidized or not. The utilization of RSBY requires at least 24 hours of hospitalization, with the exception of certain outpatient procedures like female sterilization or IUD insertion. Outpatient services such as diagnostic services are included, provided they lead to hospitalization **(Box 1)**. SACHI also maintains a toll free number whereby beneficiaries can lodge any complaints they may have about RSBY.

Pathways 5 and 6: Once an RSBY eligible health service is provided, the empaneled hospital sends

BOX 1

REQUIREMENT TO USE RSBY

1. Verification of RSBY card by photograph and fingerprint.
2. Required medical procedure is listed among RSBY services.
3. 24-hour hospitalization or specified day surgeries.
4. No discrimination with respect to pre-existing diseases.
5. Does not cover outpatient services that do not lead to hospitalization.
6. Does not cover expenses towards medicines and tests that are not related to or do not lead to hospitalization.

Source: RSBY 2015b

an invoice to the insurance company. The insurance company then reimburses the hospital for the service. Sometimes the insurance companies conduct random checks and meet clients at hospitals during their visits to prevent any reimbursement of services not provided. The insurance companies also outsource this inspection and reimbursement process to third-party administrators.

BOX 2

ILLUSTRATIVE RSBY-COVERED FP/RH SERVICES AND REIMBURSEMENTS TO HEALTH FACILITY

- Normal delivery (up to Rs. 4,000)
- Caesarian section (up to Rs. 8,000)
- Tubal ligation (Rs. 2,500)
- Vasectomy (Rs. 1,500)
- Copper-T/ IUD insertion (Rs. 500)
- Post-abortion care (Rs. 2,500–4,000)

Source: SACHI 2015

In the RSBY scheme, the majority of the annual premiums for health insurance is paid jointly by the central (75 percent) and state (25 percent) governments. The beneficiary family pays Rs. 30 per year after annual enrollment. The insured amount is Rs. 30, 000 per BPL family per year, covering up to five members. Newborns are covered as a sixth member until the card expires at the end of the year; after this, a sixth person would no longer be covered. RSBY covers a range of curative RH and family planning services, as shown in **Box 2**. A family is also entitled to receive Rs. 100 at the time of discharge to reimburse transportation costs, subject to a maximum of Rs. 1,000 per year. Those enrolled in the scheme receive a RSBY card, popularly known as 'smart card,' which facilitates service delivery under the scheme. Enrolled families are expected to show the card to an operator at the time of admission to an empaneled hospital, to verify the card and inform the beneficiary of the remaining balance. The operator also matches the client's fingerprint and photograph with the database before registration for reimbursement (RSBY 2015b).

Across 20 states of India, the proportion of eligible BPL families enrolled in RSBY is approximately 55 percent with wide variations by states; for example, over 90 percent are enrolled in Chhattisgarh and Kerala, but less than 30 percent are enrolled in Uttar Pradesh, and Meghalaya (RSBY 2015). The latest available figures show that enrollment in Uttar Pradesh is 28 percent. The enrollment rates of Allahabad, Kanpur Nagar, and Lucknow districts within Uttar Pradesh are 33 percent, 27 percent, and 40 percent, respectively, as of 31 March 2016 (RSBY 2015c).

Although RSBY has been in place for more than seven years, awareness and knowledge among its current and potential clients about the scheme and its benefits is low and varies across the country (Krishnaswamy and Ruchismita 2011). A study conducted in Gujarat showed high awareness about the scheme among BPL families (71 percent) and that many had an RSBY smart card (62 percent) (Ministry of Labour & Employment 2011). Knowledge about specific benefits offered under RSBY was low, however: only 37 percent of BPL families knew free treatment could be obtained with an RSBY smart card, and 24 percent knew that a transport allowance was available for beneficiaries. One study found that less than 20 percent of respondents who had an RSBY card received information or documentation about locations of RSBY empaneled hospitals and available services and treatment (Amicus Advisory Pvt. Ltd., 2016). Another study found that 61 percent of RSBY beneficiaries learned of RSBY empaneled hospitals through a friend or family member, while only three percent learned of them through enrollment materials, and only six percent knew whom to contact for queries about RSBY, limiting beneficiaries from becoming fully aware of its benefits (Westat India Social Sciences 2010). Anecdotal evidence suggests that urban poor women seek antenatal care, delivery services, sterilization, and post-abortion care from public hospitals rather than private, RSBY empaneled hospitals. It is

unclear if this is due to a lack of awareness of the services covered under RSBY or reflects women's preferences to not seek certain services from private hospitals. Therefore, despite the availability of insurance coverage, poor families' utilization of RSBY for FP/RH services is believed to be negligible. The barriers among beneficiaries as well as from private hospitals need to be explored to identify solutions for enhancing BPL families' access to FP/RH services in urban areas. For example, there is a dearth of evidence on the additional or hidden costs RSBY beneficiaries may incur that prevent them from utilizing RSBY facilities.

Given these challenges, the Evidence Project conducted a study in three cities in Uttar Pradesh (UP) – Allahabad, Kanpur, and Lucknow – to better understand the supply and demand factors affecting the utilization of RSBY for FP/RH services in private hospitals. Although RSBY covers both private and public facilities, the study included only private hospitals because FP/RH services are available free of cost in public health facilities. This study's focus on utilization of FP/RH services through RSBY is of particular importance in the urban context, where there is a rapidly growing need for these services among the urban poor. Based on the National Family Health Survey 3 (2005-06), 50 percent of women in urban slums in India had their last delivery assisted by a skilled birth attendant (IIPS and Macro International 2008). Only 11 percent of women received complete antenatal care (ANC) services, and 44 percent delivered at a health facility. Use of modern contraceptive methods in urban UP is about 42 percent, but use of spacing methods is only about 25 percent. The Annual Health Survey 2012-13 shows, in urban areas of UP, that unmet need for limiting was seven percent, and for spacing was eight percent, indicating demand for FP/RH services in urban areas (ORGI). This study is especially timely, as the government is keen to increase the number of RSBY beneficiaries, their uptake of health services, and the number of private hospitals participating in the program.

Objectives/Research Questions

This cross-sectional implementation research study provides comprehensive information on both the supply- and demand sides related to the utilization of RSBY for FP/RH services. The study identifies barriers and facilitating factors to RSBY's utilization by intended beneficiaries, and enrollment barriers for private hospitals, in order to enhance and increase the use of FP/RH services.

The goal of this study is to understand the supply- and demand side factors influencing RSBY utilization for FP/RH services in three metropolitan areas of UP. The study addressed the following specific research objectives:

1. To determine the level of RSBY awareness and barriers to RSBY enrollment among the urban poor;
2. To identify barriers and facilitating factors faced by enrolled families in utilizing RSBY for FP/ RH services;
3. To assess the concerns and limitations of RSBY empaneled private hospitals in providing FP/ RH services under RSBY to the urban poor; and
4. To provide programmatic recommendations for national and state governments to help improve the delivery and utilization of RSBY for FP/RH services.

The evidence generated from this study will be useful for advocating for increased access to FP/RH services through the RSBY scheme. Furthermore, the results of this study are of practical interest to the National Health Mission of the Government of India, and can inform programmatic activities to improve demand generation and increase utilization of the scheme. Finally, it is hoped that evidence generated from this study will assist the national and state governments to design and test implementation research and generate new evidence for strengthening the insurance scheme.

Methods

STUDY DESIGN, SAMPLING, AND RECRUITMENT

This section of the report describes the study design, sample size calculation, enrollment process, data collection, data management, and analytical processes, followed by brief descriptions of challenges encountered in executing the study and how those challenges were overcome. The section ends with a description of ethical considerations and the process of maintaining the confidentiality of study participants.

Study Design and Sample Size Calculation

This cross-sectional study used both quantitative and qualitative methods. The RSBY enrollment rate in the study area was 47 percent as of May 2015, reported by the SACHI in an email correspondence. The sample size for the quantitative survey was calculated using the formula,

$$N = \frac{z^2_{1-\alpha/2}\, p\,(1-p)}{d^2}$$

where:

N is the sample size required for the study

$z^2_{1-\alpha/2}$ is the level of confidence

p is the RSBY enrollment rate

d is the absolute precision.

The required sample size for this study was 383, assuming RSBY enrollment rate as 0.47, confidence level as 95 percent, and absolute precision is 0.05. With a design effect of 1.5 and 20 percent non-response rate, the total required sample size was about 720. To ensure adequate cell frequency for analysis, the sample size was increased to 800 eligible households with at least one married women aged 18-35 years.

Study Area, Population, and Recruitment of the Participants

The study was conducted in three cities of Uttar Pradesh, India: Allahabad, Kanpur, and Lucknow. These three cities are located in three different zones of Uttar Pradesh. Households in the urban slums of these three cities were screened to identify BPL families.

Challenges in Identifying the Households for the Survey

The major challenge in conducting this survey was to identify the BPL households. The latest available list of BPL households was from 2002 and had not been updated. Furthermore, while this list of BPL families includes the names of the heads of households, the addresses were incomplete, making it difficult to physically locate the houses or slums.

At first, lists of slums were obtained from the municipalities of the three selected cities. Five of the largest slums, as defined by residential population, were identified. The initial strategy was to conduct a house-listing to identify BPL families within those selected slums. On the first day of the house-listing, however, only one BPL household was identified out of approximately 100 households listed.

After this experience, the research team explored other ways to identify BPL families. The BPL list also provides the name of ration shop owners in an area. Ration shops are established by the state government, where BPL eligible families can purchase groceries at a lower cost. While ration shop owners may know the location of BPL families in their area, the addresses of the ration shops were unavailable. This made it difficult for the research team to locate the ration shops.

After several consultations with individuals living in the slums, ration shop owners were identified and visited by the research team. The ration shop owners informed the research team of the pockets where BPL families were living. House-listing in those areas yielded less than five RSBY households per 100 households listed. This was likely due to the fact that RSBY enrollment rates are not uniform throughout the cities.

