Health Inc Consortium

Towards equitable coverage and more inclusive social protection in health

Book

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Health Inc

Financing health care for inclusion

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Health Inc - Towards equitable coverage and more inclusive social protection in health

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Foreword

It is with great pleasure that we present the work done for the project Socially inclusive health care financing in West Africa and India (with acronym Health Inc) under the European Commission's seventh framework programme. Health Inc is a collaborative research project gathering six partners: in India, partners involved were the Institute of Public Health (IPH) in Bangalore, and the Tata Institute of Social Sciences (TISS) in Mumbai; in West Africa, the Research Centre for Political and Social Science (CREPOS) in Senegal, and the Institute of Statistical, Social and Economic Research (ISSER) in Ghana. These four "Southern" institutions teamed up with the London School of Economics and Political Science (LSE) in London, United Kingdom (coordinators of the overall research process) and the Institute of Tropical Medicine (ITM) in Antwerp, Belgium. The field research was conducted in Ghana and Senegal, in West Africa, and in the Karnataka and Maharashtra states (India), between 2011-2014.

When designing the research a few years ago, four thoughts inspired the Health Inc Consortium. First, a growing awareness that access to and effective utilization of health care services, and by extension social health protection (SHP), is about much more than just financial access – even if financial access matters a great deal. The purpose of Health Inc was therefore to describe and analyze financial and non-financial obstacles to SHP and their interplay in a rigorous scientific manner in a range of different settings; distill lessons from them, possibly even generate theory, applicable in the different research settings; and, eventually, feed this knowledge into the policymaking arena. A second thought was our intuition that social exclusion is a universal phenomenon – even if it has, until now, hardly been used as a concept to frame research in low-income countries. The Health Inc Consortium hypothesized that there is social exclusion in societies and countries where financial poverty is extremely widespread and where the lack of financial resources may completely overshadow the researchers' and policymakers' attention to other exclusionary mechanisms in studies of SHP. Thirdly, the Health Inc consortium opted for a mixed methods research methodology in order to go beyond the (albeit useful and necessary) quantification of the extent and profile of social exclusion (trying to find out who is actually being excluded); indeed, at the same time, we also wanted to investigate the mechanisms driving social exclusion processes i.e. addressing the question of why and how these specific sub-populations fail to make effective use of their entitlements. Finally, a fourth thought inspiring us, and certainly not the least important one, was the willingness of the Health Inc Consortium to give space to the people and to "the excluded" themselves in the study of social exclusion–and not confine the research work to a select gathering of academics working, researching and opining in their traditional comfort zones.

This Health Inc Consortium book comprises five parts. The first part of the book explores the concept of social exclusion and presents the overall Health Inc research framework, including the innovative SPEC-by-step framework (the acronym SPEC stands for "Social, Political, Economic and Cultural"). The second part is a presentation of the four country (or, in the case of India, state) case studies. The third part discusses some of the most prominent determinants of people's exclusion from social health protection while the fourth one looks into the experiences of specific vulnerable population groups. Finally, in a fifth part, the Health Inc Consortium attempts to identify some of the mechanisms shaping social exclusion, summarizes the principal research conclusions and highlights the main policy recommendations.

We, the Health Inc Consortium, are aware that a lot remains to be done, but are proud that a first step has been taken in putting social exclusion high(er) on the agenda of local, national and international policymakers working towards the goal of Universal Health Coverage.

Bart Criel, Institute of Tropical Medicine in Antwerp, on behalf of the Health Inc Consortium

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In addition we would like to thank all field interviewers, health authorities, local authorities and all other institutions that contributed to the research

List of Abbreviations

ANSD	Agence Nationale de la Statistique et de la Démographie
APL	Above poverty line
ASHA	Accredited Social Health Activists
BMCs	Budget Management Committees
BPL	Below poverty line
CBHI	Community-based health insurance
CCT	Conditional cash transfers
CHI	Community Health Insurance
CHPS	Community-based Health Planning Services
CI	Confidence Interval
CREPOS	Centre de REcherche en POlitiques Sociales
CSDH	Commission on Social Determinants of Health
DFID	Department for International Development (United Kingdom)
DHMT	District Health Management Team
DMHIS	District Mutual Health Insurance Scheme
DoL	Department of Labour
DOT	Directly Observed Therapy
EAs	Enumeration Areas
FAO	Food and Agriculture Organization of the United Nations
FGD	Focus-Group Discussion
FNR	Fonds National de Retraite
FYP	Five Year Plan
GDP	Gross Domestic Product
GHS	Ghana Health Service
GII	Gender Inequality Index
GP	Gram Panchayat
GSDRC	Governance and Social Development Resource Centre
GSS	Ghana Statistical Service
HDI	Human Development Index
ID	Identity
IDIs	In-Depth Interviews
IEC	Information Education Campaigns
ILC	International Labour Conference
ILO	International Labour Organization
IPH	Institute of Public Health

IPRES	Institut de Prévoyance Retraite du Sénégal
IRDA	Insurance Regulatory and Development Authority
ISSER	Institute for Statistical, Social and Economic Research
LMIC	Low- And Middle-Income Countries
MEKN	Measurement and Evidence Knowledge Network
MMYE	Ministry of Manpower, Youth and Employment
MoH	Ministry of Health
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organisation
NHI	National health insurance
NHIA	National Health Insurance Authority
NHIC	National Health Insurance Council
NHIF	National Health Insurance Fund
NHIL	National Health Insurance Levy
NHIS	National Health Insurance Scheme
NSSO	National Sample Survey Organization
OBC	Other Backward Caste
ODP	Outpatient Department
OOP	Out-of-pocket health care payments
OR	Odds Ratio
PCA	Principle Components Analysis
PHI	Private health insurance
PNA	Pharmacie Nationale d'Approvisionnement
PRI	Panchayati Raj Institutions
RGJAY	Rajiv Gandhi Jeevandayee Aarogya Yojana
RHD	Regional Health Directorate
RSBY	Rashtriya Swasthya Bima Yojana
SC	Scheduled Caste
SE	Standard Error
SEKN	Social Exclusion Knowledge Network
SHI	Social health insurance
SHP	Social Health Protection
SPEC	Social, Political, Economic, Cultural
SSA	Sub-Saharan Africa
SSNIT	Social Security and National Insurance Trust
ST	Scheduled Tribes

STDs Sexually Transmitted Diseases

TB Tuberculosis

TISS Tata Institute for Social Sciences

TPA Third Party Administrator

UHC Universal health coverage

UN United Nations

UNDP United Nations Development Programme

UNESC United Nations Economic and Social Council

UNGA United Nations General Assembly

UNPSDH United Nations Platform on Social Determinants of Health

UNRISD United Nations Research Institute for Social Development

USD United States Dollar

WHA World Health Assembly

WCSDH World Conference on Social Determinants of Health

WHO World Health Organisation

PART I: Introduction and methodology

CHAPTER 1: Social exclusion and social health protection in low- and middle-income countries: an introduction

Gemma Williams, Philipa Mladovsky, Fahdi Dkhimi, Werner Soors and Divya Parmar

Introduction

In 2005, World Health Organisation (WHO) member states committed to achieving universal health coverage (UHC) to ensure that all people have access to quality health services in times of need and are protected from the financial hardships of health care costs (WHO, 2005). This commitment was reaffirmed in the World Health Report 2010, which stated that health-financing systems should be designed with the aim of reaching universal health coverage (WHO, 2010) and was further supported in a 2012 United Nations General Assembly Resolution that highlighted the critical role it could play in helping to meet the Millennium Development Goals and alleviate poverty (UN, 2012). By supporting the progression to UHC, nations are acknowledging the need to honour everyone's fundamental right to health care (Chan, 2012).

Reaching universal health coverage is now a critical goal of health systems in all countries irrespective of income status (WHO, 2013). To meet the dual UHC aims of universal access to health care and financial protection from health care expenditures, many low- and middle-income countries (LMIC) have therefore initiated a number of ambitious health-financing reforms that aim to introduce prepayment at affordable prices for low socio-economic groups and targeted subsidies for indigents and other vulnerable populations. However, while such reforms have led to increased utilization of health care, it is often the case that the poor, informal sector workers and other marginalised people continue to be excluded from coverage. Furthermore, out-of-pocket payments in most LMIC continue to constitute a large proportion of total health expenditure, reaching over 50% of total health payments

in many low-income countries in Asia and Africa (van Doorslaer, 2006; WHO, 2013). Health-care patterns thus remain inequitable with the economic burden falling disproportionately on the poor. Where user-fees are charged, it becomes impossible to reach UHC, as many vulnerable people either risk financial catastrophe from paying health care costs or are prevented from accessing health services altogether.

In order to reduce the reliance on OOP payments, it is essential that health systems introduce prepayment methods that ensure risk pooling and cross-subsidization between the rich and poor and healthy and sick (WHO, 2013). This can be achieved through a variety of health-financing mechanisms such as tax-funded national health insurance (NHI), contribution based social health insurance (SHI), exemption policies and community based health insurance (WHO, 2013). These programmes aim to trigger the necessary structural transformations to enhance people's access to care, hence making health systems more equitable (Michielesen et al., 2010). However, although many low- and middle-income countries have implemented a variety of these financing mechanisms to initiate a progression to UHC, current evidence on their effectiveness shows mixed results at best, with many studies indicating that programmes have failed to reach their assigned objectives (Derbile & Van Der Geest, 2013; Witter et al., 2007; Spaan et al., 2012).

Despite considerable efforts, it is clear that few low- and middle-income countries have reached near universal coverage (WHO, 2013). There is, therefore, an unquestionably urgent need to develop and reform financing models for accessible health care in low- and middle-income countries. However, to do so, it is first important to understand why many recent health-financing reforms have failed to ensure equitable access to health care, particularly for the poorest and most vulnerable populations. It was with this aim in mind that a multi-country research project, Health Inc (Financing health care for inclusion), was devised to examine the performance of a number of social health protection policies that were implemented to counteract inequities in access to health care services in LMIC. In particular, the Health Inc project sets out to explore the role of a specific, critical factor that may be limiting the success of recent health financing initiatives: social exclusion.

Combating social exclusion has been identified as a key goal for health systems by organizations such as the International Labour Organization (ILO, 2007) and the WHO, whose 2008 World Health Report calls for "reforms that ensure that health systems contribute to health equity, social justice and the end of exclusion, primarily by moving towards universal access and social health protection" (CSDH, 2008). Furthermore, the Commission on Social Determinants of Health (CSDH) has emphasized the need to evolve "health equity intervention research" through the development of "evaluation methodologies that capture contextual and other critical influences to understand what works to make significant progress towards UHC" (CSDH, 2008). Following these calls, the Health Inc project posited that the social exclusion concept was a relevant framework through which to analyze several SHP programmes and their effectiveness. We did so in four different settings: two states of India (Karnataka and Maharashtra) and two West African countries (Ghana and Senegal). In this book, we present evidence from the Health Inc project to show how social exclusion restricts access to health services for vulnerable groups in these settings, despite recent health financing reforms. Based on this evidence, we propose strategies and policies that can enhance the inclusiveness of social health protection schemes.

The Health Inc Project

As its starting point, the Health Inc project put forward the hypothesis that social exclusion is an important cause of the limited success of recent health-financing reforms. Firstly, social exclusion can explain barriers to accessing health care. Social exclusion from health care provision may be due to disrespectful, discriminatory or culturally inappropriate practices of medical professionals and their organisations within the context of poor accessibility and quality of care. Social exclusion from health care services means that removing financial barriers does not necessarily guarantee equitable access to health care.

Secondly, social exclusion can explain barriers to accessing the health-financing mechanism itself. There are underlying social, political and cultural reasons for lack of financial coverage. Differential access to information, bureaucratic processes, complex eligibility rules, and/or crude and stigmatizing criteria for means-testing prevent socially excluded groups from enrolling in financing schemes that provide access to health care at an affordable price (e.g. community health insurance) or even free of charge (e.g. user charges exemptions). Leakage, on the other hand, may explain why more powerful and vocal groups are able to capture the benefits of targeted schemes that aim to cover the poor.

To explore whether social exclusion is in fact limiting the success of health-financing reforms, the Health Inc project undertook primary research in a number of geographical settings on a variety of social health protection schemes. In two states of India, Maharashtra and Karnataka, research was conducted on the RSBY insurance scheme. In West Africa, the National Health Insurance Scheme (NHIS) in Ghana and the Plan Sesame exemption scheme for older people in Senegal were investigated. These locations provided ideal settings for the research, as they are all experimenting on a large scale with a variety of financing mechanisms that offer tax funded subsidies to indigents and vulnerable groups and/or contributions set at a low, supposedly "affordable" price. These locations and an overview of the financing mechanisms studies are explored in part I of this book: Country Case studies.

The results and conclusions from the Health Inc project that are presented in this book aim to address a number of complex questions. What are the indicators of social exclusion in LMIC? Are vulnerable groups such as women, scheduled castes and older people, excluded from social health protection schemes? If so, through what processes does this occur? Are vulnerable groups at greater risk of exclusion than other groups? Can social exclusion explain patterns of enrolment and utilisation of health care and unmet need? What is the potential of health policy makers to reduce social exclusion in health care financing arrangements? Can anything be learnt about the influence of social exclusion on health care financing from a cross-country comparison of the health-care financing arrangements studied? By answering these questions, this book aims to provide an explanation of the mechanisms that shape social exclusion in health and to propose fundamental policies that will reduce inequalities in access to social health protection and health-care services. Before presenting these results and discussing what can be done to improve social inclusion in health-financing schemes, it is first essential to understand the context of social health protection in LMIC, the concept of social exclusion in health and the relevance of analysing social health protection schemes through a social exclusion lens.

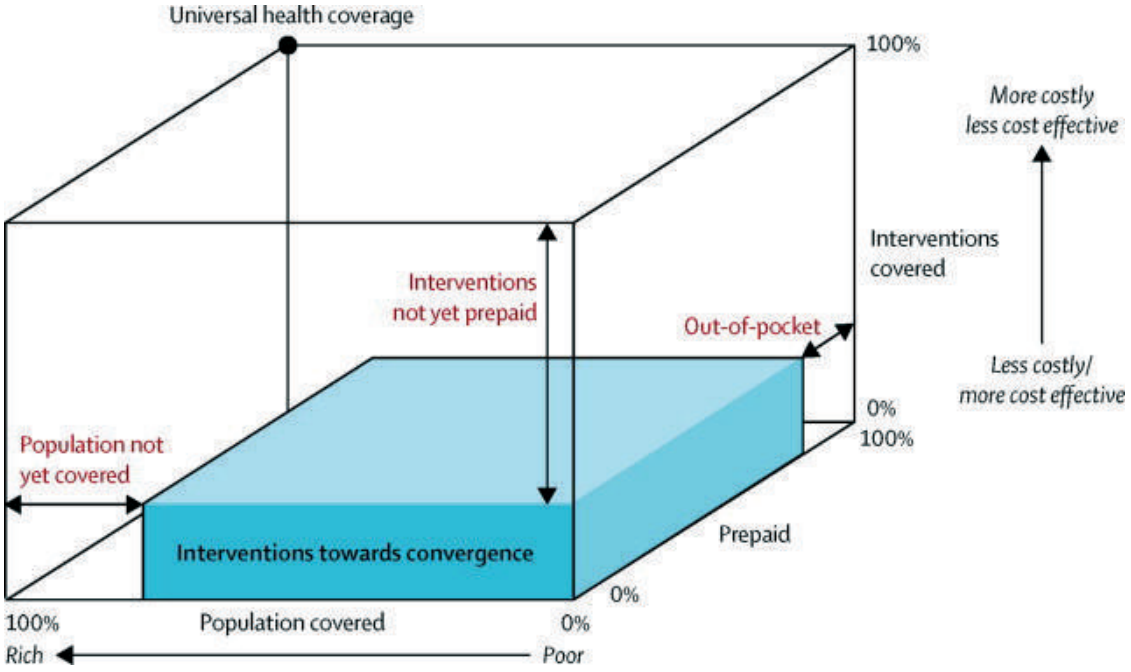
Social health protection in LMIC

Quality, appropriate and affordable health care in times of need should be available to all people. However, estimates suggest that more than 1 billion people worldwide currently lack access to affordable health care, and 150 million annually face financial catastrophe as a consequence of paying health care costs (Xu 2005). These persistent inequalities in health-care access and lack of financial risk protection violate the key principles of universal health coverage that ensures 'access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access' (WHO 2005).

In light of distinct and inequitable gaps in health systems coverage, the United Nations General Assembly has called on governments worldwide to significantly scale-up efforts towards achieving UHC for their populations (United Nations 2012). To do so, it is essential that countries develop efficient and effective social health protection systems. As illustrated in the WHO's famous cube diagram (figure 1), reaching universal SHP requires the provision of sufficient coverage in three dimensions:

- breadth of coverage (size of the population covered)
- depth of coverage (the range of benefits covered)
- height of coverage (the share of total costs covered)

Figure 1: Dimensions of universal health coverage



Source: (WHO, 2010) and (Jamison 2013)

When UHC is reached, the entire population will be covered by a comprehensive set of health interventions with few OOP expenditures for accessing those interventions (Jamison 2013). It is important that SHP incorporate the objectives of burden sharing, risk pooling, empowerment and participation, and embody the values of solidarity, social justice and equity in terms of access to good quality services according to need and regardless of income level, social status or residency (ILO 2007). When these objectives are fulfilled, SHP instruments should enrol even the most poor and vulnerable groups and ensure equitable access to essential health care services.

The goals of UHC and SHP can be met through a variety of health-financing mechanisms (WHO 2010). These include: tax-funded national health insurance (NHI); contribution-based mandatory social health insurance (SHI) financed by employers and employees; mandated or regulated private health insurance (PHI); and mutual and community non-profit health-financing schemes such as community-based health insurance (CBHI), conditional cash transfers (CCT) or subsidized vouchers. By nature, these initiatives to remove financial barriers to accessing health care fall under the umbrella of Social Health Protection programmes, defined by the International Labour Organisation as:

> *"a series of public or publicly organized and mandated private measures against social distress and economic loss caused by the reduction of productivity, stoppage or reduction of earnings, or the cost of necessary treatment that can result from ill health." (ILO, 2007)*

Each mechanism's potential strengths and weaknesses in terms of the goals of equity, efficiency and quality of care have been well documented in LMIC, and while many pathways can be taken to expand coverage, it is generally acknowledged that a mixture of mechanisms is necessary to achieve UHC (Gottret 2006; McIntyre 2007).

In recent years, and despite considerable resource constraints, many LMIC countries have accepted the call to transition towards UHC and have introduced a variety of social health protection systems. In 2003, Ghana implemented the National Health Insurance system that offered coverage to the entire population with enrolment fees waived for indigents. By 2010, it was estimated that about 50% of the population were active members with valid membership cards (Ministry of Health 2011). However, less than 10% of the revenue generated by the NHIS comes from voluntary payments, as enrolment for the informal sector and indigents remains low (Ministry of Health 2011). The Philippine National Health Insurance Program, "PhilHealth", has, in contrast, proved more successful

at expanding health insurance coverage to indigents. The Sponsored Program within PhilHealth that extends free coverage to indigents had achieved coverage rates of 85% in 2008 (Manasan 2011). However, in 2009 and 2010, enrolment figures reached 140% and 154% respectively, indicating poor targeting and leakage of benefits to non-eligible individuals (Manasan 2011).

Other countries have experimented with insurance schemes that only target vulnerable groups. In India, the RSBY scheme was introduced in 2008 to provide subsidies for private health insurance for people below the poverty line (BPL). However, enrolment rates remain consistently low. In a study carried out in districts in Maharashtra state, the proportion of poor families enrolled in the scheme was only 39% (Narayana 2010). Similarly, official RSBY figures show that enrolment among eligible households in the second year of implementation in Karnataka state was 41.2% (Rajasekhar 2011). In addition to low enrolment rates, results from an evaluation study suggest that only 1.8% of cardholders in Maharashtra have actually utilised health-care services (Jain 2011).

Similar issues of low and inequitable enrolment have been seen in many CBHI schemes. For example, in Senegal, Mali and Ghana, community health insurance (CHI) schemes have low rates of coverage of the national population and higher enrolment rates among the better-off than the poor (Jütting 2004; Chankova 2008). Furthermore, although these schemes have been shown to increase health-care utilization for members, they often provide limited financial protection and do not reduce out of pocket expenditures (Chankova 2008).

It is clear that LMIC have introduced a wide variety of SHP schemes in efforts to achieve universal coverage. However, in many schemes, the most vulnerable population groups continue to be excluded from coverage even when free or subsidized enrolment is available and remain less likely to access health care than other population groups. As previously hypothesised, one critical factor that may limit the ability of health-financing mechanisms to extend coverage and benefits to vulnerable populations is social exclusion, a concept explored in the next section.

The concept of social exclusion

Social exclusion is a widely-used term today, but not necessarily a clear-cut concept. It can varyingly be considered as a condition/status or as a multidimensional and dynamic process. When viewed as a condition/status, it is seen as an outcome where some individuals and groups are excluded, as they are unable to fully participate in society as a result of their social identity (gender, religion, race) or social location (remote areas, segregated territories, low paid jobs). Alternatively, social exclusion can be viewed as a multidimensional and dynamic process where social interactions and organizational/institutional barriers hamper individuals from attaining a decent livelihood, a country to reach a sufficient level of human development and a state to offer equal citizenship to its citizens. Social exclusion therefore generates, sustains and reproduces poverty, enhances inequalities, and restricts social, political and economic participation for some marginalized individuals or groups and prevents them from accessing institutional sites of power or engaging with powerful organizations.

These definitions of social exclusion have emerged after several decades of debate and revision, primarily in Europe and North America. The first use of the term is commonly attributed to the French politician René Lenoir (Lenoir, 1974), although underlying and related concepts had been part of European sociological inquiry for a long time (Elias, 1965). Lenoir, then Secretary of State for Social Action, dealt with social exclusion in the specific context of a welfare state and attempted to put vulnerable groups excluded from social protection into the ‘spotlight’. He did not provide an unambiguous or new definition, but deserves credit for bringing into view the notion of something wider than monetary poverty and opening the door to a great debate on the concept in Europe (Ben Aziza 2004).

By the end of the 20th century, the use of the term social exclusion was widespread among social scientists and policy-makers, often without a common definition. Anthony Atkinson postulated that the term might "have gained currency in part because it has no precise definition and means all things to all people". Yet, Atkinson also identified three recurrent characteristics within a variety of definitions of social exclusion: relativity, agency and dynamics. Relativity refers to a particular place and time (as opposed to an absolute approach in poverty measurement); agency (not identical to the term used in the capability framework) refers to exclusion as dependent on the activities of others; and dynamics refer to the relevance of future prospects beyond current circumstances (Atkinson 1998).

Ruggeri Laderchi and colleagues classify social exclusion as one of four approaches to poverty, alongside monetary, capability and participatory approaches (Ruggeri, 2003). Amartya Sen doesn't entirely agree and posits that "the perspective of social exclusion reinforces – rather than competes with – the understanding of poverty as capability deprivation" (Sen, 2000). Guildford describes how terms and emphases changed while the concept of social exclusion travelled the world. In France, and subsequently in the work of the European Union, the term 'social exclusion' is most often used. The United Kingdom similarly embraced the 'social exclusion' concept, establishing the Social Exclusion Unit that viewed exclusion as 'what can happen when people or areas suffer from a combination of linked and mutually reinforcing problems' in areas such as poverty, employment, housing and health (Bradshaw, 2004). Yet, the European Anti-Poverty Network prefers 'poverty and social exclusion'; in Scotland, emphasis was put on 'social inclusion'; and Canada launched the term 'social and economic inclusion'. As Guildford notes, behind different terms a common understanding seemed to have emerged: "Exclusion is the problem; inclusion the solution" (Guildford, 2000). Ronald Labonte welcomes the twinned concepts of social exclusion and inclusion, which he describes as a conceptual sophistication over social capital and social cohesion, while remarking on the complexity of inclusion into social systems stratified by exclusion (Labonte, 2004).

When the concept of social exclusion eventually transferred to the less developed countries, it was initially met with scepticism. Originally defined within the context of a European welfare state and often expressed in numbers of people lacking social security or employment, its applicability to developing countries with high unemployment levels and numbers of unprotected individuals was questioned (Saith, 2001). Arguably, Saith could not foresee that social exclusion would gradually adopt a much less restrictive definition. His apprehension of social exclusion being an impractical concept for dealing with large groups is understandable, as there was a long transitional period where the shift in focus from outcome to process was welcomed but rarely applied. Indeed, it took researchers and policy actors quite some time to go beyond counting outcomes and instead to begin analyzing processes. As late as 2005, some international development actors still regarded social exclusion as much an outcome as process. Today, process thinking prevails and most scholars agree that social exclusion, far from being carved in stone and without being a conceptual newness, is a highly relevant approach in development because it underscores the processes of deprivation, its relational aspects and the need for transformation (Sen, 2000).

Social exclusion in health and social exclusion from social health protection

Although the concept of social exclusion quickly gained momentum in development circles in the aftermath of the 1995 World Summit for Social Development, it was only more than a decade later that – under the impulse of the WHO's Commission on Social Determinants of Health (CSDH) – it started permeating the field of health. In 2008, the third and last overarching recommendation of the CSDH was "to measure and understand the problem and assess the impact of action", including what was termed "health equity intervention research" (CSDH, 2008). The 2011 World Conference on Social Determinants of Health reiterated the CSDH's recommendations and made a plea for "research on the relationships between social determinants and health equity outcomes" (WHO, 2011). The CSDH therefore established a set of key transversal themes to be investigated in order to better understand the causes and consequences of inequities in health. At the core of these themes was the concept of social exclusion.

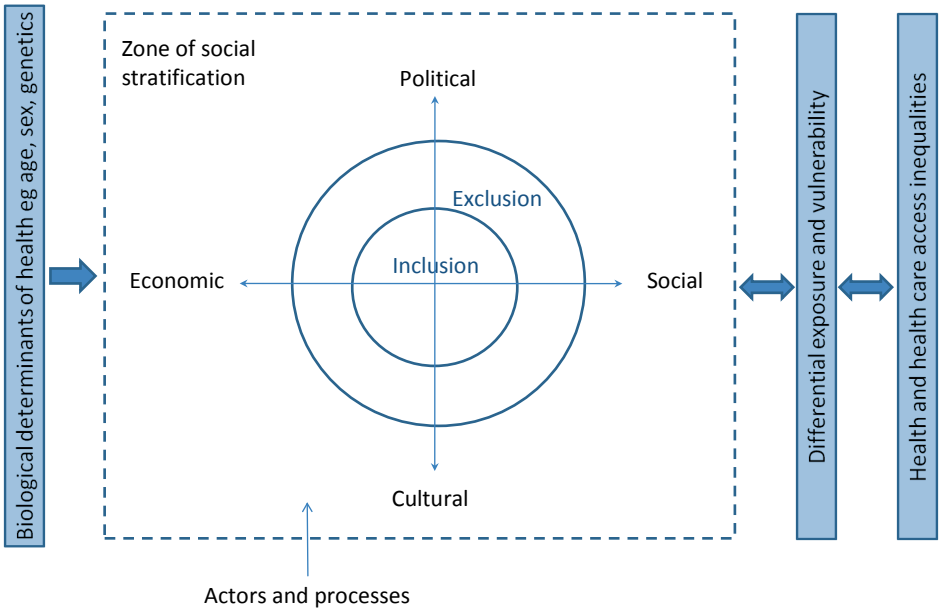
In order to explore the issue of social exclusion in health, the commission established the Social Exclusion Knowledge Network (SEKN) whose aim was to present a framework for understanding and tackling social exclusion. The SEKN network clearly framed it as a process with the specific request to "unravel unequal power relationships" that may affect the effectiveness of equity-oriented interventions (Mathieson et al., 2008). In the SEKN's Final Report to the CSDH, social exclusion was defined as: "dynamic, multidimensional processes driven by unequal power relationships interacting across four main dimensions – social, political, economic and cultural – and at different levels including individual, household, group, community, country and global levels" (Popay 2008). It is this definition of social exclusion that was adopted by the Health Inc. project.

Based on SEKN's understanding of social exclusion, the Health Inc consortium developed an analytical framework that aimed to highlight exclusion from effective coverage and to capture causes and risk factors across four dimension of power relationships that constitute the continuum from inclusion to exclusion: economic, political, social and cultural (Popay 2008). Given the complex, multidimensional, dynamic nature of social exclusion, 'risk-factors' or 'drivers' of social exclusion in each dimension interact and are often mutually reinforcing in their impact on social exclusion. The key characteristics of each dimension are described below:

- The social dimension is constituted by proximal relationships of support and solidarity (e.g. friendship, kinship, family, clan, neighbourhood, community, social movements) that generate a sense of belonging within social systems. Along this dimension, social bonds are strengthened or weakened.
- The political dimension is constituted by power dynamics in relationships which generate unequal patterns of both formal rights embedded in legislation, constitutions, policies and practices and the conditions in which rights are exercised – including access to safe water, sanitation, shelter, transport, power and services such as health care, education and social protection. Along this dimension, there is an unequal distribution of opportunities to participate in public life, to express desires and interests, to have interests taken into account and to have access to services.
- The economic dimension is constituted by access to and distribution of material resources necessary to sustain life (e.g. income, employment, housing, land, working conditions, livelihoods, etc.).
- The cultural dimension is constituted by the extent to which diverse values, norms and ways of living are accepted and respected. At one extreme, along this dimension, diversity is accepted in all its richness; at the other, there are extreme situations of stigma and discrimination.

The SEKN Final Report also highlights the importance of social exclusion in health and health care. The "dynamic, multidimensional processes" that drive social exclusion lead to "a continuum of inclusion/exclusion characterised by unequal access to resources, capabilities and rights which leads to health inequalities" (figure 2).

Figure 2: Relationship between social exclusion and health inequalities



Source: adapted from (Popay 2008)

The social exclusion lens is increasingly recognized as a relevant concept through which to analyze Social Health Protection programmes, as it presents a framework through which the social, political, economic, cultural and institutional dimensions of society shape human vulnerabilities (Babajanian, 2013). For Health Inc research, the social exclusion perspective was adopted, as "it can help not only examine the effects of social protection on different dimensions of deprivation, but also expose its ability to tackle broader factors and conditions that produce and reproduce deprivations" (Babajanian, 2013). Ultimately, the social exclusion lens can expose the social and institutional factors that prevent some SHP programmes from extending protection to the most vulnerable individuals.

Social exclusion as a cause of the limited success of health financing reforms

Social exclusion can help cause or enhance inequity in health financing in two main ways. Firstly, social exclusion can explain barriers to accessing health care. Social exclusion from health-care provision may be due to disrespectful, discriminatory or culturally inappropriate practices of medical professionals and their organisations. This problem may be experienced within the broader context of poor accessibility and quality of health care (WHO 2000; Carrin G 2008). Unfortunately, it is often those who need health care the least that use services more, and more effectively, than those with the greatest need, a paradox known as the "inverse care law". The inverse-care law is the principle that the availability of good medical or social care tends to vary inversely with the need of the population served (Hart 1971). Those with the greatest need are often poorer and socially excluded population groups. The inverse-care law also means that removing financial barriers through tax funded systems, or via any other financing arrangement, does not necessarily guarantee equitable access to health care. Reducing financial exclusion is a necessary but by no means a sufficient condition to make sure that people in need can access quality health care.

In addition to barriers to accessing health care services, social exclusion may also, more directly, restrict access to health-financing mechanisms. Underlying social, political, economic and cultural barriers may result in insufficient breadth, depth and height of coverage. For example, one barrier to accessing a social health protection scheme may be that the steps required to access a health financing mechanism are socially unacceptable. Evidence suggests social exclusion is embedded in organisational structures and processes, such as differential access to information,

complex eligibility rules and crude and stigmatizing criteria for means testing (Popay 2008). Free health care through means-tested subsidies, such as vouchers or subsidised premiums, may in theory promote greater financial inclusion, but social exclusion has been found to restrict the reach of targeted policies disadvantaging those in most need (Mkandawire 2005). This partly explains why, even if possession of a voucher or exemption card makes care available free of charge, often only a small proportion of the eligible population enrols in user charges exemption schemes (Willis 1995; James 2006).

Social exclusion may also have an important impact on contributory schemes. If the insurance is organised in a way that is socially, politically or culturally inappropriate, unacceptable or inaccessible, enrolment may be low even if the premium is affordable to poor and informal sector workers. For example, a study in Ghana found that more than 20% of the respondents reported that they had not heard about the National health Insurance Scheme (NHIS), and the majority of these were concentrated among the poor population. Others did not register because they did not trust the genuineness of NHIS (Asante 2008). In India, research done at a community health insurance programme found that while both the poor and the better-off populations enrolled in equal proportions, the better-off tended to use the services more than the poor. This was mainly because of the bureaucratic barriers to reimbursement faced by the poor (Ranson, 2006). Leakage, which is understood as an inclusion error in means-testing (Peyre Dutrey, 2007), and unequal distribution of capabilities and access to information may explain why more powerful individuals and groups are able to capture the benefits of targeted schemes that aim to cover the poor.

Extending the scope of research on social exclusion into health financing in LMIC

Social inclusion has long been a concept used in research in high-income countries, but large gaps in knowledge remain in terms of health-financing policy in LMIC. While studies on social exclusion in LMIC and health are available, they do not focus specifically on health financing. There are almost no systematic studies of how social, political or cultural exclusion occurring in the broader environment may affect access to equitable health-financing arrangements. Instead, studies tend to focus more narrowly on the negative effects of poverty measured in terms of income, expenditure or assets, and the poor quality of health care, or on community participation in health-financing arrangements. These barriers are clearly important, but there has been a lack of attention paid to explaining why the financing system has been unable to overcome them.

Limited attention has also been paid to assessing the “human component” of health systems development (CSDH 2008). The WHO Commission on Social Determinants of Health report (2008) argued that as well as studying the social determinants of health, “research and policy need to focus on the human component of health-systems development”. The report further argues that understanding this aspect of health systems is crucial since “processes of management and decision-making within the health system itself are important avenues for reducing inequity and empowering the excluded and marginalised” (CSDH 2008). A recent review has also highlighted the need for “systematic and coherent bodies of work underpinned by both the intent to undertake rigorous analytical work and concern to support policy change” in this field (Gilson and Raphaely 2008).

The Health Inc project has responded to these gaps in evidence, both in terms of analysis and policy, by identifying how social exclusion influences equity objectives of health-financing policies and recommending policies that can enhance social inclusion. Commonalities across geographical contexts were also explored through a comparative analysis of the complex processes by which social exclusion prevents access to health care in diverse locations, including Ghana, Senegal and the Indian states of Maharashtra and Karnataka. As explained previously, these locations provided ideal settings for the research, as they are all experimenting on a large scale with financing mechanisms that aim to increase access to health care for vulnerable groups. The schemes also differ markedly in

terms of funding mechanisms, targeted beneficiaries, enrolment procedures and benefit packages and provide a variety of social, political and cultural dimensions that intersect within these financing arrangements. Lastly, the different schemes have experienced different levels of success, which provides a rich environment for studying both positive and negative cases.

By undertaking this research, the Health Inc project has provided much needed evidence on the role social exclusion can play in causing and enhancing inequities in health and health-care access. The results and conclusions in this book show how social inclusion/exclusion can help account for successes and failures in the development and implementation of policies which can result in accessible and acceptable health-financing mechanisms that serve vulnerable groups. The policy recommendations for combating social exclusion and enhancing social inclusion can help shape necessary reforms that will ensure equitable health systems that advance the cause of universal access and social health protection (CSDH, 2008).

Outline of the book

In this introductory chapter, we have provided the rationale for the Health Inc project and the need to study health and social health protection through a social exclusion/inclusion lens. We have explored social health protection in low- and middle-income countries and the concept of social exclusion and social exclusion as it related to health care. In the remainder of this book, we present results from the four Health Inc study sites before bringing together this evidence to help us present recommendations for reducing social exclusion in health-financing schemes.

Following this introductory chapter, we first present the methodological framework, the SPEC-by-step tool that guided Health Inc research. In chapter two we show how the SPEC-by-step tool was developed by grafting the SEKN's Social, Political, Economic and Cultural (SPEC) conceptual framework on social exclusion onto a step-by-step deconstruction of the health-financing scheme under study. We show how this tool enabled us to study who was excluded at each implementation step – from being aware of a scheme through to enrolment, receiving membership cards, utilising health care and receiving financial protection – and how and why this exclusion occurred.

The remainder of the book is then divided into three further sections. In part II, which contains four chapters, we introduce Country Case Studies that explore the study settings, detail the research methods used and present a brief overview of key results in each location. In chapter three we present the Ghanaian country context and an overview of the National Health Insurance Scheme (NHIS). In chapter four we next review the Senegalese context and the Plan Sesame. Next, we provide an overview of the RSBY insurance scheme in Maharashtra in chapter five before exploring the Karnataka context and RSBY in chapter six.

In part III of the book, we explore in-depth the results presented in the Country Case Studies by analysing the different steps of the SPEC-by-step tool in detail. In chapter seven, we explore enrolment in RSBY in Karnataka. Using a mixed methods analysis, we explore if and how the design and implementation of the enrolment process in RSBY influences who gets in to the scheme and who does not, given the existing social exclusionary process in the community. We next analyse enrolment in RSBY in Maharashtra in chapter eight using a mixed methods approach to estimate enrolment rates and to determine whether social exclusion is correlated with enrolment of households. In chapter nine, we explore utilisation of health care within the context of NHIS in Ghana. Using regression models, we explore the impact of socio-economic factors on the utilisation of public and private outpatient healthcare services in Ghana.

In part IV of this book, we explore the social exclusion of specific vulnerable groups from the health-financing schemes being studied. In chapter ten, we present comparative evidence from Ghana and Senegal to test the hypothesis that socially-excluded older people are less likely to enrol in NHIS and Plan Sesame. In chapter eleven, we assess whether Ghanaian women are excluded from participating in the NHIS, analyse the types of women that are excluded and explore the processes by which this exclusion occurs. In chapter twelve, we attempt to establish the generative mechanisms that explain exclusion of indigenous people from social health protection in rural Karnataka.

In part V, the final section of our book, we bring together the results presented in parts II, III and IV to draw conclusions on social exclusion in health. In chapter thirteen, we explore the "mechanisms" shaping social exclusion in health and assess their "confrontation" with the existing body of knowledge on this issue. Finally, in chapter fourteen, we draw the book to a close by presenting the overall conclusions from the Health Inc project suggesting policy recommendations and the way forward for combating social exclusion and enhancing social inclusion in low- and middle-income countries.

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CHAPTER 2: Health Inc methodology and the SPEC-by-step tool

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Introduction

Redress of health inequities is a necessary condition for health systems to be people-centred and effective. Numerous interventions in health financing and social health protection aim at reducing health inequities; yet inequities persist, driven more often than not by social exclusion (Popay et al., 2008). Practical tools for assessing health inequities are few, and for assessing social exclusion in health, virtually non-existent. In this chapter, we describe how the Health Inc research consortium developed a generic tool to structure the assessment of social exclusion from social health protection initiatives and how the iterative application of this SPEC-by-step to social health protection schemes gradually evolved into a search for the generative mechanisms of social exclusion.

In 2008, the Commission on Social Determinants of Health (CSDH) made a case for "health equity intervention research" (CSDH, 2008). In 2009, the sixty-second World Health Assembly (WHA) ratified the CSDH's recommendations and urged in concrete terms "to generate new, or making use of existing methods and evidence (…) in order to address the social determinants and social gradients of health and health inequities". One of the ways forward highlighted by the WHA was the use of disaggregated data to detect health inequities and to measure the impact of policies on health equity (WHA, 2009). The 2011 World Conference on Social Determinants of Health (WCSDH) reiterated the CSDH's recommendations and made a plea for "research on the relationships between social determinants and health equity outcomes with a particular focus on evaluation of effectiveness of interventions" (WCSDH, 2011). Known as the Rio political declaration on social determinants of health[1], the conference's statement was endorsed by the sixty-fifth World Health Assembly (WHA, 2012) and reconfirmed by the sixty-sixth World Health Assembly (WHA, 2013). A couple of months later, the WHO released its 'Handbook on health inequality monitoring' (WHO, 2013).