The research team then approached the SACHI office to obtain a list of RSBY households. The officials were unable to provide the names and addresses of RSBY households for ethical reasons, but did offer the total number of RSBY enrolled households by zone. From this list of zones, the research team visited every zone in the cities: three zones in Allahabad, five zones in Kanpur, and six zones in Lucknow. In each zone, the research team asked residents about the location of ration shops. The ration shop owners provided the areas where BPL families were living. A subsequent house-listing was completed in these areas, which yielded good results, approximately 30 RSBY enrolled households per 100 households listed. The process of approaching ration shop owners to help identify pockets of BPL families was followed in all of the selected study cities.

An additional method was applied to identify RSBY families in Kanpur and Lucknow. In these cities, the state government runs slum rehabilitation programs, whereby many BPL families moved to low-cost government apartments. There are approximately 100 such apartment buildings with 16 apartments in each building, for a total of 1600 BPL households. We divided the apartment buildings into two segments, 50 buildings in each, and conducted the house-listing of the first 40 buildings in each segment. While the study team could have selected all potential respondents from these apartment buildings to cover the target sample size for Kanpur and Lucknow, a diverse representation of RSBY households was also important, so two sampling strategies were employed in these two cities.

Recruitment Process of the Individual

From each RSBY enrolled household that was listed, the number of married women 18-35 years of age was also listed. It was originally planned that the sample would be obtained from 15 slums, but 51 slums were visited to achieve the required sample size. A total of 7699 households were listed. Of these, 3109 were BPL households, and of those, 1886 were RSBY households. Out of those RSBY households, 1022 had at least one married woman aged 18-35 years.

During the quantitative survey, we visited all the RSBY households listed and invited eligible women to participate in the survey. If more than one eligible woman of an RSBY family was available and agreed to participate in the survey, one woman was randomly selected using a lottery method.

We attempted to interview adult men from all RSBY households listed. If an eligible woman of the household had already participated in the survey, we requested to interview the husband of that female respondent. If the husband was unavailable, we interviewed the head of the household. If both husband and household head were not available, we interviewed any adult men older than 18 years from the RSBY household.

DATA COLLECTION

The study team developed a bilingual data collection tool, in English and Hindi, for interviewing women and men. Additionally, socioeconomic characteristics of the participants were collected. The researchers developed a computer-assisted personal interviewing (CAPI) program for all three data collection surveys using

CS-Pro software. The investigators, supervisors and field coordinator were trained for one week to understand the aim and objectives of the study, be familiarized with the data collection schedule, and practice data collection using mini-laptops. The training included role-plays and mock interviews. The tools were then field tested, and queries were clarified in the review meeting. The investigators conducted the survey using CAPI installed on mini-laptops. Use of mini-laptops accelerated the data processing and enhanced the data quality, as it allows application of appropriate logics for skips and checks. The quantitative data were collected September-October, 2015.

The in-depth interviews (IDIs) of women were conducted by the female investigators, and IDIs of the hospital heads and health providers were conducted by the male investigators. Additionally, the IDIs of male members of RSBY families, and of the ration shop owners of the public distribution system, were conducted by Population Council's research team. The investigators were trained for two days by the Population Council research team. The training included rapport building with respondents, explaining the purpose of the interview, taking informed consent for the interview and its recording, conducting the interview, operating the voice recorder, and developing the transcripts. The men's IDIs were conducted in May, 2015 and women's IDIs were conducted in December, 2015. Interviews of hospital heads and health providers were conducted in different phases, between June, 2015 and February, 2016. The transcripts of the interviews developed in Hindi were typed for analyses in Atlas-ti software.

Challenges in Data Collection Activities

The men, and sometimes even women, of RSBY households are daily wage earners and work even on weekends. Many of them, especially the men, were not available for interviews during usual working hours. The research team visited the survey area more than once, and often early in the morning, before the respondents left for work, to conduct interviews.

Selecting the informants for qualitative interviews was a challenge since the utilization of any health service in participating empaneled private hospitals was low, leaving limited options. Repeated visits were made to interview informants, as often they were not at home even on weekends. The empaneled private hospitals do not have high caseloads for FP/RH services. Often a hospital head is the only service provider in a hospital. Hospitals generally do not have any permanent Ob-Gyns but call them only if they are needed. Private doctors are on the rosters of many private hospitals, and they call each other depending on the expertise required to provide care. Providers selected for interviews were frequently at other hospitals, busy attending to patients or operating in the theater; prior appointments were made with each provider or hospital head, but some interviews had to be rescheduled.

Final Sample Size Achieved

The RSBY enrollment rate in the three selected cities is not equal. Allahabad, Kanpur, and Lucknow have 1,000, 9,000, and 16,000 enrolled RSBY families, respectively. The sample size of 800 was distributed according to the proportion of enrolled families in the three cities, so the city samples were 100 in Allahabad, 300 in Kanpur, and 400 in Lucknow. Among the listed RSBY households with eligible women (married and between the ages of 18-35 years), we interviewed participants from 810 households, who were available and agreed to participate in the study. In many cases, women and men from the same household were not both available during the visit, so we were not able to interview a woman and a man from every household. Therefore, out of 810 households, we interviewed 726 women and 640 men. The number of women and men finally interviewed in each city are presented in **Table 1**.

TABLE 1. SAMPLE SIZE OF THE PARTICIPANTS

Name of the City	Sample Target	Women Interviewed	Men Interviewed
Allahabad	100 women and men	80	75
Kanpur	300 women and men	291	244
Lucknow	400 women and men	355	321
Total	**800 women and men**	**726**	**640**

We studied the concerns and limitations of RSBY empaneled private hospitals for providing FP/RH services under RSBY by conducting in-depth interviews with 20 hospital heads and doctors of RSBY empaneled hospitals: seven in Allahabad, five in Kanpur, and eight in Lucknow. Some of the hospital heads are also doctors. We also conducted in-depth interviews with 17 women (two from Allahabad, seven from Kanpur, and eight from Lucknow) and eight men (one from Allahabad, one from Kanpur, and six from Lucknow) of RSBY families.

DATA MANAGEMENT AND ETHICAL CONSIDERATION

Data from all the mini-laptops were downloaded to the researcher's computer, where the data were compiled into respective databases for households, women, and men. The data were carefully reviewed for possible errors like duplication while downloading. Coding for city, area, slum, and household number were checked with the household data. The data with unique codes assigned to each participant are stored in the researcher's password-protected office computer. The text responses for 'others (specify)' options were examined and re-coded. The inconsistencies and validity of the data were checked by the research team. All IDIs were digitally recorded; however, during the interview the names and other identifiers were not mentioned, to maintain the confidentiality of the informant. The digital voice files were stored in researcher's password-protected office computer. All transcripts of the qualitative interviews were loaded into Atlas-ti software. Two researchers prepared a code-list for qualitative analysis and coded the transcripts accordingly.

The Institutional Review Board (IRB) of the Population Council reviewed the study protocol, study tools, informed consent forms, and process of maintaining confidentiality for ethical considerations. All members of the study team had research ethics training and received the certificate of participation.

BACKGROUND CHARACTERISTICS

The background characteristics of the female and male participants are presented in **Table 2**. The median age of female respondents was 30 years, and for male respondents was 35 years. While the majority of women interviewed were between the ages of 30 and 34 (48 percent), the majority of interviewed men were 35 years old or older (55.6 percent). In terms of education, 43.7 percent of women could neither read nor write. For men, however, proportions of educational attainment were greatest at the two extremes: 32 percent could not read or write, while 28.6 percent had attained 12th standard or above. Sixty percent of women reported that their monthly family income was less than Rs. 5,000 (equivalent to $77). Only six percent reported that their monthly family income was more than Rs. 10,000 (equivalent to $154). Most women (80 percent) reported that they were not working outside their home (not presented in the table). The overwhelming majority of female and male respondents have had a child, 89.1 percent and 86.7 percent, respectively. The median number of children was three, and about six percent of women were pregnant at the time of the survey.

TABLE 2. BACKGROUND CHARACTERISTICS OF WOMEN AND MEN PARTICIPANTS

	Women % (N=726)#	Men % (N=640)#
Median age, in years	30.0	35.0
Age group		
< 25 years	24.0	9.5
25 - 29 years	23.5	15.9
30 - 34 years	47.5	18.9
35 years or more	5.0	55.7
Educational status (in completed years)		
Cannot read and write both	43.7	32.0
Primary (5th standard)	18.7	17.2
8th Standard	15.6	13.0
Secondary (10th standard)	10.5	9.2
Higher secondary (12th standard) and above	11.5	28.6
Monthly family income*		
Up to Rs. 3,000	20.4	-
More than Rs. 3,000 to Rs. 5,000	41.0	-
More than Rs. 5,000 to Rs. 7,500	23.4	-
More than Rs. 7,500 to Rs. 10,000	9.0	-
More than Rs. 10,000	6.2	-
Have a child	89.1	86.7
Number of children (Median, Minimum-Maximum)	3, 1-8	3, 1-9
Currently pregnant	6.3	-

** Data on monthly family income were collected from women only*
 # All women and men

KNOWLEDGE ABOUT RSBY

Sources of Information About RSBY

The majority of respondents learned about RSBY from their neighbors (46 percent of women and 44 percent of men) **(Table 3)**. The second most common source of information about RSBY was local ration shop owners, with 27 percent of women and 45 percent of men reporting this as a source. About 26 percent of men learned about RSBY from an RSBY enrollment campaign at the community level, while almost 22 percent of women reported learning about RSBY from their husbands. Less than five percent of both women and men learned about RSBY from Anganwadi workers (government frontline health workers), NGO personnel, health providers, and from mass media like radio, newspaper, or television.