As pointed out a decade ago by Graham (2004), it is important to make a distinction between the social determinants of health and the social determinants of health inequalities, as the latter often persist even if the former are remedied: "(u)sing one model to explain both health and health inequalities can blur the distinction between the social factors that influence health and the social processes that determine their unequal distribution". The CSDH's Social Exclusion Knowledge Network (SEKN) was aware of this drawback and advocated using the concept of social exclusion as a particular and unique framework for understanding the social determinants of persisting health inequities (Popay et al., 2008). The CSDH itself was less cautious when using the indistinct conjunction "social determinants of health and health inequities" (CSDH, 2008) when grouping both determinants in one conceptual framework (based on Solar and Irwin, 2007)[2]. Accordingly, the commission's advocacy for generation of knowledge and monitoring relied on disaggregation of health data more than on exploration of inequitable processes per se. WHO's recent guidelines on 'health inequality monitoring' are predominantly based on health indicators topped up with half a dozen positional (not hierarchical, not contextual) determinants called 'equity stratifiers' under the acronym PROGRESS[3]. The CSDH's Measurement and Evidence Knowledge Network (MEKN), however, had argued for methodological diversity, and for adding process evaluation to widen the evidence base on the determinants of health inequities. Added to this, the MEKN saw a need "to provide answers not only about what interventions work to address SDH, but also how they work and in what context" (Kelly et al., 2007). The CSDH's Social Exclusion Knowledge Network (SEKN) had made a case for "focusing (…) on processes driving inequality, power relationships, and agency (exclusion by whom?), and on the multi-dimensionality and the inter-linkages between different forms of deprivation (exclusion from what?)". This, according to the SEKN, would be no easy job in the absence of "a single validated measure of social exclusion", of which the existence would be problematic anyway[4]. The impasse to overcome was one of quarrelling over definitions of social exclusion, limited applicability of welfare-state specific indicators in a global context, mismatch between survey indicators designed for other purposes and the measurement of social exclusion, and failure of quantitative approaches to provide insight into the experience of suffering exclusion (Mathieson et al. 2008).

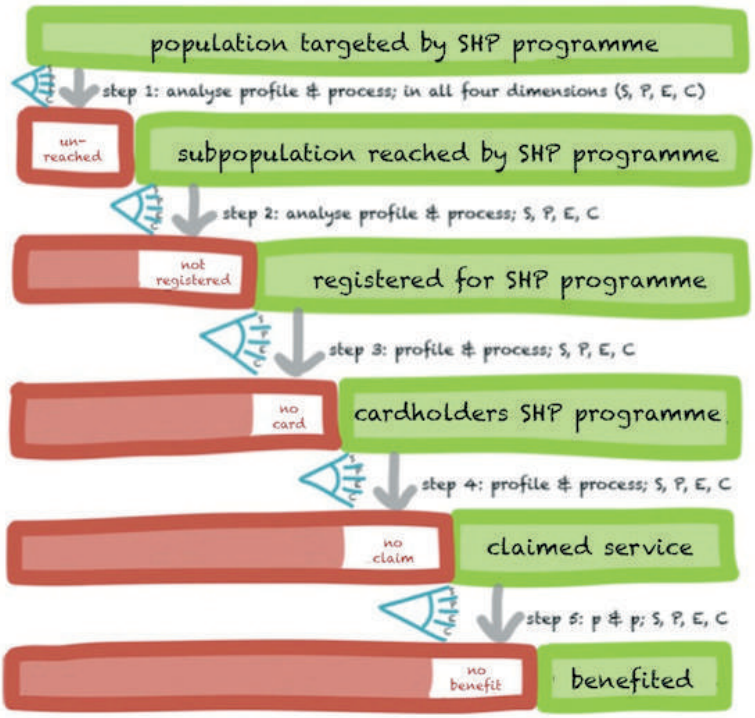
As mentioned in the introductory chapter, the Health Inc collaborative research project has been exploring the interface between social exclusion and social health protection. A chain of arguments sustained the choice for social health protection (SHP) as our field of study: the CSDH recommended social protection as one among important policies to bring about health for all (CSDH, 2008), and the United Nations Economic and Social Council followed up with a call for national social protection floors (UNESC, 2009) – an initiative endorsed by the United Nations General Assembly (UNGA, 2009), backed by the International Labour Organization[5] and receiving increasing global support (UNPSDH, 2013). Within this initiative, social health protection – its coverage defined as effective access to affordable quality health care and financial protection in case of illness (ILO, 2008) – is an essential feature (ILC, 2012) in line with the overarching goal of universal health coverage (WHO, 2010).

The 2010 World Health Report concluded that improved health financing is a necessary means to the end of universal coverage, but that more than improved efficiency is needed to achieve equitable coverage (WHO, 2010). Health Inc goes a step further and puts forward the hypothesis that social exclusion (see chapter 1) is an important cause of the limited success of recent health-financing reforms in terms of social health protection (SHP). Based on this hypothesis, the project explores the interface between social exclusion and social health protection within three large-scale health-financing schemes in four states/countries: Rasthrya Swasthya Bima Yojana (RSBY, 'National Health Insurance Programme' for below-poverty-line households) in the states of Maharashtra and Karnataka in India, the plan Sésame (free health care for the elderly) in Senegal, and the National Health Insurance Scheme (NHIS) in Ghana.

Development of a generic tool

To start with, the Health Inc project adopted the SEKN's definition of social exclusion as a range of "dynamic, multi-dimensional processes driven by unequal power relationships interacting across four main dimensions – economic, political, social and cultural – and at different levels including individual, household, group, community, country and global levels" (Popay, 2008). We reordered the four dimensions into the acronym SPEC (Social, Political, Economic and Cultural), grafting a SPEC lens onto a step-by-step deconstruction of any health-financing scheme under study: the SPEC-by-step tool. Our stepwise deconstruction – following the flow of people through the scheme – is essentially people-centred, not resource-centred. Thus, it is deliberately distinct from the mainstream collecting-pooling-purchasing approach in health-financing analysis. In our view, while the three-functions approach is today's best fit to analyse the efficiency of health financing, only a people-centred approach can unpack the dynamics of social exclusion/inclusion in social health protection. An additional expected advantage of a people-centred approach is the implication of the schemes' target groups in the research in accordance with the SEKN's call for the inclusion of the "tacit knowledge of all involved, especially the planned beneficiaries of the interventions or actions" (Kelly et al., 2007).

Figure 1: The generic SPEC-by-step tool



In constructing the tool, we broke down a hypothetical, generic SHP programme into a series of steps, each step excluding a number of people (Figure 1). The excluded are shown on the left in a red box; the non-excluded to the right in a green box. For the sake of clarity, we limited the series of steps to six levels with five steps connecting them. Arguably, the actual numbers of levels and steps can be more (or less) in particular programmes; furthermore, we assume that a programme would accommodate the required modifications in the event of contextual adaptation. Also, and again arguably, the focus on exclusion only and the linear order of levels and steps are simplifications. Steps themselves can also be a reduction of reality, neglecting the iterative character of, for example, becoming aware of a programme (see Step 1). Furthermore, uncalled-for inclusion (leakage) is not explicitly taken into account by the tool. Finally, we recognise that feedback loops might be needed, e.g. when a programme requires periodic registration or card renewal.

Step 1: From population targeted to subpopulation reached

We start the cascade with Level 1: the population targeted by SHP programme, or those, in theory, eligible for entering the programme, i.e. the declared target population of a given SHP programme in a given context and in a given time. This means that we do not analyse whether the eligibility criteria for setting the target was exclusionary or inclusionary: this would be beyond the scope of the tool. It also means that the target population can change if the programme policy changes, e.g. when the Indian government adds domestic workers to the population eligible for RSBY. A target population can be as big as the general population – as is the case in the NHIS in Ghana – or a subpopulation – such as people aged over 60 in the Sésame in Senegal plan. Ideally, all targeted people become aware of the programme and are given the possibility of entering the programme. We refer to this as being reached by the programme. In real life, it is rarely the case that the entire target population is reached. Thus, Level 1 is followed by Level 2 – subpopulation reached by SHP programme, and in the cascade between Level 1 and Level 2, people are lost in Step 1. These are referred to as the unreached.

Analysis should include asking the 'who', 'how' and 'why' questions: what are the profiles of the unreached, how are they different from those reached by the programme, and what might be the reasons for their being unaware of and/or not being addressed by the programme? Answers for these questions on profile and process should be sought in all four dimensions of social exclusion: social, political, economic and cultural (symbolised by the SPECtacle). The existing literature on SHP by and large fails to answer these questions, typically stopping at the discovery of "lack of information".

In contrast, the SPEC-by-step tool looks for underlying causes and mechanisms: it generates hypotheses on causal patterns of exclusion. After applying the SPEC-by-step tool to the target population of the SHP programme, and having generated such hypotheses, we can fine-tune these hypotheses by applying the tool to subpopulations that are known to be excluded in a particular context – examples cited by Health Inc are Dalits and Adivasis in India, migrants and minorities in Ghana, migrants and Fula (Peul) people in Senegal and women everywhere.

Step 2: From subpopulation reached to those registered

We now go down to Level 3, the (sub)subpopulation of those registered for SHP programme. Many SHP initiatives entail a registration process. However, of those eligible for and reached by a programme, not all register (or enrol, depending on the particular terminology). We thus have an additional group – the not registered – lost in what becomes Step 2.

As was the case in Step 1, the 'who', 'how' and 'why' questions are repeated in Step 2, with answers sought in all four dimensions of the SPECtacle. This entails examining the profiles of those that did not complete the registration process (and compare these profiles against the profiles of those who did) and scrutinising how and why the registration process was not completed.

Here again, classic SHP analysis faces a conundrum: lack of 'affordability' is usually put forward as an explanation, whereas those most in need are less likely to join even if registration fees are close to zero. The SPEC-by-step tool, based on the hypothesis of social exclusion as an underlying mechanism, is expected to provide answers here.

Step 3: From registered to cardholders

We again descend the series of steps and reach Level 4, the (sub)(sub)subpopulation of cardholders. In many SHP initiatives, those registered are supposed to receive a card that enables them to access stipulated benefits. However, not everyone who registers receives their card on time; some don't receive their card at all. Besides, programmes might require periodic renewal of the card, which may confront potential beneficiaries with the same hurdles again. We thus have an additional group – those with no card – lost in what becomes Step 3. We refer to a cardholder only when a person's/household's card is valid[6].

Again, the 'who', 'how' and 'why' questions will be asked with answers sought for in all four dimensions of the SPECtacle, examining the profiles of those that do not hold a valid card (and comparing these profiles against the profiles of those who do hold a card) and scrutinising whether social exclusion can explain how and why some registered do not hold a valid card while others do.

Step 4: From cardholders to people claiming health services

We go down one more step and reach Level 5, the (sub)(sub)(sub)subpopulation of those people who actually claimed service. In many cases, not all cardholders decide to visit a service provider and request services, despite having a health problem that merits treatment by a service provider. Potential reasons for not doing so are manyfold. In Step 4 we thus lose an additional group: those who make no claim for the services they need[7].

As before, the 'who', 'how' and 'why' questions will be asked with answers sought in all four dimensions of the SPECtacle by examining the profiles of those that do not claim health services provided through the SHP programme (and compare these profiles against the profiles of those who do) and scrutinising whether social exclusion can explain how and why some cardholders do not claim services while others do.

Step 5: From claiming to adequately benefiting from health services

We descend once more and reach the final Level 6, the (sub)(sub)(sub)(sub)sub-population of those people who actually used and benefited from the health services as considered reasonable and due under the SHP initiative. In Step 5 we lose a last group that we call no benefit: those people who claimed the service but did not receive the benefits as stipulated by the programme.

Again, the 'who', 'how' and 'why' questions will be asked with answers sought in all four dimensions of the SPECtacle, examining the profiles of those who were unable to benefit from the services as stipulated under the programme (and comparing these profiles with the profiles of those who were able) and scrutinising if social exclusion can explain the how's and why's.

At this final level, the SPEC-by-step tool – focusing on unequal power relationships leading to social exclusion – can unpick what classic SPH analysis classifies as 'implementation errors': service users who still pay for what should be provided free of charge according to the programme, who receive only part of the benefit stipulated by the programme, or receive services that are inconsistent with their needs.

About the tool

The SPEC-by-step tool is essentially an example of "making use of existing methods" (WHA, 2009), as it combines the recently developed SEKN four-dimensional framework with a logic inspired by a model put forward nearly half a century earlier. While the former is well known, the latter deserves some clarification. In 1967, Maurice Piot published his "simulation model of case finding and treatment in tuberculosis control programmes" (Piot 1967). The Piot model starts from a description of the steps people go (or don't go) through between becoming ill with active tuberculosis (TB) and being cured by the TB programme under consideration (Dujardin et al. 1997). Operational

efficiency of the programme is expressed as the probability that a person does proceed from one step to the next. The original model was presented as a predictive one based on computed scores, though the author also expected it to stimulate critical thinking on existing programmes and invited others to do so. He did not invite in vain: for decades now, the Piot model has been adopted and adapted in a range of disease control programmes.

In TB control, Dujardin et al. (1997) applied the model to identify problems arising from the integration of TB control into general health services, as was the case when Directly Observed Therapy (DOT) was launched. Over time, several modifications to the programme that reduced loss of patients along the course – decentralisation of diagnostic procedures for instance – are largely due to the identification and quantification of bottlenecks in application of the Piot model.

Mumba et al. (2003) produced a close translation of the Piot model for malaria control, giving due credit to the original. Unger et al. (2006) applied it to highlight the need for strengthening health services to boost the performance of malaria-control programmes.

Robays et al. (2004) drew upon the Piot model to identify under which conditions sleeping sickness control would benefit from the introduction of new technologies. Jenniskens et al. (1995) used a Piot-like model to demonstrate the advantages of decentralising screening of pregnant women for syphilis control, but failed to acknowledge the original. A subsequent WHO publication (2005) gave rise to a nickname: the 'supposed to' model[8].

The Piot model had its most impressive track record in the control of sexually transmitted diseases (STDs), starting with its proposed application for improved case detection and management of STDs at the VIIIth International Conference on AIDS in Africa (Buvé et al. 1993). It gave rise to the 'operational model of the role of health services in STD case management' of Dallabetta et al. (1996), was renamed 'Piot-Fransen model of STD management' by Hayes et al. (1997), again recognised as Piot model by Amaral (1998) and reintroduced as such by Laga at the 1998 12th International AIDS Conference (Mayaud and McCormick, 2001), yet survived as 'Piot-Fransen model' for over a decade (Hudson, 2001; Thieren, 2005). Most importantly, the model has been fine-tuned over time and – as happened with its cousin in TB control – its application improved both programme uptake and cure rate (Buvé et al,. 2001).

Our approach is thus neither unique nor innovative per se. As the previous examples demonstrate, our preference for a stepwise follow-up of a target population is preceded by a long history of a similar approach in disease control that evolved from an explicitly predictive model to a successful assessment tool. Our construct is also preceded by the proposal – in the field of social health protection – of a step-by-step 'head count framework' for the analysis of targeting interventions (Meessen and Criel, 2008). While arguably the first, the Piot model was not unique, several authors (Thieren, 2005; van Olmen et al., 2012) recognise the analogy between Tanahashi's conceptualisation of health service coverage (1978)[9] and the Piot model.

What differentiates the SPEC-by-step tool from the original Piot model is the absence of a strictly predictive character exclusively based on quantitative data: our tool allows for and explicitly requires input of qualitative and quantitative data. What differentiates the SPEC-by-step tool from the recently developed 'step-by-step health inequality assessment' (WHO 2013) is our prioritisation of a people-centred perspective[10]. The people-centred orientation is further reinforced – and this might be called innovative – by our drafting of the SPEC lens (or SPECtacle) onto the stepwise deconstruction of an SHP programme.

The SPEC-by-step tool, as described above, is a generic tool and not to be applied without previous adaptation to the characteristics of both the SHP initiative wherein social exclusion will be assessed and the context wherein that initiative is executed. In Health Inc, we adapted the SPEC-by-step not only according to the specific characteristics of three different SHP programmes (RSBY in India, plan Sésame in Senegal, NHIS in Ghana), but also according to the differing implementation modalities of RSBY in Karnataka and Maharashtra.

In all four Health Inc study states/countries, the research teams experienced the SPEC-by-step tool as useful for the identification of key steps within the programme coverage cascade and for the estimation of expected rates of exclusion in each step. The adapted tool allowed the taking of informed decisions on what data to collect and by which data collection tools. With regard to data analysis, two experienced constraints were then needed to further split up the steps and the lack of absolute boundaries between the steps: some can overlap in content or in time. In contrast, three substantive advantages of the tool were identified: (1) the tool enables the researcher to maintain a focus on the interface between SHP programme and social exclusion, preserving him/her from getting lost in generalisations; (2) the tool enables the researcher to maintain a systemic and people-centred perspective, allowing meaningful framing of the findings; (3) the tool allows the researcher to identify dimensions that remain important throughout all steps, to also identify dimensions that dominate in the initial steps and then start filtering out, and to differentiate between predominant group exclusion in the initial steps and predominant individual exclusion in the final steps. From a researcher's perspective, these advantages added relevance to the ultimate policy recommendations.

In Karnataka – where the RSBY programme was still in expansion during data collection – the IPH Health Inc research team saw itself confronted with the interest of stakeholders in a limited set of steps. Implementers (insurance companies and so-called third-party administrators) were mainly interested in the results of the first steps up to the cardholders. Policymakers initially expressed interest only in "how many got it and how many used it". Ultimately, the SPEC-by-step tool allowed for visualisation of significant exclusion at all steps. When confronted with such graphical representation, policymakers and implementers stopped blaming the potential beneficiaries that didn't take up the scheme and became sensitive to possible flaws in the scheme's design and implementation.

In Maharashtra – where the RSBY programme was never implemented in the entire territory and gradually withdrawn since 2010 when the state-specific SPH programme Rajiv Gandhi Jeevandayee Arogya Yojana (RGJAY) was rolled out – the TISS Health Inc research team nevertheless experienced the mechanisms of social exclusion identified in RSBY as relevant points of attention in the further development and monitoring of RGJAY.

In Senegal – where the plan Sésame was designed to provide free health care to all aged over 60 with no other prerequisite than the presentation of an identity card – the CREPOS Health Inc research team was able to clarify to the policymakers how major portions of the elderly are still excluded from the programme's reach, from claiming services, and ultimately from benefits.

In Ghana, the ISSER Health Inc research team fine-tuned the SPEC-by-step tool further by breaking down the social, political and economic dimension of the SPECtacle into specific sub-dimensions, such as discrimination and deprivation, social markers/drivers of social exclusion, social capital, social participation (S), political resources, political and civic participation (P), economic resources, and economic participation (E).

Unpacking the black box

In all four study states/countries, answers on the 'who', 'how' and 'why' questions in all four SPEC dimensions were sought through a genuine mixed-method approach, starting with a survey-based quantitative strand and followed by a qualitative strand consisting of in-depth interviews and focus group discussions in an explanatory sequential design (Creswell et al., 2003).

For answering the 'who (is excluded)' and 'what (they are excluded from)' questions, household surveys were the most important tool and data source. The surveys were based on a comprehensive list of commonly agreed variables. Sampling was meticulously adapted to the local study context, as documented further on in the respective case-study chapters.

For answering the 'how (are people excluded)' and 'why (are they excluded)', the in-depth interviews and focus group discussions (FGDs) became more important as data collection and continuous analysis progressed. To get the most from the FGDs – and to avoid common misapplication of FGDs due to adaption of market research conventions unfit for social science – three capacity-building Health Inc Newsletters (17 September 2012; 1 October 2012; 31 October 2012) were dedicated to the subject. We modelled our FGDs to "allow participants to generate their own questions, frames and concepts and to pursue their own priorities on their own terms, in their own vocabulary" (Kitzinger and Barbour, 1999) and to "capitalize on the interaction within a group to elicit rich experiential data" (Asbury, 1995). We indeed expected a richness of data and were aware of the consequences. As Barbour (2007) puts it, "analysis then becomes more than simply plucking themes out of the data and involves a process of interrogating the data, contextualizing comments, developing tentative explanations and subjecting these to further interrogation and refinement".

To deal meaningfully with the ever-increasing volume and complexity of our data, we deliberately adopted a theory-oriented approach inspired by the realist concept of generative mechanisms (Chen and Rossi, 1989; Elster, 1989; Demetriou, 2009). Indeed, a theory-oriented approach is well suited in complex social systems: it takes into account the interaction between agency and structure and can provide plausible explanations as to how interventions have produced their results, in which conditions and for whom (Marchal et al., 2010). Having identified the need for the identification of generative mechanisms, a product of iterative abstraction linking explanans and explanandum (Astbury and Leeuw, 2010; Sayer, 2002), we dedicated an exploratory partner meeting (see Soors, 2013) and two Health Inc Newsletters (30 April 2013; 31 October 2013) to advance this analytical strategy. Considering social exclusion as the central process to understand, we thus moved beyond description to the identification of the process' mechanisms. The results of this inquiry will be presented in Chapter 11.

Endnotes

[1] Not to be confused with the 1992 Rio Declaration on Environment and Development, nor with the 2012 Rio+ Declaration on Sustainable Development.

[2] This was to some extent remedied when Solar and Irwin arrived at the 'Final form of the CSDH conceptual framework' (Solar and Irwin, 2010). The earlier framework had "social determinants of health and health inequities" throughout (CSDH, 2008, p. 43), whereas the newer one grouped "social determinants of health inequities" under 'structural determinants' leading to 'intermediary determinants' under which the "social determinants of health" than resorted (Solar and Irwin 2010, p. 6).

[3] PROGRESS stands for Place of residence, Race or ethnicity, Occupation, Gender, Religion, Education, Socioeconomic status and Social capital or resources (WHO, 2013). The acronym stems from the pre-CSDH era (see Gwatkin, 2007) and the resulting concept of 'equity stratifiers' is arguably restrictive when compared to the CSDH framework.

[4] "(A)lthough politicians, policy makers and other stakeholders may wish for a single composite index of 'social exclusion' derived from multiple data sources, this approach is highly problematic: theoretical concerns include the concept's multi-dimensionality and dynamism, while from a pragmatic perspective, there are potential pitfalls in developing rules for aggregation and weighting of data and problems with variations in the quality and availability of appropriate data" (Mathieson et al., 2008, p. 39).

[5] See http://www.socialsecurityextension.org/gimi/gess/ShowTheme.do?tid=1321

[6] We have used enrolled as a synonym for registered, and not as a synonym for cardholders (as in often the case in SHP studies) to avoid confusion. Unfortunately, not all enrolled people are cardholders.

[7] Note that 'claiming' here refers to claiming care, as in claiming a right (person-and people-centred), not to claiming reimbursement from an insurance scheme (finance-centred).

[8] Because the consecutive steps were now formulated in terms of "what is supposed to happen, but does not" (WHO, 2005).

[9] Tanahashi (1978) put forward a stepwise assessment of health service coverage from target population to ultimate goal, deconstructing service provision in the consecutive steps of availability coverage, accessibility coverage, acceptability coverage, contact coverage and effectiveness coverage. Tanahashi's categorisation has been influential in health services research and enjoys renewed attention in the actual debate on universal coverage (Evans et al., 2013).

[10] This people-centred perspective deliberately takes the analysis to a next level. While scheme-centred evaluations might for example detect low enrolment in rural areas due to registration in the day time, a people-centred enquiry will go on asking why scheme designers and implementers did not take into account that the poor have no other choice than to be busy in the field.

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PART II: Country Case Studies

CHAPTER 3: Who is excluded in Ghana's National Health Insurance Scheme and why: a social, political, economic and cultural (SPEC) analysis

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Background

Ghana is a low- middle-income country in West Africa with a land size of 238,537 km^2 and a population of 24.6 million people (GSS, 2012). The county's per capita income is estimated US$3,718. Ghana's economy since political independence in 1957 has been dominated by the agricultural sector in terms of employment creation and contribution to GDP. The dominance of the sector, which is characterised by subsistence agriculture and a major contribution of cocoa exports, has seen a decline since the 1990s. Ghana's major export commodities include cocoa, gold, diamonds, timber, horticulture and oil, while her major imports include capital equipment, petroleum products and foodstuffs.

In terms of human development, Ghana's performance is relatively low with vast disparities across the country. Ghana ranked 135th on the Human Development Index (HDI) out of 187 countries and territories in 2012 with a value of 0.558. The index, however, falls to 0.379 when it is adjusted for the level of inequality in the country. The life expectancy of the population is estimated at 64.6 years. Though Ghana's adult literacy rate of 65% is relatively high in Africa, the mean years of schooling is only 7.0 years. Only about 29% of the population has at least secondary education. The low human development is manifested in widespread poverty and deprivation among the population. About 28.6% of Ghana's population is estimated to be living below PPP US$1.25 per day, while 31.2% of the population lived in multidimensional poverty, while an additional 21.6% were vulnerable to multiple deprivations (UNDP-Ghana, 2013).

There is marked spatial development inequalities in Ghana between rural and urban communities as well as between northern Ghana and southern Ghana with respect to access to socio-economic services (Aryeetey et al., 2009). While access to improved water sources is generally good at 80%, only 10% of the population has access to improved sanitation facilities. For instance, while 91% of urban areas have access to improved sources of drinking water, the proportion was 69% in rural areas (GSS, 2012). Available data indicate that poverty is endemic in the three northern regions of Ghana where at least 6 in every 10 persons are poor (Aryeetey et al., 2009). A regional analysis of the multidimensional poverty index in Ghana also revealed that multidimensional poverty was much higher in the Northern region (80.9%), Upper East region (80.8%) and Upper West region (77.6%) (GSS, 2013). From a gender perspective, the gender inequality index (GII) for Ghana also reflects gender-based inequalities in reproductive health, empowerment and economic activity. Ghana's GII value of 0.565 ranked it 121st out of 148 countries in 2012 (UNDP-Ghana, 2013). Participation in the labour market is about 72% for men compared to 66.9% for women.

With these development inequalities in the country, certain groups of persons have been identified as being more likely to be socially excluded from participating fully in Ghanaian society. They include persons with insecure livelihoods many of whom are engaged in semi-subsistence food farming, migrant farm labourers and settlers, the elderly with no family support and pension, persons with disabilities with no employable skills, urban slum dwellers in the formal sector, and children in difficult circumstances, including street children and the poor (UNDP-Ghana, 2007).

The health sector in Ghana

Health care in Ghana is delivered through a system consisting of four categories of service providers. The health system is made up of public facilities, private for-profit facilities, private not-for-profit facilities and traditional medical practitioners. In terms of ownership, about 65% of all the health facilities in the country are publically owned. The private for-profit facilities represent 26.4% while the private not-for-profit facilities owned by religious groups represent 6.6%, but they have been estimated to provide about 42% of the total health services in the country (MOH, 2009). Quasi-government facilities mainly operated by the security services and the universities represent the remaining 2.1%.

The organisation and the administration of the health sector are done through a well-defined structure with the Ministry of Health (MOH) at the apex. The MOH is responsible for national health policy formulation, monitoring and evaluation, and resource mobilisation. It also regulates health services delivery. The Ghana Health Service (GHS) is also responsible for the implementation of national health policies and the management of public health facilities, but its activities excludes those of the teaching hospitals and the quasi-government facilities. The teaching hospitals provide tertiary services and also provide the highest level of medical education and research in the country.

At the regional level, every region has a Regional Health Directorate (RHD) to provide supervision and management support to the districts in the region. The region also has a regional hospital that provides specialised clinical and diagnostic care and serves as a referral hospital for the region. The District Health Management Team in each of the districts of the country is also responsible for district health planning, budgeting, management and supervision of facilities under its jurisdiction. The district has a district hospital that usually serves between 100,000–200,000 people in a clearly defined geographical area and could have between 50-60 beds. It provides mainly primary health care services and some secondary care and operates as the first referral hospital for the district.

At the base of the structure are the Budget Management Committees (BMCs), which are responsible for service provision at the sub-district and community levels. The sub-district is served by a health centre that provides primary health care and outreach services. The communities could also have rural clinics and Community-based Health Planning Services (CHPS) to provide basic preventive and curative services for minor ailments at the community level (MOH, 2009). All health facilities in the country need accreditation from the National Health Insurance Authority (NHIA) to be able to serve NHIS members.

Health financing in Ghana

Over the past few decades, Ghana has initiated various health sector reforms aimed at improving the overall health system and increasing access to healthcare services for all groups of people. Healthcare financing in Ghana has gone through many dynamics: recognition of free healthcare at the eve of independence in 1957, introduction of the nominal fee in the 1970s, and the initiation of cost-recovery mechanisms through user fees (traditionally known in Ghana as "cash and carry") in 1985. The latter was part of a broad strategy to reduce government spending on the health sector and curb the shortages of essential medicines and medical supplies. While the financial aims of the reform were achieved, it resulted in inequities in financial access to basic primary healthcare. For the poor, the "Cash and Carry" system of paying for healthcare at the point of service was a key financial barrier to accessing healthcare resulting in inequalities in access to health care with its attendant poor health outcomes. Unequal health care utilization in Ghana is greatly influenced by the socio-economic inequities. The unequal access to health care is a reflection of the sharp inequalities in Ghanaian society. In the late 1990s, the Government of Ghana declared its intention to abolish the system and began exploring the feasibility of introducing a national health insurance scheme to be managed at the district level.

In summary, health-care financing in Ghana over the years has come from a combination of sources including general taxation, financial credits, external assistance, out-of-pocket payments (user fees) and health insurance. Total expenditure on health as a percentage of gross domestic product (GDP) has increased from 4.8% in 2000 to 5.3% in 2011. Private expenditure on health as a percentage of total expenditure on health in Ghana is still high, though it has declined from 50.6% in 2000 to 44.1% in 2011 (WHO, 2014). Despite the presence of the NHIS, the ratio of household out-of-pocket payments for health to total expenditure on health, which was 47% in 2000 and 37% in 2009, is still higher than the WHO recommended threshold of 15-20% (Schieber, et al., 2012; WHO, 2010). This is an indication that many households in Ghana are making out-of-pocket payments for health.

An overview of the NHIS

The National Health Insurance Act (Act 650) was passed into law in 2003 with the main objective of increasing access to healthcare (by making it more affordable) and thereby improving health outcomes. One important feature of the NHIS is the establishment of the National Health Insurance Fund (NHIF). The purpose of the fund as defined in Act 650 is to provide finance to subsidise the cost of provision of healthcare services to members of district mutual health insurance schemes (DMHIS) licensed by the authority.

In 2012, a new law, the National Health Insurance Act 852, replaced Act 650 to consolidate the NHIS by bringing the operations of all the DMHIS under the NHIA to remove administrative bottlenecks, introduce transparency, reduce opportunities for corruption and facilitate effective governance of the schemes.

The NHIS benefits package covers over 95% of the most common and prevalent disease conditions in Ghana. This includes general outpatient and inpatient care, generic medicines, emergency care, comprehensive delivery care, diagnostic tests, oral health and eye care. Under the new Act, family planning commodities and services were included in the benefits package. However, highly specialised care such as organ transplants, dialysis for chronic renal failure and drugs such as HIV retroviral drugs (that are not on the NHIS drug list) are not covered by the scheme (NHIA, 2008).

Financing sources for the NHIS

The NHIF has five main sources that accumulate funds to operate the NHIS: the National Health Insurance Levy (NHIL), 2.5% social security deductions from formal sector workers managed by the Social Security and National Insurance Trust (SSNIT), Government of Ghana annual budgetary allocations proposed and approved by parliament to the NHIF, accruals from investments of surplus funds held in the NHIF by the National Health Insurance Council (NHIC) and grants, gifts and donations made to the NHIF (Figure 1). In addition to these are the voluntary contributions paid by subscribers to the various DMHIS. The contributions/premiums vary among the DMHIS. These contributions are retained at the district level for claims payment and administrative support at that level.

NHIS Coverage

The National Health Insurance Act exempts certain categories of persons from paying premiums to become members of the NHIS. The exempt groups under the Act include SSNIT pensioners, individuals aged 70 years or more, children under 18 years and indigents (i.e. the poor and destitute). In July 2008, pregnant women were also added to the exempt group.

According to the National Health Insurance Act (Act 650) of 2003, all persons resident in Ghana other than the Armed forces of Ghana and the Police service are required to belong to a health insurance scheme. So the entire population of the country is targeted by the NHIS. Though membership of the NHIS is mandatory, implementation has so far been voluntary due to the difficulty in enforcing the Act. People have to register once with the NHIS (i.e. the ever registered) by paying their required premium and registration fee unless they are exempted. To be active members of the scheme however requires that the ever registered members continue to renew their membership annually. It is therefore possible to find individuals who have ever registered with the NHIS but have lost their membership because they have refused to renew their status (i.e. the previous members). Some of the ever registered individuals may also be without valid NHIS cards because at a particular point in time they may be in the waiting period or due to failure of the NHIA to supply them with their card. Data from the NHIA indicates that only 36% of the national population of 24.6 million were active members (i.e. valid card holding members) of the NHIS in 2012. The regional distribution of the NHIS membership in 2012 is presented in Table 1.0.

Table 1.0: NHIS Subscribers by Region and Category, 2012

Region	Actives (2012 New + 2012 Renewals)			2010 National Population	Actives in 2012 as % of Total Population
	Informal	Exempt	Total		
Ashanti	582,104	954,453	1,536,557	4,780,380	32%
BrongAhafo	374,695	719,519	1,094,214	2,310,983	47%
Central	226,906	451,326	678,232	2,201,863	31%
Eastern	393,774	642,491	1,036,265	2,633,154	39%
Gt. Accra	464,066	736,681	1,200,747	4,010,054	30%
Northern	208,048	544,267	752,315	2,479,461	30%
Upper East	172,635	388,724	561,359	1,046,545	54%
Upper West	125,360	267,540	392,900	702,110	56%
Volta	281,581	452,817	734,398	2,118,252	35%
Western	324,776	573,994	898,770	2,376,021	38%
NATIONAL	3,153,945	5,731,812	8,885,757	24,658,823	36%

Source: NHIA as at June 4, 2013

About 65% of the active members of the NHIS were made up of premium-exempt groups with children under 18 years of age forming the bulk. Despite the broad range of exemptions, membership is lowest among the poorest socio-economic quintiles owing to the cost of registration and annual premiums (Sarpong et al, 2010; Jehu-Appiah et al. 2011; Asante and Aikins, 2008). Results from a recent national survey showed that the about 70% of women aged 15-49 years had ever registered with the NHIS compared to about 56% of men in the same group. The results further showed that urban dwellers were more likely to be registered with the NHIS while the proportion of the ever registered who did not have valid NHIS cards were higher among rural women (40.5%) and men (44.4%) (GSS, 2012).

Aim of the study

The aim of the study in Ghana was to understand why the majority of Ghanaians are not active members of NHIS and to explore the extent to which social exclusion could explain this. The study sought to identify the individuals and groups of persons who are more likely to be excluded from the NHIS due to socio-cultural, political and economic reasons.

Methods

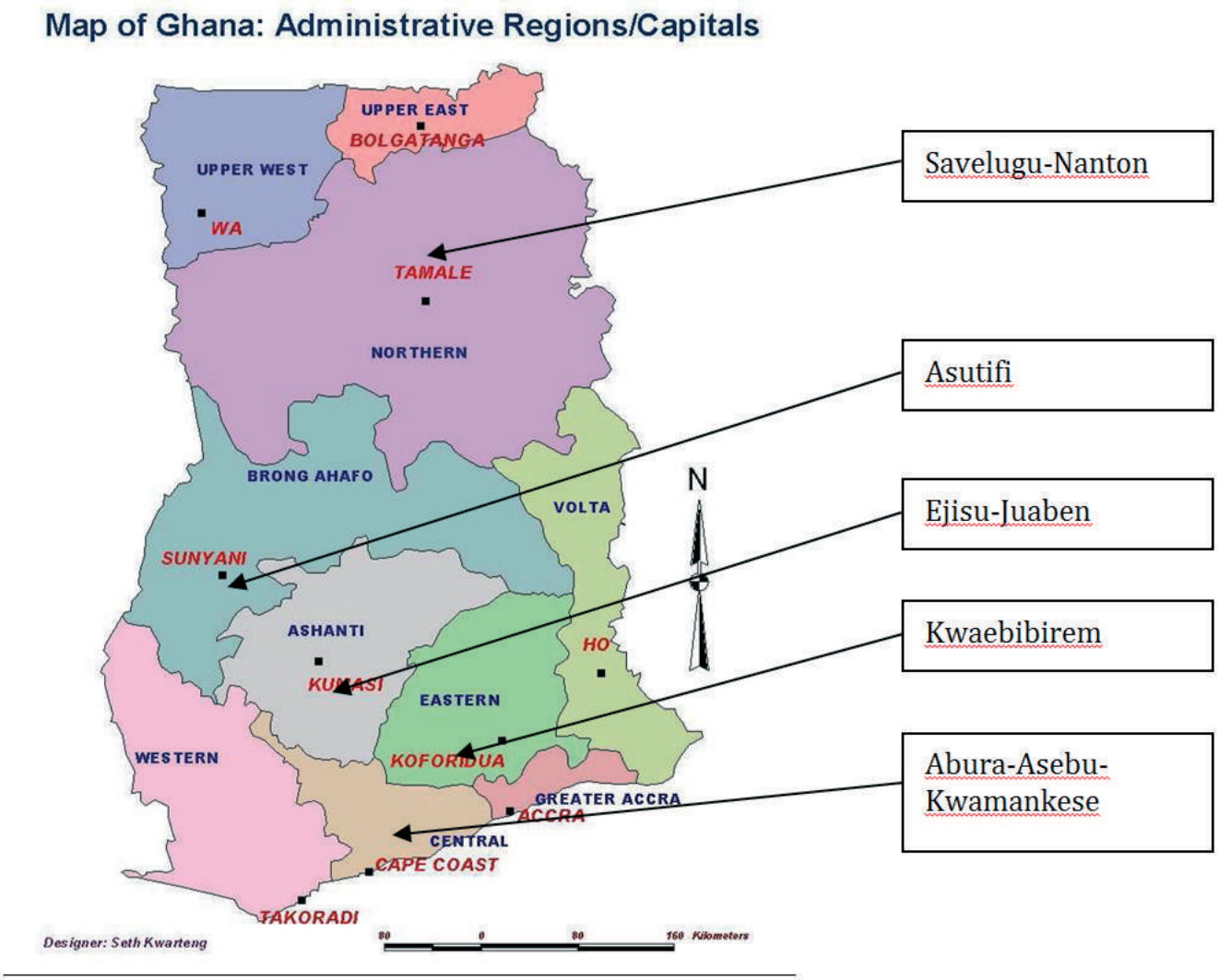
SPEC-by-step framework adopted by Health Inc. in Ghana

The Health Inc. research team in Ghana adopted the SPEC-by-step framework aimed at providing a simple yet structured checklist to guide our analysis of social exclusion in Social, Political, Economic and Cultural dimensions. The study used a mixed-methods approach involving both quantitative and qualitative tools.

Quantitative data collection

We collected data from 4,050 representative households in five districts covering the 3 ecological zones (coastal, forest and savannah) in Ghana. The household survey was conducted using Enumeration Areas (EAs) based on the 2000 Ghana Population and Housing Census for the selected districts. The five districts comprised: Abura-Asebu-Kwamamkese in the Central region, Kwaebibirem in the Eastern region, Ejisu-Juaben in the Asante region, Asutifi in the Brong-Ahafo region and Savelugu-Nanton in the Northern region (Figure 1). The household survey was used

to identify households and individuals who are excluded from the NHIS at each step – from enrolling to accessing healthcare. Two questionnaires were used for the quantitative study, namely the main household questionnaire meant for the household head and the SPEC pull-out questionnaire administered separately to the household head and the spouse if available.



The main household questionnaire gathered information relating to the socio-economic and demographic characteristics of the household members, their health status, NHIS membership status, reasons for non-membership, access to social services and ownership of assets and household consumption expenditure. The SPEC questionnaire, on the other hand, assessed the awareness and opinions of the household head or the spouse on specific social, political, economic and cultural factors that are likely to act as drivers of social exclusion. It also assessed their opinions on the NHIS. Both sets of questionnaires were pre-tested by ten trained research assistants before the main survey. The relevance, wording of questions, order of questions, multiple choices questions and average time needed per respondent were all assessed during the pre-test. Based on the results of the pre-test, modifications in the questionnaires were made.