TABLE 3. SOURCE OF INFORMATION ABOUT RSBY AS REPORTED BY WOMEN AND MEN*

	Women % (N=726)#	Men % (N=640)#
Insurance company representative at enrollment	13.2	0.6
Family and relatives		
Husband	21.6	-
Other family members	14.9	3.0
Relatives	0.7	0.5
Health Care providers		
Government doctor	0.7	-
Anganwadi worker	2.5	-
Private doctor	0.3	-
NGO Personnel	0.1	-
Community		
Ration shop owner	27.4	45.2
Community campaign	9.2	25.6
Friend	4.1	7.2
Neighbor	46.1	44.2
Ward member/ representative	0.4	0.8
Media		
Newspaper/ pamphlets	0.6	1.1
TV/ Radio	1.4	0.2

** Multiple choice answers, totals may not equal 100 percent*
 # All women and men

During the house-listing, we asked the 1,239 non-RSBY BPL families about their reasons for not enrolling. Nearly 94 percent of them reported that they did not know that such a scheme existed. About five percent of these non-RSBY enrolled families reported that they visited the RSBY enrollment camp and completed the enrollment procedure but did not receive the RSBY card, so their enrollment was not completed. The remaining one percent of the families reported that they did not enroll in RSBY because they thought it cost money.

In the in-depth interviews, both men and women described various sources of information about RSBY:

"Everybody in my neighborhood was talking about the enrollment into smart card [RSBY card]. So we went, and got our card made." (Woman, 30 years, Kanpur)

"I came to know about the health insurance scheme from the ration shop owner. We made this card when he told me. The camps [enrollment] were set up twice at his place. … I did not get anything before my enrollment in writing like leaflet or did not see anything about the scheme in poster or television." (Man, 36 years, Lucknow)

"There was a camp at the place where I got our ration card. We were asked to fill a form, and they prepared the card. But they did not tell anything about the card, so we have not used it yet. They gave us the card and we have kept it." (Man, 23 years, Lucknow)

"I saw about RSBY in a book. I did not read that but I saw in a book. My elder sister-in-law read it and told me about the scheme." (Woman, 34 years, Lucknow)

Knowledge of RSBY Entitlements

Knowledge of RSBY-subsidized services among women and men of families enrolled in RSBY is presented in **Figure 2**. Spontaneous responses were first recorded, while responses not initially mentioned by respondents were then asked individually, by prompts. The results presented in Figure 2 show combined spontaneous and prompted responses.[1] Overall, men showed higher knowledge of RSBY entitlements than women. Over 65 percent of women and men reported that general treatments like surgeries and medication can be obtained using RSBY. About 31 percent of women and 40 percent of men knew that delivery services (normal delivery, assisted delivery, and cesarean delivery) are covered under RSBY, and 25 percent of women and 33 percent of men knew about reproductive health services for complications during pregnancy, after delivery, and other gynecological services. Only 19 percent of women and 30 percent of men knew that family planning services were offered through RSBY. A higher percentage of women (31 percent) knew about the availability of hysterectomy through RSBY than men (19 percent). One in three men and women did not know about any services covered under RSBY.

FIGURE 2. KNOWLEDGE OF RSBY-SUBSIDIZED SERVICES AMONG WOMEN AND MEN OF RSBY FAMILIES

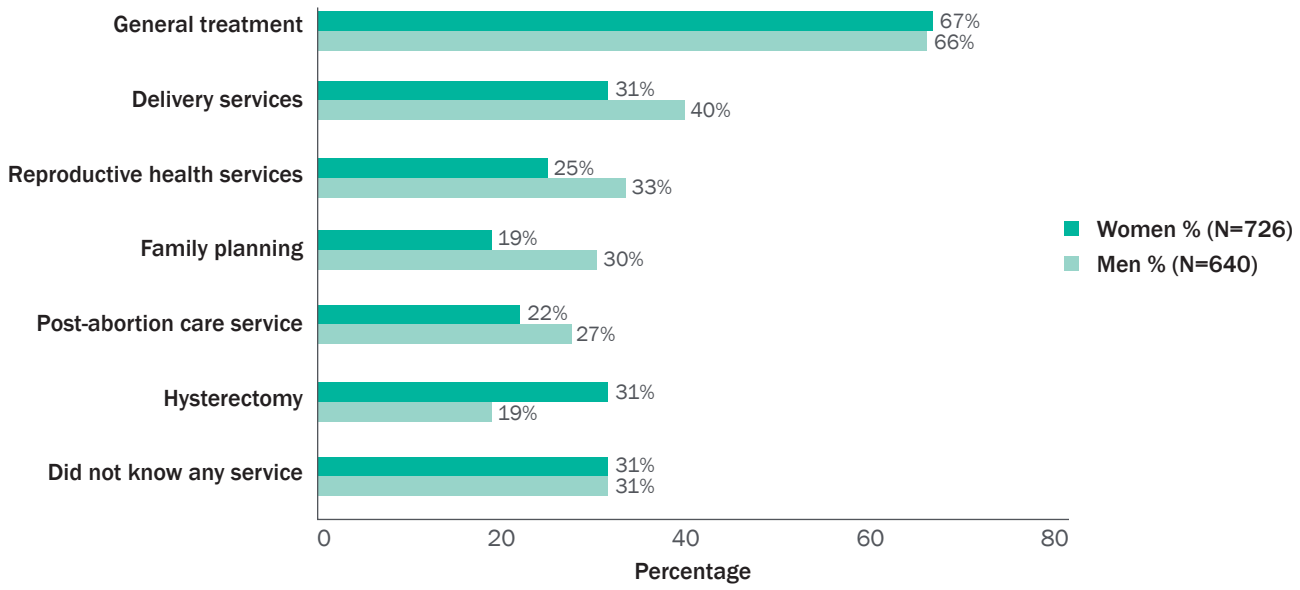


Table 4 shows knowledge of RSBY-subsidized FP/RH services among women and men of RSBY families. Overall knowledge of RSBY-subsidized FP/RH services was low (mostly below 30 percent). Knowledge among women was five to ten percent lower than men. Among the different services, knowledge of delivery services under RSBY ranged from 19 to 34 percent, while knowledge of RSBY-subsidized FP services was the lowest, ranging from 14 to 24 percent.

[1] Spontaneous knowledge of various FP/RH services ranged from 1-9% for women, which increased to 20-30% after prompting. Even after prompting, knowledge remained low.

TABLE 4. KNOWLEDGE OF RSBY ENTITLEMENTS AMONG WOMEN AND MEN OF RSBY FAMILIES*

	Women % (N=726)#	Men % (N=640)#
FP services can be availed		
Female sterilization	17.9	23.8
Male sterilization	14.9	20.2
Copper-T insertion	13.9	19.2
Did not mention any family planning service	82.1	75.6
Delivery services can be availed		
Normal delivery	24.5	33.8
Assisted delivery	19.4	24.2
Cesarean delivery	26.2	32.3
Treatment for delivery complications	22.9	26.7
Did not mention any delivery service	71.9	64.2
RH services can be availed		
Regular ANC check-up	18.2	25.5
Ultrasonography	18.5	25.2
Pregnancy-related complication	19.0	21.7
Tests and ultrasonography leading to hospitalization	20.1	24.5
Did not mention any RH services	77.5	70.5
Post-abortion services can be availed		
Removing products from uterus	16.7	18.8
FP services after abortion	14.2	18.4
Did not mention any post-abortion service	82.2	78.4

** Multiple choice answers, totals may not equal 100 percent*
 # All women and men

Knowledge of RSBY Enrollment and Service Provisions

Women and men's knowledge of the enrollment process for RSBY and its coverage provisions are presented in **Table 5**. In-depth interviews with men before the quantitative survey show that men were the main decision-makers for enrolling their families in RSBY. Therefore, we asked about knowledge of the enrollment process and provision of health service utilization in RSBY only from male members of RSBY families. About 65 percent of men correctly knew that the card was valid for one year, 67 percent knew of the enrollment costs, and 66 percent were aware of the yearly family coverage. A smaller proportion of men (47 percent) knew that renewal of the RSBY card costs Rs. 30. More than half of male respondents (59 percent) correctly reported that only inpatient services could be availed through RSBY, but less than half of the male respondents (42 percent) knew that a minimum 24-hour hospitalization is required to qualify for RSBY coverage. More than one in three men (38 percent) reported not knowing the types of services covered through RSBY. A higher percentage of women (14 to 18 percent) than men (2 to 8 percent) knew that RSBY also covers medical tests, cost of drugs, and food for the patient, but overall knowledge among both groups was low.