Qualitative data collection and analysis

The qualitative analysis was used to understand the reasons why individuals were not enrolling and accessing healthcare, specifically exploring the role of social exclusion. First we conducted stakeholder mapping to identify and categorise key stakeholders. This was followed by focus group discussions (FGD). The purpose of the FGDs was to understand the perceptions of the socially excluded on the performance of the NHIS and to identify the barriers

they face at each step of the SPEC tool. Analysis of the FGDs aimed to indicate the extent to which social exclusion acts as a barrier at each of the SPEC steps (Table 2). Qualitative interviews were audiotaped using digital audio-recorders and transcribed into Microsoft Word for Windows. In select cases, the original word or phrase in Akan language was left in the transcript. Transcripts were reviewed and entered into NVivo 10, a qualitative software analysis package. The data was coded for analysis using QRS Nvivio 10 and exported into Microsoft Word for write up.

Table 2: Potential Target Groups for the Formation of Focused Groups

Targeted population (Potential targets–who?)	Type	#
Never insured	Voluntary exclusion Socially excluded (unreached)	2
Previously insured	Voluntary exclusion Socially excluded	2
Registered but yet to received ID card	Socially excluded	2
Currently insured (Valid card holders)	Non claimers (not using available services) Non-users (benefits not provided/received)	2
Total per district		8
Overall total (8 FGDs x 5 districts)		40

Results

A total of 4,050 households with 16, 178 members were interviewed from the five districts. The Savelugu-Nanton district in the Northern region accounted for 27.5% of the total household members. This was followed by Asutifi (19.7%) while the remaining three districts had a little over 17% each. The majority (53%) were urban dwellers compared to 47% in rural communities. About 53% of the total household members surveyed were females. Children under 18 years constituted about 48% while the elderly (≥70 years) formed just 3.8%. The remaining 48.5% were aged between 18-69 years (Table 3).

For the marital status of household members aged 15 years or more, the majority (56.8%) ware either married or had partners. The remaining were either divorced (6.2%) or widowed (6.6%) while 30.5% had never married. Close to 65% of the household members surveyed reported to be Christians, while 33% were Muslims. The remaining 2% either belonged to other religious groups or belonged to none. Not surprisingly, about 56% of the surveyed population were Akans, because the Akan ethnic group dominated 4 out of the 5 districts surveyed, which is the dominant ethnic group in Ghana. The Mole-Dagbani, who are mostly found in Northern Ghana, represented 29.5% of the sample. The remaining belonged to other minority ethnic groups including a few non-Ghanaians. For household members aged 6 years or more, about 77% reported to have attended school. Just a little over half (35%) reported to have completed junior high or middle school (9-10 years). About 19% had completed primary school (6 years) while 35.2% had less than 6-years primary education. Only about 11% had secondary or higher education. The mean years of schooling for household members aged 6 years and above was 7.0years. The AAK district (6.9 years) and the Savelugu-Nonton district (5.5 years) had means below the total sample mean, while Kwaebibirem had 7.2years, Asutifi had 7.3 years with Ejusi-Juabeng having the highest of 7.7 years.

In terms of households' socioeconomic status, about 18% were in the lowest wealth quintile, while 19.9% were in the highest wealth quintile. About 21% were in the middle quintile.

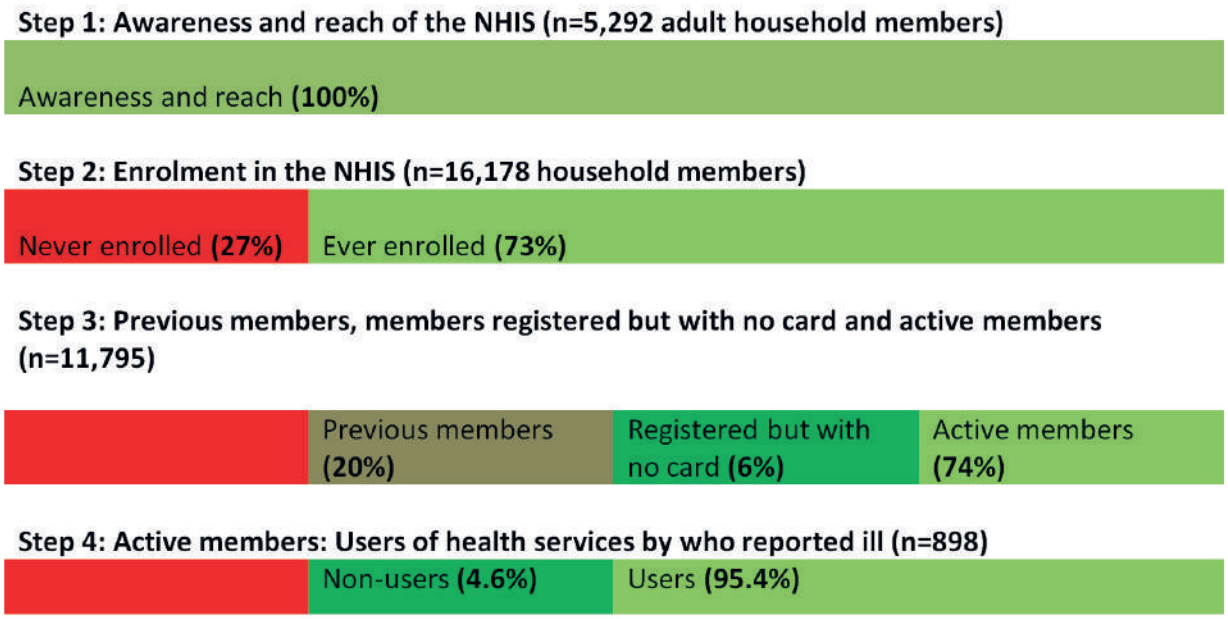
Table 3: Summary Description of the Sample

Characteristics	Frequency (n=16,178)	Per cent (100%)
Sex		
Male	7,537	46.6
Female	8,641	53.4
Age		
Children (under 18 years)	7,716	47.7
Adult	7,830	48.5
Elderly (≥70 years)	608	3.8
Marital status (≥15 years)		
Never married	2,843	30.5
Married/in union	5,291	56.8
Divorced/separated	573	6.2
Widowed	614	6.6
Religion		
Christian	10,503	64.9
Muslim	5,341	33.0
Traditional	104	0.6
None	194	1.2
Other	15	0.1
Missing	21	0.1
Ethnicity		
Akan	8,976	55.5
Ga/Dangme	467	2.9
Ewe	781	4.8
Guan	77	0.5
Mole-Dagbani	4,781	29.5
Other	1.039	6.8
Highest school grade completed (≥6 years)		
Pre-school	3,202	35.2
Primary	1,681	18.5
Middle/Junior High school	3,152	34.6
Senior High school	656	7.2
Vocational/Technical sch.	130	1.4
Post secondary or higher	275	2.8
Don’t know	19	0.2
Mean years of schooling (≥6 years)	9,725	7.0
Wealth quintile		

Characteristics	Frequency (n=16,178)	Per cent (100%)
Lowest	2,980	18.4
Second	3,218	19.9
Middle	3,343	20.7
Fourth	3,414	21.1
Highest	3,223	19.9

Results from the SPEC-by-step tool captured social exclusion in the NHIS across demographic indicators, health status and healthcare utilization (see figure 3). For constructing the tool, we broke up the NHIS into a cascade of steps, each step excluding certain types of people (Figure 2).

Figure 3: SPEC-by-Step Analysis



In discussing the reasons behind people's decision to enrol or not with the NHIS, it is important to understand the SPEC dimensions of exclusion in Ghana that affect people's access to health-financing mechanisms and their ability to access healthcare when needed. These dimensions are discussed below.

Socio-cultural Dimension

The results of the household survey showed that nearly 73% of household members had ever registered with the NHIS since its inception in 2005. This suggested that awareness of the NHIS was high among the populace. About 54% of the household members were active NHIS members (currently insured) during the survey. The results showed that the currently insured had a high proportion of females, married individuals and urban dwellers although the five districts studied were generally rural.

Twenty-three (23) per cent of the never insured claimed that they did not need health insurance because they never got sick. This reason was also given by 15% of those who had withdrawn their membership. While awareness of the NHIS was quite high, many people did not understand the principle of health insurance. The never insured had a negative perception of the NHIS, concluding that health insurance was meant for the poor and the sick. Additionally,

41% of the adult household members who responded to the SPEC questionnaire belonged to a social organisation compared with 34% of the never insured. This suggested that the never insured had limited social capital and a limited understanding of the importance of the entire community's contribution to the scheme, which serves to help other people when they fall sick. Finally, cultural practices and social hierarchies in Ghanaian societies are closely bound, with historical origins that determine social interactions.

Political Dimension

The political dimension includes the unequal access to social services such as healthcare, education, water and sanitation that exists between rural and urban areas. The results showed that the never insured had to cover longer distances to reach the nearest educational, health and transport infrastructure and services. Some respondents also complained about the long distances to NHIS registration centres. This can affect the decision to enrol with the NHIS. as people are hesitant to pay for services that are unavailable or difficult to access. One of the major barriers to healthcare in Ghana is physical inaccessibility to health facilities for a large proportion of the population. The Ghana Human Development Report of 2007 identifies spatial polarisation as a major driver of exclusion (UNDP-Ghana, 2007).

Unequal power relations between medical professionals and their patients and lack of trust in medical staff can discourage people from accessing healthcare from health facilities and therefore affect their willingness to enrol in the NHIS. Disrespectful, discriminatory or culturally inappropriate practices by medical professionals and their organisations play a role in why some people are excluded from accessing health services and receive poor quality of care. This brings to the fore the issue of power relations and trust. Although the age and sex of a doctor or nurse did not matter to the currently or never insured, a higher proportion of the never insured felt their concerns, questions and feelings were not taken seriously by medical staff, and a lower proportion of the never insured strongly agreed that they were treated with respect at the health facility. A few individuals had withdrawn their membership from the NHIS or had decided not to enrol with the NHIS because of a lack of trust in the scheme and bad experiences with health professionals in the past.

Economic Dimension

Economic status was a major determinant of why some people had never insured with the NHIS or why some of them had withdrawn their membership. About 54% of the never insured and 51% of those who were yet to receive their registration cards were in the bottom two wealth quintiles compared with 29.8% of the currently insured and 37.4% of the previous members.

Active membership was higher in well-endowed districts like Kwaebibirem and Asutifi and lowest in Savelugu-Nanton and Abura-Asebu-Kwamankese, which have higher levels of poverty. Active membership was also higher among households in the higher wealth quintiles. Forty-eight (48) per cent of the never insured and 44% of the previous members attributed their non-membership to NHIS premium/registration fees, which they perceived to be expensive. Again, 9% of the never insured and 12% of the previous members reported that they did not have the money to pay the premium/registration fees. It is important to note that about 52% of the never insured engaged in agriculture compared with 44% of the currently insured who were small-scale food crop producers. The small-scale food crop producers are one of the poorest groups in Ghana (UNDP-Ghana, 2007).

Conclusion

As countries try to achieve universal healthcare coverage by introducing prepayment programs, Ghana has made some amount of progress with the NHIS. Though membership of the NHIS is expected to be mandatory, implementation has so far been voluntary due to the difficulty in enforcing the Act. A smaller insurance pool means fewer people are sharing the risks and a higher burden is on those able to pay the premiums. In spite of the expanded programme in exemptions, this study has shown that there are some groups of people who are unable to access health services due to financial constraints and geographic access to health facilities. Physical inaccessibility to health facilities was identified as one of the major barriers to health services. and this has the potential to affect the decision by households to enrol with the NHIS.

Although the level of awareness of the NHIS was clearly high among the populace, it seemed that many people did not understand the principle of health insurance. Those who had never insured or had been previously insured felt that health insurance was meant for the poor and the sick. Also, unfavourable power relations and lack of trust can discourage people from accessing healthcare from health facilities and therefore a low desire to enrol with the NHIS.

Although the NHIS has attained noteworthy achievements in providing healthcare to Ghanaians, there is still the major challenge of extending coverage to the poor and vulnerable population segments that are currently excluded. In terms of policy, this study has highlighted the need for extensive educational and public awareness programmes to improve the perception of the NHIS and the principles underlying insurance to encourage more people to join the scheme. It is expected that individuals with high social capital are more likely to enrol in the NHIS because they appreciate the solidarity concept behind voluntary insurance schemes. Educational and registration campaigns could target social groups such as religious groups and traders associations. Groups exempted from contributing should also be made aware of their status with special efforts to register them. Geographical exclusion is an issue for the NHIS – registration centres should be more accessible and transportation facilities should be provided in areas excluded because of their physical distance from health facilities. Improvement in the provision of more health infrastructure in hard-to-reach areas would be an added advantage.

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CHAPTER 4: Senegal and Plan Sésame

Alfred Ndiaye, Maymouna Ba and Werner Soors

This chapter describes and analyses Plan Sésame, an exemption scheme from healthcare payments targeted at the elderly in Senegal, from a social exclusion perspective. We first describe the general background of Senegal and its social security system with a focus on social health protection. We then briefly discuss Plan Sésame and our study methods. After presenting and discussing our study results, we explore the possibilities of making Plan Sésame more inclusive.

Background

Senegal is a relatively small country (196,712 km2) bordering the Atlantic coast in West Africa. Its population of roughly 13 million (ANSD, 2013) is concentrated in the west of the country, with 7,748 inhabitants/km2 in the capital region of Dakar and only 15 inhabitants/km2 in the eastern region of Tambacounda. Senegal has a young age structure, with 42.1% of the population under 15 years and only 3.5% over 65. Today, the urban population (58%) outnumbers the rural population. While being a multi-ethnic society, Islam is the predominant religion (94%) with Islamic communities typically organized in Sufi orders or brotherhoods and playing a key role in social life.

In mainstream economical terms, Senegal is classified as a low-income country with a high poverty headcount. Applying a broader concept of development, Senegal is still categorized as a low-human development country: its Human Development Index ranks it at 154th place among 186 countries (UNDP, 2013). Men have on average six years of schooling; women score lower with four years of schooling. Overall, gender disparities – including schooling – exclude women from decision-making and deprive them of employment opportunities. More than two thirds of all workers are to be found in the informal sector; 34% of all workers earn less than $1.25 PPP a day. Again, poverty is highest among women, and concentrated in rural areas. Social security coverage as percentage of employment is only 5.1% (ANSD, 2011; ANSD, 2013; RdS-MEF, 2004; RdS-MEF, 2006; World Bank, 2013).

Not unsurprisingly then, the greater part of the Senegalese population lacks access to basic social amenities. In rural areas, more than half of the population is in a precarious situation with nearly 40% having no access to tap water. While some improvements has been made over the last decade – for example in access to education – inequalities between regions, between urban and rural areas, between socio-economic groups and between men and women are still manifest (RdS-MEF, 2009; Diagne, 2012).

Access to health services is particularly difficult for large segments of the population. In rural areas, over 58% of the population is more than 30 minutes from the nearest accredited health facility; even in the capital region, this is the case for nearly 43% (RdS-MEF, 2004). Barriers to access to care are numerous, but transport difficulties related to distance and poor quality of roads remains a major constraint.

Despite this bleak picture, the Senegalese still value solidarity and mutual assistance as core values. Each individual is connected to a network of communities that evolve around a standard of cultural life and religious beliefs. The proliferation of all kinds of associations contributes to the development of relational networks and social networks. The more one broadens the horizon of his personal, family, or ethnic brotherhood, the more one gives oneself ways to escape from poverty. However, traditional Senegalese society has a strong hierarchical organization that does not promote equality of opportunity and reduces the potential dynamic of solidarity and support. Most ethnic groups still have caste-like social stratification. In rural Senegal, the expanded family is still the norm, whereas in urban areas an evolution towards nuclear families and individual lifestyle is noticeable (Pilon et Vignikin, 1996). Massive rural-to-urban migration often means that the elderly become house guardians in many villages (Demonsant, 2007).

Social health protection in Senegal

Social health protection in Senegal places great emphasis on the formal sector, while 70% of the workforce operates in the informal economy. Three sub-systems can be distinguished: formal social security, alternative systems of healthcare financing (community health insurance and targeted exemptions), and informal mechanisms of social protection.

Formal social security is compulsory for civil servants and private-sector wage earners and managed by either the Ministry of Economy and Finance or mutual companies called Disease Providence Institutes.

Two types of alternative health-care financing systems operate in Senegal. First, and for more than a decade now, Community Health Insurance (CHI) schemes aim to offer coverage to those left aside by formal social security and is based on voluntary contributions. While more widespread than in other West African countries, CHI in Senegal still only covers 4% of the total population (Soors et al., 2010) Second, the government has started various subsidised targeted exemption programmes with the ambition of reaching the most vulnerable groups. These interventions, however, have great difficulties in reaching their recipients: a significant proportion of the poor continue to be excluded from health services. Informal social security mechanisms can still be found in villages as well as urban communities. These solidarity funds are used to help members cover medical or funeral expenses.

To this scattered and inefficient amalgam of social health protection initiatives is added a health service delivery system that is characterised by a lack of staff, in both qualitative and quantitative terms, and predominantly focused on maternal and child health. The combined deficiencies of the Senegalese social heath protection and health service delivery systems generate barriers to access to care for the population in general and for the elderly in particular. The elderly – defined as people over 60 in Senegal –today constitute less than 5% of the total population due to a lower life expectancy, but are expected to make up 9% by 2050. In spite of their greater need for health care, most elderly do not have any health protection coverage.

The elderly and Plan Sésame

Since 1980, associations representing the elderly have voiced their demand for free access to health care. Two decades later, in 2006, the government announced Plan Sésame. It thereby responded to the precarious socio-economic situation of this population group, as widespread household poverty in households no longer encourages communities and families to take care of their elderly.

Plan Sésame targets all Senegalese citizens aged 60 and older, whether they are retirees of the formal sector or not. Nearly 70% of its beneficiaries are old people without shared financial resources, with neither pension nor health coverage. Plan Sésame is financed by both the government and the private sector (IPRES, Institut de Prévoyance Retraite du Sénégal, a private institution, under state supervision, responsible for pensions in the formal sector). Launched as an initiative of the Presidency, a range of actors are involved in the management and implementation of the plan: the central Ministry of Health, regional and district health offices, hospitals, and the national medical stores. Access to services through Plan Sésame is based on the possession of a national identity card. Services are covered at government health posts, health centres and hospitals, following the habitual reference procedures of the health care delivery system. The initially comprehensive benefits package – including diagnostic tests, hospitalization, surgery and drugs – was substantially scaled down from 2009 due to a lack of financial resources.

Methods

Within the Health Inc consortium, we adopted the SEKN concept of social exclusion as a dynamic and multidimensional process. We studied social exclusion within Plan Sésame along its four dimensions – social, political, economic and cultural –applying the SPEC-by-step tool developed by the research consortium as described in Chapter 2. This has facilitated the analysis of differential access to care, the identification of groups of elderly excluded at each stage of the process, and an explanation of how these people come to be excluded.

Adapting the general Health Inc research framework to the local context, based on the main assumption that lifting financial barriers is not necessarily sufficient to counteract social exclusion, six general and four specific research questions were formulated:

(1) What are the reasons for the poor performance of Plan Sésame as a health financing mechanism?
(2) What does social exclusion of the elderly in Senegal mean and how is it manifested? What are its key indicators?
(3) Is social exclusion an obstacle to the development of health-care financing for the elderly who work in the informal sector, and – if yes – to what extent?
(4) Does the implementation of Plan Sésame reduce social exclusion of the elderly or, on the contrary, increase it?
(5) To what extent has Plan Sésame been able to reduce social exclusion in Senegal?
(6) What is the ability of policymakers to increase social inclusion through health-care financing in Senegal?
(7) How has Plan Sésame been perceived at different levels and in different sectors of the health system?
(8) To what extent did information on Plan Sésame reach the intended users?
(9) What was the effect of Plan Sésame in the use and quality of health care?
(10) What was the effect of Plan Sésame on household expense in health care?

To answer our research questions, we applied a mixed-methods approach, encompassing literature review, actor mapping, household survey, semi-structured interviews and focus group discussions. Quantitative and qualitative data and analysis were combined to deal with all dimensions of exclusion and older people's access to care.

We conducted our field research in four administrative regions: Dakar, Diourbel, Matam and Tambacounda. The sites were selected following rational criteria relevant to the subject of our study: (1) urban/rural stratification; (2) access to a health facility; (3) poverty levels; (4) size of the population aged 60 and over; and (5) existence of a hospital to take care of Plan Sésame beneficiaries. The selected sites have both urban and rural areas (with the exception of Dakar) and are culturally and ethnically diverse. They include 41% of the population, 29% of total area and 38% of the elderly in Senegal.

The household survey

The household survey was intended to find out who, among the elderly, was excluded and from what parts of access exactly. We used random sampling, ending up with 2,998 households with at least one old person in every household. Our sample is representative of the population aged 60 years and over and was allocated proportionally to the number of the old people living in each site.

The framework of the National Agency of Statistics and Demography (ANSD, Agence nationale de la statistique et de la démographie) was used to distribute households within the sites. This framework divides each department into several census districts. Within the selected households, we targeted the head of household and one person aged 60 and over living in the household. Informed consent was obtained from each targeted individual. Of the total sample, 98% were completed, corresponding to 2,933 elderly among 31,710 household members. For data entry we used CSPro software; for data analysis (descriptive statistics and statistical inference), SPSS.

Semi-structured interviews and focus group discussions

We conducted a total of 80 semi-structured interviews – 34 with individual elderly and 46 with health system actors – and 19 focus group discussions with members of associations or groupings of elderly. The semi-structured interviews and focus group discussion were intended to find out how and why the elderly are still excluded. In a sequential mixed-method setup, the qualitative strand (semi-structured interviews and focus group discussions) of our research was thus designed to make sense of, and deepen the results of, the quantitative strand (the household survey). Informed consent was obtained.

We performed an essentially qualitative data analysis of all 99 transcripts applying deductive coding using NVivo software.

Results

The households we surveyed are large, each with an average of 10.8 members, and relatively young: members aged under 34 represented 68% of the total. Theelderly make up 12% of all members. The masculinity ratio (number of men per woman) is 0.93. Heads of household are relatively old: 74% of them are aged 60 or over while only 7% are under 40. Living conditions in households are difficult: 38% of household heads earn less than €127 per month, while the monthly food expenditure of more than half of them already exceeds this amount. Average household monthly health care expenditure does not exceed €13 for half of the households.

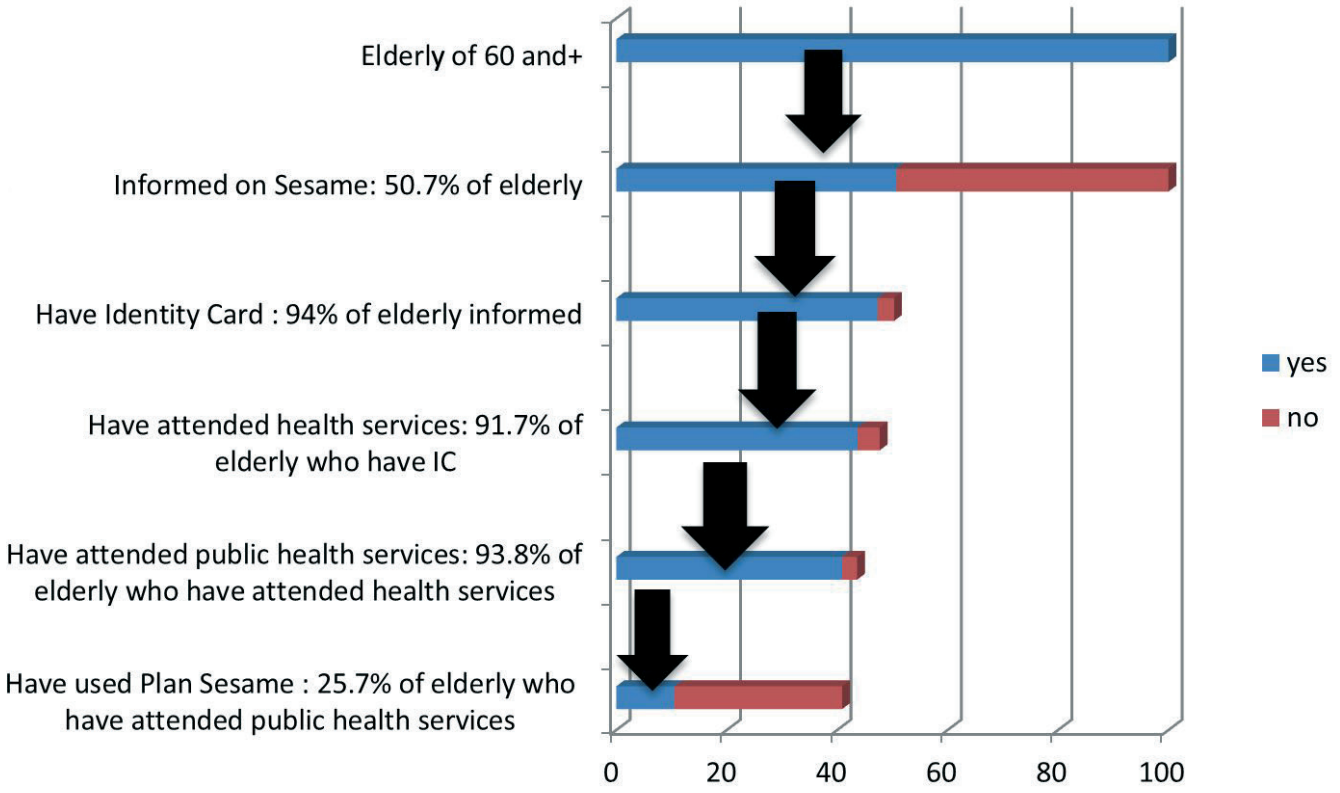
Slightly more than half (51%) of the older people we surveyed live in rural areas, 59% are married and 37% are widowed. Most of them are illiterate (73%). Nearly 60% are less than 70 years old; 12% are over 80, and most of the dependent elderly are to be found in this age group. They live with their grandchildren, siblings, relatives, stepsons and stepdaughters, or with unrelated persons who constitute 40% of the household members.

Of the elderly surveyed, 42% still earn a living from agriculture or small business, and 45% claim to be self-supportive. However, 73% of the are fully or partially supported by their children. Only 63% of the elderly receive a pension, which is less than 50,000F CFA (€76) a month. Of all older people surveyed, 20% have a monthly income of less than 50,000 F CFA (€76) and 62 % less than 100,000 F CFA (€152). Nearly 70% of the elderly do not have any monetary or in-kind savings. A large part of the elderly's expenditure is dedicated to food (39%) and health care (23%).

The health status of the elderly surveyed is clearly a reason for concern: 52% were ill or injured in the two weeks preceding the survey; 24% suffer from a chronic condition; and 10% have a disability. A narrow majority of elderly (58%) has therefore sought medical attention, mainly in public health facilities (71% of visits). Health posts, health centres and hospitals are all visited with health posts being the most frequent first resort (35%) followed by hospitals and health centres. When visiting a health facility, outpatient care was rated satisfactory by 52% of users and inpatient care by 67%. Access to health care is not always easy for the elderly: 42% could not access any health facility, of which 12% had unmet hospitalisation needs. Lack of financial resources was the most mentioned reason for not accessing health services (57% forwent outpatient care; 74% forwent inpatient care). Overall, only 5% of the elderly declared they were able to financially support their health care needs. Distance is another problem: in rural areas, a majority of the elderly judged the nearest health facility too far to walk (hospital 65%; health centre 54%). The elderly frequently referred to feeling helpless, facing long queues in the health facilities and repetitive appointments causing endless and painful back-and-forth journeys.

To understand how and to what extent Plan Sésame did or did not remedy the access deficit of the Senegalese elderly, a closer and more structured look is needed, which is provided by applying the SPEC-by-step tool (see Figure 1).

Figure 1: Plan Sésame's SPEC-by-step



At first sight, our SPEC-by-step tool reveals that Plan Sésame performed badly from the very start, largely lacking the necessary material to inform its potential beneficiaries. Nearly half of the elderly are unaware of the plan's existence. Among those who were informed, 67% still do not know how the plan operates and, particularly, what services are offered. In the end, only 10.5% have received needed and covered services.

Remarkably, the typical profile of an old person who received a full benefit of Plan Sésame is that of an educated man in an urban area, retired from the formal sector. This should be interpreted as a typical example of the so-called Matthew effect or inverse care law, referring to more uptake of services by those who need it less, and less by those who need it more (Deleeck et al., 1983; Tudor Hart, 1971).

Of those who ultimately benefited, 83% judged that Plan Sésame had reduced their health spending. This might explain why Plan Sésame is seen as a useful initiative by a more vocal part of the population, whereas it suffers from a negative image among the poor elderly whom we surveyed.

Discussion

Our study has allowed us to better understand the marginalisation and exclusion of the elderly in Senegal. There is no doubt that the specific social, political, economic and cultural circumstances of the elderly, as a social category, make them particularly vulnerable and easily marginalized. In addition, the social status of the elderly is gradually deteriorating in terms of respect received from younger people and in terms of social participation. The traditional role of the elder head of household, proudly assuming responsibility for his offspring, is waning. Economic crisis and subsequent impoverishment and deepened poverty are a heavy burden for the traditional solidarity networks and particularly affect social support for the elderly within the family, as witnessed by several of the interviewed. Most importantly, one in two of the elderly people interviewed expresses suffering from loneliness as a major concern, despite still being surrounded by a family.

To this core social dimension is added the political dimension of exclusion, where policymakers dedicate insufficient resources for the specific needs of the elderly – thereby maintaining structural and agency-related causes of access deficits. Illiteracy remains unaltered. Space for civil and political participation of the elderly seems not to be widening, but narrowing.

As mentioned before, the elderly not only face economic difficulties, they often are economically dependent on others, be they family (73%) or not, which again increases the likelihood of marginalisation in times of financial hardship and shifting societal values.

Culturally, the elderly have a hard time. They have considerable difficulties to cope with, such as the effects of urban migration and the gradual loosening of family ties. Besides expressing loneliness, one in two are pessimistic about the future of their offspring. Nearly three in four seek refuge in religious activities, mosques and churches as a last resort.

Can Plan Sésame be made more inclusive?

It is clear from the analysis that the mechanisms – in the social, political, economic and cultural spheres described above – that increase marginalization of the elderly and ultimately reinforce their exclusion are equally at work in society at large as within Plan Sésame. Bringing down incidences of social exclusion among the elderly will thus need multi-sectorial and sustained efforts over and above improvements in Plan Sésame. In the health sector itself, substantial improvements are also needed on the supply side.

That said, there is certainly room for improvement in Plan Sésame, that until now has been seriously underfunded, poorly implemented and resulted in improved access for a very limited proportion of Senegal's elderly – i.e. not representing those most in need. Funding and implementation can certainly be improved provided there is political will. The number of beneficiaries should then be increased, with particular attention to be paid to the elderly from households in the informal sector who today still have no health coverage at all.

The key actors from Plan Sésame we interviewed all agree that improving Plan Sésame only is not sufficient: such effort must be complemented by other social policies. They also voice a number of major recommendations.

First, they stress the need to fight against the economic insecurity in which older people live. Government and associated pension institutions must contribute to improve the living conditions of the elderly by generalizing and increasing pensions. They also see a role for private actors, associations and NGOs to target social programmes at the elderly, particularly the poorest.

Second, facilitating the elderly's access to health services is also seen as an urgent need – beyond the financial contribution of Plan Sésame. To do so, the government could develop a specific programme for the elderly to improve hospitality in the health facilities, as well as the availability and affordability of drugs in health-care facilities, specifically so for those chronic conditions most suffered by the elderly

Third, the training of health staff should be enhanced in order to take better care of the basic needs of both health care and social support of the elderly. It is hoped for that staff will then be more empowered to respond adequately to the needs of the elderly, including the outcomes of marginalisation and exclusion.

Finally, with regard to Plan Sésame , all actors agree on the need to resume and maintain funding on the one hand and to establish a dedicated and effective administration on the other. This agreement reached, it is now time to deliver.

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CHAPTER 5: Maharashtra case study summary

Soumitra Ghosh

Introduction

Marx postulated that "The history of all hitherto existing society is the history of class struggles" (Marx and Engels, 1848). But many scholars engaged in dalit studies assert, "the history of hitherto existing society in India is the history of caste struggles" (Gait, 1913; Ghurye, 1961; Kancha Illaia, 1993; Omvedt, 2012). Though the debate about the root cause of such social setting in India remains inconclusive, there is little disagreement over the fact that, in Indian society, certain social groups and religious minorities such as Dalits, Adivasis and Muslims have been facing exclusion, discrimination and deprivation for generations. This phenomenon remains unabated even after the Indian constitution prohibited identity based discriminatory practices. Like other states, caste based discrimination is not uncommon in Maharashtra, as is evident from the recent violence against specific castes in the state (Khairilanji incident).

According to some scholars, recent economic reforms have made some impression on the existing caste system in India by dismantling the age-old tradition of not pursuing occupations that are considered to be lowly for those belonging to higher castes. Similarly, those on the lower rungs of the caste hierarchy are now able to participate in occupations that were earlier restricted to higher castes (Prasad, 2008; Kapur et al., 2010). However, these observations cannot be generalized, as the traditional association between caste and occupation continues to persist in India (Beittile, 2012; Omvedt, 2012). As a result, there is still a strong correlation between caste and economic status (Deshpande, 2000; Thorat and Newman, 2009; Chaudhury, 2012), considered to be a cause of exclusion from access to productive resources such as land, education and health (Desai and Dubey, 2012).

Further, a major concern is that the high economic growth achieved during the past two decades also led to higher levels of income inequality in all social groups, including those belonging to the traditionally discriminated groups such as Schedules Caste (SC), Scheduled Tribe (ST)1 and Muslims (Thorat and Dubey, 2012). These vulnerable groups continue to fare poorly in terms of developmental indicators than the general population (Desai and Dubey, 2012; World Bank, 2011). For example, in 2011-12, the poverty rate among STs was 54%, more than three times the rate for all groups in Maharashtra (Panagariya and More, 2013). Not surprisingly, vulnerable groups have far worse health outcome indicators than others (IHDR, 2011). For instance, the tribal children aged between 1 and 4 years have significantly higher mortality rate than non-tribal children (World Bank, 2011).

Indeed, access to health care for poor and vulnerable groups is constrained by financial reasons: non-availability of public health services, discrimination by the privileged and other barriers (Baru, 2010; Shivakumar, 2011; Thorat, and Sadana 2009; Sabharwal, 2011). In fact, despite being sick, more than a quarter of the poor did not seek health care at all in 2004, citing some of the aforementioned reasons (Ghosh, 2014). Often, a major untreated illness results in losing a job, income source, the indebtedness of household or the death of the earning member in the family. All of these result in a chronically poor status of the family and increase their risk for social exclusion, as they are less likely to receive adequate education, be less aware, less empowered and have low social and political standing (Pathak et al., 2010).

Overview of Maharashtra's health system

Not much is known internationally about Maharashtra's health system. With a gross domestic product per capita of $1368, Maharashtra is a lower-middle income state in India. But with a population of 112 million, it is almost equivalent to Mexico, the eleventh most populous country in the world. Maharashtra covers over 308,000 km2. It is the second largest state in terms of population and third largest state by area; it also happens to be the most industrialized state in the country. Table1 provides some key indicators. The incidence of poverty stands at 25%. As can be seen from the table 1, the population belonging to (SC) and (ST) is substantial.

In India, health is the responsibility of the state, local and central governments. Curative health services are provided by both public and private facilities. The private sector plays a dominant role in the provision of outpatient and inpatient services: in 2004, 79% of Maharashtra's citizens resorted to a private source of outpatient care, while 67% resorted to a private source of inpatient care (Ghosh 2014).

The private sector comprises private hospitals, polyclinics, nursing homes, dispensaries and general physicians. Although the public sector's contribution in terms of providing health care is diminishing, it still has the largest network of health facilities. Both urban and rural areas of Maharashtra are served by a decentralised public health system operating at three levels of care: primary, secondary, and tertiary.

Table1. Key indicators of Maharashtra, India

Indicator	Maharashtra
Population (2011)	112 million
% of SC population (2011)	11.8
% of ST population (2011)	9.3
% of Muslim population (2011)	13.4
Annual Population Growth Rate (2001-2011)	1.6%
Per capita State Domestic Product (2010-11)	$1368
Poverty headcount 2009-10	24.5
Doctor-population ratio	1:1382

Indicator	Maharashtra
Bed-population ratio	1:1200
Life expectancy at birth (2011)	73.4 years
Infant Mortality Rate 2011	25
Maternal Mortality Rate (2007-09)	104
Child malnutrition rate 2012 (% of children below 2 years old)	22.8%
Per capita public health expenditure	$7.77

1$=Rs.61; Source: 1, 2. Census 2011, Registrar General of India, New Delhi;

3. GOI, Ministry of Finance, Economic Survey 2011-12.

4, 5, 6. Sample Registration System 2012, India

In its first decades after independence, India had a top-down approach for developmental planning and programme implementation. The first effort to replace this occurred in 1993 in the form of an amendment to the constitution. The 73rd amendment made some fundamental changes in the governance structure of the country. For the first time, it provided legal recognition to the 'Panchayats', which had existed for centuries as a traditional local governance body. It defined the Panchayati Raj Institutions (PRIs) as a three-tier system of local government. One of the key provisions of the 73rd amendment was the participation of the SCs and STs in the local administration. However, in Maharashtra, the level of participation of SC, ST and OBCs in PRIs is not proportionate to their percentage of population. The representation in PRIs is even lower than in many states, such as West Bengal and Madhya Pradesh (Ventatesu in 2005). The denial of equal participation of these vulnerable groups at the panchayat (local government) level implies lack of political voice, leading to potential exclusion from access to public resources such as education, health and social welfare programmes.

The act also created a major provision through which the state can devolve as many as 29 subjects, including health, to PRIs. All these measures concerning fiscal decentralisation are being looked at as an attempt to enable the government and the rural community to interact closely, thereby making development more locally sensitive and participatory (Shekhar et al., 2006). In other words, this was an important step towards strengthening the voice of the rural poor.

In accordance with its policy of promoting decentralisation, the central government designed the National Rural Health Mission (NRHM2) in such a manner that many of its activities are intricately linked to PRIs. For example, Village Health, Sanitation and Nutrition Committee (VHSNC), a key element of NRHM, is formed and managed by the 'Gramsabha', or village council, which is a part of the PRI. VHSNC has a mandate to monitor health at community level and government health-related initiatives, develop village health plans, and create awareness in the community about health services etc. Thus, the PRIs now have a say in the allocation of resources and the delivery of health services in accordance with the needs of the community.

Health financing

Public health investment is very low in India, and Maharashtra is not an exception. The states make the major contribution to public health spending followed by central and local governments. The total per capita public-health spending in Maharashtra turns out to be only US $ 7.7. Hence, out-of-pocket (OOP) payments have been the main source of health financing in Maharashtra. This considerably impedes access to health care. According to one estimate, one-tenth of Maharashtra's population did not seek care at all due to financial constraints in 2004, thereby exposing themselves to health risks (author's own estimate from National Sample Survey data). And those who utilize the services face severe financial hardships in terms of experiencing catastrophic expenditure and impoverishment

due to OOP health payments. The over-reliance on OOP payments for health care increased the poverty ratio by 4.9 percentage points, and almost a fifth of the households in Maharashtra experienced catastrophic health expenditure in 2004-05 (Ghosh, 2011). Clearly, the health system in Maharashtra lacks considerably in terms of providing health service and access to financial risk protection, two important aspects of Universal Health Coverage.

Acknowledging the health insecurity issue of the poor, Government of India (GoI) launched one of the world's largest social health protection initiatives, called Rashtriya Swasthya Bima Yojana (RSBY), in 2008 to provide them insurance cover. RSBY was not only seen as a potential solution to the issues regarding access to health care for the poor, it was also viewed as a tool to reduce poverty and inequality.