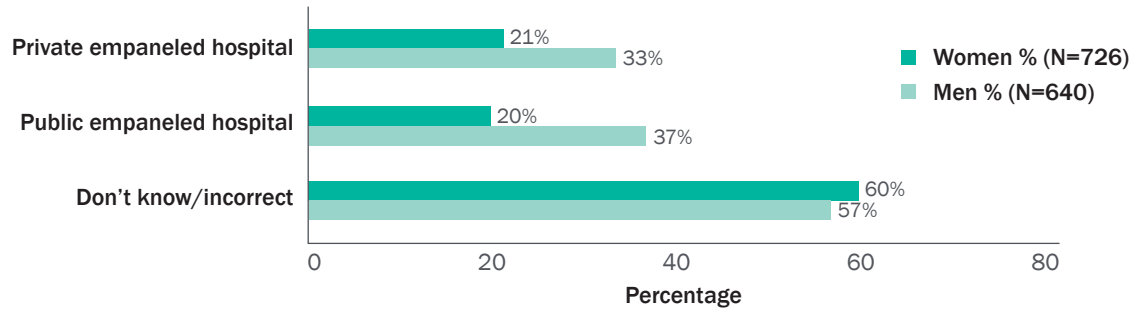
TABLE 5. KNOWLEDGE OF ENROLLMENT PROCESS AND SERVICE PROVISIONS THROUGH RSBY

	Women % (N=726)#	Men % (N=640)#
RSBY card validity of 1 year*	-	63.3
Enrollment cost of Rs. 30 for RSBY*	-	67.2
1-year family coverage costs of Rs. 30,000*	-	66.3
Renewal cost of Rs. 30 for RSBY*	-	47.2
Type of health service entitled through RSBY*		
Only inpatient service	-	58.9
Only outpatient service	-	0.8
Both inpatient and outpatient services	-	2.8
Do not know	-	37.5
Minimum duration of hospitalization (24 hours) necessary for RSBY utilization*	-	41.9
RSBY for medical tests	14.3	2.0
RSBY for drugs costs	17.4	8.1
Provision of food for the patient	17.9	7.3
Did not correctly know any of the entitlements	75.1	12.7

** Data on these variables were collected from men only*
 # All women and men

Figure 3 presents knowledge of RSBY-supported facilities among women and men of RSBY-enrolled families. About 20 percent of women knew that RSBY services can be availed in empaneled private or public hospitals. For men, this was slightly higher: 33 percent of men knew about availability of RSBY in private empaneled hospitals and 37 percent knew about availability of RSBY in public empaneled hospitals. The overwhelming majority of women (70 percent) and more than half of men (57 percent) either did not know of any health facilities that accept RSBY insurance or incorrectly named RSBY-supported health facilities.

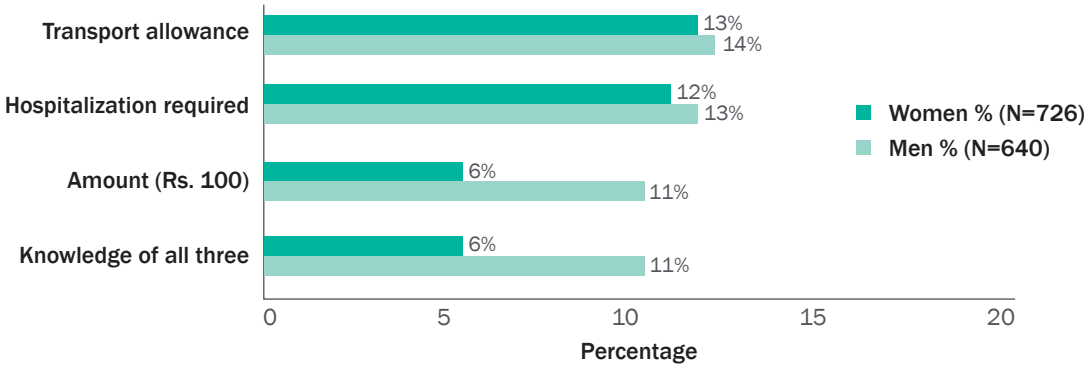
FIGURE 3. KNOWLEDGE OF RSBY-SUPPORTED FACILITIES*



**Multiple choice answers, totals may not equal 100 percent*

Figure 4 shows respondents' knowledge of RSBY-supported transport reimbursements. Overall, few respondents (12.5 percent of women; 14.4 percent of men) knew the correct transportation reimbursement amount. Only six percent of women and 11 percent of men knew that the reimbursement existed, that it required a hospitalization, and the amount reimbursed.

FIGURE 4. KNOWLEDGE OF RSBY-SUPPORTED TRANSPORT REIMBURSEMENT



Knowledge of RSBY entitlements, including transportation, are crucial for better utilization of the scheme. The head of an RSBY family said,

"Earlier, I did not look at the board [in the hospital with information about RSBY] carefully. At the time of discharge, I had a chance to go through the board and got the full information. It was written on the board that card (RSBY) users can get Rs. 100 for transport. So, before leaving the counter I asked whether I could go or if there was anything else left. He told me to go, then immediately called me back and gave me Rs. 100. I thought if I asked him about this amount probably he would not have given it to me and I would have spent my own money. At least I got some benefit of waiting outside and reading the board."
(Man, 24 years, Lucknow)

Access to Healthcare Services

The study explored several issues that influence access to RSBY health services, including the receipt of a list of empaneled hospitals at the time of enrollment every year, the list's current availability at the time of interviews, distance to the nearest empaneled hospital and time to travel there, and awareness of the RSBY telephone helpline. Results of these indicators are presented in **Table 6**. A little less than 30 percent of females and males were given a list of empaneled hospitals at the time of enrollment. A little more than half of female respondents (56 percent) do not know the distance to the nearest hospital or how long it would take to reach it (51 percent). These indicators were much lower for men (about 13 percent).

TABLE 6. ACCESS TO HEALTHCARE SERVICES THROUGH RSBY

	Women % (N=726)#	Men % (N=640)#
Empaneled hospitals list given at the time enrollment	28.8	28.9
Location of hospital list received at enrollment		
Kept in a known location and accessible for use anytime	12.4	8.1
Kept somewhere at home	12.8	17.3
With someone else	0.7	0.2
Lost	2.2	3.0
Don't know/ remember	0.7	0.3
Distance to nearest empaneled private hospital		
Within 2 km	4.7	12.8
2 km to within 5 km	8.4	37.0
5 km to within 10 km	10.2	30.2
10 km or more	6.1	7.2
Don't know	70.7	12.8
Time to nearest empaneled private hospital		
Less than 15 min	6.6	12.2
15 min to less than 30 min	7.6	35.6
30 min to less than 1 hour	14.6	31.7
1 hour or more	5.5	8.0
Don't know	65.7	12.5
Heard about RSBY helpline number	16.8	8.0

 # All women and men

USE OF RSBY

Use of Empaneled Health Services

Respondents were asked whether they or anyone in their families had received services from an empaneled private hospital, and results are shown in **Table 7**. Around 13 percent of women and 18 percent of men reported that they or someone else in their family used health services from a private empaneled hospital. Family members mostly used general treatment services (11 percent reported by women and 15 percent reported by men). No female respondents reported that they or another family member used family planning services at a private empaneled hospital, while only one male respondent reported that someone in his family used family planning services.

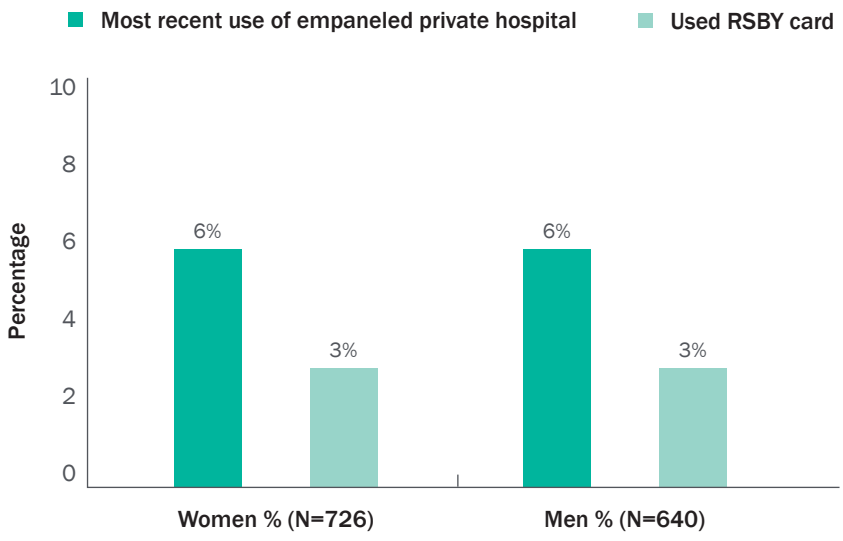
TABLE 7. FAMILY USE OF HEALTH SERVICES AT PRIVATE EMPANELED HOSPITALS SINCE OBTAINING THE LAST RSBY CARD

	Women % (N=726)#	Men % (N=640)#
Since obtaining the last RSBY card, use of RSBY (personal use + family members covered)	12.8	17.5
Type of health services received		
General treatment/ operation	10.5	15.3
Delivery services	1.7	1.6
Family planning	-	0.2
Post-abortion care	0.3	0.8
Hysterectomy	0.7	0.3

 # All women and men

Respondents were asked the most recent person in their family who used private empaneled hospital services. **Figure 5** presents data for respondents who reported that they themselves used empaneled private hospital services with their RSBY card. A very small proportion (6 percent) of women and men reported use of health services from a private empaneled hospital. Of the six percent who used those services, only half used their RSBY card.

FIGURE 5. RESPONDENTS' USE OF EMPANELED PRIVATE HOSPITAL AND RSBY CARD



The reason for not availing health services at empaneled private hospital was asked to both women and men of the RSBY families (**Table 8**). The most common reason (62 percent) reported by women for not using services at a RSBY hospital was that they did not know that the service they were seeking was covered by RSBY. About 31 percent of women and 42 percent of men reported that they did not feel the need to go to a private hospital. About 28 percent of men and 5 percent of women reported that they did not know why they did not seek health services from an RSBY empaneled private hospital.

TABLE 8. REASON FOR NOT AVAILING HEALTH SERVICES AT RSBY EMPANELED PRIVATE HOSPITAL*

	Women % (N=553)#	Men % (N=528)#
Individual/family level reasons		
Did not know/nobody told us	62.1	27.5
Services are not good there	2.3	0.6
Card is worthless/ not of benefit to me	0.6	0.2
No need to go to a private hospital	31.4	42.2
Family members suggested not to go	-	0.2
Money for transport was needed	3.4	1.1
System level reasons		
Hospital takes money for service	7.1	2.8
Likely to be hospitalized	0.6	0.2
Do not provide service I am looking for	-	0.4
Problem in enrollment data	0.8	0.6
Use of card discouraged by hospital	1.0	-
Do not know/do not remember	5.4	27.8

** Multiple choice answers, totals may not equal 100 percent.*
 # Women and men who did not avail or have any family member avail health services at empaneled private hospital.