In 2008, the Department of Labour (DoL) of the Government of Maharashtra was given the responsibility of implementing RSBY to remove financial barriers and improve access to health care for the poor.

Overview of RSBY

Key features of RSBY

RSBY is publicly financed, implying that premiums are paid by the central and state governments with the contribution fixed at 75% and 25% respectively. Its aim is to reach out to the unorganised sector workers, in particular the 32 million below poverty line (BPL) persons3 in Maharashtra. Under RSBY, a BPL family can enrol a maximum of 5 members by paying a token enrolment fee of ₹30 (50 dollar cents) per year, and the enrolled families are entitled to receive secondary level hospital care for around 750 specific procedures up to an annual sum of ₹30,000 ($500). Unlike usual private health insurance, in RSBY, pre-existing conditions and maternity care are included. However, the notable exclusion is outpatient care, which is more impoverished than inpatient care (Bhandari, Berman and Ahuja,.0 2010). In order to enrol under RSBY, it is mandatory that the name of the household features on the BPL list that is prepared by the Ministry of Rural Development in rural areas and the Municipality or Municipal Corporation in urban areas.

The design of RSBY is quite unique. It was conceived to be a public-private-partnership model wherein the government would finance and provide stewardship; private players, namely commercial insurance companies, are chosen in each district by a bidding process. As per the contractual agreement between the Ministry of Labour, Government of Maharashtra and insurance companies, the latter is responsible for carrying out information, education and communication (IEC) activities for generating awareness about RSBY among the target population, identifying and enrolling the BPL households, processing the claims from the hospitals, and monitoring the behaviour of the providers to prevent unnecessary utilisation of insured services. In practice, most of these activities are carried out by private firms known as third party administrators (TPAs) and smart card vendors contracted in by the insurance companies. They act as a service integrator between the insurer, the insured and the health service provider (Gupta, Roy and Trivedi, 2004).

The insurance company and TPAs are supposed to carry out Information Education Campaigns (IEC) through various means, like distribution of pamphlets and handbills; and secondly, by displaying the list of beneficiaries at the Panchayat office or by contacting them directly. In many instances, TPAs in turn contract a number of NGOs to generate awareness among BPL households and smart card vendors to carry out the actual enrolment operations. For service provision in Maharashtra, RSBY has established a network of hospitals with only private providers, and those enrolled can seek cash-less inpatient care from this identified network of hospitals.

Current status of the scheme in Maharashtra

Based on programme data provided by the DoL, in 2008, the scheme was implemented in seven districts of Maharashtra in the first phase. By 2011, two years after the program launch, a total of 28 districts completed the first round of enrolment under RSBY. In 2013, the scheme was at various stages of implementation across districts with the duration of the programme varying from 2 to 4 years. In 2012, the Government of Maharashtra started a new state-specific scheme, namely Rajiv Gandhi Jeevandayee Aarogya Yojana (RGJAYS), in 8 districts of Maharashtra that provided coverage for tertiary care expenses up to 1.5 lakh ($2,459) for eligible families, i.e. BPL families as well as above poverty line (APL) families with income up to ₹100,000 ($1667). The scheme covers 971 surgeries, therapies and procedures under 30 specialties with 121 follow up packages. The RGJAYS pays a premium of ₹333 per eligible family to a commercial insurance company depending on the number of orange ration cards (for APL families), yellow ration cards (for BPL families), and Antyodaya and Annapurna cardholders in the state based on data provided by the Food and Civil Supplies department. Both public and private hospitals are empanelled for providing services. Consequently, the RSBY scheme was withdrawn from 6 districts. In Mumbai and Mumbai Sub-urban region, RSBY was never implemented due to the non-availability of BPL data. In 2013, RGJAY was extended to cover the whole state, and RSBY has been temporarily withdrawn from Maharashtra since October 2013.

The evidence on RSBY enrolment levels and patterns of utilization emerging from various studies paint a disturbing picture of RSBY's implementation in Maharashtra. From Narayana's (2010) study, it appears that after the end of the first year of implementation in 2010, only 39% of BPL families were enrolled according to the programme data in eleven districts of Maharashtra, the lowest across seven states; more worryingly, Rathi et al. (2012) found that within the Amravati district, Maharashtra ST-dominated blocks recorded the lowest enrolment. Studies conducted in other Indian states found that a large number of poor households still lack access to RSBY; and among those covered by RSBY, utilization of needed health care has remained limited (Rathi et al., 2012; Rajasekhar, 2011; Devadasan, 2013).

However, the majority of these studies focusing on enrolment and other issues either relied on the programme data, or they are based on small, localised geographical areas. Hence, the extent to which their findings can be generalised is questionnable.

Aim of the study

Our literature review further reveals that although many studies have looked at different implementation aspects of RSBY to date, there has been no in-depth assessment of RSBY's impact on access to health care. The current study therefore aims to understand why eligible BPL households are not able to enrol in RSBY, and access its benefits and to explore the extent to which social exclusion could explain this.

Methods

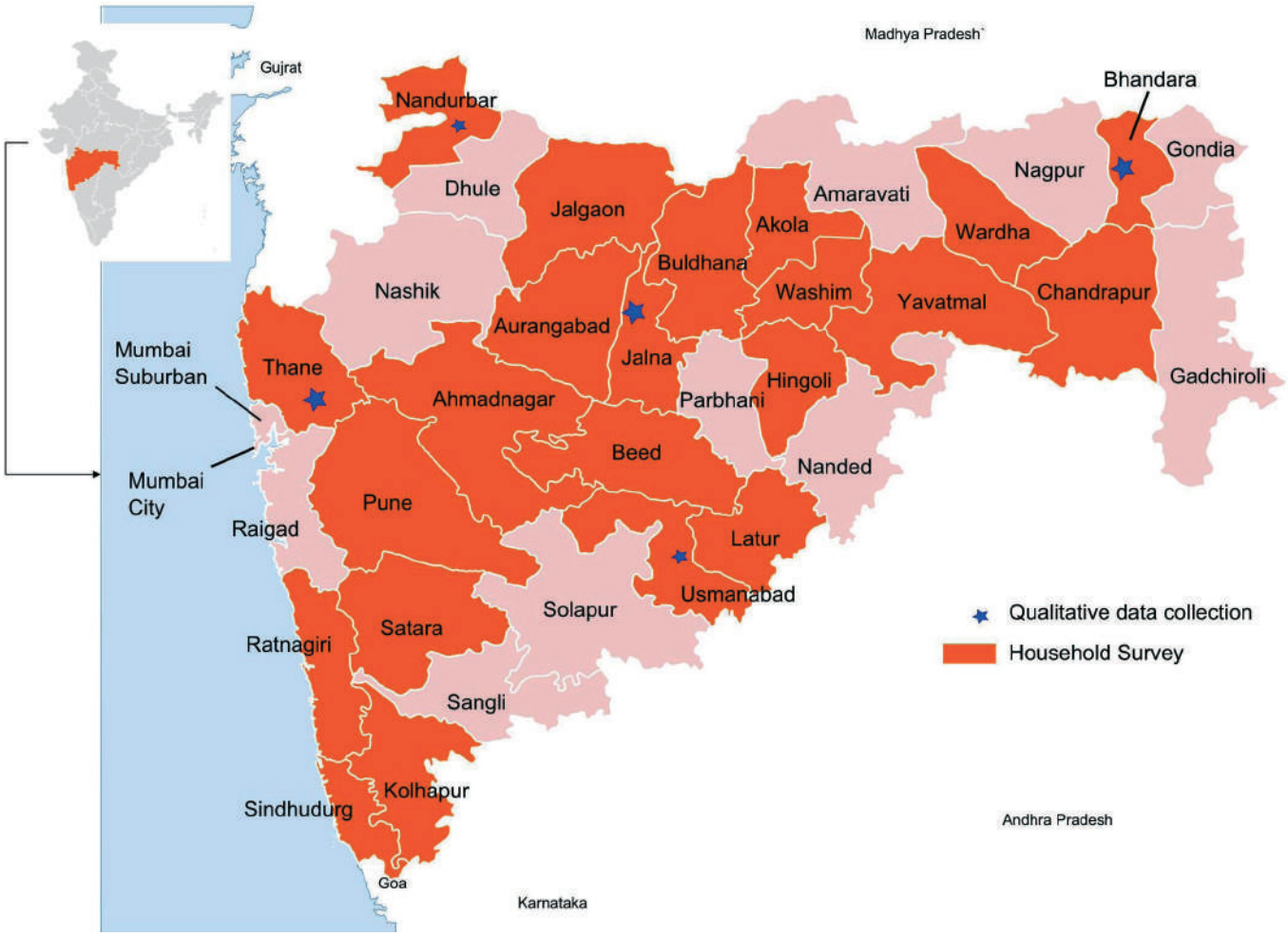
We used a social exclusion framework to study the above objectives. In order to apply the concept of 'social exclusion', we adapted the SPEC analytical framework (for details on social exclusion and on SPEC, see previous sections by Williams et al. and Soors et al.) to identify possible reasons for the limited success of RSBY in Maharashtra. With the help of survey data, the SPEC-by-step tool was applied to break down RSBY coverage into a cascade of steps with each step determining the proportion of households excluded and non-excluded by the programme. While the survey data allowed for quantification of excluded population at each step of RSBY implementation, qualitative data were used to answer the research questions, such as how and why exclusion takes place.

Quantitative arm

The quantitative data for this study came from a large scale survey conducted in Maharashtra from November 2012 to February 2013 across 22 districts that met the inclusion criterion of having experienced at least 2 years of RSBY implementation. The remaining 6 districts were excluded, as they hadn't completed 2 years of RSBY implementation. The household survey used a multi-stage stratified sampling design for the rural and urban sampling domains. The rural sample was typically selected in two stages: the selection of Primary Sampling Units (PSUs), which are villages or groups of villages (in the case of small linked villages), with probability proportional to population size (PPS) in the first stage, followed by the selection of below-poverty-line (BPL) households using systematic sampling within each selected PSU in the second stage.

In the urban domain, a three-stage sampling procedure was followed. The reason for adopting a three-stage sampling design is that urban areas are quite large; therefore, it is difficult to list all the households directly from the resulting list. In the first stage, wards were selected with PPS. From each selected ward, one or two segments were selected with PPS in the second stage followed by selection of BPL households using systematic sampling within each selected segment in the third stage. A total of 6000 households were included, giving a final sample of 29,585 individuals.

Figure 1. Selected districts in Maharashtra, India (the quantitative survey was carried out in the 22 coloured districts and the qualitative survey was carried out in 4 districts with * sign and bold font)



Qualitative arm

To capture the experiences of eligible beneficiaries in relation to RSBY and to identify the barriers that prevent them from the programme, we conducted a total of 17 FGDs, 34 in-depth interviews (IDI) with the members of BPL households, and 3 in-depth interviews with individuals involved in the management of RSBY at different levels, including DoL officials, insurance company representatives and Third Party Administrators (TPAs). A purposive sampling technique was used for selection of sites as well as participants for FGD and IDIs. Initially, 22 districts were grouped into four major regions. Then from each of these zones we chose one district purposively, totalling 4 districts for inclusion. Within each district, PSUs were visited based on the information of the household list prepared for the survey. The PSUs were broadly categorised into two groups based on high and low enrolment rates. Each PSU was then randomly selected from each category. In districts identified as 'Tribal Districts', we selected PSUs with tribal population. A total of 15 PSUs were visited.

Within the PSU, for FGDs and IDIs, potential participants from BPL households were identified. We ensured representation from all genders, different castes and tribes, religious groups and elderly groups. The topic guide for the FGDs consisted of five sections of probes: resources and problems, concepts of social exclusion, social institutions in their community, presence of collective action and, lastly, RSBY. For IDIs, respondents were interviewed using semi-structured probing guides that included: social exclusion, process of becoming a member in RSBY, perceptions, knowledge and utilization of RSBY, access to health services in the locality and details of the hospitalization.

The discussions and interviews were conducted and transcribed in the native language, which were then translated to English and transcribed verbatim. We examined the verbatim transcripts for consistency and completeness. NVivo 7 was used for managing the texts from FGDs and IDIs. The coding was completed in two stages: first, the text was coded with an inductive approach using principles of grounded theory; second, we used probing guides and research questions to prepare a 'framework of hierarchical' codes that are related with the SPEC-by-step tool.

Results and discussion

Descriptive summary statistics of the sample

This section provides a profile of the socio-demographic characteristics of the household population in the survey sample. The sample population of 29,858 individuals is relatively young: the average age is 30 years with approximately 25% below 14 years of age, 63% aged between 15 and 59 years and 12% aged 60 and above (Table2).

Table2. Descriptive characteristics at household and individual level, Maharashtra, 2012-13

Characteristics	Mean (SD)
Individual	Total
Sex ratio (%)	
Male	50.8
Female	49.2
Age group (%)	
0-14	24.8
15-59	62.9
60+	12.3
Age	30.2 (20.1)
Marital status1 (%)	
Never married	23.8
Currently married	66.0
Widowed/Divorced/Separated	10.20
Poor health status3	4.1
Household	
Caste (%)	
SC	33.4
ST	19.3
OBC	28.6
Others	18.6
Religion (%)	
Hindu	79.1
Muslim	9.2
Buddhist & Others	11.7
Share of BPL households that belong to	
Quintile 1	20.0
Quintile 2	20.0
Quintile 3	20.0
Quintile 4	20.0
Quintile 5	20.0
Male headed household (%)	79.1
Mean household size	4.9 (2.3)
Highest education level in household	9.1 (4.1)
Household head with chronic health problems (%)	6.2
Monthly household consumption expenditure2	US$101
Total households (N)	6000
Total population (n)	29585

The mean household size is 4.9; 49% are female and 51% are male. About a quarter of the population is unmarried (24%) and two-thirds of them are currently married. However, almost one-tenth of the population is widowed, divorced or separated. Only 4% of the sample population is perceived to have poor health.

The distribution of households by religion reveals that about 79% of them are Hindus, 9% are Muslims and 12% are others, comprising Buddhists, Christians, Jains and Sikhs. The majority of BPL households belong to marginalized social groups, such as Scheduled Castes (33%), Scheduled Tribes (19%) and Other Backward Castes (29%). The remaining 19% are 'others'. Males head about 79% of households. Education measured by highest education level achieved by any member in the household is low at a mean of 9 years. The average monthly household consumption expenditure is US$101. More than 6% of household heads reported to have been suffering from chronic health problems.

SPEC-by-step Results

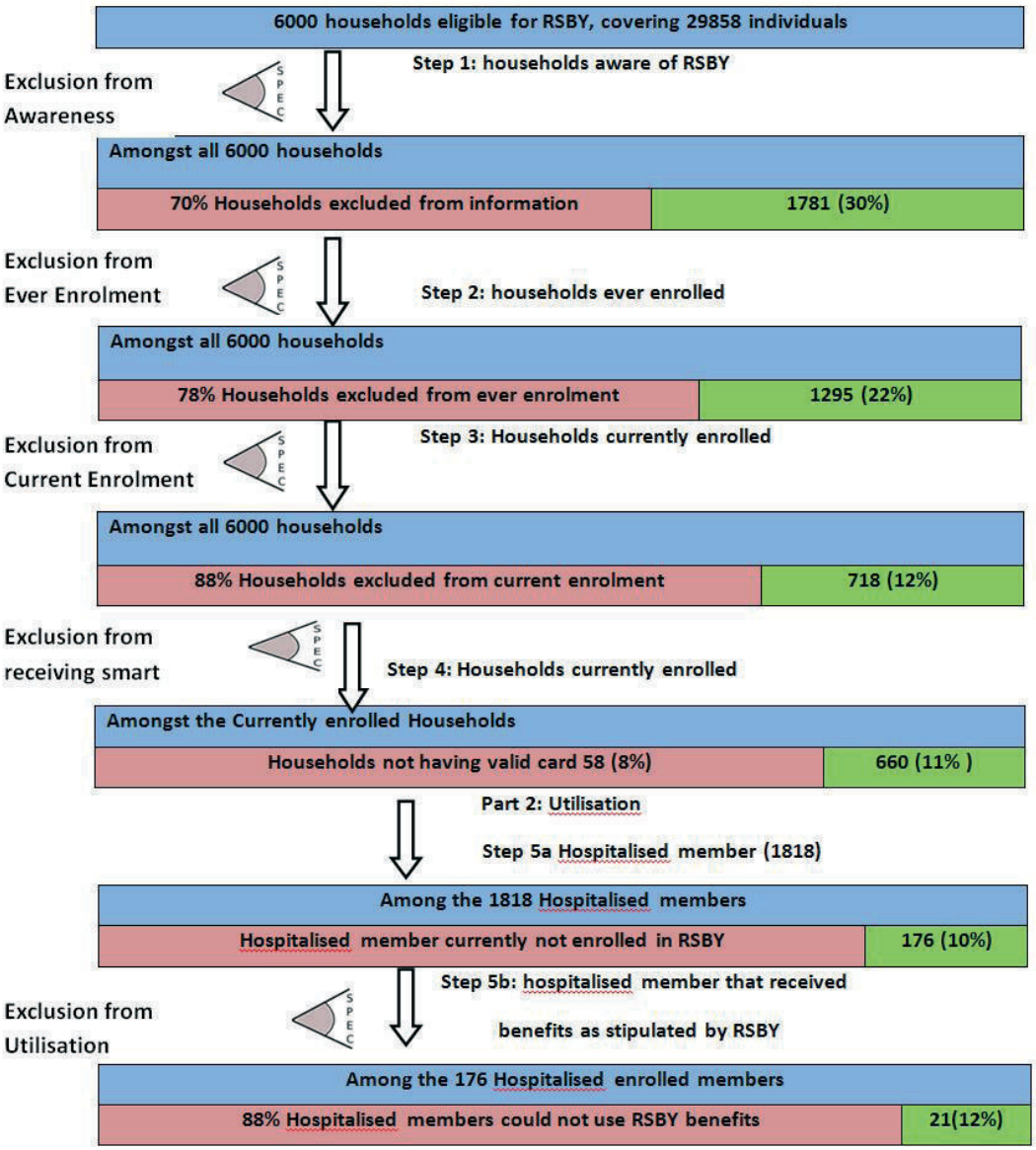
Using the SPEC-by-step tool, we tried to quantify the extent of non-coverage at various steps of RSBY implementation on the basis of quantitative data. The quantitative data was also employed to identify the characteristics of excluded households and individuals at each step. The qualitative data contributed to understanding the social, political, economic and cultural processes that led to exclusions of households from accessing RSBY in Maharashtra.

Step 1. Awareness of RSBY

Figure 2 shows that of the 6000 BPL households interviewed, only 30% reported that they knew about the scheme, with rural households having a considerably higher level of knowledge than their urban counterparts. Besides, the level of knowledge about the programme's features was found to be very limited by even those who were enrolled in RSBY. Using their responses regarding the composition of the benefit package in the survey, we classified them into three categories: 'fully aware'– those who could tell about all the components; 'partially aware' – those who had knowledge about any of the components; and 'not aware'– those not able to provide any correct answer. Only 4% were found to be fully aware. We have provided a detailed analysis on awareness in chapter 7.

Figure 2. Description of RSBY coverage in Maharashtra, 2012-13

Part 1: Awareness and Enrolment



As explained earlier, the insurance companies and TPAs are primarily responsible for awareness generation in the community. The in-depth interviews with beneficiaries and implementing officials reveal that, in practice, they greatly relied on Panchayat members, Block Development Officers and 'Anganwadi' workers for contacting them directly despite little or sometimes inadequate incentive. The enrolling agencies often approached the PRI members for making arrangements for enrolment in their villages. Peons of the gram panchayat, Anganwadi workers, ASHA workers and personnel of the Revenue Department were the key actors in reaching these BPL households. Hence, the role of PRI was very vital in making the eligible beneficiaries aware about RSBY.

Such over-reliance on PRIs for IEC as found in Maharashtra left enormous scope for the exclusion of BPL households from knowing about RSBY in two ways. First, local officials at Panchayat office were found to be reluctant to do the RSBY related work, as this was not their department's work; therefore, least priority was given to those activities. Second, it has been generally observed in previous studies that access to public resources largely depends on the political affiliation of person/households/groups; hence, the chances of getting information are less for those not

associated with the political party locally in power (Besley et al., 2005, Bardhan et al., 2008, Markussen, 2011). The analysis of the survey data also confirmed the same households that are active in local politics and have political contacts had significantly higher chances of getting information about RSBY (OR=1.9; CI: 1.7-2.1) from the local authorities and vice-versa.

Apart from institutional and political factors, certain characteristics of households seemed to have influenced the access to information related to RSBY. For example, female-headed households and households with uneducated heads were less likely to receive information about RSBY; more worryingly, across all social categories, the tribals were clearly at a disadvantage in terms of having knowledge about RSBY compared to other social groups. Notably, the level of awareness among ST households was lowest (25%) across social groups. This was also reflected in the FGD's wherein a participant residing in the tribal area narrated their experience regarding the process of information exchange about the scheme.

"... we were told that... this booklet consists of the names of hospitals and services) which can be used for the hospitalization relatedservices); we were not told in face about the card except that the facilities are covered in the bookletand one can read and understand them from it." (Source: Nandurbar ruraltribal FGD)

The above narrative clearly reveals the reasons as to why the level of knowledge about the scheme is very low among the beneficiaries. The TPAs and insurance companies did not take into account the socio-economic context of the beneficiaries at all while designing the IEC activities and disseminating information about RSBY. It is a well-known fact that majority of STs either do not have formal education or have very limited educational achievements and therefore to expect them to go through the RSBY booklet to know about the scheme is very unrealistic. In short, the IEC materials and dissemination strategies worked to the disadvantage of people with low educational achievements or groups like Tribals.

Step 2. Ever enrolment in RSBY

Upon enquiring about the insurance status of the BPL households, it was found that 22% were ever enrolled under RSBY. The ever enrolment rate of BPL households was considerably higher in rural areas (27%) than in urban areas (13%). Ever enrolled are those who became a member of RSBY at some point since the beginning of the scheme but may not necessarily remain enrolled in the scheme.

The qualitative evidence points to several reasons for a low-enrolment rate. Flawed BPL list, death of the head of the household, seasonal migration, lack of administrative support on the ground, cost of enrolment, no compulsive mandate on the insurance company to achieve higher enrolment rates, limited and inflexible time span of enrolment and ineffective oversight by the DoL, appeared to be important design and implementation related factors that affected enrolment activity on the ground. Besides, wider contextual factors such as corruption and nepotism were reported by participants as prime mechanisms of exclusion from any social-protection programme.

As per the narratives of the respondents and focus groups, enrolment in general was conducted in a haphazard and shoddy manner.

> *"We asked them that our photos were not taken yet, so they replied that their duty was only of 8 days but they spent 15 days. Still our photo was not taken, though we have yellow card."(Male participant from FGD in Nandurbar)*
>
> *"The problem was, they had not informed before coming. So, when they came, we were not there. Then they came again, too, on another day. But they had not informed. So, we couldn't make it again… (Male participant from FGD in Nandurbar)"*

"they (people of enrollment agency) informed in the village (through village head–sarpanch) that there will be a card distribution and everyone whose name features in the list are requested to stay back for getting the card (enrollment). Some households did not listen to it (or were not able to understand it) and went on to work (to various places out of the village) thus they were not able to get the cards" (In-depth interview, rural areas, Bhandara)

Except for one PSU in Nandurbar, none of the other participants reported that they were provided with a note or saw their names on the list. In most cases, they were informed through the network of PRI members in rural areas and ward members in urban areas. As explained earlier, this strategy was not successful. Findings from the qualitative data analysis suggest that it led to the exclusion of households with no political clout or any proximity to the main village area or close to politically active households.

"Family member: yes they do not share valuable information. They feel that if we are getting benefits of welfare programmes then why to bother about the rest of the households. Why should we even pay attention to these people? They will realize the benefits of welfare programme when they get to know about it from other sources. "(FGD, Jalana urban 1)

We also examined the RSBY coverage across social groups at the village level. Given the history of social discrimination, it was not surprising to find that tribal households were excluded from accessing RSBY. For instance, we noticed that a household from a tribal settlement was not enrolled in subsequent rounds, though a villager under the same Gram Panchayat (GP) but from a non-tribal village was enrolled consecutively. On asking the female head of a tribal household what may possibly explain the reason for her exclusion from RSBY, she replied that she was not aware of such a scheme. When it was pointed out that others got the information from the GP, she made the following remark:

"They received wells, land. They provide employment to those who already have enough and let the poor die"

"Yes! That is it! They will come there (in the Gram Panchayat) and leave from there. They will not come here." (Woman whose husband is hospitalized and who is not enrolled)4

Hence, the qualitative results showed that apart from administrative and design-related issues, spatial isolation, social stratification as well as political neglect were some of the mechanisms that explain the reasons for exclusion of eligible households from enrolment.

Another issue is the 'intra-household' exclusion that occurs due to the following reasons. Firstly, RSBY imposes a five-member limit on the enrolment of a household. However, 34% of the households had more than five members, implying that because of the five-member limit in the scheme, some vulnerable members, like women and children, may have been excluded from the coverage of RSBY. Second, almost 40% of the enrolled households reported that not all five members were included in RSBY, as there was no clarity on who can be enrolled from a family. Our qualitative data revealed that at a later stage when people went on to use the card, many people found that the name of a particular family member was not included on the card.

"Yes, we had taken this card to the hospital. But they said that his name is not there on this card. His son and his family were travelling to other place for sugarcane cutting, so he was not able to enrol his name in this card and the hospital said that his name is not there on this card; so won't get any benefits of the scheme. He gave his photo but his family left" (tribal woman in Nandurbar)

Step 3. Current enrolment in RSBY

The analysis of the survey data revealed that only 12% of the BPL Maharashtra households were currently enrolled in the scheme. As observed in cases of ever enrolment, the current RSBY enrolment rate of the BPL population was higher in rural areas (14%) compared to urban areas (8%). A large number of households (90% and 77% in rural and urban areas respectively) said that they had neither any information saying that the card could be renewed, nor that there was any camp held for reenrolment. Further, the qualitative results suggest that the empanelled hospital's refusal to treat patients under RSBY, the non-availability of empanelled hospitals in the vicinity and the lack of knowledge about the listed hospitals have reduced the scheme's acceptance in some areas. Many BPL households refused to be re-enrolled in RSBY: they thought it was not worth spending 50 cents to obtain the RSBY smart cards and perceived this to be a waste of money because they were unable to utilize the services to which they were entitled.

Analysing the quantitative data, we identified the determinants of current enrolment of RSBY (details are provided in chapter 9). The results suggest that male-headed, non-labourer households, households belonging to a majority religion and those residing in urban areas and from Vidharbha region were less likely to be included in RSBY. The odds of reporting enrolment was also found to be significantly lower among single-member households than joint and extended families (OR=0.47). With regard to social dimension indicators, households that did not know any influential person were less likely to be enrolled (OR=0.81) in RSBY than those with wider social networks. Those who expressed a lack of trust in institutions such as local government, national government, judicial system, press etc. were significantly less likely to be enrolled in RSBY. In other words, the above findings indicate that a low level of social capital was associated with lower levels of enrolment in RSBY. Such within group cohesion may lead to inclusion of some households while excluding single member households or households from other castes or religions. Interactions within a certain group were stronger but interactions between two groups, for instance Muslims and Hindus, or scheduled tribes and others, were very poor. Also, factors such as migration or lack of interaction in the community led to poor information exchange and exclusion from enrollment. In addition, community ties are much stronger in rural areas compared to urban areas. This social isolation along with implementation problems such as the delay in launching the scheme in urban areas and an incomplete BPL list are responsible for lower participation in RSBY in urban areas. Besides, the analysis of the quantitative data suggests that households which were vulnerable in all dimensions of social exclusion5 were less likely to be enrolled into RSBY.

Step 4. Possession of RSBY cards

For utilizing the services covered under RSBY, it is essential to have an RSBY smart card. However, of the currently enrolled households, 5% did not possess smart cards. Analysis of the survey data reveals that technical problems were reported as a reason for not getting the smart card by 37% of the currently enrolled respondents who did not have smart cards. A third of them also said that they did not know why they had not received the card. Delay in the distribution of smart cards was consistently reported in almost all focus-group discussions. Further, in one of our field visits, we noticed that cards were kept with the Gram Panchayat and were not distributed to households.

Step 5. Utilisation of RSBY services

Finally, the utilisation of RSBY services was very low in Maharashtra. It was found that among the households with valid RSBY cards with at least one hospitalisation case in the year prior to the survey date, only 12% of them had used the cash-less services from the listed hospitals of RSBY. The qualitative interviews help to explain the reasons for non-utilization of services. Lack of information regarding the listed hospitals, inability to recognise the use of the smart card, non-availability of listed hospitals in their neighbourhood and invalid smart cards were the leading causes of non-utilisation. One beneficiary narrated his experiences relating to RSBY:

"Oh...these are hospitals located in Bhandara. We go to Bramhapuri which is close to us and we know the doctors, and list of hospitals in Bramhapuri (nearby town) are not given here, then what's the use of it...? Every year these people come and take thirty rupees from us and yet the card is useless at any (in the respondent's town) hospitals here" (IDI-1, enrolled male 1)

Conclusion

Our research has demonstrated that the design and implementation-related issues only partly explain the reasons for the limited success of RSBY in Maharashtra. The evidence shows that access to RSBY is also shaped by social, political, economic and cultural processes that have significantly impacted the performance of RSBY in terms of achieving universal population and service coverage within the target population. As the implementation of the scheme was embedded in existing social, economic, political and cultural structures, the inequalities in these structures further deepened the inequalities in access to RSBY. The analysis unravelled ways in which the exclusionary processes reinforce and reproduce inequalities in access to RSBY. For instance, households that did not know any influential person were significantly less likely to be enrolled in RSBY than those with wider social networks. Unless these exclusionary processes are recognised and addressed while designing and implementing social welfare programmes, inequities in access to these programmes, including RSBY, will persist.

Low awareness and enrolment are the major concerns; hence, these issues have been explored in detail in chapter 7 and 9 respectively. The BPL list is very problematic, as it significantly excluded eligible households and persons thereby depriving them from obtaining the benefits of RSBY. Such findings strongly suggest that instead of relying on the BPL list, it will be better to have wider criteria for enrolment in the scheme. In order to improve the access of RSBY, there should be more emphasis on educating BPL families about the programme. More importantly, the IEC activities should be carried out in such a manner that information about RSBY and its benefits reaches the vulnerable population and, if necessary, a clear policy bias in terms of allocation of resources should be introduced in order to provide access to RSBY to the unreached vulnerable population groups.

Urban households were found to be more disadvantaged than rural households in terms of RSBY coverage. Hence, the nodal agency needs to monitor the enrolment activities more closely to improve the awareness level and enrolment in urban areas. The utilisation of services was poor, particularly in rural areas. Given these findings, the role of commercial insurance companies and TPAs should be critically reviewed and, a public agency should instead be given the responsibility for awareness generation and enrollment of workers. Efforts should also be made to empanel public hospitals so that access to RSBY translates into access to care for vulnerable households. If RSBY is reintroduced, DoL should focus on improving it by abandoning its current target based approach and instead adopt a 'universal' approach for enrollment (covering all workers engaged in the unorganised sector), providing more control to the nodal agency, scrapping the 'compulsory annual renewal policy' and expanding the benefit package. Finally, the findings of our study clearly suggest that any social health protection programme such as RSBY would be more successful at reaching the unreached vulnerable population if it was implemented by a public agency with a pro-social inclusiveness approach embedded in its policy framework.

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Endnotes

1 Recognising the socio-economic differences among the various population groups, the Government of India classified its population on the basis of their social and economic conditions as Scheduled Tribe (ST), Scheduled Caste (SC), Other Backward Class (OBC) and Others. ST is the most socio-economically disadvantaged followed by the SC and OBC and together they comprise 67% of India's population, with SC at 16.6%, ST at 8.6% and OBC over 42%.

2 National Rural Health Mission, started in 2005 represents an important initiative by the central government to address the health care needs of the rural population by strengthening the public health system in rural areas.

3 The acronym BPL is used for below-poverty-line households in India. A BPL census is periodically conducted by Ministry of Rural Development, Government of India in all the states for identifying the poor households for social support. The identification of BPL household is not based on the poverty line defined by the Planning Commission GOI, but is determined by using various parameters that score the households in a range of 0 to 52. This method was used in 2002 BPL Census to rank all the households on the basis of these scores in a typical village and the BPL households were chosen using a cut-off.

4 Text in verbatim added to improve understanding of the reader to local settings.

5 In chapter 9, we have provided a detailed description of how an index of 'social exclusion' is constructed using indicators of SPEC dimensions.

CHAPTER 6: Karnataka case study summary

Tanya Seshadri, Gayatri Ganesh, Anil MH, Mahesh Kadammanvar, Maya Elias, Manoj Kumar Pati, Thriveni BS, Arun Nair, N Devadasan

The Karnataka context

Karnataka: a land of inequities

In India, a few groups have historically faced exclusion: the Dalits and Adivasis (recognized as Scheduled Castes (SC) and Scheduled Tribes (ST) respectively), religious minorities and women (World Bank, 2011). The proportion of below poverty line (BPL) households among SC and ST communities reflects these entrenched inequalities: 37.9% of SC and 43.8% of ST population are BPL, whereas in the remaining population only 22.7% are BPL (Planning Commission of India, 2007). Regional inequalities persist with some states lagging behind others in health and development. (Baru R, 2010).

Karnataka is the ninth largest state in India in terms of size and population. It is considered to be one of the better-developed states with respect to human development indicators. However, within Karnataka, regional inequalities manifest in development indicator disparities. Karnataka ranks sixth among the major states in India in gender development, but the picture is of an adverse sex ratio with wage differentials, lower literacy rates, and worse health outcomes for women (National Information Commission, 2012; Planning and statistics commission, 2006). Just like in the rest of India, inequalities are seen across the rural-urban divide in terms of socio-economic indicators and health outcomes favouring the latter in most cases (Census 2011). Inequities in terms of human development indicators are also reported between districts and also within each – across administrative sub-district divisions (taluks) (Karnataka State Planning Board, 2008; Karnataka Human Development Report 2005).

Health financing in India: focus Karnataka

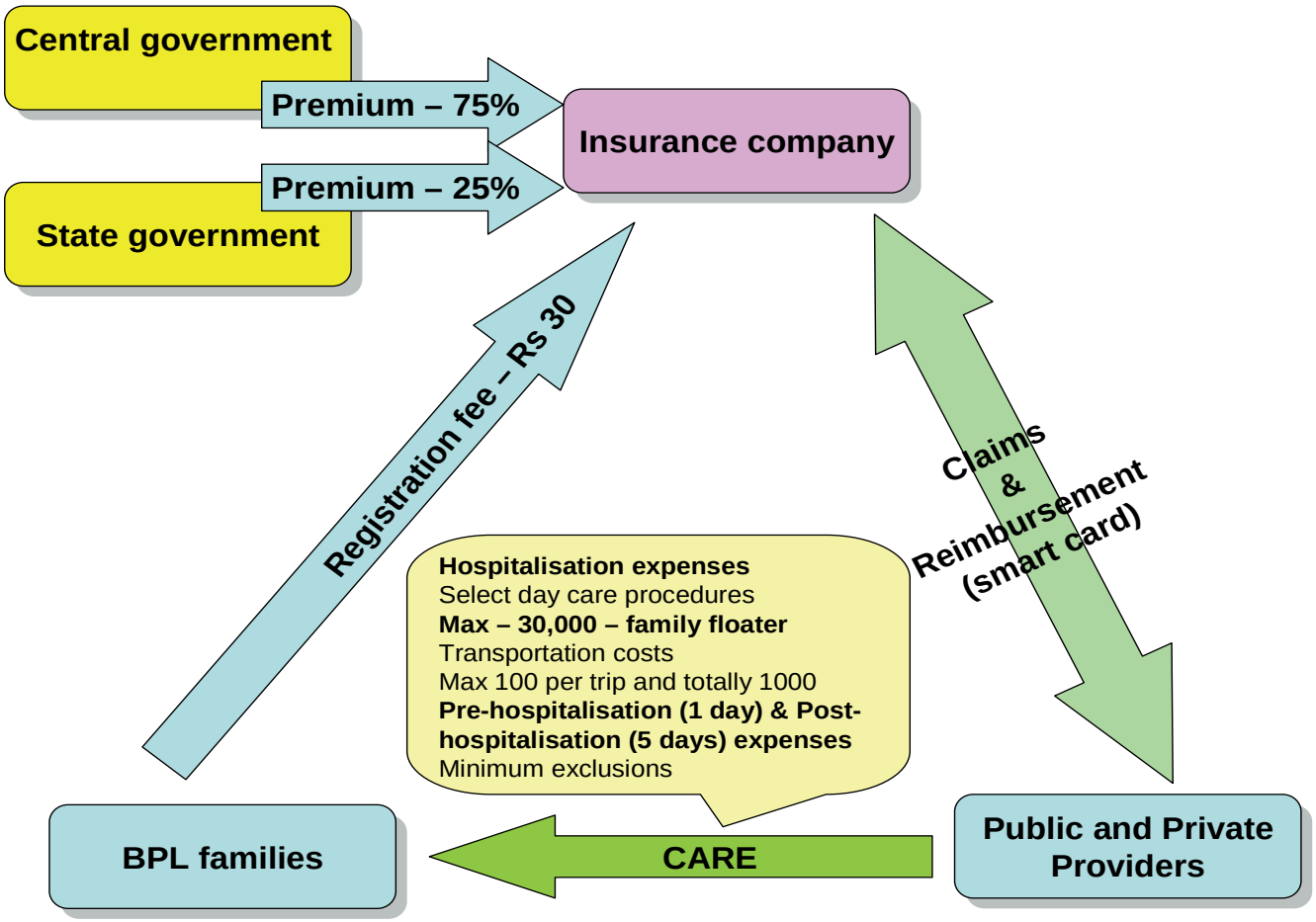
Health related expenditure, or 'iatrogenic poverty', is identified as a key reason for impoverishment in India with studies reporting that it affects nearly 2-3% of the population every year (Van Doorslaer, 2006; Central Bureau of Health Intelligence, 2011; Meessen B, 2003). In India, people contribute 71% of the total health expenditure through out-of-pocket (OOP) payments at the time of illness; while the federal, state and local governments combined contribute only 27% (High level expert group committee, 2011; Central Bureau of Health Intelligence, 2011). The high level of OOP expenditure by individuals is one of the highest reported among low- and middle-income countries. To address this issue, especially in rural India, the federal government launched the National Rural Health Mission in 2005, which aimed to increase the share of GDP spent on health from 0.9% to 3% thereby increasing resource allocation (Ministry of Health and Family Welfare, 2005). In addition, the federal and various state governments initiated different health insurance programmes targeted at various groups to provide social health protection, such as the Universal Health Insurance Scheme by the Ministry of Finance, Rashtriya Swasthya Bima Yojana by the Ministry of Labour & Employment (explained later), and Rajiv Arogyashri Yojna by the state government in Andhra Pradesh, etc.

In Karnataka, the picture is similar with the government spending only 28% of the total health expenditure (Karnataka Knowledge Commission, 2010). The recent budgetary allocation on health decreased to 3.4% in 2008-09, a decrease from 5.1% a decade earlier (Yareseeme AS, 2010). With high OOP expenditure and the risk of impoverishment, financial protection for the poorest section of society, i.e. below poverty line (BPL) households, was a priority; subsequently, the government introduced various financing schemes, listed below, for vulnerable sections of society, including a few health insurance schemes like Rashtriya Swasthya Bima Yojana and Vajpayee Arogyasri Yojana.

Rashtriya Swasthya Bima Yojana

In 2007, the Ministry of Labour and Employment, Government of India, launched Rashtriya Swasthya Bima Yojna (RSBY), translated as National Health Insurance Scheme, for BPL households with the aim of improving access for BPL households to quality medical care for treatment of conditions involving hospitalisation through an identified network of health service providers. The scheme is completely subsidised by the central and state governments and contribute 75% and 25% of the premium respectively. A nominal yearly adherence fee of Rs. 30 per five-member family is paid. A summary of the design of RSBY is provided in Figure 1.