Table 9 shows two types of barriers to RSBY use for respondents who reported use of private empaneled hospitals: program-related and user-related barriers. The program-related barriers included lack of funds in the card to access treatment, hospital refusal to accept RSBY card citing expiration, mismatched fingerprints of care seekers, and lack of human resources in hospitals to help users complete routine hospital paperwork. User-related barriers included the perception that the card is only for serious illnesses, and forgetting to take the card to the hospital during emergency situations. More than 80 percent of both men and women reported that non-utilization of the card was due to program-related barriers.

Table 9 also shows out of pocket expenditures (OPE) among women and men who were successfully covered for services under the RSBY insurance scheme. While no payment should be made when covered under RSBY insurance, roughly 50 percent of women and men reported out of pocket expenditures for services at RSBY empaneled hospitals.

TABLE 9. BARRIERS TO UTILIZATION OF RSBY FOR PRIVATE HEALTH SERVICES

	Women % (N)#	Men % (N)#
Experienced barriers when using the card	65.2 (46)	79.5 (39)
Program related barriers	90.0 (30)	83.9 (31)
User related barriers	10.0 (30)	16.1 (31)
Out of pocket expenditure for those who were successfully covered under RSBY	53.8 (26)	47.1 (17)

 # Women and men who availed health services in the private empaneled hospital

Successful Experiences Using RSBY Card

"When I became ill, I started vomiting, had loose motion and abdominal pain, so I got admitted. Doctors examined and did ultrasound test and said I had some problem in my uterus…. The representative of those who give money to the hospital [insurance company representative] also came to verify and talked to me. He asked me if I am having any trouble, and doctors showed the papers to him. He examined all the reports and then my operation began. I used card for Rs. 30,000 and that can be seen in the computer. They gave me the transport money." (Woman, 34 years, Lucknow)

"I went to [Hospital Name] hospital to remove my uterus. They deducted Rs. 4,000 from the card. I was admitted for two days. Then they asked for Rs. 13,000 more. So I transferred myself into a different hospital, where I was admitted for 12 days and got my operation done. With cost of medicine and doctor's fee we spent Rs. 8,000 at the second hospital." (Woman, 30 years, Kanpur)

"My daughter had fallen from a bicycle and fractured her leg. I deposited Rs. 9,000 when we got her admitted. At the time of discharge, they asked Rs. 6,000 more so I showed the card. Then they did not charge me anything extra but I did not get back the money we deposited. We got her treatment done for Rs. 9,000 using the card. I did not show the card earlier because I did not know I had to show the card." (Man, 45 years, Lucknow)

"Two years back I was hospitalized for 15 days for a stone [gall-stone] operation. Some hospital staff said that the card is expired. We quickly reported that to the hospital head. He inquired and ensured that the card will work. They said they will operate using the card but we need to pay extra. The treatment was of Rs. 50,000 but we spent only Rs. 20,000 and got operated." (Man, 65 years, Allahabad)

Unsuccessful Experiences Using RSBY Card

"I went to the RSBY private hospital for hysterectomy operation … they said we will get reimbursement of only Rs. 6,000 using the card. The cost of hysterectomy operation was around 10-11 thousand rupees. Since I was not fully covered by the card and I could manage to pay the full amount with the help of my relatives … I thought I would go to a known place for surgery rather than at a new hospital [empaneled hospital]. So I did not get my operation done at the RSBY hospital." (Woman, 34 years, Lucknow)

"About 6 months ago, I suffered from heart problem. My family took me to the hospital. At that time, we were all in a hurry, we were in distress, our brain was not working, and we could not think properly. So we did not take the card with us for the admission." (Man, 47 years, Lucknow)

"My son had an accident and broke his arm. We took him to the hospital. They refused to accept the card. They did not say anything. I don't know whether the card is no longer valid because it was more than a year since we got the last card." (Woman, 35 years, Allahabad)

Quality of Care Received

Table 10 shows the perceived quality of care received by female and male respondents who used private empaneled hospital services. Overall, respondents reported receiving high quality services. Both male respondents (85 percent) and female respondents (74 percent) reported that the business hours of the empaneled private hospitals were convenient. Over 80 percent of women and men felt their providers greeted them in a friendly manner, listened to their health problems attentively, and spoke to them with courtesy and respect. Over 76 percent of women and 80 percent of men reported that their services were as expected, or better. About 63 percent of women and 87 percent of men reported that they would like to return to the hospital if required and would recommend it to others. About 46 percent of women and 56 percent of men felt that empaneled private hospitals are better than public hospitals for health services such as family planning, delivery, or post-abortion care. However, around one-fourth of the respondents mentioned that they waited for an hour to get services.

TABLE 10. PERCEIVED QUALITY OF CARE RECEIVED AT PRIVATE EMPANELED HOSPITALS*

	Women % (N=46)#	Men % (N=39)#
Beneficiary informed that the following services are covered by the RSBY card*		
Mother and child health service	13.0	56.4
Delivery service	15.2	61.5
FP service	15.2	61.5
General treatment	23.9	64.1
Treatment of post-abortion complication	6.5	56.4
Waiting time before treatment		
Less than 15 minutes	30.4	28.2
16 to 30 minutes	23.9	30.8
31 to 60 minutes	13.0	10.3
More than 60 minutes	23.9	23.1
Don't remember	8.7	7.7
Convenience of hospital hours		
Very convenient	60.9	56.4
Convenient	13.0	28.2
Not convenient	10.9	7.7
Very inconvenient	15.2	7.7
Provider greeted in a friendly manner		
Yes	80.4	87.2
No	17.4	7.7
Don’t remember	2.2	5.1
Provider listened to problems		
Yes, attentively	78.3	82.1
Somewhat attentively	10.9	7.7
Inattentively	10.9	5.1
Don't remember	-	5.1
Provider spoke with courtesy and respect		
Yes	80.4	89.7
No	19.6	5.1
Don’t remember	-	5.1
Received services as expected		
As expected	58.7	74.4
Better than expected	17.4	5.1
Not as expected	23.9	12.8
Cannot say	-	7.7
Would return to that hospital	63.0	87.2
Would recommend hospital to others	67.4	84.6
Type of hospital that is better for family planning, delivery, post-abortion care services		
Empaneled private hospitals	45.7	56.4
Public hospitals	26.1	38.5
No difference	10.9	2.6
Cannot say	17.4	2.6

** Multiple choice answers, totals may not equal 100 percent*
 # Members from RSBY-enrolled families who availed health services from empaneled private hospitals

Awareness and Use of Contraceptive Methods

Family planning practice and awareness among married women of RSBY-enrolled families are presented in **Table 11**. Almost all of the women were aware of one or more modern FP methods; only two percent reported that they did not know of any method. Awareness of female sterilization was the greatest (81 percent), followed by pills (72 percent), condom (64 percent), injectable contraceptive (31 percent), and emergency contraceptive pills (2 percent). About 15 percent reported awareness of various traditional methods; however, there is a possibility of underreporting. In India, talking to strangers about sex, family planning, and specific methods is still considered taboo. Talking of traditional methods, like withdrawal, or rhythm method, with someone outside close family, or even within the family, can cause discomfort among women.

TABLE 11. AWARENESS AND CURRENT USE OF CONTRACEPTIVE METHODS AMONG MARRIED WOMEN OF RSBY FAMILIES

	Women % (N=726)#
Aware of FP method*	
Female sterilization	80.6
Male sterilization	36.0
IUD/ Copper-T	61.7
Injectable contraceptive	31.1
Oral contraceptive pill	72.0
Condom	64.0
Emergency contraception pill	1.9
Traditional method	15.4
Not aware of any method	1.5
Current FP method use (N=680)	
Female sterilization	20.3
Male sterilization	0.3
IUD/ Copper-T	3.5
Injectable	0.9
Oral contraceptive pill	4.1
Condom	11.5
Emergency contraception pill	0.6
Traditional methods	10.1
Not using any FP method	48.7
Source of FP method (N=280, modern method)	
Public hospitals/ health center	51.1
Private hospital/ clinic	12.9
Empaneled private hospital	0.4
Medical store	28.6
NGO/ charitable hospital	7.1

 # All women
** Multiple choice answers, totals may not equal 100 percent*

About 90 percent of women had at least one child. Only six percent of women were pregnant at the time of the survey, and about half of them (51 percent) were using a contraceptive method. Women had mostly accepted female sterilization (20 percent) followed by condoms (11 percent). About 10 percent of women were using a traditional method of FP such as the rhythm method, withdrawal, or abstinence; four percent of

women were using copper-T. About half of modern contraceptive users (51 percent) obtained their current method from public health facilities, primarily those who underwent sterilization or copper-T insertion. Condom and pill users obtained them from medical stores. Less than 13 percent obtained their current FP method from private hospitals or clinics, and very few (less than 0.5 percent) women got their FP method from an empaneled private hospital.

Utilization of RSBY for Reproductive Health Services

Utilization of RSBY by female respondents for three types of reproductive health services, antenatal care, delivery services, and post-abortion care, is shown in **Tables 12-14**. The tables also present the reasons for non-utilization of empaneled private hospitals for each reproductive health service. The reasons for not visiting empaneled private hospitals for these services, detailed below, were of three types: program-related reasons, lack of knowledge of availability of those services in empaneled private hospitals, and individual and family perceptions. The major, program-related reason was distance of hospitals from homes. Among individual or family perceptions, users thought treatment in private hospitals to be costly, or family members did not suggest private hospitals, or that the quality of care in private hospitals is not as good as in public hospitals.