Figure 1. Diagrammatic representation of RSBY programme



Source: Devadasan N, 2008

As of December 2012, the scheme is functioning in twenty-six states and union territories covering 439 districts. Around 33.2 million households have been enrolled across the country with more than 12,500 hospitals empaneled and 4.3 million hospitalisations recorded. In Karnataka, RSBY was implemented from early 2010 and is administrated by the Department of Labour. Details of programme implementation in Karnataka are shown in Table 1.

Table 1. Status of RSBY implementation in Karnataka since launch

Policy year		Year 1	Year 2
No. of districts		5	30
Geographical area covered		Rural only	Both rural and urban
Type of eligible households		BPL households	BPL and MNREGS beneficiaries
No. of eligible households		338,931	4,076,642
Enrolment rate		46.4%	41.2%
No. of hospitals empaneled	Public	66	318
	Private	113	478

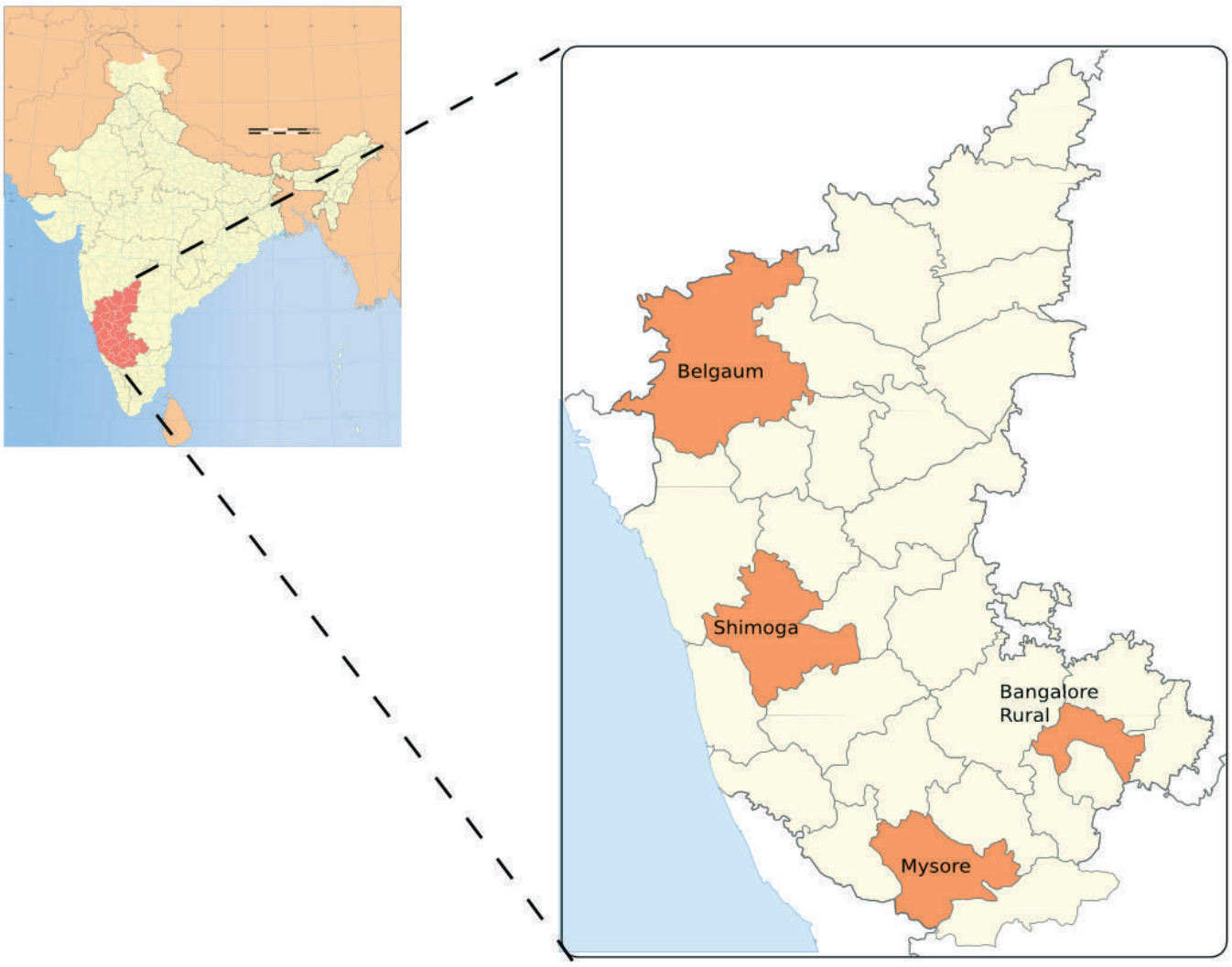
Source: Karnataka status on RSBY website 2012

The Health Inc. team in Karnataka, led by the Institute of Public Health Bangalore aimed to identify the type of households and groups who are excluded from accessing RSBY at various stages of implementation, and we attempt to understand the mechanism of their exclusion. Ultimately, the goal of this research is to help make RSBY and similar programmes more inclusive.

Methods

We conducted our study in four districts of the southern Indian state of Karnataka as shown in Figure 2. We applied a mixed methods approach based on an explanatory sequential design (Creswell et al. 2003), making use of household surveys across four districts followed by in-depth interviews and focus group discussions with stakeholders.

Figure 2. Study districts shown on the Karnataka map



Source: Constructed with maps from Wikimedia commons, User:Planemad.

While the quantitative arm seeks to identify and quantify the exclusion faced by people at each step of RSBY implementation, the qualitative arm then takes the study to the next level to try and uncover the mechanisms of that exclusion.

Quantitative arm

We conducted a baseline household survey in four districts of Karnataka (Bangalore Rural, Belgaum, Mysore, and Shimoga) where RSBY was in its second round of implementation. Using the state government list of eligible households in 2011-12 as our sampling frame, we surveyed 6040 households across both rural and urban areas. We selected the study households using a multi-stage sampling strategy, first at the administrative sub-division (taluk) level, then at the Gram Panchayat (GP) (first level of government comprising a cluster of villages), and finally randomly sampling households within the GP. Based on the probability proportional to size approach, we sampled the required number of households at each level.

Through an initial baseline survey, we collected demographic, socio-cultural, economic and political characteristics of the households along with their engagement with RSBY. In three monthly follow-up surveys, we checked for hospital utilisation among all surveyed households. From households who had experienced hospitalisation, we collected information on their inpatient event through a semi-structured interview.

All questionnaires were administered in two local languages: Kannada (all districts) and Marathi (Marathi-speaking population in Belgaum district). Survey data at household and household-members levels were entered using Epidata v3.1 and analysed using SPSS v20. We prepared descriptive and inferential statistics to gain a preliminary idea about the interactions among the different variables across social, political, economic and cultural dimensions of social exclusion. Following this, we explored the interaction between certain variables, and also with outcome variables such as presence of awareness and being enrolled in RSBY. We selected multivariate analyses (logistic regression) to take this forward to identify possible predictors of exclusion. Identification of the key predictor variables mainly followed from the existing research questions of the study, literature review, and the initial preliminary analyses. This further helped frame specific hypotheses, like ST households are less likely to be enrolled in the scheme than general category households; households with political contacts/networks are more likely to be aware of the scheme than those without etc. (Katz HM, 1999; Menard S, 1995) (elaborated in chapter 8).

Qualitative arm

We used the preliminary quantitative findings from the household surveys to develop a matrix consisting of a basic social profile and the performance of RSBY implementation in each GP for all districts. We held additional discussions among a few excluded groups identified during the survey (such as with tribal communities, with women, and in areas with high migration). In total, we conducted 22 focus group discussions with eligible beneficiaries across the four selected districts. We also conducted in-depth interviews with stakeholders, including GP members, women self-help group leaders, local village administrators and implementers of RSBY, including field key officers, Third Party Administrators (TPA) and insurance company representatives (n=32).

Following informed consent, the discussions and interviews were audio-recorded while the researchers also took notes. Recordings were translated from the local language Kannada (and Marathi in Belgaum) to English, and then transcribed verbatim. The transcriptions and their translations were checked by the interviewers/moderators for errors. Three researchers coded these transcripts using deductive coding with an a priori coding frame (Miles & Huberman, 1994). The study team jointly devised a coding scheme based on the interview guides, background literature, hypotheses and preliminary findings from the quantitative survey. Periodically cross-checking each other's work to maintain consistency, the team members coded the material and then further grouped material into emerging topics and themes in an iterative manner. Eventually, the qualitative findings were triangulated with the quantitative results.

The Institutional Ethics Committee of the Institute of Public Health Bangalore provided ethical approval to the study on 24 March 2012.

Results

Our study population consisted of 6040 households eligible for RSBY (5217 rural, 913 urban) comprising 33,117 people. The study was conducted across 15 sub-divisions of the four districts. The general profile of the study population is shown in Table 2. Only 9.1% of households belonged to religious minorities, while 32% households belonged to the disadvantaged social categories called Scheduled Caste (SC) & Scheduled Tribe (ST). The median household size was 5 ranging from 1-30. Around 40% of the population are dependents (age <18 and >60 years); 47.6% of the adult women never went to school, twice the proportion among men (26.5%). A similar pattern was also seen among earning patterns across the genders with 64.6% (nearly two-thirds) of adult women not earning, nearly thrice the proportion among men (23.4%). Among the earners, 29.7% of the adults are casual wage labourers (37.3% among men, 21.9% among women). Another point to note is that a quarter of the study households do not speak Kannada (i.e. the state's official language), which is used for information campaigns. The other common languages spoken are Marathi (11.5%, mainly in Belgaum) and Urdu (6.8%, mainly in urban areas) among others.

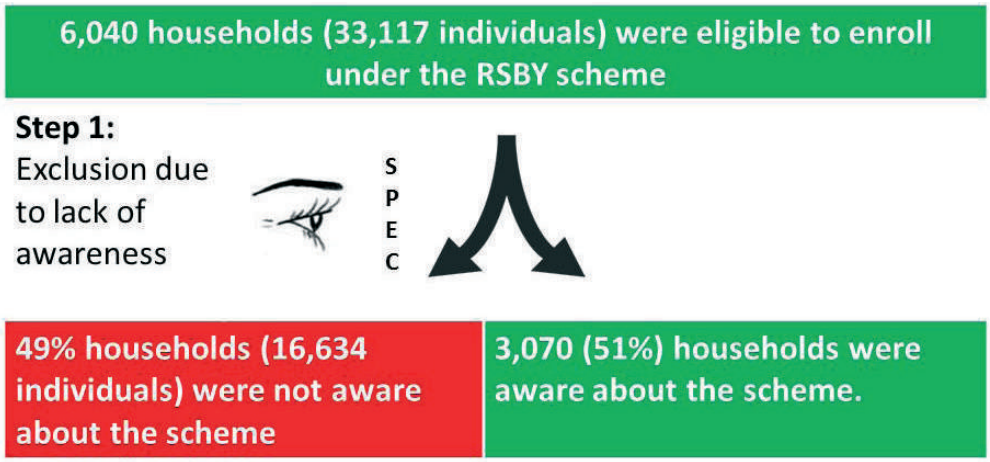
Table 2. General profile of study population

Characteristics		Frequency	Per cent (%)
Total number of households		6,040	
Total population included		33,117	
District	Bangalore rural	499	8.3
	Belgaum	3,018	50.0
	Mysore	1,504	24.9
	Shimoga	1,019	16.9
Religion	Hindu	5,487	90.8
	Muslim	431	7.1
	Christian	17	0.3
	Others	105	1.7
Social category	General category	672	11.1
	Other Backward Caste (OBC)	3,268	54.1
	Scheduled Caste (SC)	1,378	22.8
	Scheduled Tribe (ST)	553	9.2
Median household size		5 (1-30)	
Household size	Small (5 members or less)	3,772	62.5
	Large (more than 5 members)	2,268	37.5
Age group	Less than 18 years	10,067	30.4
	18 – 59 years	19,515	58.9
	60 years & above	3,535	10.7
Sex ratio (No. of females per 1000 males)		968	
Adult literacy rate			57.7
Education (18 years & above)	Never Went to School	8,497	36.9
	Up to primary school	3,398	14.7
	Up to high school	7,487	32.5
	Above high school	3,668	15.9
Occupation (18 years & above)	Not earning	10,062	43.7
	Casual wage labourer	6,853	29.7
	Self employed	4,963	21.5
	Salaried	1,172	5.1
Kannada speaking households		4,412	73.0
Household has a ration card		5,801	96.0
Type of ration card	'Poorest of poor' BPL Card	527	8.7
	BPL Card	4,395	72.8
	APL Card	832	13.8
At least one member migrated for employment		423	7.0

We present the rest of our results as per the SPEC-by-step tool, highlighting the three steps of RSBY's implementation (awareness, enrolment and utilisation) followed by a description of the type of people excluded at each step and a summary of the reasons for their exclusion.

Step 1: Exclusion from awareness of RSBY

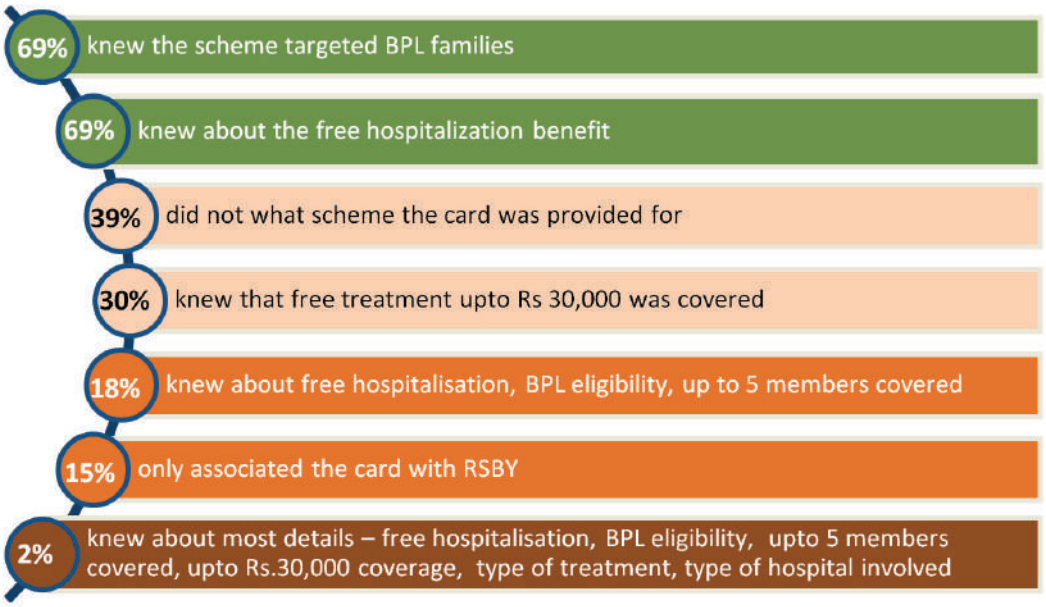
Figure 3. Step 1: Exclusion from becoming aware of RSBY shown using the SPEC-by-step tool



At the first step, we found that 49 % of households were completely unaware of RSBY (i.e. never heard about the scheme and never seen the RSBY card) as seen in Figure 3. Even among those who were familiar with the scheme, awareness about the details of the scheme was patchy. Figure 4 shows the differences in details of awareness among the aware households. Three broad levels emerged: first, 41% who were only familiar with the scheme (i.e. heard about the scheme or seen the card only); second, 9% who were also aware of basic details about the scheme, like eligibility and purpose; and third, 1% who knew about the scheme's benefits in detail. Furthermore, it was noted that awareness of the scheme did not imply awareness of the enrolment camp, while enrolling in the scheme did not imply awareness of details of how to receive the benefits or what the benefits of the scheme are. Poor depth of awareness of the enrolment camps and how to use the scheme are key barriers to enrolling and benefitting the scheme in the subsequent steps.

As per RSBY guidelines, Insurance companies (and third party administrators, TPA) are responsible for delivering the information, education and communication campaigns (IEC) to make people aware of RSBY and thereby enrol in the scheme. Field key officers (FKO) and Gram Panchayat (GP) members revealed that the camp organisers delegate this responsibility either to them or health workers a few days to a week prior to the enrolment camp with little-to-nil incentives. Nearly half of the households (44%) named the GP members or local officials as their informant about the scheme, followed by word-of-mouth from family or friends (23%) and from local health volunteers (19%).

Figure 4. Details of the scheme known to the aware households (n=3070)



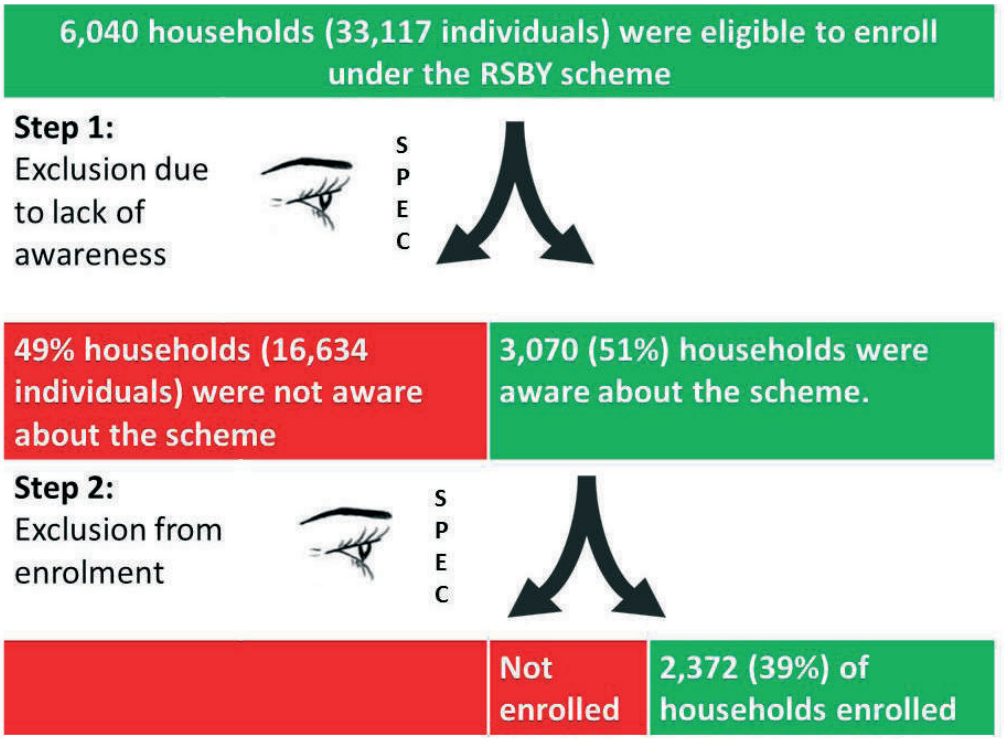
The local socio-political networks are fraught with existing socio-political biases, and relying mainly on these local networks led to the same biases influencing how awareness was spread to all beneficiaries. Most of our discussions revealed that beneficiaries believe that local authorities/GP members mainly share the information within their socio-political networks. A common perception was that authorities tended to favour those whom they perceived to be politically useful–the term 'useful' implying being helpful in rallying political support for them or by doing odd jobs for them. The importance of socio-political networks is apparent at this step. When questioned about this perception, GP members/local authorities admitted that they did rely on their networks to get the information across. They reported that they used this strategy due to the short notice provided to them by the camp organisers and not due to vested interests. Both local authorities and health volunteers were provided minimal-to-nil incentives to undertake this work by the organisers. Given their own workload, their own poor awareness of the scheme, and the limited time given to them, they often resort to quick strategies, like spreading the information through their networks or amongst those residing near their office to get the minimum work needed done.

An occupational group found to be on the other side of the political radar were casual wage labourers. Discussions among the community revealed that casual wage labourers are largely unavailable during the day when often information is disseminated or discussions are conducted, prioritising the earning of their wages rather than participation in any local social or political work. Both the local authorities and the beneficiaries themselves recognise this as a reason why casual wage labourers often remain uninformed, but given their poor socio-political participation, they remain neglected.

Given the large number of households left out at this step, the main factors identified as key predictors of exclusion at this step mainly involve socio-cultural and political factors. Social category, language spoken and socio-political participation were identified as key determinants of exclusion at this step, with lower rates of awareness among proportions of non-native Kannada speaking households (45% v 53%), households that did not participate in local politics (47% v 60%), and households residing more than 5 km from the nearest PHC (44% v 55%). Compared to other social categories, ST households recorded lower awareness rates (47% v 51%), while households in the lowest wealth quintile had poorer awareness when compared to the others (45% v 52%). Key factors are explored in detail in chapter 8, while the experience of ST households is reported in detail in chapter 14.

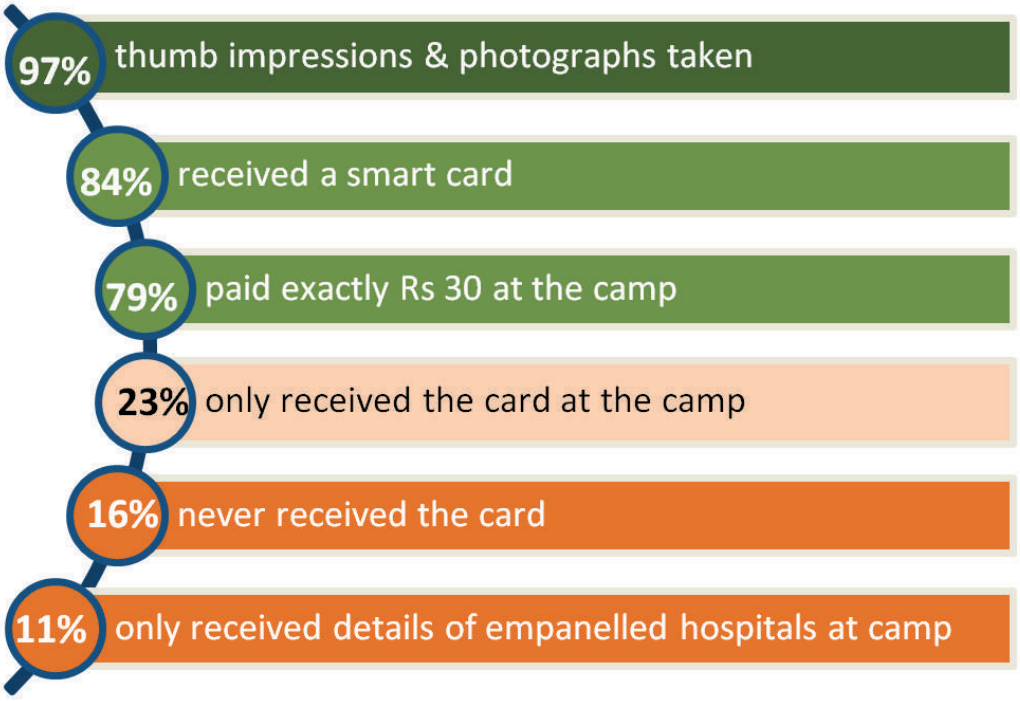
Step 2: Exclusion from enrolment in RSBY

Figure 5. Step 2: Exclusion from enrolling in RSBY shown using the SPEC-by-step tool



A total of 39% of households finally enrolled in the scheme as seen in Figure 5. This implies that 77% of the aware households enrolled in the scheme. The enrolment rates varied across the districts and across the taluks within a district (more details provided in chapter 8). In rural areas, the scheme was in its second year of implementation, but only 12% reported having enrolled in the previous round of enrolment. The urban enrolment rate was 44%, while the rural enrolment rate was 38%. During discussions, many reported that the main message of the information campaigns were details of the enrolment camp and not the benefits of the scheme. Only 1988 (84%) of enrolled households actually received the required smartcards for utilising the scheme (Figure 6). Of these, only a quarter received them at the camp as per guidelines, while another fifth (19%) received it after a month.

Figure 6. Details of the enrolment camp process (n=2372)



Similar to the step above, the limited lead time provided and reliance on local socio-political networks to inform, organise and even distribute cards after the camp often led to those not on the 'political radar' to miss out on the opportunity of enrolling in the scheme or receiving the cards. Of the 671 aware households that did not enrol, 52% reported that they did not know about the enrolment camp being conducted and hence missed the opportunity. Since the enrolment camp is organised on a particular day and time only at the local GP, those who were not available at the village, like casual wage labourers or migrants, have no alternate opportunity to enter the scheme.

During the camp, the discrepancies were often unrecorded, as many of the local organisers had limited-to-nil understanding of the scheme themselves, leading to misinformation being communicated to the beneficiaries (such as children were not eligible, only the head of household needs to enrol, etc.). In some cases from two districts, the camp organisers were reported to not speak the local language, which made communication with beneficiaries tedious and often led to errors in details on the card. Very few respondents reported technical glitches preventing them from receiving the card.

Following the camp, some local authorities and health workers reported poor incentives with high workload and, at times, non-payment of incentives as reasons for being disinterested in actively distributing the cards. Known social contacts and those who actively sought out the cards were given the cards, but those who did not were often not reached. In some villages, beneficiaries reported that local administrators used the cards as leverage to extract unpaid dues and, in some cases, bribes, thus dissuading locals from collecting their cards. Casual wage labourers and a few respondents from SC, ST communities reported being poorly treated by local authorities when they questioned them about schemes. Some reported being made to wait long hours to gain access to the people responsible, which meant having to forfeit their daily wage earnings.

Similar to the previous step, socio-cultural and political factors also determined the odds of enrolment into the scheme (in detail in chapter 8). Households headed by women and the elderly recorded lower enrolment rates than their counterparts (34% v 40%; 36% v 41%). Again, the social category of the household, especially ST households, and the lowest wealth quintile reported poorer enrolment rates in comparison to the other corresponding categories/ quintiles (30% v 40%; 33% v 41%). The experience of the former is detailed in chapter 14 exploring the possible mechanisms for this exclusion. In chapter 8, we further explore the determinants of exclusion from enrolment.

Exclusion within the household

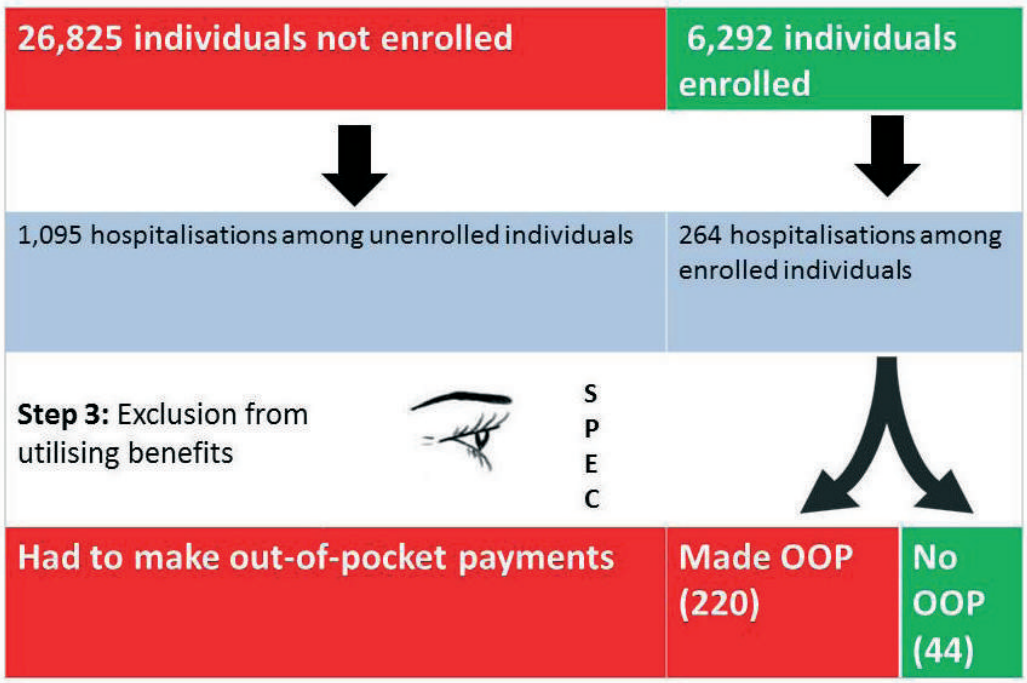
In RSBY as per design, up to five members can be registered on each card in a given household. In a large household (more than 5 members), some members are excluded by default. Among households with RSBY cards, 58% of household members (6,221 of 10,704) within these households reported to be registered on their cards; hence, they could potentially benefit from the scheme if hospitalised. Overall, this amounts to 19% of the total study population (33,117) as seen in Figure 5. Given RSBY's cap on how many in a household can be covered, the term fully-covered is defined as up to 5 members registered on the card in a household. Only 50% of small-sized households (up to 5 members) and 31% of large households (more than 5 members) were fully covered based on this definition, bringing the average card size (average number of household members registered on one RSBY card) to 3.1 members (further elaborated in chapter 8).

Beyond the design, in many cases misinformation about eligibility and enrolment procedures appeared to lead to the exclusion of part of the household. In some large households, decisions on who would register were also looked into. In most instances, the highest earning member of the household (usually the oldest son) would take decisions on welfare schemes, and the women of the household had little to no say in whether they were enrolled. Our data suggests that gender, age and relationship to the head of the household determine one's chances of being enrolled.

Step 3: Exclusion from utilisation of RSBY

The hospitalisation rate (or inpatient admission rate) was calculated to be 42 hospitalisation episodes per 1000 beneficiaries for six months among registered members in cardholding households, while the hospitalisation rate was 34 per 1000 among those not registered. This difference is statistically significant ($z=2.2402$, $p<0.05$).

Figure 7. Step 3: Exclusion from benefitting from RSBY shown using the SPEC-by-step tool



A total of 264 hospitalisations were recorded among people reported as registered on the RSBY card during the baseline survey. Of these, only 33 hospitalisations (13%) benefitted from RSBY by using the card as seen in Figure 7. However in another 11 cases during the six months of following up the study households, the study households informed about the scheme by the investigators pursued their local authorities to secure their RSBY card and were able to benefit from the card as well. Given the low number of utilisations of the card, we included these

cases thus bringing up the total to 44 hospitalisations that benefitted from RSBY. Among those who reported their hospital-related expenditure (90%), none reported a cashless experience and all incurred some out-of-pocket health expenditure with a median of Rs 5500 (Rs 30 to Rs 34,500). Around 15% experienced hardship financing (borrowing, pawning or mortgage), though this was relatively less than for non-beneficiaries.

The common reasons cited for not using the card were ignorance of what the card was for, visiting a hospital not empanelled under RSBY, and forgetting to take the card for the hospitalisation, especially during emergencies. Most beneficiaries visited hospitals based on the perceived good reputation of the hospital, referral by doctors, or if near to their house (28%, 16% and 15% respectively) (data not shown). Given the small number of card utilisation, no significant patterns of social exclusion were identified, however some beneficiaries did report in the interviews that having social contacts in or related to the hospital facilitated their accessing appropriate services and hence, the scheme.

Conclusion

We found that exclusionary processes operate at all steps of implementation of the RSBY scheme. These exclusions are driven by social factors (age, gender, language, literacy), political factors (having political contacts), economic factors (being a daily wage earner, subsistence living, migrant labourers, inability to pay bribes), and cultural factors (religion, caste, tribal). Moreover, each step is intrinsically linked with the others so that exclusions in one stage have repercussions on others and vice versa. RSBY itself is not capable of addressing the existing exclusionary processes in society, with implementation often succumbing to these exclusions. Our data shows unequivocally how caste, gender, literacy, religion and socio-political networks influenced access to RSBY at all steps of implementation. By adopting a social exclusion lens, we have tried to uncover the exclusionary processes that impede access to RSBY.

Implementers and policy makers of RSBY should pay special attention to lapses in procedure that aid exclusion and focus on the inclusion of vulnerable groups, given that the scheme targets the lost, disadvantaged (socially, economically and politically) section of society in the first place. Overall, three core strategies emerged that we believe can significantly address the social exclusionary mechanism identified in the study. The first strategy is for the social health protection scheme (RSBY in this case) to make an explicit commitment to cover vulnerable groups that face socio-cultural, political and economic exclusion within the population they target. Second, it is key that such schemes involve civil society and community-based organisations in all stages of implementation of the scheme, starting from the planning itself. The third strategy involves strengthening the monitoring and evaluation processes to ensure redress of grievances from the grassroots to even service providers with transparency of processes and effective utilisation of implementation-related data to ensure informed reforms are made to the scheme on a continuous basis. Hence, the application of a social exclusion lens by policy makers and implementers can help transform existing social health protection schemes into more socially inclusive policies.

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PART III: A SPEC-by-step analysis of social health protection programmes

CHAPTER 7: Awareness about Rashtriya Swasthya Bima Yojana in Maharashtra, India

Harshad Thakur

Introduction

The use of private health care facilities forces Below Poverty Line (BPL) households towards more out of pocket (OOP) expenditure, catastrophic payments and/or neglect of their health (Thakur, Ghosh et al. 2009; Ghosh 2011). Catastrophic health expenditure remains a cause of impoverishment in the majority of households in India (Ghosh 2011; Shahrawat and Rao 2012). The 12th five-year plan (2012-17) discusses the pressing need of acting against such impoverishment and makes a plea for inclusive health interventions (Planning Commission, Govt. of India, 2012). As a part of improving access to health services and minimizing the economic impact, several State Governments in India have experimented with health insurance schemes, particularly for economically vulnerable households. Schemes such as Aarogyasri in Andhra Pradesh and Yeshaswini in Karnataka are key examples of state-specific health insurance schemes (Forgia and Nagpal 2012).

Government of India launched one of the world's largest social health protection programmes, known as RSBY (Rashtriya Swasthya Bima Yojana, translated as National Health Insurance Scheme) in the year 2008 specifically to provide financial protection from catastrophic health expenses to BPL households and improve access to health services. In Maharashtra, the RSBY scheme was first launched in seven districts in late 2008 and then gradually extended to rest of the state (32 of 35 districts). Chapter five and www.rsby.gov.in provide a more detailed description of RSBY.

The RSBY scheme essentially depends on the insurer to involve the local governance structure in deploying strategies such as the pre-enrolment campaign, IEC (Information, Education and Communication) activities through announcements and advertising at public places to inform the targeted population. The tasks of IEC activities are often shifted to Third Party Administrators (TPAs1) who also provide enrolment and print smart cards.

Initially, the scheme was highly regarded by some for its excellent technical architecture and its spirit in providing business opportunities to all the stakeholders involved. The portability of usage of the scheme made it more efficient compared to other state-specific health insurance schemes (Palacios 2011). Recent studies on RSBY, however, present inconsistent and contradictory findings.

Since its inception in 2008, RSBY claims to have covered more than half of the targeted population2. However, there is substantial variation across the states and within the states (Sun 2011; Dror and Vellakkal 2012; Nandi, Ashok et al. 2013). Little is known about why some people have not enrolled and whether there is sufficient awareness about the programme in the community. Concerns have also been raised about the impact of the scheme. For example, in a study from Gujarat it was seen that while RSBY has managed to include the poor under its umbrella, it has provided only partial financial coverage. Nearly 60% of insured and admitted patients made OOP payments (Devadasan, Seshadri et al. 2013). Considering the Government plans to invest more in state-specific health insurance schemes as a key mechanism to finance health services, it becomes all the more important to explore the RSBY experience in more depth than has been the case to date. This chapter focuses on awareness levels in the target population.

In one study, the awareness and enrolment rate in Maharashtra was found to be lower than the national average, raising concern over the success of the scheme (Rathi, Mukherji et al. 2012). Secondary data analysis also indicates that the programme implementation in the districts of Maharashtra is poor (Nandi, Ashok et al. 2013). In a study in Himachal Pradesh, India, the majority of households were aware about the scheme and their eligibility; however, when it came to the 'know how' and the 'know where' of using the scheme, only 49% of respondents were provided with any written literature by the enrolling agencies, and only 15% of respondents received the list of empanelled hospitals (AmicusAdvisoryReport 2011). In another report from Uttar Pradesh, India, awareness amongst the enrolled population was low with 42% of respondents aware about the scheme with women being less aware (37%) compared to men (44%) (AmicusAdvisoryReport 2011). In a study in Karnataka, India, the majority of households (71%) reported being familiar with the name and card of RSBY (Aiyer, Sharma et al. 2013). Another survey carried out in 2010 in the State of Karnataka after the implementation of RSBY reports that high proportions of eligible households were aware of the scheme (Rajasekhar, Berg et al. 2011). A study in the Durg District of Chhattisgarh found that the majority of BPL households were aware of the purpose of RSBY (84%) and benefits covered (90%); however, they lacked an understanding of the eligibility criteria (27%), the validity of the smart card (25%) and the total number of members covered in the scheme (31%) (Nandi, Nundy et al. 2012).

The literature on RSBY by and large remains descriptive; there is hardly any scientific study on RSBY in Maharashtra and rigorous research evidence is lacking. These few studies describe awareness of the households (or its heads) in terms of their understanding of eligibility criteria, process of enrolment, benefits of the scheme (such as services covered, pre-existing diseases and amount of coverage) and ability to know the operational details (such as validity of the smart card, total members covered in the scheme and so on).

In Maharashtra, the RSBY scheme is being withdrawn and will cease in early 2014, as a new state-sponsored health insurance scheme – Rajiv Gandhi Jeevandayee Arogya Yojana (RGJAY) was rolled out in 2010 and gradually expanded to cover the entire Maharashtra state by year-end 2013. More information on RGJAY in Maharashtra is available on www.jeevandayee.gov.in .

While Maharashtra state is replacing RSBY with RGJAY, there are many other states in India continuing with the RSBY scheme along with their own state-specific schemes. Thus, it becomes all the more important to look at the performance and relevance of RSBY for Maharashtra. However, there is no systematic assessment on the level of awareness factors responsible for poor awareness in Maharashtra and the mechanisms/processes associated with it.

In this context, there are many important questions, such as what is the level and pattern of awareness, enrolment and utilization among the BPL population regarding RSBY? Who are excluded from participation in RSBY in spite of being a BPL household? What are the possible factors responsible for this?

The objectives of the current chapter are to assess the current status of RSBY among the BPL population in Maharashtra in terms of the first step: awareness. In addition, we attempt to identify the social, political, economic and cultural (SPEC) factors that may be in part responsible for better or poor awareness. Then we assess the depth of awareness and sources of information among aware households. In addition, we also present the mechanisms (how and why) of being aware or unaware.

Methods

The study followed a mixed-methods approach. After a review of the literature, both qualitative and quantitative methods were adopted for answering the research questions. Permission from the Institutional Ethics Committee was obtained; in addition, written consent was taken from all the respondents.

Data Collection – The quantitative data were collected using a household survey where 22 districts with a minimum two-year of scheme implementation were selected. A systematic multi-stage sampling design was adopted in both rural and urban areas covering 6,000 households (29585 individuals) across 22 districts. Additionally, we selected five districts for the qualitative data collection and conducted 18 Focused Group Discussions (FGDs) and 34 In-Depth Interviews (IDIs) with eligible BPL household members to supplement the findings. Chapter five, the case study in Maharashtra, provides more detailed information on the data collection.

Data Analysis – In the current chapter, we focus on the first step: awareness. The chi-square test was applied using SPSS 15 for comparing aware and not aware respondents for different independent categorical variables.

The qualitative findings helped to supplement the findings from the quantitative results. The findings were used to discuss why the households were not aware, or only superficially aware of the scheme. We used principles of grounded theory to code the transcripts and then used the results to explain mechanisms associated with low or high awareness.

Limitations–There are certain limitations of this paper that need to be explained. The first is the definition of awareness, which was only concerned with whether the respondents have seen the RSBY cards or not. It is possible that a respondent may know about RSBY but may not have seen the card. Furthermore, the details of awareness were available only for the enrolled households. Secondly, as RSBY was implemented in Maharashtra only 4-5 years ago, and the scheme was in the process of being wound down during the period of our fieldwork, this might have affected some low-awareness results. Thirdly, only descriptive statistics are used. Regression analysis is planned at a later stage. Finally, due to space constraints, the qualitative data are not fully exploited and analysed in this chapter. Further analysis will also be done at a later stage.