Utilization of Antenatal Care Services

Table 12 shows the utilization of RSBY for ANC services among enrolled female respondents. Currently pregnant women and women who had delivered a child within the two years before the interview were asked questions on ANC. About 23 percent of women experienced complications during their last pregnancy, and 92 percent of them went for advice or check-up for complications. Of those who went for advice or check-up for the treatment of a complication, 49 percent went to a public facility and 49 percent went to a non-empaneled private health facility. Only two percent went to empaneled private hospitals for treatment of the pregnancy complications. About 46 percent of women did not know about the use of RSBY for the treatment of pregnancy complications. Also about 52 percent of women did not go the empaneled private hospitals for the treatment of pregnancy complications due to individual or family reasons noted above.

TABLE 12. UTILIZATION OF ANTENATAL CARE SERVICES AMONG WOMEN OF RSBY FAMILIES WHO ARE CURRENTLY PREGNANT OR DELIVERED A CHILD IN THE LAST TWO YEARS

	Women	
	N	%
Received ANC checkup (N=218)#	**193**	**88.5**
Experienced complication during pregnancy (N=218)	49	22.5
Went for advice/check-up for complications (N=49)	45	91.8
Places for advice/ checkup for complication (N=45)		
Empaneled private hospital	1	2.2
Non-empaneled private clinic/ hospital	22	48.9
Public hospital/ health center	22	48.9
Reasons for not going to empaneled private hospital (N=44)*		
Program-related reasons	2	4.5
Lack of knowledge	20	45.5
Individual or family perceptions related to service	23	52.3

** Multiple choice answers, totals may not equal 100 percent*
 # All women who are currently pregnant or delivered a child in the last two years

Utilization of Delivery Services

Utilization of delivery services among women who were enrolled in RSBY and had delivered within the two years prior to the survey is presented in **Table 13**. Most women (80 percent) had normal delivery, 18 percent of women had cesarean delivery, and two percent had an assisted delivery. More than half of the deliveries (52 percent) took place in a public hospital, and about 24 percent took place at home. Less than two percent of women delivered in an empaneled private hospital. About 68 percent of women did not go to empaneled private hospitals for their delivery services due to individual or family reasons. About 37 percent of women did not know about the availability of delivery services under RSBY.

TABLE 13. UTILIZATION OF DELIVERY SERVICES AMONG WOMEN OF RSBY FAMILIES WHO DELIVERED IN THE LAST TWO YEARS

	Women % (N=182)#
Type of delivery	
Normal delivery	79.7
Assisted delivery	2.7
Caesarean delivery	17.6
Place of last delivery (N=182)#	
Empaneled private hospital	1.6
Non-empaneled private clinic/hospital	22.0
Home	24.2
Public hospital	52.2
Reason for not going to empaneled private hospital for delivery*(N=179)	
Program-related reasons	9.0
Lack of knowledge	36.9
Individual or family level perceptions related to service	67.7

** Multiple choice answers, totals may not equal 100 percent*
 # All women who delivered in the last 2 years

Utilization of Post-Abortion Care Services

Table 14 presents the utilization of post-abortion care among women who had abortions within the two years prior to the survey. Only nine percent of women experienced abortion; of those, 62 percent experienced complications after abortion, and of those, 83 percent visited health facilities for post-abortion care. Nearly 70 percent of women who experienced post-abortion complications visited non-RSBY private hospitals for health care.

About 27 percent (9 out of 33) of women did not know about RSBY coverage for post-abortion care in empaneled private hospitals. About 73 percent (24 out of 33) of women did not go to empaneled private hospitals for their post-abortion care due to individual or family reasons.

TABLE 14. UTILIZATION OF POST-ABORTION CARE SERVICES AMONG WOMEN OF RSBY FAMILIES WHO EXPERIENCED AN ABORTION IN THE LAST TWO YEARS

	Women	
	N	%
Experienced abortion (N=726)#	65	9.0
Experienced complication after abortion (N=65)	40	61.5
Visited clinic/ hospital for complications after abortion (N=40)	33	82.5
Place of getting post-abortion care (N=33)		
Non-empaneled private hospital/ clinic	23	69.7
Public hospital	10	30.3
Reason for not going to empaneled private hospital for post-abortion care (N=33)*		
Program-related reasons	3	9.1
Lack of knowledge	9	27.3
Individual or family perceptions related to service	24	72.7

** Multiple choice answers, totals may not equal 100 percent*
 # All women

COMMUNICATION CHANNELS

Table 15 (next page) shows respondents' exposure to various communication channels that could be possible channels for delivering messages about RSBY. More than three-quarters of women (76 percent) and half of men (48 percent) never read the newspaper. About 76 percent women regularly watch television, but only 38 percent of men watch television regularly. Most of the women (87 percent) and men (81 percent) do not listen to radio. About half of the women and 84 percent of men have a personal mobile phone, but reading or sending text messages were not very common among men and women. Both women and men showed interest in getting more information about RSBY over their mobile phone. More women (70 percent) preferred voice mail for information than men (57 percent). Of the 292 women who reported that they are literate, 84 percent preferred voicemail as the main vehicle for receiving RSBY information. Similarly, of the 186 men who reported being literate, 29 percent preferred voicemail only. Nearly all of them agreed to be contacted through the phone later to receive more information about RSBY.

PROVIDERS' PERSPECTIVES ON RSBY

The hospital heads and the doctors of RSBY empaneled private hospitals were interviewed to understand their experiences and perspectives on RSBY and recommendations for better implementation of RSBY or any similar program of health insurance by the government.

Experiences and Opinions Regarding RSBY Empanelment

Reason for Getting Empaneled

The health providers reported various reasons for RSBY empanelment and wanting to be a part of the health insurance scheme. Some said they joined RSBY to serve the poor (3 out of 20), while some thought their empanelment would widen their clientele by attracting poor people from the area (4 out of 20).

TABLE 15. COMMUNICATION CHANNELS AMONG WOMEN AND MEN IN RSBY FAMILIES

	Women % (N=726)#	Men % (N=640)#
Reading newspaper		
Never	76.4	48.0
Once in a week or less	10.6	10.2
More than once in a week	12.9	41.9
Watch TV		
Never	16.1	19.7
Once in a week or less	8.0	42.0
More than once in a week	75.9	38.3
Listen to radio		
Never	87.3	81.1
Once a week or less	3.6	6.1
2-3 times a week	4.1	10.2
Everyday	5.0	2.7
Have personal mobile phone	50.3	84.1
Read SMS on phone	15.3	30.0
Send SMS	6.3	18.8
Like to receive messages about RSBY on phone	94.4	95.2
Preferred way to receive messages on phone about RSBY		
SMS	11.5	8.2
Voicemail	70.1	56.7
Both SMS and voicemail	18.4	35.1
Agreed to be contacted later	98.8	99.8
Agreed to give phone number	83.0	99.8

 # All women and men

"We decided to be part of RSBY as it is a very important program for poor people. The concept is very good. In the beginning, there was a lot of enthusiasm in the private sector, so we too got involved in the scheme." (Hospital head, Kanpur)

"At that time we had a lot of rural poor patient and there were no other hospital in this area." (Hospital head, Lucknow)

"One of the top officials from RSBY told me why not I join this? I told him that there will be lots of a paperwork with this which will be a problem. He said that the situation is quite different now and [name of the insurance company] which is a private body will handle all the paperwork. And there is not much paperwork and I won't have to beg someone to pass my bills. He also said that I could try out on an experimental basis and if I am satisfied, I could go ahead otherwise I could withdraw myself. Only then we got interested in RSBY… My friend told me about RSBY. I am associated with a charitable hospital and we charge the least for treatment compared to others in the town in a private setup. We have all the facilities, yet we are running a hospital at almost no-profit and sometimes at the cost of some loss. I compensate the loss with my private practice. So I did not mind joining RSBY." (Hospital head and doctor, Lucknow)

"Our hospital is situated in an area, where many patients from the nearby rural area also come here. So that was the reason why we are enrolled in the RSBY." (Hospital head and doctor, Allahabad)

Experiences of Hospital Empanelment Process

The in-depth interviews revealed the experiences with the empanelment process. When the RSBY program started, the chief medical officer (CMO) of the district contacted the potential private hospitals and asked them to apply for empanelment. Teams from the CMO's office and the insurance company visited the hospitals for inspections, and if found satisfactory, the hospitals were empaneled. Now hospitals can apply online.

"It (the empanelment) happened through CMO office. They contacted us, a team visited us. They inspected the hospital and then told us to contact CMO for empanelment." (Hospital head and doctor, Kanpur, empaneled since 2008)

"I submitted the application online. Then someone from insurance company came to inspect our hospital. After the visit of the insurance company, the health officials from CMO office visited. After all these processes were completed at their level, I was informed that my hospital is approved for RSBY. I think it took about one to one and half month to get the empanelment." (Hospital head and doctor, Lucknow, empaneled in last year)

Reason why Other Private Hospitals did not get RSBY Empanelment

Out of 20 respondents who were asked why other private hospitals did not enlist, only 12 chose to comment; of those, most (7 out of 12) think it is because of the limited RSBY reimbursement package from the insurance companies.

"For example, if the package for a general patient is Rs. 500, then besides medicine and diagnostic tests, we have to provide food and Rs. 100 for transportation. So admitting such a patient causes a lot of trouble. I don't think any 40 or 50 bedded hospital in our city can afford to provide service with such a low package. Many hospitals have also appealed to revise the package." (Hospital head, Lucknow)

"The major reason is the money which we get. The rate in the package is very small. Under RSBY if you get ten thousand for a service and after tax deduction, we get only nine thousand. I am a surgeon and generally, I do the surgeries in my own hospital, I don't have to call anyone else except the anesthetist. Basically, it is the cost, it is not possible to meet the cost of surgery with the given package." (Hospital head and doctor, Lucknow)

Experiences Regarding Service Delivery and Reimbursement

Service Delivery Experiences

The providers also felt that the utilization of RSBY by its cardholders is low now compared to the start of the program. Providers also reported that utilization for FP and RH services are much less.