Results

Level of awareness – Chapter five on the Maharashtra case study provides the demographic and socio-economic characteristics of 6000 selected households. It also shows the number of people included and excluded by the programme at each step. In this study, the household was termed as 'aware' if the respondent reported that they have seen the card. Overall, it is seen that out of 6000 households, only 1781 households (29.7%) were aware of the scheme and only 1295 households (21.6%) were enrolled during the period of 2010-12. Further, it is seen that utilization of the benefits and services from RSBY remains very poor among the enrolled population. Thus, it is seen that that RSBY had a very limited success in Maharashtra.

Table 1 presents a comparison of aware and not aware households for background characteristics. It is seen that poor awareness is seen more in urban areas compared to rural areas. The Hindu community, ST (scheduled tribe) population, households with female head, illiterate population and nuclear families also seem to have poor awareness compared to other groups. The main economic activity of the household is also significantly associated with the awareness of RSBY.

Table 1 – Comparison of background characteristics among the aware and not aware households in Maharashtra

Background Characteristics	Aware (N=1781)	%	Not aware (N=4219)	%	Total (N=6000)	%	p value
Place of Residence*							
Rural	1316	73.9	2498	59.2	3814	63.6	<0.001
Urban	465	26.1	1721	40.8	2186	36.4	
Religion*							
Hindu	1315	73.8	3431	81.3	4746	79.1	<0.001
Muslim	216	12.1	338	8.0	554	9.2	
Buddhist & others	250	14.0	450	10.7	700	11.7	
Caste Categories*							
SC	607	34.1	1398	33.1	2005	33.4	<0.001
ST	294	16.5	864	20.5	1158	19.4	
OBC	555	31.2	1163	27.6	1718	28.6	
Others	325	18.2	794	18.8	1119	18.7	
Household Size							
<=5	1137	63.8	2802	66.4	3939	65.7	.0551
>5	644	36.2	1417	33.6	2061	34.4	
Type of house							
Temporary	589	33.1	1475	35.0	2064	34.4	0.310
Permanent	317	17.8	755	17.9	1072	17.9	
Semi Permanent	875	49.1	1989	47.1	2864	47.7	
Land Holding							
Yes	489	27.5	1169	27.7	1658	27.6	0.842
No	1292	72.5	3050	72.3	4342	72.4	
Main Economic Activity of Household*							
Self-employed (Agriculture)	290	16.3	664	15.7	954	15.9	<0.001
Self-employed (other)	157	8.8	321	7.6	478	8.0	
Agriculture Labour	579	32.5	1023	24.2	1602	26.7	
Casual Labour	540	30.3	1555	36.9	2095	34.9	
Regular Wage/Salary	179	10.1	565	13.4	744	12.4	
Others	36	2.0	91	2.2	127	2.1	

Background Characteristics	Aware (N=1781)	%	Not aware (N=4219)	%	Total (N=6000)	%	p value
Sex of Household head*							
Male	1454	81.6	3290	78.0	4744	79.1	<0.01
Female	327	18.4	929	22.0	1256	20.9	
Education of Household head*							
Never went to school	674	37.8	1820	43.1	2494	41.6	<0.001
Primary (1 to 5)	537	30.2	1068	25.3	1605	26.8	
Secondary (6 to 10)	456	25.6	1105	26.2	1561	26.0	
Higher Secondary (11 & 12th)	74	4.2	160	3.8	234	3.9	
Diploma & Graduate	40	2.2	66	1.6	106	1.8	
Type of family*							
Nuclear family	624	35.0	1523	36.1	2147	35.8	<0.001
Joint family	1061	59.6	2341	55.5	3402	56.7	
Single/Extended	96	5.4	355	8.4	451	7.5	

Note: Chi-square test applied, * = p value is < than 0.05, indicating a statistically significant difference

SPEC factors affecting awareness – Table 2 presents a comparison of social/cultural, political and economic dimensions/factors among the aware and not aware households in Maharashtra. For analysing the factors associated with awareness, we used key variables based on the social exclusion framework. The results suggest that the political factors are more significantly related to awareness compared to social/cultural and economic factors.

Table 2 – Comparison of social/cultural, political and economic dimensions/factors among the aware and not aware households in Maharashtra

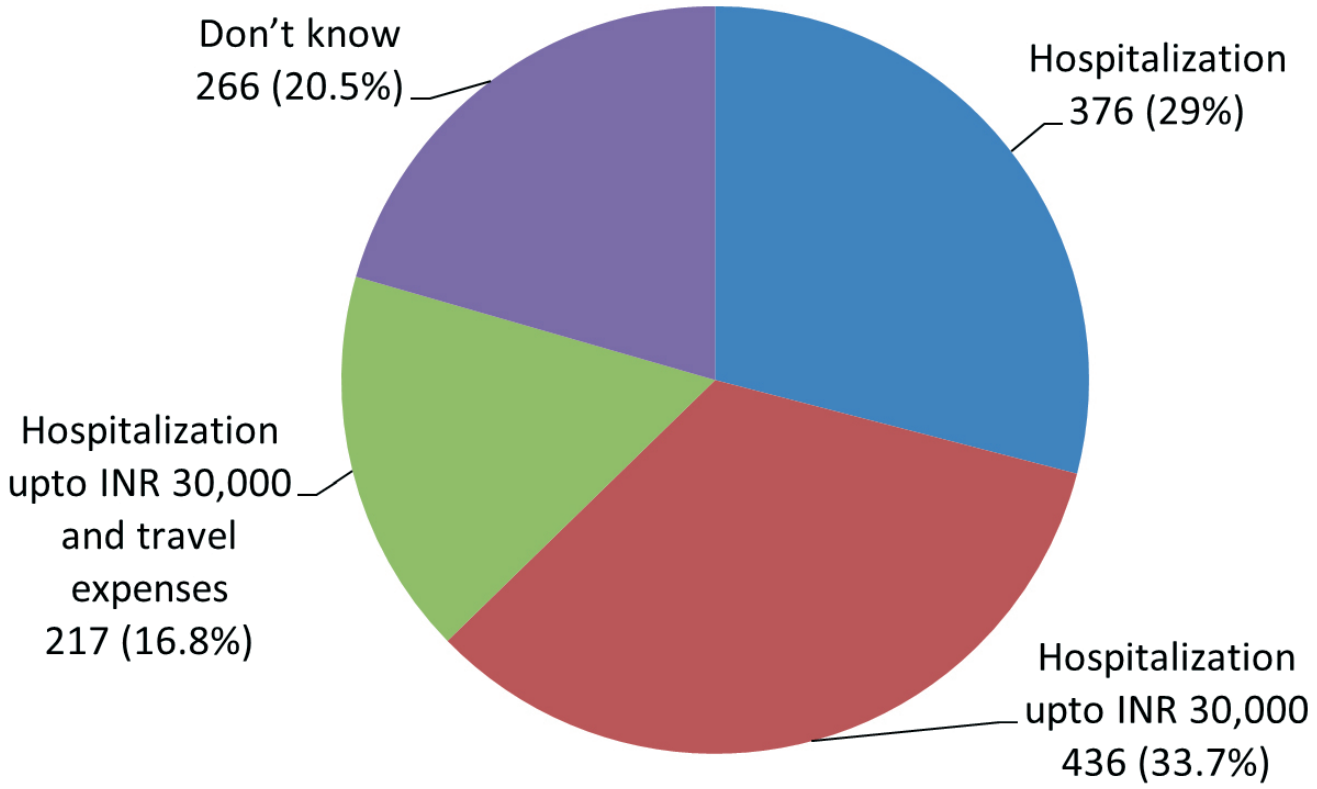
Dimensions	Aware (N=1781)	%	Not aware (N=4219)	%	Total (N=6000)	%	p value
Social/Cultural dimensions / factors							
1. Participation in social organization	376	21.1	800	19.0	1176	19.6	0.055
2. Discusses intimate and personal matters in the community*	1604	90.1	3723	88.2	5327	88.8	0.041
3. Feel that have been treated fairly because of your political beliefs, religion	1730	97.1	4097	97.1	5827	97.1	1.00
4. How often do you attend Religious Gatherings?							
Once a month or more	126	7.1	250	5.9	376	6.3	0.244
On holidays	1095	61.5	2605	61.7	3700	61.7	
Marriages/Funerals	353	19.8	896	21.2	1249	20.8	
Never	207	11.6	468	11.1	675	11.3	
Political dimensions / factors							
1. Voted in recent election*	1757	98.7	4124	97.7	5881	98.0	0.022
2. Participation in Local Politics*	994	55.8	1687	40.0	2681	44.7	<0.001
3. Political Contacts*	942	52.9	1819	43.1	2761	46.0	<0.001
4. Contested in Local Election*	52	2.9	61	1.4	113	1.9	<0.001
5. Member of Political Party*	68	3.8	102	2.4	170	2.8	0.003
Economic dimensions / factors							
1. Someone in the family a Bank account holder	1221	68.5	2858	67.7	4079	67.9	0.538
2. Had enough food in past one month*	1540	86.5	3779	89.6	5319	88.7	<0.001
3. Aware of any scheme for BPL	1440	80.9	3348	79.4	4788	79.8	0.188

Note: Chi-square test applied, * = p value is < than 0.05, indicating a statistically significant difference

The Depth of awareness – Having ascertained awareness levels and the various factors affecting the awareness, we tried to determine the 'depth of awareness'. This was examined only in the sub sample of the 1295 enrolled households. Among them, only 289 (22.3%) felt that they had received adequate information about RSBY. The majority had incomplete information on the scheme's benefits (like services covered, sum insured and empanelled hospitals); this may stand as major barrier in utilization of services and benefits.

We tried to determine the depth of awareness by asking respondents about the provision of expenditure allowed under the scheme (annual ceiling for reimbursement of the provider per RSBY enrolled household). It can be seen from Figure 1 that 266 (20.5%) of the enrolled households did not know anything about this provision; only 376 (29.0%) knew about a hospitalization benefit; 436 (33.7%) knew specifically about the hospitalization benefit upto INR 30000 per year (approx. 500US$); and only 217 (16.8%) were aware about the additional benefit of claiming travel expenses.

Figure 1 – Awareness regarding the provisions of expenditure under RSBY scheme among the enrolled households (N=1295)



The key informants and stakeholders also reinforced these findings and further stated that the strategies and efforts for creating awareness of RSBY among the BPL households were not consistent, and many such schemes are simultaneously operating across India, creating confusion for people (see below for further details of the qualitative results of the study).Survey respondents were also asked to give one main reason why they joined the RSBY scheme; Table 3 presents the findings among the enrolled households.

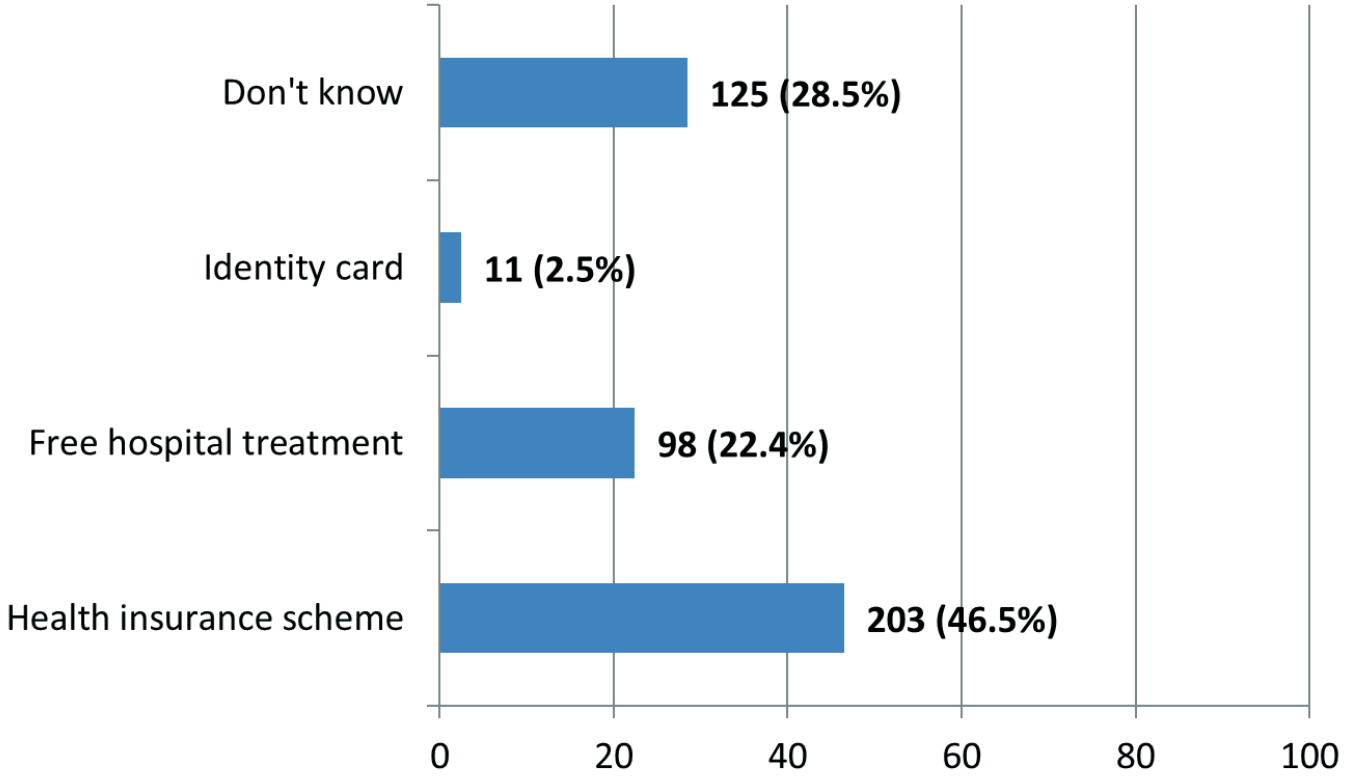
Table 3 – Main reason to become part RSBY among the enrolled households (N=1295)

Main reason to become part of RSBY	n	%
Social / community reason(sub-total)	(919)	(70.9)
1. Other community members joined so we did	793	61.2
2. Community members asked me to join	62	4.8
3. Village head or sarpanch or the gram sevak asked me to enrol	64	4.9
Technical reason (sub-total)	(358)	(27.6)
1. Protection against illness	289	22.3
2. Better access to private hospitals	36	2.8
3. The money paidout of pocket is saved in this arrangement	33	2.5
Other reason	4	0.3
Do not know / No response	14	1.1
Total	1295	100.0

The above table shows that only 27.6% of households could provide a technical reason for joining RSBY. For the majority (70.9%) of the enrolled households, it was a social/community effect or pressure that prompted them to join RSBY. This social dynamic may in part explain the poor depth of awareness observed even among the enrolled households. However, these results may also be misleading. It could be possible that many respondents who said "other community members joined so we did" might have known perfectly well that "protection against illness" was a benefit of the scheme, but this was not the main reason for joining when asked.

We also conducted further analysis on the sample of 4705 non-enrolled households, trying to determine whether they had heard about RSBY or not. It was not surprising to see that only 437 (i.e. 9.3%) had heard about the RSBY scheme. Of the 437 non-enrolled households, only 54 (12.4%) felt that they received adequate information about the RSBY scheme, while 165 (52.7%) of them tried to enrol into the RSBY scheme but could not succeed. Figure 2 presents the perceptions regarding 'What is RSBY according to you?' among these 437 non-enrolled households who had heard about RSBY.

Figure2 – The perceptions regarding 'What is RSBY according to you?' among the non-enrolled households (N = 437) who had heard about RSBY.



Source of information about RSBY – Table 4 presents the source of information about RSBY among households that are enrolled, or non-enrolled, but aware about RSBY. It can be seen that among the enrolled households, family/ social network (61.4%), followed by government efforts (32.4%), play an important role. On the other hand, among the non-enrolled but aware households, family/social network (76.7%) plays a very important role compared to other factors. Mass media does not seem to be an important source of information.

Table 4 – The source of information about RSBY among enrolled and non-enrolled but aware households (multiple responses)

	Enrolled households		Non-Enrolled households		Total	
	N = 1295	%	N = 437	%	N = 1732	%
Mass media (sub-total)	210	16.1	44	10.1	254	14.7
Radio (electronic media)	8	0.6	3	0.7	11	0.6
Television	8	0.6	20	4.6	28	1.6
Newspaper	4	0.3	7	1.6	11	0.6
Pamphlets	16	1.2	3	0.7	19	1.1
Public announcement	174	13.4	11	2.5	185	10.7
Family / social network (sub-total)	794	61.4	335	76.7	1129	65.2
Friends	85	6.6	27	6.2	112	6.5
Family members	65	5.0	54	12.4	119	6.9
Neighbours	445	34.4	188	43.0	633	36.5
By word of mouth	199	15.4	66	15.1	265	15.3
Government efforts (sub-total)	419	32.4	71	16.2	490	28.3
Government officials	36	2.8	12	2.7	48	2.8
Panchayat members	357	27.6	45	10.3	402	23.2
From the ASHA or ANM	4	0.3	3	0.7	7	0.4
At the enrolment camp itself	22	1.7	11	2.5	33	1.9
Others	10	0.8	7	1.6	17	1.0
No response	13	1.0	0	0.0	13	0.8

The above findings regarding awareness about RSBY show that there was mixed awareness in the community. However, detailed information was not known to anyone.

The mechanisms (how and why) underlying the poor awareness

We tried to ascertain the mechanisms and reasons for the poor levels of awareness mainly using the qualitative data. Here we include some remarks made by the participants in their own words.

Narrating the information exchange during the enrolment, one of the FGD participants said:

> *(...we were told that...) this booklet consists of the names of hospitals (and services) which can be used for the hospitalization (services); we were not told in person about the card except that (... all the functions of the card and...) facilities are explained in the booklet (and one can read and understand them from it). (Source: Nandurbar rural tribal FGD).*

This suggests that in some cases only booklets, but not cards, were distributed during the enrolment. Many of the illiterate or less educated might not be able to understand the booklets and hence be unable to derive information on how to obtain and use the RSBY card. Similarly, providing mere booklets of empanelled hospitals did not mean that information reached the beneficiaries, many of who are illiterate. The FGDs and IDIs also suggest that enrolment agencies were not properly trained and provided very superficial information about the RSBY.

Some households were unaware and never enrolled in the scheme, even though the enrolment was quite high in their neighbourhood. Regarding this, one of the IDI respondents stated that: “Yes, they (neighbours) do not share valuable information. They feel that if they are getting benefits of welfare programmes, then why to bother about the rest of the households.” (Source: Jalana urban IDI).

Some respondents felt that they were deliberately excluded from many schemes, including RSBY, because they were not politically well connected:

They (politically well-connected families) received wells, land. They (government agencies) provide employment to those who already have enough and let the poor die. Yes! That is it! They (RSBY enrolment agencies) will come there (in the Gram Panchayat) and leave from there. They will not come here. (Rural IDI woman whose husband was hospitalized and who was not enrolled).

The FGDs and IDIs suggest that the insurance companies relied on local governance structures for informing the potential beneficiaries about the scheme. However, Gram Panchayat members often did not view RSBY information dissemination as a priority due to numerous other primary responsibilities. Districts with active political leaders reported better enrolment and awareness about RSBY. Furthermore, it was reported that the powerful and politically connected households would not only receive benefits but would also be well informed about social protection mechanisms. The local political leaders were viewed as usually neglecting poor people. Tribal and minority groups tended to live in isolation as a result, preventing exchange of information.

Reliance on unofficial sources of information (for example, neighbours, friends etc.) was another main reason for poor awareness regarding the RSBY scheme. The households, who enrolled just because their community members enrolled, received little information from the enrolling agencies.

The enrolment was usually done on a particular day by the enrolment agencies. But there was no strategy to inform the maximum number of potential beneficiaries about this. A short-notice period to organize the camp and reach out to beneficiaries (ranging from less than 48-hrs to a week) seemed to be an important implementation issue resulting in exclusion. The awareness campaign and enrolment campaign were usually done simultaneously. Hurriedly completed enrolment left very little time for the enrolment agencies to interact with, and provide adequate information to, the beneficiaries. Also, many respondents couldn't afford to miss work and daily wages (especially the casual labourers). This lead to many households being excluded from enrolment:

The problem was they (people of enrolment agency) had not informed us before coming. So, when they came, we were not there. Then they came again, on another day. But they had not informed us. So, we couldn't make it again… (Source: Male participant from rural FGD in Nandurbar).

They (people of enrolment agency) informed people in the village (through the village head–sarpanch) that there will be a card distribution and everyone whose name features in the list are requested to stay back for the getting the card (enrolment). Some households did not listen to it (or were not able to understand it) and went on to work (to various places out of the village) thus they were not able to get the cards. (Source: Bhandara rural IDI).

Even among enrolled households, there was uncertainty about which hospitals can provide services and doubt over quality of care:

Now how we will be aware? We never went there (to hospitals, clinics…) with the intention to use the card. In addition to that I have been to several hospitals for treatment and there is no relief (cure). Now you only can tell me where should I go for treatment? If there is proper information only then we will go the hospital." (Source: Household head – woman and a casual labourer from rural district of Bhandara).

Due to a lack of awareness, several interviewees incurred expenditure for hospitalization episodes despite being covered by the scheme. "I didn't have the right information about it. Otherwise I would have saved the money that I spent on these two hospitalization episodes)." (Source: Jalgaon urban FGD respondent).

Other important findings emerging from FGDs and IDIs give ideas about the few important possible reasons and explanations for the mechanism of poor awareness. The enrolment agencies distributed chits (a small paper mentioning where and when the enrolment camp will be held) to the households whose names feature in the 2002 BPL list. There are many discrepancies in the list resulting in errors in identification of households (especially in urban areas), which lead to exclusion from information for the majority of the households. The name of the scheme was also reported as too long for the common man to remember.

Discussion and conclusions

The results reveal that the huge deficiencies in the awareness about the way the scheme functions may have led to low and unequal enrolment and utilization among the target households. Level of awareness was poor even amongst the households enrolled in the scheme. There was insufficient information exchange between the enrolment agencies and target households. At first glance, it appears that lack of effective IEC activities from the agencies that were entrusted to enrol the households in the given district emerged as a principal reason for the low awareness of the scheme. However, this is an overly simplistic – and may even be inaccurate – summary of the complex and rich results presented above, which point to the important social patterning of the failings of the IEC activities which led to greater exclusion of some groups than others.

The poor awareness about the RSBY scheme after a four-year period of the scheme's implementation in Maharashtra is an issue of serious concern. The gaps in the way users are informed about the scheme need immediate attention, as they are the key mechanisms of exclusion from access to information. Considering the association between educational attainments of the household head and role of political contacts on one hand, and awareness on the other hand, there is a need for better involvement of local governance structures for empowerment of below poverty line households. Further, we noticed that social groups such as scheduled tribes continue to be at disadvantage. These factors relating to poor awareness are likely to have a further impact on the performance of the scheme in terms of poor enrolment and utilization of the scheme's benefits when required. Government must actively facilitate the potential of these Insurance Schemes to emancipate the target group so that they may transform from mere passive beneficiaries into active participants in their health (Michielsen, Criel et al. 2011).

In previous similar studies in Maharashtra, the enrolment rate was found to be less when compared with the national average. Lower caste households (SC and ST) were poorly enrolled, it was found. Remote and tribal villages were not enrolled at all. The poor awareness, program design and schedules of enrolment were seen as primary reasons for low enrolment (Rathi, Mukherji et al. 2012).

Access to accurate information stands as a cornerstone in utilization of services in any of the targeted interventions in health (Jacobs, Ir et al. 2012), and health insurance programmes initiated by the state are no exception. Poor understanding of empanelled hospitals, services covered and the facilities therein is alarming and calls for an examination of the strategies adopted by the enrolling agencies in the states with RSBY. It is a time to re-examine the role of stakeholders involved in informing people about the health insurance scheme and take appropriate action (Reddy and Mary 2013).

RSBY in Maharashtra, as well as in other states of India and similar state-sponsored health insurance schemes, should ensure sufficient enrolment by proactively educating the vulnerable sections of the population. It is necessary to invest in infrastructure that will provide information support before enrolment, during enrolment and the post-enrolment period to vulnerable households. There is a need for adopting sustained and effective IEC activities instead of a one-time awareness campaign and simultaneous enrolment. The poor level of enrolments and renewals highlight the need to reconsider the design of the scheme. There is a need to improve awareness and

enrolment, issuing cards promptly with proper details with ongoing and prompt renewal. This needs to be done in the context of proactively educating the vulnerable sections of the population. To ensure wider enrolment of RSBY, approaches such as involvement of the workers' union (mainly informal sector) should be considered. There is also a need for monitoring and evaluation throughout all the levels of the scheme.

There can be many possible reasons for poor IEC on RSBY in Maharashtra. The most important is the poor planning of RSBY, as it was planned at national level without taking the differing social and cultural factors of Maharashtra into account. This was followed by poor implementation by the Ministry of Labour in Maharashtra, where the Ministry of Health was not involved. Poor awareness even among stakeholders such as implementers, policy makers, etc. is likely to be another important reason.

In India, another issue is that there are too many schemes running at national and state level in health as well as non-health fields. Even policy makers/implementers are unaware about the features of these schemes. Often, these schemes are announced at elections for political gain. The names of these schemes are quite similar to each other and change often. It is likely that simultaneously operating many such schemes creates confusion for the target population.

Many other states in India are running both RSBY and their state-specific health insurance schemes. But in Maharashtra, RSBY has been discontinued and replaced by the new state-specific scheme, RGJAY, initiated by the health ministry. It is therefore possible that RSBY did not get sufficient time to settle down and be properly implemented, which may also account for the low awareness.

Finally, it must be mentioned that India cannot only depend upon health insurance schemes to improve the health situation in the country. These schemes mainly take care of secondary prevention, i.e. diagnosis and treatment. But India also requires primary prevention in terms of health promotion. There is a need for overall socio-economic development with more focus on health.

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Endnotes

1 Third party administrators are the agencies acknowledged by Insurance Regulatory Authority of India, which provide ‘processing of insurance claims’ and ‘conduct of other administrative tasks’.

2 There are 68472226 households to be covered and 36985740 have been covered (http://www.rsby.gov.in/Overview.aspx, accessed on 28th April 2014)

CHAPTER 8: Implementing programmes as if social exclusion matters: enrolment in a social health protection scheme

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Introduction

In spite of best intentions, enrolment systems, particularly schemes that formulate eligibility criteria, are affected by pre-existing structural barriers in society that contribute to social exclusion (UNICEF, 2012). Such exclusionary processes vary from one area to another, even though the reasons for their existence could be the same. A variety of determinants related to individual characteristics such as age, gender, family size and several socio-political and cultural determinants have been postulated (UNICEF 2012, Acharya et al 2010). In addition, degree of enrolment is also related to complex behavioural characteristics of people, such as individual perception of risk, health-seeking behaviour, trust and previous experience with state institutions (Acharya et al 2010, Thornton et al., 2010). In fact, studies show that degree of enrolment is often not directly related to the cost; several schemes that offer near-free or no-cost enrolment are often under-subscribed (Wagstaff, 2007). Instances of large-scale educational and promotional activities to increase knowledge of health insurance have also shown limited results (King et al 2009, Thornton et al 2010).

In many low- and middle-income countries, the process of enrolling in social health protection schemes has been found to be a barrier to utilising such schemes (Acharya et al., 2010). In fact, enrolment into a scheme has been already assessed as a component of impact of a programme, often considered the most crucial in the chain from launch of a social protection scheme to achieving its objectives. However, a well-designed scheme could potentially understand the role of exclusionary processes in society and perhaps pre-empt or surpass them through a contextualised and well-implemented design where a special effort is made at the enrolment stage to ensure inclusiveness and prevent

categories or groups of people from being left behind (UNICEF report, 2012). In this chapter, we examine how the enrolment of RSBY was implemented in Karnataka, who was excluded, and why did it happen. We explore how this step influences existing exclusionary processes in society, and question whether this step itself acts as a barrier or promotes inclusiveness.

Methods

A full description of the study approach can be found in Chapter 6. In this chapter, we focus on the experience among 6040 households enrolling in RSBY across four districts in Karnataka.

In RSBY, enrolment is a one-time process that occurs annually. An eligible household is expected to voluntarily visit such an enrolment camp organised at their village/area on a particular date and confirm their name on the list with the organisers. They are expected to pay an amount of Rs.30, provide thumbprints and have their photographs taken; following this they are provided a validated smart card that enables them to benefit from the scheme in case of a hospitalisation. The former step is both necessary and sufficient for a household to be considered enrolled in RSBY irrespective of the completeness of the latter step. Hence, we considered a household to be enrolled if they satisfied the first step alone, i.e. visited an enrolment camp and confirmed their name on the list provided.

A mixed methods approach was used for data collection and analysis as outlined earlier. The quantitative findings were derived from the household surveys conducted in 2012-13 where demographic, socio-cultural, economic and political characteristics of the households were collected. The surveys also captured the households' experience engaging with RSBY with hospitalisation data collected over six months. The quantitative findings helped identify who was excluded and demonstrate patterns of exclusion. Following this, we further explored the interaction between key variables across social, political, economic and cultural (SPEC) dimensions, and with outcome variables such as being enrolled in RSBY. We conducted multivariate analyses (logistic regression) to take this forward to identify possible predictors of exclusion. This is explained in detail below. Next, we used focus group discussions and in-depth interviews with the community and other stakeholders at different levels to try and uncover how and why these exclusions happened. Findings from all sources were triangulated with each other to help present a complete picture of how we found social exclusion in the community to influence implementation of RSBY and vice versa.

Regression models

The simple logistic model used for estimating the determinants of enrolment in RSBY was defined by the following relationship (adapted from Parmar D, 2014):

$\text{Enrolled}_i = \beta_0 + \beta_{i1}X_i + \beta_{i2}SE_i + \epsilon_i$

Enrolledi is a binary variable that denotes the enrolment status of a household;

X_i is a set of general variables;

SE_i is a set of key variables selected across social, political, economic and cultural (SPEC) dimensions;

ϵ_i is the random error.

Three logistic regression models were estimated. First we estimated a simple regression model (Model A) with only X_i set of variables, then Model B with both X_i and SE_i variables; and finally, Model C with X_i variables and SPEC indices (explained below).

Variables used

Key variables across SPEC dimensions were identified through literature review and the preliminary study findings to better understand how social exclusion influenced a household's access to enrolling in RSBY. These variables were used to construct an index for each dimension (socio-cultural was merged to form a single index). Within each dimension, they were provided equal weightage as shown in Table 1 giving each index a maximum value of 100%. The higher a household scored for a given index, the greater its vulnerability to be excluded in that specific dimension.

Table 1. SPEC dimensions and variables used to construct the SPEC indices

Dimension	Domain	Variables	Weightage
Socio-cultural	Social participation	Not a member of any local social organisation/group	25%
	Religion	Belongs to a minority religion (Muslim, Christian, others)	25%
	Language barrier	Non-native Kannada speaking household (Marathi, Urdu, others)*	25%
	Social category	Belongs to ST community	25%
Economic	Relative poverty	Belongs to the poorest quintiles (Q 4 & Q 5)	33%
	Food security	Household not had enough food for 3 meals a day in the past year	33%
	Migration for work	At least one member in the household migrates out for work	33%
Political	Political participation	No household member participates in local political activities	25%
	Socio-political contacts	Household does not have any socio-political contacts (teacher, nurse/ doctor, local/state politician, etc)	25%
	Forced to vote	At least one member in the household was forced to vote in recent elections for a given candidate	25%
	Access to health services	Distance from nearest PHC >5 km	25%

*Kannada is the official language of the state of Karnataka

Acronym used: ST – Scheduled Tribe, Q – Quintile, PHC – Primary Health Centre

The different variables included in regression analysis are shown in Table 2. The dependent variable, Enrolled, is a binary variable that indicates the enrolment status of the household in RSBY. A household is considered enrolled only if they enrol in the enrolment camp conducted in their village/area.

General variables: The XI set of variables was included in all three models of regression. Since we looked for characteristics of the head of household that could determine its odds of getting enrolled, we used gender, age, literacy status, and income dependence (coding explained in Table 2). The household size of the eligible household was also included, as only smaller households (5 or less members) can be fully covered under RSBY while larger households will always be partly covered given the design.

Socio-cultural variables: Given the fewer number of variables identified in these dimensions and their considerable overlap, we merged socio-cultural variables in to one group, later as a single index (Table 2, Table 1). Historically in India, communities belonging to a minority religion and certain social categories like Scheduled Caste (SC) and Scheduled Tribe (ST) were excluded, and hence these variables were used to reflect on their possible influence on a household's odds to enrol in the scheme. Given the known socio-political tensions in bordering areas and the

significance of language barrier revealed during discussions for both awareness and enrolment, language spoken by household was included in the analysis. We created a variable, social participation, to reflect on whether any household member was a member of any local social organisation/group (e.g. self-help groups, women's groups, youth groups, occupation groups/unions).

Economic variables: The variable, Wealth index, was used to capture the household's relative economic status. We estimated relative wealth across households by developing a wealth index using principle components analysis. Household living conditions (type of house, access to safe water, latrine, and electricity, kitchen fuel used), ownership of land and household ownership of consumable goods (television, refrigerator, electric fan and two-three wheelers) were used in this analysis. The factor scores were used to develop a standardised index score that was finally divided into five groups or quintiles (Q) with Q 1 representing the wealthiest 20% and Q 5 representing the poorest 20% of households.

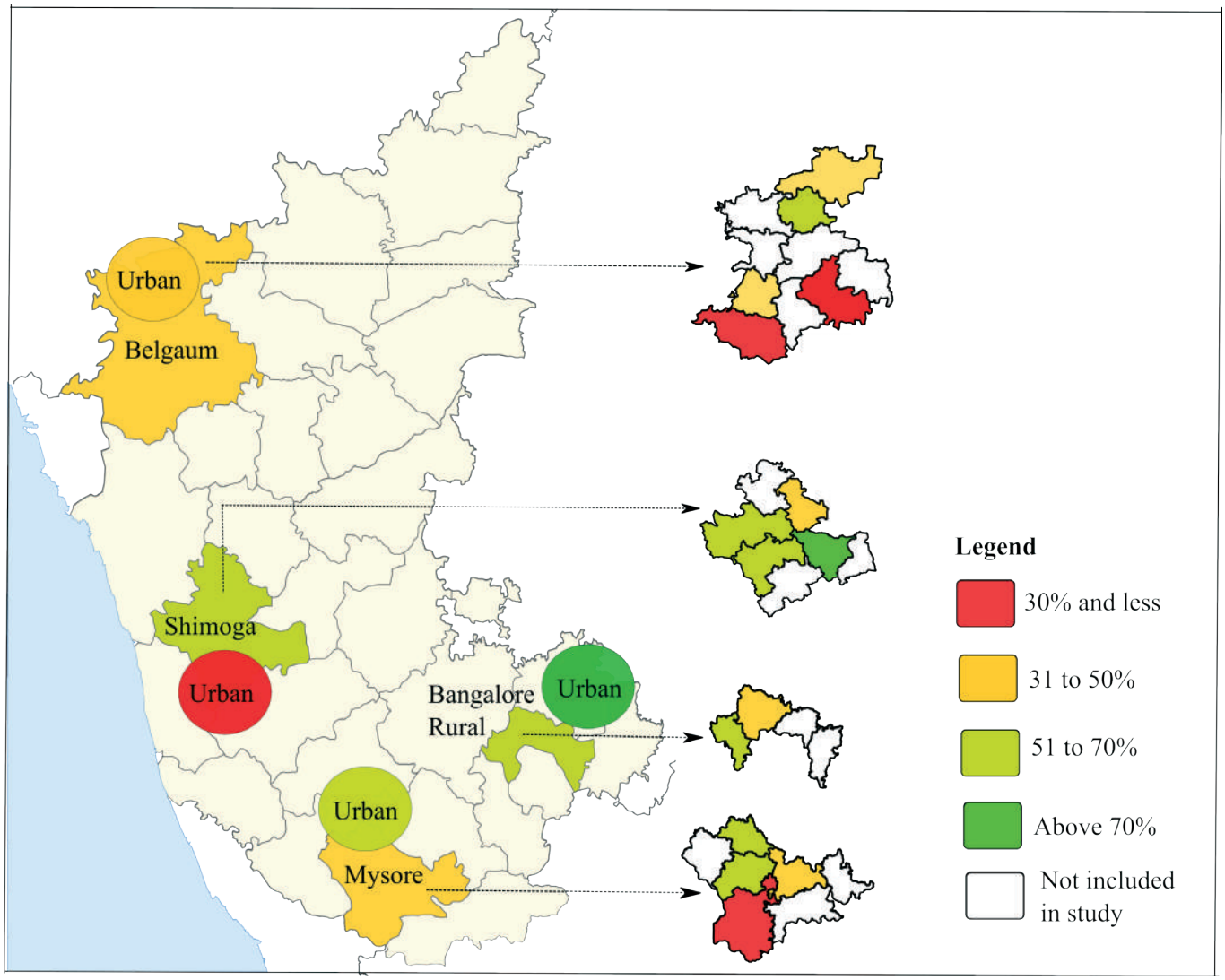
Political variables: Discussions and literature revealed that belonging to socio-political networks put some households at an advantage; conversely, those outside it at a disadvantage. To capture this information, socio-political contacts was created to include association with family or friend of the household who was at a key social or political position, like teacher, nurse/doctor, local/state politician, government official. To capture a household's access to health services, we used distance from the nearest government primary health centre (PHC) to capture this information. While initially political participation was developed to reflect participation in the democratic process of voting, the survey revealed that nearly all households alleged to have voted in the recent elections. Hence political participation used for analysis was limited to participation of any household member in local political activities like participating in local political rallies, standing in elections, etc.

Results

Patterns of enrolment

Overall, the enrolment rate was found to be 39% (2372 households) comparable to the official state figures (41%) for the second round of policy implementation in rural areas across the state (see Table 1, Chapter 6). The enrolment rates in two districts, namely Shimoga and Bangalore rural, were above 50%, while enrolment rates in Mysore and Belgaum averaged below 30%, as seen in Figure 1. Significant variations are seen both within and across the districts as shown in Figure 1. Even the best performing districts had sub-divisions that performed poorly reflecting the disparities in implementation.

Figure 1. Map reflecting the enrolment rates in urban and rural areas across and within the four districts/sites



The SPEC-by-step approach revealed that nearly half of the study households were not familiar or aware of RSBY at all (refer Figure 3, chapter 6). Hence, in the absence of awareness of the scheme, 49% of households were unable to access or enrol in the scheme. Three-quarters of the aware households did enrol in the scheme (refer Figure 5, chapter 6).

Among those who enrolled, only 84% received a smart card, thus excluding another 16% from utilising the benefits of the scheme. Only one in four enrolled households that had received a card obtained it at the camp itself, while local health workers or community representatives distributed the cards to the other households up to a month later (refer Figure 6, chapter 6). Overall, 58% (6,221 out of 10,704) of household members belonging to card-holding households reported to be registered on the card (refer chapter 6). On average, 3.1 members were enrolled per card, lower than the median household size of 5. As seen in Table 2, despite being enrolled and possessing the card, one in two households is not covered as per guidelines.

Table 2. Description of enrolled households with cards based on their size and RSBY coverage

Household size	Total number	Households fully covered (i.e. up to 5 members)
Large households (>5 members)	707	221 (31%)
Small households (5 or less members)	1281	645 (50%)
Total households	1988	866 (44%)

SPEC characteristics of the household and the member heading it were studied closely. A general description of the study population is provided in chapter 6. Descriptive statistics of key variables included in the regression analysis are shown in Table 3.