"After RSBY came, there was a huge surge of patients. …things have been sliding for the last three years and the work done in the last year is practically about one-tenth of what it used to be." (Hospital head, Kanpur, empaneled since the start of RSBY)

"Depends… in a month ten to twenty RSBY patients and not more than twenty in a month. This is probably because people knew that we have an operation theater, so only patients needing operative care come. Male patients are about 30-40 percent. Women come for gynecological surgeries like infections of the uterus and heavy bleeding, and gall-bladder surgeries, which is also common in women… women coming for family planning are very-very low, about 5-10 percent. Most of the women coming here are beyond that age, needing of family planning services. They are coming here for removal of the uterus." (Hospital head and doctor, Allahabad)

Reimbursement Experiences

The providers unanimously expressed their frustrations with the RSBY reimbursement process. Their major concern was the delay in the reimbursement process or denial by the insurance companies, even though the hospitals provided the health services following all regulations.

"Our hospital provides all health services to the cardholders. We should get our reimbursements within 20 days from the insurance company. But it gets delayed too much. We did not receive payments for the last eight months. We had a talk with the insurance company and they clearly mentioned in the mail that they had not received a premium from the government. Unless they get the premium from the government how can they pay us?" (Hospital head and doctor, Lucknow)

"Once a patient comes with a card, which is accepted by the machine, then we have no other option but to provide [the] services that he seeks. Ultimately, the insurance company says that this card does not match with their database. How would we know that the card issued by them was a genuine or a forged one…Sometimes they say that pre-existing diseases will not be covered, that was something which was not known to the private providers and goes against the spirit of the scheme to provide universal coverage…Hospitals have suffered massive losses." (Hospital head and doctor, Kanpur)

Providers' Recommendations for Improvement

The providers voiced a wide range of suggestions to improve the RSBY scheme. The most common suggestion (made by 15 out of 20 providers) was the revision of the price of reimbursement for health services. Other suggestions are to speed up the reimbursement process, revise the BPL card list, and revise the process of setting the premium paid to the insurance companies from the government for RSBY services.

"The biggest problem of all in this scheme is the cost. The services, which cost more, have less amount of package cost. For example, if we need to bring a neurosurgeon we need to pay his fees, but we can barely manage to pay his fees with the package offered in RSBY. They even give a small amount for hysterectomy especially for caesarean hysterectomy, with which it is difficult to run a private hospital. They need to revise the cost, they need to survey the running cost of the private hospitals, also need to add up the cost of surgeons and antibiotics. These are the basic requirement for surgeries. We cannot make it free of cost for everyone and incur losses.

The other point is that patients too need some awareness on how to use the card. They think that they will just get Rs. 30,000 from us. It's not like that. We also need to have some special rule for an emergency patient. If someone comes in a bedridden condition, or in a coma, how we can register his/her fingerprint. Sometimes there are network-problems, telephone does not work. We are clueless in those situations. There should be some rule or policy on what should be done in those situations." (Doctor, Allahabad)

"First of all, there should be more awareness and campaign for the scheme. The empanel hospitals should also get a helpline number. Number two, there should be better package so that everybody is benefited. Thirdly, the reimbursement should be done on time and there should not be any hassle for reimbursement. We just have a contact email address for correspondence. Sometimes we face difficulty, for example, the fingerprint is not matching for a client, or he forgets to bring his card. The company communicates that it is ok for us to provide the service and they will enter the data manually… all put together, about three lakh rupees is due for reimbursement. We wrote to them several times, even thinking of filing a lawsuit. After all, our money is at stake." (Hospital head and doctor, Kanpur)

The other suggestions made by health care providers were: beneficiaries could share the cost for medicines and special tests, and the government – while being attentive to the number of claims made - could assure the insurance companies that if the number of claims are much higher than expected, additional payment would be considered.

"Something which I would like to convey through you is that such a provision should be provided if the patients willing to pay the cost their own or can bring their own medicine and sustain the cost of necessary investigations, very necessary investigations, so that at least the quality of care may not be compromised. Otherwise, what will happen, the person may be needing fourth generation antibiotic which is costing some three hundred rupees a day which a doctor will not use because he is not going spend a lot of money directly from his own pocket." (Hospital head and doctor, Lucknow)

"The basic thing that needs to be changed is the package should not include medicines because if you include medicine you cannot afford to provide proper treatment as the price of medicines vary and their quality also varies. If you use a good quality product you will get a good result, isn't it? Medicine should be the priority and the package restricts you. Instead of increasing the package if you can separate the cost of medicine then it will be fruitful. Again, the general investigation is ok but the special investigation should not come within the package. Instead of charging 100 percent to the patient may be government will pay 60 percent and client will pay 40 percent. That will work more genuinely." (Hospital head and doctor, Allahabad)

"First and foremost, the problem of competitive bidding between insurance companies should be taken out. There must be an assurance by the government to the insurance companies that they will save a certain amount of money at the end of the policy period, five percent or ten percent; and the premium [that the government pays to the insurance companies] should be flexible, if more claims come, the premium can be higher. And they should also stick to the number of claims which are raised. The more the number of claims that are raised the higher should be the premium payout. Once this is done the insurance companies will not put the obstacles, in their claim settlement.

At the same time, they must be very vigilant to see that there is no fraud perpetrated by the private players. For that, there should be competent people to supervise the hospitals and see that unnecessary clubbing of procedures [performing unnecessary procedures] is not done. Because that is the modus operandi for most of the time; while doing one procedure, tag along another procedure, which should not be there.

The package rate should be increased so that the need to do this should not arise. It will be economical for the private sector for the participation. The incentive should be there for getting the maximum amount of patients mobilized from the rural area and the urban poor. So that the overall medical infrastructure available in the country will be utilized for the benefit of the poor people and let them pay a higher premium, not just 30 rupees. They can afford to pay 300 rupees, they can even afford to pay 1000 rupees. To cover the family of five, what they are paying is peanuts. Anybody can, anybody who even had a 100 days job under MNREGA (Mahatma Gandhi National Rural Employment Guarantee Act) can pay that premium. May be linking it to MNREGA will be a good idea. Whoever, have worked for 100 days they just pay a thousand rupees, out of the ten thousand he is earning let one thousand be deducted for the treatment of him and his family." (Hospital head, Kanpur)

Discussion

While the original intention of this study was to focus on the use of FP/RH services under the RSBY scheme, the data revealed very few users of health services under RSBY overall, and the use of FP/RH services was negligible. Given the often low quality of FP services in the public sector, ensuring access to FP/RH services through RSBY is important. The findings from this study revealed serious issues with the overall implementation of the insurance scheme that limit the urban poor from accessing these services, including FP/RH. This section reviews the key quantitative and qualitative findings, identifies constraints and barriers to RSBY enrollment and use within RSBY operational pathways described in the introduction, and includes programmatic recommendations for the enhanced implementation of the RSBY program.

STUDY IMPLICATIONS AND RECOMMENDATIONS

As a part of universal access to health care, the Indian Government developed and implemented the RSBY health insurance scheme to ensure access to quality health services by urban poor families. While nationally a little more than half (52 percent) of eligible BPL families are enrolled in the RSBY scheme, state differences in enrollment vary tremendously.

The results of this study confirmed that the enrollment of BPL families into the RSBY insurance scheme was as low as 30 to 40 percent. Results additionally demonstrated that among those families who were enrolled in RSBY, awareness of the health services covered under the scheme, knowledge of the scheme's entitlements, and overall utilization of RSBY services, particularly FP, at empaneled private hospitals was low (see Table 4, 5, and 7).

Why is knowledge and use of the RSBY insurance in Utter Pradesh so low? This study revealed several key barriers along the RSBY operational pathway that were described in the introduction section. The cumulative effect of these barriers seriously affects the implementation of the scheme and its utilization by BPL families. However, identification of these barriers can lead to recommendations to improve the implementation of the scheme. The section below identifies key challenges for each pathway and recommendations to overcome these challenges. Figure 1, the operational pathway, is presented here again for reference.