Table 3. Definition and descriptive statistics of key variables

Variables		Definition		Percentage	
				Frequency	Per cent
Enrolled		1 if enrolled, 0 otherwise		2372	39%
General					
Head of household	Female	1 if female, 0 otherwise		903	15%
	Elderly	1 if elderly (age 60 years and above), 0 otherwise		1741	29%
	Illiterate	1 if illiterate, 0 otherwise		3326	55%
	Income dependent	1 if not an earning member, 0 otherwise		1715	28%
Large household		1 if the household has more than 5 members, 0 otherwise		2268	38%
Socio-cultural					
Minority religion		1 if belongs to minority religion, 0 otherwise		553	9%
Language spoken		1 if household not native Kannada speaking, 0 otherwise		1628	27%
Social participation		1 if no household member is part of any local social organisation, 0 otherwise		2553	42%
Social category		OBC category is the reference category since it constituted the majority	OBC	3268	54%
		General	841	14%	
		SC	1378	23%	
		ST	553	9%	
Economic					
Wealth index		Q 1 to Q 5; Q 1 refers to the wealthiest 20% households while Q 5 refers to the poorest 20% households.	Q 1	1177	20%
			1206	21%	
		Q 1 is the reference category as it represents the economically better off households in the study	1106	19%	
			1096	19%	
		Q 2 Q 3 Q 4 Q 5	1242	21%	
Political					
Socio-political contacts		1 if no socio-political contacts, 0 otherwise		3610	60%
Political participation		1 if no household member participates in local political activities, 0 otherwise		5198	86%
Access to health services		1 if distance from nearest PHC >5 km, 0 otherwise		2086	35%

Acronyms used: OBC – Other backward caste; SC – Scheduled caste; ST – Scheduled tribe; Q – quintile, PHC – Primary health centre

Who heads the household matters in determining the odds of enrolment of the household as seen in Table 4. The head of a household being above the age of 60 years or a woman, and having more than 5 members in the household decrease the odds of enrolling in RSBY across the three models (Table 4).

Coming to the SPEC variables, speaking a language other than Kannada or not participating in local social groups/ organisations clearly put households at a disadvantage. Strong evidence linking the social category of the household and its odds of enrolment is shown in Table 4. When compared to OBC households, those belonging to the general and ST categories are significantly less likely to be enrolled, while despite being only half the size, the SC households are more likely to be enrolled in the scheme, thus reflecting a socio-political process.

Regarding the wealth index quintiles, a household belonging to the fifth quintile, i.e. one of the 'poorest of the poor', is less likely to be enrolled in the scheme. The farther a household from a PHC the lesser its odds of getting enrolled indicates that distance is still an issue influencing access to services and/or schemes. This again shows that those already at a disadvantage are still more likely to be excluded in RSBY. A key point to note is that similar to participation in social organisations, poor participation in local political activities also put a household at a disadvantage in enrolling in RSBY. In Model C, we see from the SPEC indices that households vulnerable in all SPEC dimensions of social exclusion have lower odds in enrolling in RSBY similar to the picture in Model B.

Table 4. Determinants of enrolment in RSBY in Karnataka (2011-12)

Key variables		Model A		Model B		Model C	
		OR	SE	OR	SE	OR	SE
General characteristics							
Head of household	Female	0.787	0.081***	0.778	0.083***	0.795	0.082***
	Elderly	0.760	0.099***	0.762	0.102***	0.746	0.101***
	Illiterate	0.902	0.055*	0.969	0.060	0.968	0.057
	Income dependent	1.168	0.100	1.174	0.104	1.183	0.103
Large household (> 5)		0.868	0.056**	0.849	0.058***	0.855	0.058***
Socio cultural variables							
Minority religion				1.130	0.104		
Language spoken				0.770	0.068***		
Social participation				0.823	0.056***		
Social category -General				0.733	0.087***		
-SC				1.183	0.070**		
-ST				0.605	0.105***		
Economic variables							
Income quintiles Q2				1.048	0.084		
Q3				0.876	0.088		
Q4				0.906	0.089		
Q5				0.696	0.089***		
Political variables							
Political capital		1.041	0.057				
Political participation		0.844	0.080**				
Access to health services		0.755	0.059***				
SPEC indices							
Socio-cultural index				0.485	0.133***		
Political index				0.612	0.132***		
Economic index				0.733	0.111***		
Number of observations		6,040		5,827		5,827	

Dependent variable: Binary variable for enrolment

Acronyms used: OBC – Other Backward Caste; SC – Scheduled Caste; ST – Scheduled Tribe; Q – Quintile, PHC – Primary Health Centre, SPEC – Social, Political, Economic and Cultural

Robust SE in parenthesis

*p<0.01, **p<0.05, *** p<0.01

Why this pattern?

We try to understand how and why the above patterns were found by reflecting on the issues with design and implementation of the scheme while exploring possible drivers of social exclusion that influence getting into the scheme. Although it is difficult to completely separate the operational issues of RSBY implementation from the exclusionary processes in the community, we attempt to explore these issues using a SPEC lens to try and reflect on how and why existing social exclusion influences access to enrolling in RSBY.

Poor awareness of RSBY

The most important issues identified were related to the poor awareness about RSBY among the eligible households, irrespective of their SPEC characteristics and also among the local RSBY actors (see chapter 6 for more details). Around half of the households that did not enrol in RSBY (52% of 671) stated that they were not aware of the details of the enrolment camp, like time, venue etc. 14 % stated they were unaware of the details of the scheme, and hence were not convinced to enrol. The camp organisers and local authorities also often appeared to lack awareness of their role, which had an impact on protocols of running the camp. While some local RSBY actors stated that they were provided training on RSBY and their responsibilities, some were completely unaware of their role at the enrolment camp or the purpose of the scheme. Consequently, they were incapable of identifying deviations from protocol when they did occur.

> *'The people who came to take photograph told that they would send it later. I did not know that cards should be given on the same day'. (FKO_Bangalore Rural)*

> *'I did not get any training. The labour inspector and some people came to Panchayat and told me my responsibility, took my thumb impression for the card and that's all. It didn't take very long'. (FKO_Mysore rural)*

The poor awareness among local organisers in turn often created misinformation and misconception about the eligibility, benefits and process of the scheme among both eligible beneficiaries and the local actors involved. For instance, in one area, a health worker mistakenly informed her local contacts that the RSBY cards had lifetime validity, which prevented eligible beneficiaries in an entire village from re-enrolling in the scheme. (It should be noted here that as per RSBY guidelines, the beneficiary household must re-enrol every year if they want to benefit from it.) Such errors at times led to denial of benefits when people tried to utilise the scheme, further reducing people's trust in the scheme.

> *'We told many people about the camp and got a good response to the call for enrolment. But then we were given a list of the people eligible for the scheme. Only a few who came had their names on the list. We told the rest of the people to go away and come some other time. But their names were not on the list actually'. (FKO_Shimoga)*

In other quarters, a growing apathy towards government schemes due to both previous negative experiences with similar schemes and lack of understanding of their entitlements dissuaded some from enrolling. A key reason identified for people's negative perception of the scheme was the lack of information available to beneficiaries about the benefits of the scheme, how to access them and where to go if a health issue arose. Only 11% of the enrolled households in our study received a leaflet at the camp with information about the hospitals empanelled in the district (refer chapter 6). In many villages, local coordinators like the Gram Panchayat (GP) members and field key officers (FKO) lacked this awareness as well. Hence, beneficiaries' negative experiences such as denial of benefits for legitimate reasons under RSBY – for instance, when benefits were claimed at a non-empanelled hospital – reinforced their poor perception of the scheme.

'We heard that they would not take the card in that hospital. You have to pay money even if you show the card. Some people went [for the camp] but did not get the card. Hearing this we are thinking whether we can miss one day of earnings for this card. I do not think it is possible.' (Resident_Mysore)

At the enrolment camp

The 2002 BPL list used to develop the list of RSBY eligible households in 2011-12 has been repeatedly criticised for its poor quality and inclusiveness (Dreze J, 2010; Mehrotra S, 2009; Mukherjee N, 2005). This was one of the most vocal problems we found while interacting with RSBY actors responsible for implementation at all levels. The list provided to the GP members was riddled with errors according to them, such as inclusion of households that did not reside in the assigned area or had moved out years earlier. While local authorities or health workers only attempted informing those on the list as instructed, few beneficiaries reported that their name was not on the list; as a consequence, they were denied enrolment at the camp.

Local village representatives and other RSBY actors reported that a very short notice period was provided to identify eligible beneficiaries, inform them of the scheme in detail and organise the camp, which were compounded by the inadequacy of the list. While guidelines clearly state that awareness activities should be carried out at least one month prior to the camp, in reality, local authorities were informed of the camp schedule and provided a list of eligible beneficiaries one day to a week prior to the camp. This is reported to have put tremendous pressure on the local actors to follow due procedure. Given their numerous other responsibilities and inadequate incentives provided by the implementers, the priority of RSBY related activities is stated to be low.

Interaction with local health volunteers and other RSBY actors revealed that promised financial incentives from the government department were often not given. This show of bad faith by the RSBY implementers made local actors less motivated to distribute cards personally to each beneficiary. Others who did receive the incentives were dissatisfied with the amount (Rs 2 per card), stating that it did not match the time and effort required to visit houses to distribute the cards. While interacting with local health workers/GP officials in a few areas, we noted that some RSBY smart cards were stored, undistributed at the office. Given this situation, local authorities often resort to quick-fix strategies like informing known contacts on the list such as friends and family, those who live near the GP office, or informing those who visit the office for other work.

'They called and said tomorrow we are coming for this Yojana (scheme). "What is it?" we asked. They give us just one day to inform the villagers. So to get at least some people what we did was we contacted known people, called them and informed them to send their people'. (FKO_Mysore)

Technical problems at the camps or with the cards was seldom reported with only 3% enrolled households not receiving their cards due to problems with the machine or electricity. Local RSBY actors appeared to recall these infrastructure breakdowns more than beneficiaries. When the cards did arrive, many of them apparently came with errors such as repetition of names and non-matching photographs. These errors were most often revealed only at the time of hospital admission, thereby preventing people from availing the benefits. In many sites across two districts, the enrolment camp organisers did not know the local language, which made communication at the camp difficult. This language barrier led to miscommunication about the process or benefits, mispronunciation and misspelling of people's names which at times prevented genuine beneficiaries from enrolling, and later also influenced utilisation for some.

What determines enrolment?

Who heads the household matters

Women-headed households are uncommon with only 15% of the households headed by women. Elderly headed households account for nearly a third of the study households (Table 3). Women- and elderly-headed households are less likely to be enrolled in RSBY (Table 4). These disadvantages are compounded further when gender intersects with age group, social category, literacy and marital status. Around 83% of these women heads are widows, with 43% above the age of 60, 86% illiterate, and 36% casual labourers (data not shown).

Socio-cultural factors

One-third of the adult study population work as casual labourers (refer Table 2 chapter 6). Such workers often go to work outside the village on a daily basis and do not return until evening or, in some circumstances, migrate out for days to months together. Due to this, they are often unavailable in the village to receive information or attend an event during the day.

> *How can we miss even one day of work? If we do not go for our work how will our family eat? They will have to starve if I cannot earn anything that day. (Resident_Belgaum)*
>
> *People like daily wage earners… they work on the same day and earn money on the same day for living. Such people will not come... (FKO_Bangalore Rural, rural area)*

Some respondents reported that those who depend on daily wages prioritise this daily income over all else and are not interested in participating in regular social or political activities. On the other hand, this behaviour makes them less politically useful to local authorities (useful here implies helpful in rallying political support or doing odd-jobs for those in political power); hence, minimal effort is made to reach out to them to ensure access to this and similar schemes.

Non-native Kannada speaking households were mainly in urban areas and the Belgaum district. These households are less likely to be enrolled (Table 4) due to the language barrier. This is particularly important in a district like Belgaum that shares its border with another state and where the proportion of Marathi (the language of the adjacent state) speaking households is significant. For instance, 64% of study households (n=506) in Khanapur sub-division of Belgaum are Marathi-speaking, and the enrolment rate of that sub-division was only 15%, nearly half of the district average (Figure 1).

Social category of the household is also seen to determine the odds of enrolling in RSBY (Table 4). We found a difference in the enrolment rates between SC and ST households from our survey. While ST households are less likely to be enrolled, the situation was reverse for SC households (Table 3). The exclusion experience of ST households is detailed in chapter 14. Despite the better enrolment chances for SC households, discussions in the community revealed that the only a few who reported being actively denied access to scheme/services by local authorities due to their caste were respondents from SC communities. For instance, in a village in Mysore district, SC beneficiaries were made to wait at the end of the line by the local authorities irrespective of when they arrived at the camp. Eventually the camp organisers wrapped up the camp early in the evening before the SC beneficiaries could enrol. Many SC households organised themselves into main villages due to which the whole village is able to access the scheme and the overall numbers look good, however in villages where these households are a minority, they still report being socially excluded.

Whom you know matters

As mentioned earlier, households with no membership in local social organisations, no local political participation and belonging to ST communities have decreased odds in enrolling in RSBY (Table 4). Local organisers stated that socio-political networks are largely relied on due to a degree of helplessness at their end given the short timelines with no intended bias on their parts. However, many FGD respondents stated that they (beneficiaries) perceived this dependence on networks as deliberate actions by the local actors to restrict benefits to their contacts or use information as a bargaining tool to elicit other work or money – a feature not restricted to RSBY but also to other government schemes. These networks are perceived to be in favour of those with political power.

As mentioned earlier, those who depend on daily wages for subsistence do not often participate in regular social or political activities and are commonly ignored by local administrators/political actors. It is interesting to note that respondents often believed that gaining political contacts or political power would help an individual overcome the perceived disadvantage of one's social category (SC or ST).

> *'All our young people together made a plan and chose one person from our community for gram panchayat (GP) member seat, and he stood for election from general category won because we all elected him. Now we get all the facilities like road, house everything from him. He gives all the information. Till now, nobody gave us any information'. (Resident_Belgaum)*

Relationship between the local government and the eligible households

In some areas, both GP members and beneficiaries say that the GP used the RSBY card as a means to collect pending taxes. Those who failed to pay up were denied the card as a penalty. This could be another reason for the poor and delayed distribution of cards following the camp.

> *'If we have some pending payments they will not give us the card. We can see that our card has come but until we pay our balance we cannot get the card. Not all people have the money to pay'. (Resident_Bangalore Rural)*

Though most of the enrolled households did not receive the card at the camp (77%), over time they often failed to follow up on the card with the GP. The negative image of the scheme and its perceived lack of benefits (explained earlier) are stated as some of the important reasons for this. Some respondents who did seek out the card at the local GP office reported being treated poorly by local administrators. This dissuaded them from approaching the GP office again.

Some instances provided by both the local organisers and the beneficiaries provide a better picture of the relationship between them. When interviewed, a few GP members admitted that, at times, they quickly provided the card to those who asked questions or who raised their voice and threatened to complain in order to avoid trouble. Some respondents also reflected on this, stating that coming together in groups provided better political standing to question local authorities for services.

> *'Even after 3 to 5 months the card is not given to us. If we ask, they [GP] will say "We will give it to you when it comes, go now, why are you forcing us so much? Why will we keep it pending if it has come? Will we eat the card? If it comes we will give it to you. Go now, do not argue with us', this is their reply. (Resident_Bangalore rural)*

> *'If we start demanding our rights they [authorities] start quarrelling with us, shouting at us, telling us we have no right to question them.' (Resident_Belgaum)*

'If we all go together and start fighting with them [authorities] then they sometimes give us because they don't want us to start causing trouble. But mostly we are not united–we do not join as a big group and go'. (Resident_Belgaum)

A few reported that the local authorities demanded money in exchange for providing their RSBY cards. Similar demands were reported for accessing other welfare schemes as well. Those who cannot afford this, or for whom the informal payment outweighs the expected benefits, do not approach the authorities at all. Some people do not view this as corruption but as a means to recover money that was spent formally or informally during their election campaign. While some community members justify this behaviour, others regard it as unfair.

'We have to give money only. After that they will give. We have less money to buy our food. On top of that how will we have money for giving here also'?' (Resident_Mysore)

Discussion

In the last decade, the state government of Karnataka has focused on improving access to health services among the poor with the launch of various health financing mechanisms and other health specific schemes targeting BPL households. While the schemes are often evaluated to assess their impact on financial protection or on their implementation outcomes, evidence is limited to assess their ability to address social inequities present in this population. Our study attempts to address these issues by exploring if and how existing social exclusion influences the access to a social health protection scheme and, conversely, how the design and implementation of a scheme leaves social exclusions unchallenged.

Our findings reveal that the step of enrolment in RSBY both in terms of design and implementation when viewed through the SPEC lens reveals exclusion due to the operational issues of the scheme itself but also amplifies the social exclusion of certain vulnerable groups. As per guidelines, the design and process of implementation of RSBY is neutral to gender, age, caste or religion of the targeted beneficiaries. However, it targets a population that already represents different groups of socio-politically disadvantaged communities. The programme's failure to recognise this reality allows existing exclusionary processes to continue and inadvertently exaggerates the exclusion of vulnerable groups or individuals. A household belonging to the fifth quintile, i.e. one of the 'poorest of the poor', is less likely to be enrolled in the scheme while distance is still an issue influencing access to services and/or schemes as seen in Table 4. This again shows that those already at a disadvantage are again more likely to be excluded in RSBY.

Discussions with respondents revealed that there exists confusion in people's minds with various state and federal welfare schemes emerging with similar eligibility (commonly targeting the BPL population) or with similar enrolment procedures. Some respondents mistook the RSBY card with an Aadhar card (unique identification card issued by government of India), a bank ATM card and even a mobile SIM card, thus reflecting the confusion in their minds (see chapter 6). The cap on number of household members (up to 5 members only) covered by the scheme in a large household is a limiting factor of the design of RSBY, as benefits can only be availed by those household members who have their name and relevant information registered on the card. Of the 1988 enrolled households that received the card, only 58% of the household members were registered and hence covered. On average, 3.1 members were enrolled per card, lower than the median household size of 5. Hence even if the scheme arrives at the doorstep of an eligible household, it will not provide financial protection to the entire household in the case of hospitalisation.

Our results show that while the determinants can be listed discretely, they often intersect putting certain vulnerable households or communities further at a disadvantage. The two sub-divisions with the lowest enrolment rates (<20%, Figure 1) in the study are already known to be two of the most under-developed regions in the entire state in terms of their socio-economic development indicators (Karnataka State Planning Board, 2008). These regions are characterised by difficult physical access with forests, relatively poor socio-economic development, and have

a significant ST population, who we see in our study to be persistently excluded at all steps of implementation. One of the two mentioned also has a significant Marathi speaking population with political instability. Yet the programme does not plan or develop additional mechanisms to extend access to RSBY to the eligible beneficiaries in these regions. The 'business model' approach of RSBY, where the insurance company is paid a premium for each household enrolled irrespective of who or where this household is, ensure these adverse conditions do not appear 'profitable' to the actors involved. Despite the explicit social mandate of RSBY, the policy design and procedure for implementation laid out pursues numbers, leaving the most vulnerable behind to deal with their own adversities.

RSBY incorporated two key designs into their programme to facilitate utilisation by migrant workers: the first is the ability to use the scheme in almost all states in India across insurance companies; the second is the introduction of a 'split card' system that allows any household to divide the total amount covered across two cards. This allows the migrant to carry a card, and hence the benefits, while his/her family who remain behind can also use the card, and hence the benefits. This reflects the scheme's priority to include those who migrate for work among the unorganised sector. While RSBY adopted a social exclusion lens to design and implement the utilisation process in relation to migrant workers, they did not bring this understanding to design a flexible enrolment process to ensure that migrant workers could enrol themselves anywhere they work.

In our study, it was seen that due to the short notice given to the local administrators/health workers, the eligible households get to know about the scheme only a few days (in some cases, on the day itself) before the camp is organised. With such short notice, it is impractical and costly to travel back to one's native village and missing out on a few days' earnings to attend the enrolment camp. Poor awareness of the split card was also found among the study households (<2%). At times, it is the head of household or the income earners who travel out for work, and eventually they are not registered on the card even if the household is enrolled.

> *'They [his son and wife] go for six months and come back only for festivals or during rainy season when there is no brickwork. When they come back, they will also go outside the village for any other manual labour work. I think it will be difficult for them to come for this scheme'. (Resident_Belgaum)*

Our results show the importance of socio-political participation in determining the odds of a household from enrolling in the scheme. Our discussions further confirmed and explained how participation in local socio-political processes lead to some being favoured and others being excluded. Being a member of local social organisations, belonging to a particular social category, working as casual labourers, and speaking another language significantly influenced their odds of enrolling in the scheme (Table 4). Reliance on local socio-political networks by insurance companies (or third party administrators) to spread awareness about the scheme and organise the enrolment camp makes local authorities a key gateway to accessing the scheme. This in turn allows the existing socio-political biases in the community to influence the implementation of RSBY as well. To truly reach out to the most vulnerable households, RSBY will have to invest in more politically neutral processes for implementation of the scheme, and strengthen its grievance redressal and monitoring and evaluation mechanisms.

The study has some limitations given its aim to capture the complexity of social exclusion. While the current mixed methods approach provides valuable insights into understanding the type, extent and, to some degree, the mechanism of prevalent exclusion in the community, a theory-driven approach may be more useful to better understand these mechanisms. The study households comprised of households sampled from the general population and did not target specific vulnerable groups like ST households or female-headed households. The experience of exclusion faced by these groups hence captured in this study carries this limitation. Last but not

the least, all possible variables influencing enrolment were not included in the regression analysis. Some of these variables were significantly skewed, like possession of voter's identification or ration card; however, omitting these and other variables may bias results by overestimating the effect of other independent variables on enrolment, though this effect is most likely to be small.

Conclusion

When viewed with the SPEC lens, RSBY cannot ignore the existing exclusionary processes at play, particularly among the target population known to have poor health indicators, adverse socio-political circumstances affecting its health seeking behaviour and vulnerability to financial adversities. The key message for policymakers involved in designing and implementing RSBY and similar programmes is to adorn the SPEC lens to understand the populations targeted by the programme and use this perspective to design multiple, flexible strategies to ensure that the programme reaches its intended beneficiary and that vulnerable individuals or communities are not forgotten in pursuit of universal aims.

As outlined in chapter 6, three core strategies emerge from our study that we believe will strengthen the implementation of the scheme by addressing the social exclusion processes outlined in this chapter. The first strategy: make an explicit commitment to cover vulnerable households that involves localised sensitive procedures to identify these households or communities using appropriate incentives to those involved and flexible enrolment procedures, bearing in mind the working patterns of those targeted with sensitisation of key stakeholders involved. The second strategy: involve civil society and community-based organisations in all stages of implementation involving well-formulated, locally adapted and targeted information campaigns, facilitation of referral and hospitalisation processes, and, most important, provide insight into how these households are excluded in the first place and then develop strategies to overcome these. The third strategy: strengthen the feedback and evaluation mechanisms involving key stakeholders from the grassroots to state level so they participate in a continuous monitoring process that ensures transparency and promotes inclusiveness. This way, social health protection schemes like RSBY through their inclusive designing and implementation process can ensure that they protect vulnerable households as envisioned.

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CHAPTER 9: Social exclusion and its effect on enrolment in Rashtriya Swasthya Bima Yojana in Maharashtra, India

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Introduction

Although the Indian economy has been on a high growth trajectory ever since the economic reforms were initiated in the late 1980s, findings from national sample surveys and other sources suggest that the developmental model pursued in the last two decades not only failed to produce a 'trickle-down effect', but even exacerbated overall and rural-urban income inequality (Pal and Ghosh 2007; Mehta & Sarkar, 2010). In fact, when inequality is quantified along the lines of per capita income, India is among the worst performing countries in the world (Murgai et al., 2011). Furthermore, concerns have been expressed regarding the exclusionary character of the economic growth achieved during this neo-liberal era, with higher rates of poverty reduction being achieved among non-deprived majority groups than among vulnerable groups such as Scheduled Tribes (STs), Scheduled Castes (SCs) and Muslims (Dubey & Thorat, 2012).

Large inequalities are also reflected in the considerable disparities in access to basic services like education, health and nutrition across rural-urban populations and communities (Kabeer, 2006; Baru et al., 2010). This has been reflected in the significant differences in human development outcomes between excluded and non-excluded social groups (Planning Commission, 2011). There is evidence that despite having higher healthcare needs, individuals belonging to marginalised communities face greater access-related barriers than other groups because of their social identities (Borooah, 2005; Hoff & Pandey 2006; Acharya, 2010). Partly as a result of this, they also have poorer health outcomes (International Institute for Population Sciences and Macro International, 2007).

Acknowledgement of the need for an inclusive growth first came from the government when it made the goal of 'inclusiveness' central to its vision for the Eleventh five-year plan (FYP 2007-12). The "inclusive growth" strategy has been reiterated in the Twelfth FYP (2012-17). The new approach emphasises the need to achieve higher and faster economic growth, which would benefit all including the poor, the traditionally disadvantaged populations such as SCs, STs, Other Backward Castes (OBC), Muslims and women (Planning Commission, 2012). The Planning Commission explained in the Twelfth FYP document: "The social justice objectives of the Twelfth Plan can be achieved with full participation in the benefits of development on the part of all these groups. This calls for an inclusive growth process which provides opportunities for all to participate in the growth process combined with schemes that would either deliver benefits directly or more importantly help these groups to benefit from the opportunities thrown up by the general development process." (Planning Commission, 2012)

As a corollary to the government's efforts to address social exclusion by achieving socio-economic development of these disadvantaged groups, there was a strong push in the Eleventh plan for improving their access to health. During this plan period, Government of India introduced many social health protection (SHP) programs particularly for the poorer and vulnerable sections of the population. For instance, in order to address equity in access to hospital care and provide financial protection against the costs of health care, Rashtriya Swasthya Bima Yojana (RSBY) was launched for the below poverty line (BPL) households working in the unorganised sector in 2008. (For details on RSBY, see chapter 5.)

India's health financing system and RSBY

India's public spending on health still continues to hover around 1% of GDP. The health financing system relies heavily on household out-of-pocket (OOP) spending. While private spending constitutes 70% of total health expenditure in India, OOP payments account for 86% of private spending (Government of India, 2009). As a result, more than 30% of those who suffered from an illness did not seek treatment in 2004 owing to financial reasons (NSSO, 2006). OOP health spending is a leading cause of impoverishment, increasing the poverty ratio by 4-5% every year (Ghosh, 2011; Bhandari, Berman & Ahuja, 2010; Garg & Karan, 2008).

Implementation of RSBY in Maharashtra

In Maharashtra, RSBY was introduced in 2008 and the Department of Labour (DoL) was the nodal agency for administration of the programme. The scheme relied mainly on private commercial insurers and private hospitals to provide cashless inpatient care to the beneficiaries. As explained in chapter 5, the scheme was implemented in a phased manner in the state, starting with seven districts in the first phase. By 2013, 32 of the 35 districts in Maharashtra were covered by RSBY.

In 2012, the Government of Maharashtra launched its own scheme, Rajiv Gandhi Jeevandayee Aarogya Yojana (RGJAY), to protect the Below Poverty Line (BPL) and Above Poverty Line families with income up to Rs. 100,000 against tertiary care expenses in eight districts on a pilot basis. In the second phase in 2013, RGJAY was expanded to cover the whole state. Notably, RSBY has been temporarily withdrawn from Maharashtra since October 2013 as the state government has not taken any decision on whether or not to continue RSBY. (Details regarding the health system of Maharashtra and implementation of RSBY in the state are provided in chapter 5.)

Review of existing studies

Schemes such as RSBY and RGJAY are seen by policy makers not only as a potential solution to the issues regarding access to healthcare for the poor and disadvantaged castes and tribes, but also as a tool to reduce poverty and inequality. However, several studies show that a large number of poor households still lack access to RSBY (Rathi et al., 2010; Rajasekhar et al., 2011; Devadasan et al., 2013). The existing literature suggests that the uptake has not been uniform; rather it varies significantly across regions, states, districts and households (Sun, 2011; Narayana, 2010).

Nandi, Ashok and Laxminarayan (2013) tried to assess the factors associated with the variations in participation and enrolment in RSBY. Based on district-level regression analysis, the authors inferred that the socioeconomic attributes of the districts have an effect on a district's participation in RSBY. They found that districts dominated by communities such as scheduled castes and scheduled tribes are less likely to participate and enrol in RSBY. This has serious implications in terms of providing access to health care and financial protection to the disadvantaged population groups. A recent study (Karan, Selvaraj & Mahal, 2014) which examined the trends in out-of-pocket (OOP) health payments across social groups found that despite the implementation of National Rural Health Mission1 (NRHM) and RSBY, the utilisation of inpatient care among SC/ST households has hardly improved compared to the more affluent households (top 20% of households). Further, the SC/ST and Muslim households have experienced significant rise in OOP spending compared to their more advantaged counterparts during the period between 2005 and 2012. This discrepancy is a matter of great concern as the current policy focus is to make RSBY and other welfare programmes socially inclusive. The authors of the above-mentioned study (Karan, Selvaraj & Mahal, 2014) also stressed the need to investigate the reasons that public health financing programmes like RSBY lack effectiveness in reaching less advantaged castes and religious minorities. There is a growing body of literature that probes into the underlying reasons that the vulnerable population groups do not have access to public health care services and programmes. These studies point out that apart from systemic issues, certain social and religious groups in India face discrimination in accessing public health services owing to their social identities (Sadana & Thorat, 2009; Baru et al., 2010; Sabharwal, 2011). Since RSBY is aimed at poor households and more than half of them belong to marginalised communities, we conjecture that the implementational failure to provide access to RSBY to eligible households can be explained from a social exclusion perspective. Hence, in this chapter, we try to investigate the influence of social exclusion on uptake of RSBY.

Methodology

We adopted the SEKN (Social Exclusion Knowledge Network) definition of social exclusion as "dynamic, multi-dimensional processes driven by unequal power relationships interacting across four main dimensions- Social, Political, Economic and Cultural (SPEC)" (Popay et al., 2008). This definition was operationalised in the following manner. An extensive review of literature was undertaken on the SPEC dimensions (for details, see chapter 2). This allowed us to deepen the SEKN framework by listing a number of measurable variables for each of the above dimensions. However, social and cultural dimensions appear to be closely related and therefore they were integrated into one dimension: sociocultural. A detailed description of data collection has been provided in chapter 5 of this volume. We have used only quantitative data for this chapter. The variables were structured such that affirmative responses were equated with greater vulnerability for exclusion in that dimension and those responses were assigned 1. These variables were used individually and also to construct an index of social exclusion (see below).

Both bivariate and multivariate analyses were undertaken. Due to the similarities of results between bivariate and multivariate analyses and insignificant additional insights emerging from bivariate analysis, the findings of bivariate analysis are not included. The discussion of enrolment and its determinants are therefore largely founded on the results of regression models.

Our theoretical framework (for details, see chapters 1 and 2) puts forward the hypothesis that, ceteris paribus, the chances of being enrolled in RSBY decrease as the extent of social exclusion increases for households. Empirically, our aim is to estimate the effects of 'social exclusion' on the likelihood of enrolment, using BPL households' decision to enrol in RSBY as the dependent variable. This is a dichotomous variable indicating the current enrolment status of BPL households (enrolment = 1, non-enrolment = 0). Our key variables are the ones that capture the SPEC dimensions of social exclusion. We also included a number of independent variables that represent households' background characteristics to adjust for differences in how households may analyse the pros and cons of enrolment in RSBY.

We employed four multivariate logit regression models. In the first model, we only included the background factors. Following this, in the second model we considered all covariates representing background characteristics and the SPEC indicators. In the third model, SPEC indices were introduced along with other covariates. In the final model, we included SC, P and E indices, controlling for the effects of background characteristics. The variables used in this study are described in Table 1 and explained in more detail below.

Sociocultural dimension

Three indicators were used to measure dimensions of social capital of a household, defined as "the information, trust and norms of reciprocity inhering in one's social network" (Woolcock, 1998). The first indicator, social_network, measured vertical linkages in the social network of the household and was based on the question: "Do you know anyone (amongst your acquaintances and relatives who help you often) who is a: (i) doctor or nurse in health facility; (ii) teacher of school or university; (iii) local politician; (iv) state politician; (v) civil servant?" The second, indicator asso_socialgroups, was used to reflect whether any member of the household is part of any social group or institution such as Gram Panchayat, Self Help Groups, NGOs, social clubs, etc.

The third indicator,2 trust_institutions, reflects the extent of trust that the household head has in various bodies (e.g., local government, national government, police, judicial system, press, labour unions, religious institutions, banks). In the survey, respondents were asked to rate their trust for the said bodies on a scale of 1 (complete trust) to 4 (no trust at all). The responses of the statements are aggregated to a combined score, ranging between 10 and 40. A higher score reflects greater trust in the above institutions. Since there is no given standard for defining the threshold value below which the household can be considered as having low faith in institutions, the number of households facing exclusion from 'institutions' has been quantified here as those exceeding a cut-off of 20 which is half of the maximum possible score. Low levels of social capital have been found to be associated with lower levels of enrolment in voluntary health insurance in other contexts (Mladovsky et al., 2014).

The indicator discriminated measures if the head of the household felt discriminated. This variable was created using the following question: "Are there times when you feel you have not been treated fairly because of your political beliefs, caste, religion, economic status, occupation?" Single member households may be more likely to be socially vulnerable (Enarson, 2007) and therefore the variable family_type is included.

Political dimension

We try to capture this dimension using indicators that gauge the households' ability to engage in political decision-making. The variable Access_politicians was included to assess if the household usually approaches Panchayati Raj Institutions3 (PRI) or ward member for solving any problem. Another variable, Political_participation, was included. A household is considered to have participated in democratic processes if it is a member of any political party or voted in previous elections. The variable participation_meetings is indicative of a household's participation in 'Gramsabha' or 'Ward committee' meetings.

It has been generally observed in previous studies that access to public resources largely depends on political connections and affiliation (Besley et al., 2005; Bardhan et al., 2008; Markussen, 2011). For example, Das (2013) found that political affiliation of the household plays an important role in getting work under the Government's flagship scheme, Mahatma Gandhi National Rural Employment Guarantee Scheme (MNREGS), in West Bengal, India. Also, the politically active households had a greater likelihood of receiving work under the MNREGS than the politically inactive households.

We included variable access_facility as a proxy for understanding access (geographical) to the health facility.

Economic dimension

The information on monthly household consumption expenditure (MHCE) was used for categorising the households into quintiles. While the first three quintiles, Q1 to Q3, were combined into one category, representing the poorest of the sample BPL families, the remaining quintiles Q4 and Q5 were combined into a second category. Standard of living of households was found to be associated with enrolment in RSBY (Nandi, Ashok & Laxminarayan, 2013). The relatively poorer ST households had a significantly lower likelihood of getting RSBY coverage (for details, see chapter 14). The propensity towards financial exclusion is captured by a variable, bank_account, which indicates whether the household has a bank account. Another variable, access_socialwelfare, was constructed on the basis of responses to the following question: "Have you benefitted from any of the social welfare schemes such as Antodaya Yojana, Indira Awas Yojana, Annapurna Yojana and Janani Suraksha Yojana?" It has been observed that in India, quite often the vulnerable households are deprived of access to social welfare programmes (Haan, 2013).

Additional variables

Existing evidence suggests that a host of other factors may influence the enrolment of households in RSBY and voluntary health insurance in general (Vellakkal, 2013; Nandi, Ashok & Laxminarayan, 2013). We controlled for a number of these factors such as education, caste, religion, place of residence, region, economic activity, gender of household head, if any household member has a chronic disease, if the head of household reported 'poor' health status, and if there is an elderly member in the household.

SPEC indices

We used Principal Component Analysis (PCA) for constructing indices for each of the above SPEC dimensions. PCA is a statistical procedure that transforms a set of possibly correlated variables to a fewer number of uncorrelated factors or components. With the help of PCA, we converted a catalogue of indicators to a simple composite index of social exclusion, namely SPEC index. This was the single measure of socioeconomic and political disadvantage for each household.

The major limitation of this study is that it is entirely based on quantitative data; further work is needed to incorporate the qualitative results of the study to further unravel the processes of exclusion from RSBY.

Results

Table 1 provides descriptive statistics of the variables (mainly percentages) included in the study. Only 12% of the sampled BPL households were currently enrolled in RSBY. About 65% of the households in the sample reside in rural areas. In terms of regional distribution of the sample, one-fifth of households were from Vidarbha, the most underdeveloped region in Maharashtra. The distribution of households by religion reveals that about 21% of them were Muslims, Buddhists, Christians, Jains or Sikhs and the rest were Hindu (79%). More than half of the sampled BPL households belonged to disadvantaged social groups such as Scheduled Castes, and Scheduled Tribes (53%). About 21% of the BPL households were headed by females. Also, 42% of household heads had no formal education.

Table 1. Descriptive characteristics of the variables

Variables	Definitions	Percentage
Currently enrolled	1 if household reported as currently enrolled in RSBY; 0 otherwise	12%
Background characteristics		
Education	1 if head of household is educated; 0 otherwise	58.4%
Disadvantaged social group	Household belonging to SC/ST	52.7%
Minority religion	1 if household belongs to Muslims/Buddhists (minority religion)	20.9%
Rural residence	1 if household residing in rural areas; 0 otherwise	64.7%
Backward region	1 if household residing in “Vidarbha” region; 0 otherwise	20.1%
Economic_activity	1 if the main type of economic activity in the household is “labour”; 0 otherwise	63.0%
Chronic_HH	1 if household has member with chronic disease	29.2%
Bad_health	1 if head of household reported ‘poor’ health status; 0 otherwise	6.9%
Female_HH	1 if head of household is female; 0 otherwise	20.8%
Elderly_HH	1 if household has at least one elderly member; 0 otherwise	46.1%
Domains		
Sociocultural		
No_social network	1 if household did not know someone who is a doctor/nurse in health facility, teacher or any other influential person; 0 otherwise	27.9%
No_asso_social group	1 if not part of any social group/institutions such as Gram Panchayat, Self Help Groups, NGOs, social clubs, etc.; 0 otherwise	84.0%
Discriminated	1 if at times they felt discriminated because of their caste, religion, economic status, occupation, etc.; 0 otherwise	2.9%
No_trust_institutions	1 if expressed lack of trust on institutions such as local government, national government, judicial system, press etc; 0 otherwise	32.4%
Family type	1 if the family is “single”; 0 otherwise	3.6%
Political		
No_access_elected representative	1 if household usually does not approach PRI member/ward member for solving any problem; 0 otherwise	54.0%
Politically_not_active	1 if not an active member of any political party or did not vote in previous elections; 0 otherwise	2.0%
No_access_healthcare	1 if does not have a health facility close by; 0 otherwise	22.2%
Non_participation_ meetings	1 if does not attend Gramsabha or ward committee meetings; 0 otherwise	4.1%
Non expression_opinion	1 if does not feel free to express opinion during a group meeting, religious meetings, political meetings; 0 otherwise	90.4%
Economic		
Poorest	1 if household belongs to poorest 60% of the households defined in terms of monthly consumption expenditure quintiles; 0 otherwise	59.8%
Financial exclusion	1 if household did not have a bank account; 0 otherwise	31.8%
Non_access_ socialwelfare	1 if household has not benefitted from any social welfare schemes; 0 otherwise	32.8%

More than 29% of surveyed BPL households reported having members suffering from chronic health problems. Further, 7% of the household heads reported having poor health. Almost one-fourth of households reported a long travel time to reach the nearest health facility from their home. In other words, for many households, access to health care is constricted by the poor availability of health facilities in nearby vicinities. A third of BPL households did not have any bank account and a similar percentage of eligible households did not receive any benefits from the social welfare programmes other than RSBY. Not surprisingly, a considerable proportion of households (33%) expressed lack of trust in institutions such as government, judiciary and media.

Factors affecting enrolment

Results from our logistic regression analyses on determinants of enrolment are presented in Table 2. The first model includes only background characteristics. The analysis indicates that households with characteristics such as having female heads, head of households with some level of formal education, residing in rural areas, affiliation with minority religion and head of households reported to have poor health status were more likely to receive RSBY coverage. On the other hand, if the households happened to be from backward region, chances of enrolment in RSBY were significantly lower (OR=0.42; $p<0.001$) than their counterparts from relatively developed region in Maharashtra. The effects of above factors on enrolment remained almost unchanged in all models even after other SPEC variables and indices were included.

Model II includes background characteristics and SPEC variables. It is evident that SPEC variables significantly influence the enrolment status of the households. Among the sociocultural dimension level indicators, family type, social network and trust in institutions are observed to be significantly associated with enrolment. The odds of reporting enrolment were lower among single-member households (OR=0.47; $p<0.001$) than joint and extended families. Households that did not know any influential person were less likely to be enrolled in RSBY (OR=0.80; $p<0.001$) than those with wider social networks. Those who expressed lack of trust in institutions such as local government, national government, judicial system, the press, etc., were significantly less likely to be enrolled in RSBY (OR=0.36; $p<0.001$).