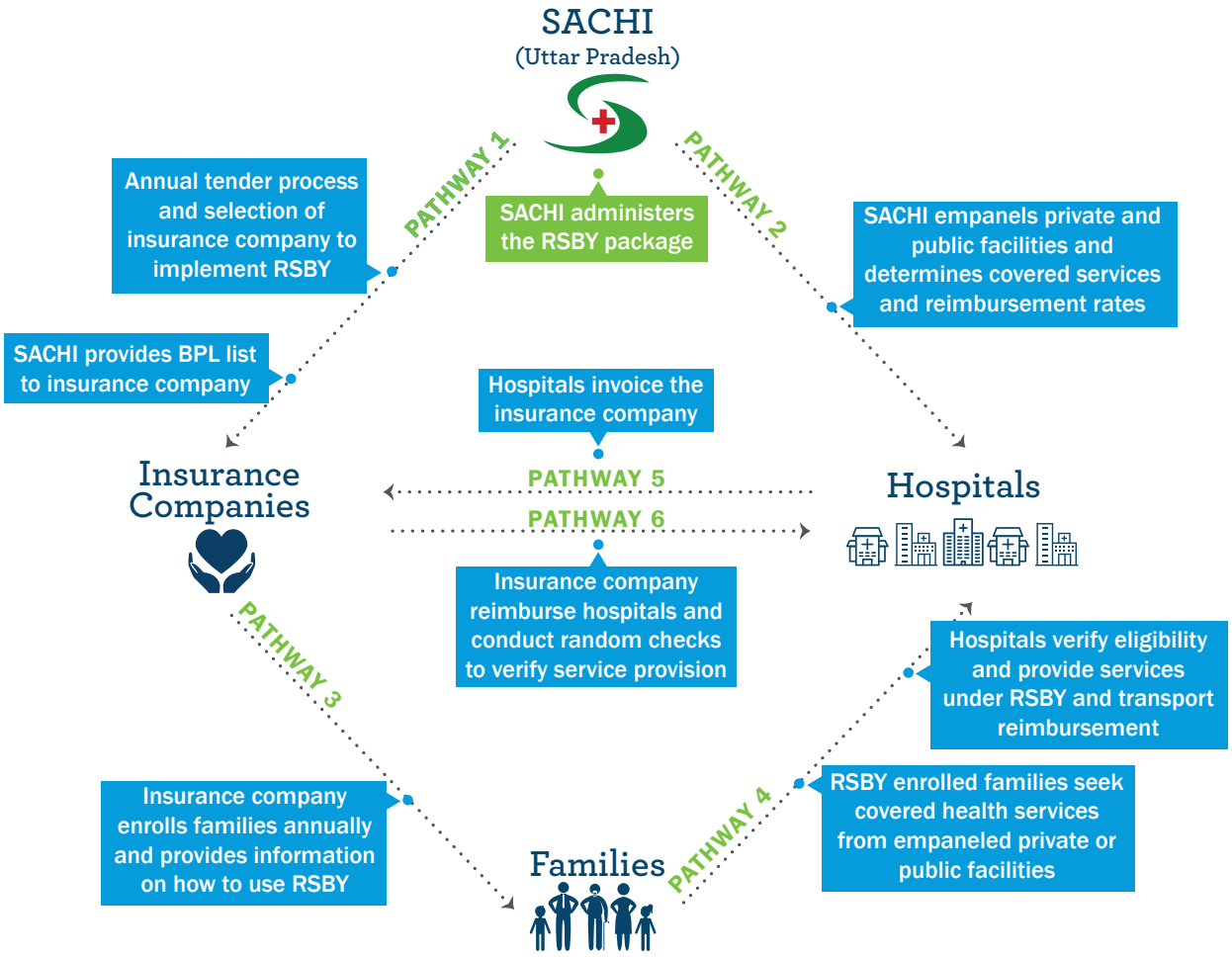
Pathways 1 and 2 – SACHI's Selection of Insurance Company and Empaneled hospitals

Challenges and Recommendations

Challenge 1: The only way the insurance companies can identify potential RSBY enrollees is through the BPL family list provided by SACHI. However, this list was last updated in 2002 by the state government in UP. Therefore, insurance companies are likely not reaching the most current BPL families – in the 14 years that have elapsed, new families have become BPL while others may have improved their economic situations and no longer qualify. In addition, as evinced during the house-listing portion of the study, addresses of the BPL families were poorly recorded in the BPL list. This was likely a barrier to insurance companies' efforts to enroll BPL families. Incorrect or incomplete address information can also cause a problem after enrollment at service delivery points and hinder acceptance of the RSBY card.

> **Recommendation:** The state government should update the list of BPL families in Uttar Pradesh at least once every five years. The updated list will allow insurance companies to contact current BPL families to encourage enrollment in RSBY. The updated list will also help reduce the mismatch of home addresses and individual members' records provided at enrollment and verified subsequently at service delivery, reducing potential refusal of the RSBY card by empaneled hospitals.

FIGURE 1. SCHEMATIC DIAGRAM OF THE OPERATIONAL PATHWAYS OF RSBY



Challenge 2: Empaneled hospitals reported that the reimbursement amounts set by SACHI for many general health services are very low. Often the RSBY package rates are well below market rates, and thus providing many of the services under the RSBY scheme is a financial loss to hospitals.

> **Recommendation:** SACHI could consider revising the reimbursement rates for services under the RSBY package in consultation with representatives of empaneled private hospitals. A reasonable reimbursement rate of health services will encourage empaneled private hospitals to provide the health services under RSBY, and potentially encourage more private hospitals to become empaneled hospitals, which would increase access for BPL families.

Challenge 3: In order to win the bid to become the RSBY insurance company, companies often quote a low premium to the government, which becomes impractical to implement, and proves to be difficult to reimburse the empaneled hospitals for too many RSBY clients.

> **Recommendation:** The state government could consider revising the bidding process and premiums. Furthermore, the state government could consider engaging insurance companies in a particular district for longer periods of time, instead of annual bids. This could help insurance companies feel more confident investing in systems to improve the service, reduce the need for enrollees to re-enroll annual-

ly, and generally reduce confusion. The state government could assess families' willingness to pay more than the current annual registration fee of Rs. 30.

Challenge 4: The RSBY program only covers two types of FP methods, IUD and sterilization. Private hospitals do not keep condoms or oral contraceptive pills because these are typically sold by chemist shops. However, the government recently added injectable contraceptives to the public health system services, so this method should also be available in the RSBY package.

Recommendation: To enhance choice for women who seek FP services from empaneled private facilities, SACHI should include injectable contraceptives in the RSBY insurance package.

Pathway 3 – Insurance Company and RSBY Enrollees

Challenges and Recommendations

Challenge 1: Knowledge about the RSBY scheme and its entitlements, including FP/RH services, is low among BPL families. Many families who are entitled do not enroll in the scheme. An intensive, multi-channel campaign to raise awareness of RSBY and to encourage enrollment among BPL families is necessary to increase enrollment rates.

Recommendations: There are several methods that could be pursued to raise awareness of RSBY among BPL families:

- Data show that ration shops, where BPL families can go to access lower cost groceries, were the second most common source of information on RSBY for women, and the most common source for men. This channel of information should be maximized, with information on the program given to ration shop employees, visual media displayed in these shops, and perhaps even using these locations for enrollment campaigns.
- Word of mouth from neighbors was the main source of RSBY information for women, and the second highest for men, showing that social networks are very important for increased knowledge. Newly enrolled families can be given information on the program to provide to their neighbors.
- Health workers, such as Anganwadi workers or those who work for NGOs, who visit BPL families at home, could be added as sources of information of the RSBY plan. They can be provided with information to provide when they visit families, including information about coverage of FP/RH services under RSBY. Since this would be an added task for these workers, some type of remuneration system, possibly through the insurance company, could be established for new RSBY enrollees referred by the workers. Health workers can also inform and remind enrollees about the toll free number available for complaints about the RSBY card, if any.
- SMS and voice messages to mobile phones can be used to increase awareness among BPL families about RSBY and upcoming insurance company enrollment camps. Data show that more than 50 percent of women and almost 85 percent of men have a personal mobile phone, and of these, most of the women and men agreed to be contacted later on their mobile phones. Both women and men overwhelmingly preferred messages by voicemail (70 percent and 57 percent respectively), however, 12 percent of women and 8 percent of men preferred SMS. Both of these methods could be investigated by insurance companies, to raise awareness of RSBY and inform prospective enrollees of when and where they can enroll.
- Existing programs that work to increase health knowledge among target groups that include BPL families could be approached to include messages on RSBY in their programming. They could also assist with the development of informational materials that are appropriate for both literate and illiterate audiences, to expand the reach of informational posters and brochures.

- Empaneled hospitals can become locations for insurance company representatives to have an information/enrollment desk so those coming in for services can easily learn about the program and enroll during their visits. Also, if empaneled private hospitals conduct health camps or outreach work, they can include messages on RSBY in these existing activities to raise awareness among BPL families about the program and the process for enrollment.
- Give special attention to raising awareness and facilitating utilization of RSBY for FP/RH services. The greatest use of FP/RH services by women was for delivery services. Information boards in delivery wards and recovery areas describing the FP/RH services offered under RSBY offer an opportunity to raise awareness of and increase utilization of other RH services, including FP.

Pathway 4 – Empaneled hospitals and RSBY families

Challenges and Recommendations

Challenge 1: Due to low levels of knowledge about processes, services, and benefits offered under RSBY, enrolled families often fail to produce their RSBY cards at hospital admission and complete the appropriate paperwork, leading to out of pocket payments for covered services, or denial of services.

> **Recommendation:** Upon enrollment, insurance company representatives should provide RSBY families with easily understandable written/visual instructions accompanying a verbal explanation of covered services and the process for utilizing services in empaneled facilities. Community meetings hosted by the insurance company and/or local NGOs could also be established to inform and remind clients of their entitlements and ensure that enrolled families hold empaneled facilities accountable for providing covered benefits and services. Empaneled hospitals can ensure they have at least one person on staff at all times who is well versed in the rules and regulations of RSBY to assist with these clients.

Challenge 2: Often the information retrieved by swiping the card does not match with the client's information, due to a variety of issues including poor internet connections to the insurance company system and incorrect or incomplete enrollee data in the system, and therefore these clients are unable to use the card for covered services.

> **Recommendation:** The computer enrollment system should be improved to minimize errors in data and biometric information entry that can result in denials of coverage at points of service. The possibility of linking the RSBY card to the national unique identification number and card (Aadhaar card) issued by the Unique Identification Authority of India could be explored by the government.

Pathway 5 and 6 – Insurance Company and Empaneled Hospitals

Challenges and recommendations

Challenge 1: It can take months for the empaneled hospitals to receive reimbursements from the insurance company. Hospitals also often have reimbursements declined by the insurance company after providing services to clients, due to pre-existing conditions, providing wrong or unnecessary services, or providing services to a non-enrolled person. Such issues discourage hospitals from participating in the insurance program, as financial losses or delays make it hard for private facilities to meet their operating expenses.

> **Recommendation:** The process for reimbursement to hospitals should be studied by the insurance companies to identify barriers and delays, and a mechanism to increase the speed of reimbursements should be developed.

These barriers are related to every step of the operational pathway of RSBY. The cumulative effect of these barriers seriously affects implementation of the scheme and its utilization by BPL families, including FP/RH services. It is essential that stringent monitoring and accounting be instituted to prevent possible misuse of the scheme and, therefore, the government's funds. Identifying barriers in the operational pathways, as this study has done, will help identify recommendations to improve the implementation of the scheme.

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