With regard to political domain, the results indicate a positive relationship between enrolment and political participation of households. Households with lower political participation, in terms of whether they have a member active in a political party and attend meetings organised by local government members, had a lower likelihood of enrolment.

Interestingly, the MHCE showed no significant effect on enrolment. However, households that did not receive any benefit from other social welfare schemes were also likely to be at a disadvantage (OR=0.75; $p<0.001$) with respect to participation in RSBY, compared with those who benefitted from such schemes.

Model III presents association between different SC, P and E indices and enrolment, controlling for the effects of background characteristics. As observed in model II, the indicators of various dimensions of social exclusion are important determinants of enrolment, and the same has been confirmed by the results of model III. Except for the economic index, all other indices were found to be significant factors of enrolment. In other words, the results clearly show that households that are disadvantaged in all dimensions of social exclusion had a lower likelihood of enrolling in RSBY.

In model IV, SPEC index was introduced along with other background variables. We observed that social exclusion measured by proxy indicator SPEC index was a significant factor in deciding whether or not a household would be enrolled in RSBY. Finally, model V reports the univariate association between SPEC index and enrolment of BPL households. In this univariate regression analysis, a unit increase in SPEC score for households reduced the odds of enrolment by 24% (OR=0.76; p<0.001). Notably, the results remained almost unchanged even after including background characteristics in model IV (OR=0.76; p<0.001).

Table 2. Results of logistic regression on determinants of enrolment in RSBY, Maharashtra

Variables	Model I	Model II	Model III	Model IV	Model V
Background Characteristics	**OR**	**OR**	**OR**	**OR**	**OR**
Educated	1.17	1.18	1.18	1.19	
Disadvantaged_socialgroup	0.95	0.95	0.93	0.94	
Minority_religion	1.38**	1.33**	1.38***	1.37**	
Rural_residence	2.23**	2.13*	2.11*	2.04***	
Backward_region	0.42***	0.42***	0.42***	0.43***	
Economic_activity	1.24*	1.32**	1.58**	1.34**	
Chronic_HH	1.07	1.09	1.01	1.06	
Bad_health	1.40*	1.61**	1.48**	1.49**	
Female_HH	1.29**	1.33**	1.32*	1.29*	
Elderly_HH	0.97	0.95	0.99	0.97	
Domains					
Sociocultural					
No_social network		0.80*			
No_asso_social group		0.97			
Discriminated		0.83			
No_trust_institutions		0.36***			
Family type		0.47***			
Political					
No_access_elected representative		1.01			
Politically not active		0.35***			
Non_access_healthcare		1.09			
Participation_meetings		0.74**			
Non_expression_opinion		0.74*			
Economic					
Poorest		0.92			
Financial_exclusion		1.02			
Non access_socialwelfare		0.75***			
Sociocultural index			0.75***		
Political index			0.84***		
Economic index			0.96		
SPEC index				0.76***	0.76***

Note. *p<0.05; **p<0.01; ***p<0.001

Discussion and conclusion

This study points to evidence indicating that social exclusion, as we measured it in our study, was significantly associated with lower enrolment of BPL households in RSBY in Maharashtra.

The findings indicate that female-headed households were more likely to take up RSBY; this is in line with the findings of Nandi, Ashok & Laxminarayan (2013). The greater likelihood of enrolment among female-headed households could be attributed to the process of registration for RSBY. As per the earlier RSBY guidelines, the household head has to be physically present at the enrolment station and this may have improved the chances of female-headed households' enrolment in the programme vis-a-vis male-headed households, as the males were more likely to be at work during the day when the enrolment camps were held. Also, a large number of male heads were not alive anymore and therefore those households could not be enrolled in RSBY.

The odds of enrolling in RSBY were significantly higher for households belonging to minority religions such as Muslims and Buddhists compared to Hindus. This can possibly be understood by the fact that in Maharashtra, within the dalit community, the Ambedkarite Mahars are the most politically organised and assertive caste compared to other castes (e.g., Matang caste) (Teltumbde, 2003). Coincidentally, Mahars embraced Buddhism when Ambedkar had called for mass conversion of dalit people. This may explain why the enrolment rate is better among the Buddhists. Being politically assertive may have helped them get enrolled in RSBY. However, the reasons for higher enrolment among Muslims are different. It is to be noted that there is a disproportionate concentration of poverty among the Muslims in Maharashtra, particularly in urban areas (Panagariya & More, 2013) and the patterns of Muslim settlements suggest that they tend to reside in concentrated localities in both rural and urban areas. Therefore, from the Third Party Administrator's (TPA) point of view, it is a very cost-effective strategy to cover the Muslim-dominated areas as it is relatively easier to get many BPL households at one place for enrolment. However, further research needs to be carried out to fully understand this.

Enrolment was positively correlated with rural residence. The following reasons could explain lower enrolment in urban areas. First, there is a lack of pressure on the TPAs to improve enrolment in the urban areas as insurance companies have an incentive to focus on the rural areas. According to the Insurance Regulatory and Development Authority (IRDA) regulations (IRDA, 2011), insurance companies are supposed to meet the rural sector obligations by earning at least seven percent of their premium revenues from rural areas. Further, in Maharashtra, one of the large TPAs told us that their main interest is financial inclusion (delivering financial services at affordable cost to the disadvantaged and low-income population) and therefore they were keen on participating in RSBY operations in the rural areas.

In the case of voluntary health insurance, it is expected that households with elderly members and with members having chronic health problems would be keen to get enrolled as they are likely to use health care services extensively. Our results do not support this hypothesis of adverse selection, in line with the findings of Sun's (2011) study. On the contrary, it appears that the insurance companies actually selected 'low risk' or 'relatively healthier' households for enrolment. However, the deaths of older persons may have also contributed to that finding.

Among different economic groups, the most vulnerable groups are the agricultural labour households (rural) and the casual labour households (urban). Membership of these groups strongly overlaps with Scheduled Caste (SC) and Scheduled Tribe (ST) status. The dual occurrence of being an asset-less casual wage labourer household, in either rural or urban areas, from either a dalit (SC) or adivasi (ST) community, has deepened the 'prevalence, depth and severity' of poverty (Sundaram & Tendulkar, 2003). We found that 'labour households' were more likely to be

included in RSBY. This could be because of the fact that RSBY was extended to MNREGS workers in 2012. In fact, of the total MNREGS workers, almost 80-85 percent belong to BPL. Since it has been found elsewhere (see chapter 6) that identification has been relatively easier for MNREGS workers, the enrolment rate has been better compared to other occupation categories.

Social exclusion and enrolment

The results clearly suggest that social networks influence enrolment in RSBY. While households with an influential person amongst their acquaintances and relatives had higher odds of enrolment, the single member household had lower odds of enrolment. These clearly signify that the households without any social capital face exclusion in accessing RSBY. It would therefore be warranted that RSBY exploit existing social networks for improving coverage, for example, by involving community-based organizations and workers' trade unions for enrolling the BPL households. Additionally, emphasis should be given to making the eligible households fully aware of their entitlements to access RSBY.

Our findings show that households vulnerable to political exclusion as reflected in lower engagement in the political decision-making process were found to have lower odds of enrolment. This is commensurate with existing literature that finds substantial evidence of 'political clientelism' in allocation of benefits of social welfare programmes (Das, 2013; Markussen, 2011; Besley et al., 2005, Bardhan et al., 2008). In other words, these studies found that those who are either members or supporters of political parties have greater access to social welfare programmes. In case of RSBY, as TPAs often sought the help of the local Panchayat (Local Government) functionaries to spread the message about RSBY enrolment among the beneficiaries, it is quite likely that households that are politically active and attend political meetings, Gram Sabhas,4 were more likely to have known about RSBY and subsequently enrolled in it. Besides, it was found in other contexts that people who actively participate in political activities could have a greater level of trust in government institutions leading to greater participation in government programmes including health insurance schemes (Parmar et al., 2014).

It is encouraging to note that economic status of the BPL household was not associated with enrolment. However, households that had not benefitted from any social welfare programmes were also significantly less likely to be enrolled in RSBY (OR=0.75; $p<0.001$).

SPEC indices and SPEC index of social exclusion

The results concerning the SPEC indices of social exclusion closely correspond to the findings pattern observed for individual variables above. Both sociocultural and political indices are significantly related to enrolment in RSBY, suggesting that households that are socioeconomically disadvantaged are also less likely to get enrolled in RSBY. Further, the findings of the fourth and fifth models suggest that social exclusion captured through a SPEC index was significantly associated with lower enrolment of BPL households in RSBY in Maharashtra. These results confirm our initial hypothesis that, ceteris paribus, the chances of getting enrolled in RSBY can be restricted by social exclusion. Since RSBY, the social health protection programme, is mainly targeted to BPL households engaged in the unorganised sector, a majority of the households may turn out to belong to socially excluded groups. The evidence from our study strongly suggests that serious efforts need to be undertaken at various levels to make RSBY socially inclusive. First of all, after assessing the goals and design of RSBY, we find that there are several aspects that need to be modified so that it can reach the socially excluded households. We found that there are serious issues with the current target-based approach adopted for enrolment and the strategy used for identification of eligible beneficiaries. Notably, the Ministry of Labour and Employment (MoLE) relies only on the BPL list for identifying eligible beneficiaries. However, existing evidence suggests that BPL data is highly problematic as it significantly

excludes poor households, thereby depriving them of benefits of welfare schemes such as RSBY (Ram, Mohanty & Ram, 2009; Dreze & Khera, 2010). The implications are far more serious for the disadvantaged groups such as SCs, STs, agricultural labourers, and landless households as these groups face higher rates of exclusion from the BPL list (Swaminathan, 2008).

The Government has partly acknowledged this issue by adopting a two-pronged strategy. One, it is planning to use the new BPL list based on the 2013 socioeconomic census for implementing RSBY and other social assistance programmes. This is a better approach per se but it will not be able to fully mitigate the risk of exclusion (Dreze & Khera, 2010). Two, it decided to extend RSBY coverage to other unorganised sector workers such as domestic workers and MNREGS cardholders. However, recent evidence indicates that even using the current BPL and MNREGS beneficiaries' lists, RSBY has not been able to expand the population coverage significantly. For example, over sixty percent of targeted households in Karnataka were not enrolled in RSBY in 2013 with higher levels of exclusions occurring among socially excluded groups (Seshadri et al., 2013). Hence, the current strategy of using a 'targeting' approach for RSBY is proving to be ineffective.

Thus, if the programme is continued in Maharashtra and elsewhere, it should adopt the universal approach, as it would be more effective at including all the needy and socially excluded households. The other issue is that the design of RSBY is such that the Ministry of Labour and Employment (MoLE) has hardly any control over the TPAs and Third Party Vendors (TPVs). Interestingly, TPAs and TPVs are the ones who are actually implementing the programme on the ground. The MoLE should make appropriate changes in the guidelines so that the TPAs or TPVs can also be made accountable to the system. Alternatively, since the commercial insurance companies and their TPAs have limited interest in awareness generation and enrolment, their role may be reviewed and instead an independent public agency should be given responsibility for enrolment of workers and more emphasis should be given to include the households at risk of social exclusion.

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Endnotes

1 National Rural Health Mission, started in 2005, represents an important initiative by the central government to address the health care needs of the rural population by strengthening the public health system in rural areas.

2 The terms ‘variable’ and ‘indicator’ are used interchangeably throughout the manuscript.

3 Panchayati Raj Institutions (PRIs) are the lowest rung of the government (local self government).

4 Gram sabha is an important part of Panchayati Raj Institutions (Local government). By default, all the adult citizens of the village are included in a Gram sabha. All important decisions taken by the Panchayat (Local government) need to be discussed in the Gram sabha and ratified by it. Gram sabha even has the power to change the decisions of the Panchayat.

CHAPTER 10: Safeguarding individual's utilisation of healthcare: the case of the NHIS in Ghana

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Introduction

Ghana's National Health Insurance Scheme (NHIS) was launched in 2003 with the ultimate aim of providing affordable and equitable access to basic health-care services for the entire populace. A review by the Ghana Health Service (2008) shows that since the start of the NHIS in 2003, overall outpatient department (OPD) cases have increased markedly, suggesting that the NHIS policy has led to an increase in health service usage (Ghana Health Service, 2012). However, some previous studies in Ghana have also shown that individuals from richer quintiles are more likely to be enrolled into the NHIS scheme than those in poorer quintiles (Asante & Aikins, 2008; Bjerrum & Asante, 2009; Chankova et al., 2010).Mou et al. (2009) also found health insurance enrolment lowest in the vulnerable groups. This invariably implies that access to healthcare is restricted to individuals who are able to afford insurance, leaving the poor and other vulnerable groups who need to be financially assisted to register without access to care.

As described in this book's introductory chapter, there is the hypothesis that social exclusion is an important cause of the limited success of recent health-financing reforms.In Ghana, health inequities are seen to be a major form of social exclusion. There is striking evidence of rural-urban disparities in access to health-care services, inequitable distribution of health workers, and striking disparities in access to health services between rich and poor (GHS, 2008). Recently, attention has been given to the challenge of developing a broader, more comprehensive social-protection system that would address the vulnerabilities and risks facing various population groups, especially the poor. For instance, the NHIS has an exemption policy in place to ensure that the poor and vulnerable groups in society have access to healthcare; the exempted groups include the poor, children under the age of 18 years and

the elderly (70 years and above). Yet some vulnerable groups do not have access to health insurance (Blanchet et al., 2012; Mou et al., 2009).For the scheme to maintain its relevance as a tool that promotes universal coverage, there is a need to develop requisite strategies to reduce the barriers that discourage poor and vulnerable groups from accessing healthcare.

This paper therefore seeks to assess the impact of NHIS membership onthe utilisation of outpatient health-care services in Ghana.The rest of the paper is structured as follows:first, themethodology, including the strategy for devising the SEKN (Social Exclusion Knowledge Network) is provided; the definition of social exclusion as the "dynamic, multidimensional processes driven by unequal powerrelationships interacting across four main dimensions – Social, Political, Economic and Cultural"(Popay et al., 2008) is then presented; it is followed by the empirical results. Thereafter, the discussion section follows and a final section provides a brief conclusion.

Methodology

Data

The study uses data collected from a cross-sectional survey of 4050 representative households in five districts in Ghana covering the 3 ecological zones (coastal, forest and savannah).Further details on the study locations and sampling strategy can be found in chapter three.Data on health services utilisation was collected using a disaggregated classificationof formal health providers (Regional hospital, District hospital, Private/NGO hospital, Public health centre, Private clinic, Mission/NGO clinic, Private pharmacy, License chemical store) of outpatientcare. In this paper,only utilisation of outpatient services at those formal providers is considered.The recall period for outpatientvisits wastwo weeks.

The SPEC Methodology

Based on the multidimensional nature of social exclusion, a four dimensional framework was developed by the research team (Health Inc) to allow the study to capture all aspects of social exclusion. Through literature review, Health Inc explored each of these four dimensions, resulting in the Health Inc SPEC framework. The social dimension is constituted by proximal relationships of support and solidarity (such as friendship, kinship, family, neighbourhood, community, social movements) that generate a sense of belonging within social systems. Social bonds are strengthened or weakened along this dimension (SKEN, 2008). The political dimension is constituted by power dynamics in relationships that generate unequal patterns of formal rights embedded in legislation, constitutions, policies and practices and the conditions in which rights are exercised, including access to safe water, sanitation, shelter, transport and power and to services such as healthcare, education and social protection. Along this dimension there is an unequal distribution of opportunities to participate in public life, to express desires and interests, to have interests taken into account and to have access to services. In the context of this study, we looked at two main areas: political resources and political and civic participation. The economic dimension is constituted by access to, and distribution of, material resources necessary to sustain life (such as income, employment, housing, land, working conditions and livelihoods). The final area is the cultural dimension where we consider the patterns of relational exclusion that have been found to have cultural and historical origins, and where people uphold norms and values that lead them to set themselves above others based on a variety of attributes. Boundaries between social and cultural dimensions are difficult to draw because social participation is highly connected to cultural aspects such as values and norms translated into current social practices.

Choice of variables

A range of patient characteristics determines whether patients are willing and able to make treatment choices. Some of these choices may also be influenced by social and cultural factors (Sahn & Stifel, 2003; Lindelow, 2005; Amin et al., 2010). There is a large volume of literature indicating that wealth and income affect treatment-seeking behaviour, especially in accessing formal health facilities (Akin et al., 1995; Gertler and van der Gaag 1990; Sahn & Stifel, 2003).Besides providing financial risk protection from the economic consequences of illness, health insurance is meant to improve access to healthcare (Nyman, 1999; Hsia et al., 2000). Insurance in healthcare enablesaccess to care, as it aims to lower prices at the point of care through risk-sharing thereby improving health outcomes. Literature on health insurance and its effect on health serviceutilisation have been vast and varied. To date, the RAND Health Insurance Experiment remains the only study to discover the causal effects of health insurance on access to healthcare. The RAND experiment was a randomised trial that focused on the effects of cost sharing on utilisation and health outcome (Newhouse et al., 1993). The results showed that people delay or forego healthcare when payments were required at the point of service.In recent times, other studies undertaken in Asia and Sub Saharan Africa (Chen et al., 2007; Ekman, 2007;Hsiao, 2007;De Allegri, 2008 and Mensahet al., 2010) have found that having health insurance greatly increased the utilisation of both outpatient and inpatient services. Other cost and non-cost factors also influence the ability to utilise health services. In the literature, some of these include income, education, wealth of the household, cost of transportation, cultural beliefs and practices, political and health systems and even environmental conditions (Trivedi, 2000; Katung, 2001; Adamson et al., 2003). Most of these factors have been included in the SPEC framework explained in the previous section.

The dependant variable is a binary variable reflecting the use of formal healthcare (i.e. regional hospitals, district hospitals and public health centres). Informal care includes all individuals who did not seek care from formal health-care providers.We consider individuals who reported illness in the two-week period prior to the survey date. Among the independent variables are individual and household characteristics. Individual characteristics include age, gender, education, health insurance status and nature of illness. The SPEC variables include marital status (single or married), social networks (belonging to a social group or not), which fall under the sociocultural category.Household characteristics include a household welfare index as a proxy for a household's economic status. This is considered under the economic dimension. Five variables were created with the fifth quintile (richest) used as the base group (the omitted variable). The political category includes distance to health facility (irrespective of mode of transport).

Regression models

Our basic regression model for determinants of utilisation can be defined as:

$$Useri = \beta 0 + Vi\beta 1 + Xi1\alpha + \epsilon i1$$

Where i = 1…n represents individuals. Useri is a binary variable that denotes whether the individual used formal care or not. Vi is a set of SPEC variables (as described in Table 1), Xi is a set of remaining variables that may determine utilisation, and ϵicapturestherandom shock.

Three logistic regression models are estimated. First, we estimated asimple regression model (Model 1) with only Xi variables, we then ran the regressionwith all variables–Xi and Vi variables in Model 2, and in the third model (Model 3)we included Xi variables and the SPEC index.

Table 1: Description of variables in estimation

Dependant variable	Variable Abbreviation	Mean	Std. Dev.
User		0.914	0.280
Independent variables			
Individual characteristics			
age=<18 years	< 18 YEARS	0.477	0.499
18-69*		0.485	0.500
70 years and above	> 70 YEARS	0.038	0.190
Male	MALE	0.466	0.499
Female*		0.534	0.499
No education*	NO EDUC	0.362	0.481
Some primary	PRIMARY EDUC	0.183	0.387
JSS/Middle	JSS EDUC	0.342	0.474
Secondary and above	SECONDARY EDUC	0.113	0.317
Insured	HEALTH INSURANCE	0.732	0.443
Uninsured*		0.268	0.443
Chronic*	CHRONIC	0.037	0.189
Travel time to facility**			
District Hospital:			
Less than 15 mins.		0.189	0.419
15 to 60 mins.		0.593	0.513
above60 mins.*		0.226	0.444
Regional Hospital:			
Less than 15 mins.		0.033	0.419
15 to 60 mins.		0.403	0.620
above60 mins.*		0.616	0.617
SPEC variables			
Sociocultural (SC)			
Single		0.436	0.496
No_association		0.611	0.529
Political (P)			
Political_participation		0.909	0.288
Economic (E)			
Wealth Quintile:			
First		0.205	0.403
Second		0.202	0.401
Middle		0.226	0.418
Fourth		0.179	0.383
Fifth*		0.189	0.391

* Comparison group

** travel time irrespective of mode of transportation (in minutes)

Empirical results

Description of sample

Table 2 presents the percentage share of individual and household attributes of the users and non-users groups. The users had a higher percentage of individuals with active insurance status (64%) compared to 50% of the non-users. We found that among the users, 53% lived in urban areas; among the non-users, 44% lived in urban areas. Also, among the users, 17% were found to be in the lowest wealth quintile compared to 24% among the non-users. Also, 30% of non-users were more than one hour from the nearest district hospital compared to 19% of users.

Table 2: Characteristics of users and non-users of health-care services with reference to the recent reported illness/injury

Characteristics	Status		Total
	Users	Non-users	
Social dimension			
Sex			
Male	39.9	42.7	40.1
Female	60.1	57.3	59.9
Residence			
Urban	53.3	44.4	52.6
Rural	46.7	55.6	47.4
Age			
Children (≤18 years)	44.9	35.3	44.1
Adult	47.1	54.3	47.7
Elderly (≥70 years)	8.1	10.3	8.2
Insurance status			
Active members	63.7	50.43	62.6
Previous members	15.1	17.9	15.3
No card	4.0	5.1	4.1
Never insured	17.2	26.6	17.9
Political dimension			
% of adults (≥18 years) who ever attended school (n=796)	65.1	73.0	65.8
Mean years of schooling (≥6 years) (in years)	7.1	7.1	7.1
Access to health (% of population who are more than 60 minutes from the nearest health facilities)			
Regional hospital	60.8	62.6	61.0
District hospital	19.7	29.9	20.5
Private/NGO hospital	32.0	33.7	32.1
Public health centre	3.3	7.9	3.6
Private clinic	23.4	28.7	23.7
Mission/NGO clinic	29.4	28.7	29.3
Private pharmacy	17.2	19.8	17.5
License chemical store	2.3	1.7	2.5
Access to transport and administrative infrastructure (mean time in minutes)			
The nearest tarmac road	19.0	27.3	19.7
The nearest all-seasoned road	7.5	11.1	7.8
Weekly market	25.3	28.8	25.5
Daily market	15.5	21.3	16.0
District capital	42.0	51.6	42.8
The nearest place with daily bus /taxi services	9.5	10.0	9.6

Economic dimension			
Wealth quintile (economic resources)			
First	17.2	23.9	17.8
Second	21.9	17.1	21.6
Middle	21.3	23.9	21.6
Fourth	21.0	17.1	20.7
Highest	18.5	18.0	18.4
Current employment status (≥15 years)			
Self-employed	69.0	64.9	68.6
Paid employment	7.7	5.2	7.5
Student	6.1	5.2	6.0
Apprentice	1.1	1.3	1.1
Retired	6.1	9.1	6.4
Unemployed	7.6	7.8	7.6
Other	2.4	6.5	2.8
Cultural dimension			
Religion			
Christian	73.0	82.8	73.8
Muslim	25.0	12.9	24.0
Traditional	0.9	0.9	0.9
Other	1.1	3.5	1.2

Reasons why healthcare was not sought for the recent reported illness/injury

About 76% (89) of the household members who reported an illness or injury during the two-week period but did not seek healthcare gave reasons for their action. Table 3 presents the reported reasons by the health insurance status of the respondents. The main reason cited by the majority (46%) of the respondents was that the illness/injury was not considered as a serious condition. This was cited by 63% of the active NHIS members who did not seek care. All5 non-card holders and 54% of the never-insured considered the cost of seeking healthcare as high to them. About 21% of the previous members indicated that they preferred to try traditional medicine while another 16% thought the illness was spiritual. Also, about 15% of the active members did not seek healthcare because they wanted to self-medicate.

Table 3: Reasons for not seeking healthcare for the recent reported illness by insurance status

Reason	Insurance status				Total (n=89)
	Active members (n=41)	Previous members (n=19)	No card (n=5)	Never insured (n=24)	
Illness not considered serious	63.4	42.1	0.0	29.2	46.1
High cost of seeking healthcare	4.9	15.8	100.0	54.2	25.8
Preferred to try traditional medicine	9.8	21.1	0.0	4.2	10.1
Preferred to try self-medication	14.6	0.0	0.0	8.3	9.0
Illness was considered spiritual	0.0	15.8	0.0	0.0	3.4
Other	7.3	5.3	0.0	4.2	5.6
Total	100	100	100	100	100

Table 4 shows the facilities from where the sick first sought healthcare during the recent reported illness/injury. About a third (34%) of the active NHIS members (valid card holders) visited the public health centre, which was followed by the district hospital (22%) and the pharmacy/drug store (11%). The results indicate that about 43% of the previous members of the NHIS sought healthcare from the pharmacy/drug store and about 19% sought care from the public health centre. For those without cards, the majority (38%) visited the public health centre followed by the pharmacy/drug store (27%). About 38% of the never insured visited the pharmacy/drug store while 23% sought care from the public health centre. About 7.5% of them also resorted to self-medication with modern medicines.

Table 4: First source of healthcare for the last reported illness/injury

Facility	Insurance status				Total (n=1,315)
	Active members (n=837)	Previous members (n=198)	No card (n=53)	Never insured (n=226)	
Regional hospital	4.9	3.5	15.1	3.1	4.8
District hospital	21.6	9.6	15.1	9.3	17.4
Private hospital/clinic	13.9	7.1	3.8	8.0	11.4
Public health centre	34.2	18.7	37.7	22.6	30.0
Mission/NGO hospital/clinic	9.6	2.5	0.0	3.1	7.0
Pharmacy or drug store	11.2	42.9	22.6	37.6	21.0
Traditional/spiritual healer	0.2	0.0	0.0	1.8	0.5
Home treatment with traditional remedies	1.0	3.5	0.0	2.2	1.5
Home treatment with orthodox medicine	0.6	6.1	0.0	1.3	1.5
Self-medication with traditional medicine	0.7	2.5	1.9	3.5	1.5
Self-medication with modern medicine	2.2	3.5	3.8	7.5	3.4
Total	100	100	100	100	100

Effects of individual characteristics and SPEC variables on choice of health care provider

The regression results in Table 5 show the effects of some variables on the choice of formal health facilityfor males and females separately. The dependent variable is made up of only the respondents who indicated that they were ill and sought treatment for that illness within the two-week period preceding the date of interview. This therefore affected the sample size since most of the respondents indicated that there were not ill during that period. The dependent variable is a dichotomous variable where 1 means a person used formal means of treatment and 0 means the person chose traditional treatment option.

The results inModels 1 and 2 show the marginal effects of the individual characteristics and the SPEC variables respectively on the dependent variable whereas the results inModel 3 show the combined effects of both the individual characteristics and the SPEC variables on the dependent variable.The regression results in Model 1 indicate that males have a lower probability (6.6% lower) in using formal health facility than their female counterparts. Males are less likely to use formal treatment because most males in Ghana are less concerned about their health and also view the continuous attendance at the hospital as a sign of weakness. As a result, they usually resort to self-medication/home treatment at the initial stages of sickness. Most males often turn to the formal treatment options when the sickness aggravates or the home treatment is ineffective for a relatively long period of time.

The results in the Model 1 also depicts that the probability of using formal health facility for treatment increases with the level of education.Individuals with JSS/Middle school education are more likely (with a higher probability of 0.041) to use a formal treatment provider relative to those with no education. Similarly, those with secondary education and above are most likely (9.4% more likely) to seek treatment from a formal health-care facility compared to those with no education. Hence, as a person becomes more educated, that individual moves away from using traditional treatment options that are more likely to be viewed with suspicion by the more educated. A well-educated person is relatively more enlightened about the dangers and the benefits associated with the traditional and formal treatment options respectively and therefore more likely to opt for the formal treatment options, all other things being equal.Also, persons who have enrolled on a health insurance scheme have a higher probability of using formal treatment options compared to those who are not insured. This is so because all the various forms of health insurance schemes in the country use formal health facilities. Therefore, any individual who enrols on any health insurance scheme would mostly use formal treatment options.

The results in Model 2 also show that males are less likely to use formal treatment options relative to females. The results also depict that those in the first wealth quintile are more likely to use formal treatment options than those in the fifth wealth quintile. The results in Model 3 further confirmed that males are less likely to use formal treatment options than females. The results also confirm that the significance and the probability of using formal treatment option increases with the level of education (with no education being the comparison group). Those with health insurance cover are still more likely to use formal healthcare compared to those with no health insurance cover. However, compared to those living less than 15 minutes from the regional hospital, individuals who are 15 to 60 minutes away from the regional hospital are less likely (0.043 probability lower) to use a formal treatment option.

We consider some other variables that were not statistically significant yet had interesting coefficients. The results in Models 1 and 3 reveal that those between the ages of 18 and 69 inclusive are less likely to use formal treatment options relative to those below age 18. However, persons who are 70 years and above have a higher probability of using formal health facilities than those below age 18. Also, persons who are closer to district hospitals (less than 15 minutes and 15 to 60 minutes away from the hospitals) have higher probabilities of using formal treatment options relative to those who are far (more than 60 minutes) from district hospitals. Finally, the results in Models 2 and 3 indicate that those who are single (i.e. never married, divorced or widowed) are less likely to use formal care compared to those who are married.

Table 5: Estimation of Models (1-3) showing the Probability of Choice of Healthcare provider in last 2 weeks

Variables	Marginal Effects		
Dependent variable: Use of Formal facility	**Model 1**	**Model 2**	**Model 3**
age 18-69	-0.027		-0.007
Age 70 and above	0.012		0.025
Male	-0.066***	-0.055*	-0.066***
Some Primary	0.036		0.040*
JSS/Middle school	0.041*		0.048*
Secondary and above	0.094***		0.097***
Insured	0.068**		0.061*
Chronic	0.016		0.007
Travel Time to Facility:			
District hospital			
Less than 15minutes	0.030		0.031
15 to 60 minutes	0.011		0.011
Regional hospital			
Less than 15minutes	-0.242		-0.283
15 to 60 minutes	-0.040		-0.043*
SPEC Variables			
No association		-0.034	#
Single		-0. 011	-0.029
Wealth Quintile: First		0.051**	0.043
Second		#	#
Third		#	#
Fourth		0.027	-0.004
Number of Observations	667	607	645
LR Chi2	35.32	11.93	39.21
Prob> Chi2	0.000	0.036	0.000
Pseudo R-Squared	0.081	0.031	0.090

Notes: # Not enough observations

*p<0.1, **p<0.05, ***p<0.01

Discussion

This paper seeks to investigate factors that affectthe utilisation of outpatient healthcare services in Ghana. Noticeably, health insurance status, education and gender have been shown to be the three main determinants. A large proportion of the insured who reported ill sought care from formal health care providers compared to the never-insured. One of the main aims of the NHIS scheme is to improve access to healthcare,and this could be an early indication of the success of this policy intervention. Members withvalid health cards were likely to seek care from formal health-care facilities. This finding is similar to the results of other studies (Chen et al. 2007; Ekman, 2007;Hsiao, 2007;De Allegri, 2008 and Mensah et al. 2010). Education, and quite specifically having secondary education and above, is a significant determinant of choice of care. This supports the social exclusion theory that says that causes of inequality are based in the fundamental structures of social systems (Popay et al., 2008). A higher education allows access to knowledge and understanding of the scheme with the subsequent benefits of being covered by the scheme.Gender, which is another sociocultural factor, is a significant determinant of utilisation of care. The study shows that a higher percentage of users are women (60%) and males were less likely to use formal health-care services.Possible explanations include the fact that fewer men enrolled in the NHIS or preferred not to seek care from formal facilities. Indeed, more likely, men who could not afford to pay the premiums for all household members would prefer for the women and children in the households to be insured. This finding is intriguing and needs more attention, as the consequences of males increasingly opting out of the health insurance scheme does not only negate the risk-sharing principle underlying insurance but may have far reaching consequences for their future health. Are men voluntarily excluding themselves from the scheme or is this a consequence of other factors? Efforts should be made to target men and encourage them to join the scheme.

Although we did not seek to understand why individuals were not enrolled in the scheme, one of the enabling factors we flagged was wealth status. Previous studies in Ghana have shown that individuals from richer quintiles are more likely to be enrolled in the NHIS scheme than those in poorer quintiles (Mou et al., 2009; Chankova, Atim and Hatt, 2009). However, even if those in the highest quintiles are more likely to enrol, the results of this study show quite the opposite when it comes to utilisation of care. In our Model 2, where we consider only the SPEC variables, the individuals in the lowest quintile are more likely to seek care from formal health-care services compared to individuals in the highest quintile. When we control for all other variables (Model 3) wealth becomes an insignificant determinant of utilisation of care. A potential explanationcould be that the wealthiergroups were not seeking care from NHIS accredited facilities whether private or public.

Greater support from families, friends and communities is linked to better healthand hence the relevance of social networks in the utilisation of care. Social networks provide the necessary channels for the dissemination of information, some of which may enable individuals to hear about the NHIS scheme and be encouraged to enrol in it and therefore gain access to health-care services (Owoo & Lambon-Quayefio, 2013). In this study, although not significant, those who were not part of any social groups were less likely to use formal health services.

This study has produced some interesting findings, but it is not without a number of limitations. First, we are unable to draw‘causal’ relationships between the dependent and independentvariables due to the cross-sectional nature ofthe data. Also, the independent variables may not capture the complete range of sociocultural, economic and political variables as explained in the SPEC methodology.

Conclusion and policy implications

We analysed the factors which determine choice of care in the framework of social protection,the bedrock of Ghana's health insurance scheme. The results indicate that health insurance status, gender and education are significant determinants of health-care utilisation patterns. Compared to the uninsured, the insured are more likely to choose formal health facilities than informal care, which confirms our initial hypothesis and also the results of other studies conducted on the NHIS in Ghana. However, several other factors may explain these findings. Affordability is not the only barrier for access to health services. Geographical, social, cultural, informational, political, and other barriers also come into play.

In theory, the NHIS can be an effective system that provides universal access to health care that is affordable, available and offers financial protection in times of illness.Yet, equity concerns about the NHIShave been raised about its ability to ensure equitable access for vulnerable groups has received attention over the years. How soon the NHIS is able to address these issues will determine the sustainability of the scheme. Currently, the voluntary nature of the scheme means that the risk pool has been narrowed mainly to the poor and sick with the exception of those whose contributions to the scheme are automatically deducted at source. On the basis of social solidarity this should not be the case. Regardless of age, gender, ethnicity, income, or geography, efforts must be made to encourage more people to enrol in the scheme in order to avoid inequities between formal and informal workers, and between the rich and the poor.

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PART IV: The experience of vulnerable groups

CHAPTER 11: The inequitable access of Plan Sésame by older population in Senegal, a qualitative analysis of the exclusionary processes

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Introduction

In most African sub-Saharan countries, the informal sector is not covered by the social security system. The elderly are no exception, with very few public policies specifically targeting them (Aboderin, 2008). In Senegal, the population aged 60 and over represented 5.2% of the total population in 2011 (ANDS, 2011). Among them, only 30% are officially covered in case of adverse health events (République du Sénégal, 2009). These latter are either affiliated to the Institut de Prévoyance Retraite du Sénégal (IPRES), the pension scheme for employees in the formal private sector, or to the Fond National des Retraites (FNR), the national pension fund for the civil servants. Besides their increased vulnerability to diseases, older people are also affected by a growing economic insecurity (Antoine, 2007). This insecurity is exacerbated by ongoing social transformations (youth unemployment, loss of solidarity), which negatively affect the support they traditionally received from their kin networks (Pilon, 1995; Antoine, 2007; Aboderin & Ferreira, 2009).

In 2006, these circumstances constituted the main arguments to justify the introduction of a health financing policy targeting the older population, named Plan Sésame1. This policy is of particular interest for the research community because it targets a widely under-studied category of population in Africa. There is an urgent need to redress this imbalance due to the rapid growth of the population of old people,2 which will create new policy challenges (Locoh & Makdessi, 2000; Golaz, 2012). The need for this study also arises from the results of a recent study showing that,

despite their increased need for health care, the older population have often not benefited from Plan Sésame (Leye et al., 2013). This chapter aims to analyse how social exclusion impedes both access to information on, and use of, the Plan by the older population. The concept of social exclusion (see Chapter one), mentioned throughout the analysis, made it possible to identify the main factors of inaccessibility to Plan Sésame.

Methods

The analysis builds on qualitative data collected through three methods: a review of the literature; in-depth interviews (IDIs); and focus group discussions (FGDs). For the review, we analysed the legal framework (bill, law, directive and decrees, from the government), various national policy documents and evaluation reports on Plan Sésame. Data derived from interviews and focus groups were collected in four different sites, both urban and rural. The corpus of qualitative material used for this analysis consists of 34 interviews with older persons, 54 interviews with stakeholders of various profiles and operating at different levels (Ministries, health structures, international organizations, communitarian or professional associations), as well as 19 focus groups conducted both with pensioners affiliated to IPRES and FNR and informal sector community groups3.

Data processing was conducted using the NVivo software. The interview data were analysed thematically following a deductive coding method. This deductive coding was followed by a thematic content analysis, which helped us refine the coding frame.

Results

Plan Sésame: low utilisation rooted in implementation limitations

In chapter four, we presented evidence on the low inclusiveness capacity of Plan Sésame. Indeed, since its inception, only a minority among the targeted age group have benefited from its coverage (see Chapter four). The analysis below shows how gaps in the communication strategy, as well as the absence of a sound payment mechanism, resulted in low utilization of the Plan.

The absence of a communication strategy

Interviews with the various stakeholders showed that the communication strategy was overlooked during the implementation of Plan Sésame. Indeed, after a few attempts to communicate on the Plan at inception, and exclusively through mass media, not much was done to maintain a sufficient level of awareness. This uncoordinated and fragmented communication strategy was ineffective, especially in rural areas where there is not much radio and television coverage:

In some areas, they do not even have a radio. So if you use this method to sensitize them [the target population|], you will not reach them. For example, those who live in Dindifélo, on the hills, they do not even have radio to keep them informed. (Social worker–Rural)

Moreover, the vast majority of the interviewed health workers admitted that communicating on Plan Sésame was not part of the general information given to the patients at the facility level.

“The Plan Sésame, nobody advertised it. By contrast, there is not a single day without advertising on HIV/AIDS, which we all fear. We do not advertise for Plan Sésame. Doctors do not talk about it. Social workers do not talk about it. Neighbourhood leaders do not talk about it... They hide Plan Sésame. “(FGD, Association of Disabled persons, Rural)

Because of this lack of information, nearly half of the targeted population – i.e. the older population – did not know about the existence of Plan Sésame (see Chapter 1). Furthermore, interviews and focus groups with the elderly show that even among the elderly who are informed, people did not fully understand the way Plan Sésame operates:

“I heard about Plan Sésame but we are not part of it; it does not exist in our neighbourhood; I don’t know how it works. I don’t know which way to go to it.” (Female, 60 years old, Rural)

This paragraph shows that the absence of explicit, structured and comprehensive communication strategies is an important weakness of Plan Sésame. Below, we explain how and why the lack of information particularly affected more vulnerable groups and compromised their use of Plan Sésame as soon as it started.

Hospital-centrism of Plan Sésame

Plan Sésame operates in all public health facilities at all levels of care: health posts, health centres and hospitals. It covers individuals who meet the eligibility criteria, including the ability to present their digital national identity card. Coverage is conditional on having passed through the referral system: a referral letter is a prerequisite to access higher levels of care. However, health workers, especially from the in-charge of lower level facilities, explained that health posts do not implement Plan Sésame:

“I have never implemented Plan Sésame at the post [...] I have the required papers with me, but when they come for consultations, I won’t give them free drugs. I do not do it, indeed.” (Nurse Head of a post, Rural)

This situation is due in large part to the way funds for Plan Sésame are allocated. Hospitals are pre-financed and paid on a fee-for-service basis, while lower level facilities (health centres and posts) are reimbursed by services in kind, especially by drugs from the National Drug Procurement Centre, the Pharmacie Nationale d’Approvisionnement (PNA). This has negatively affected the implementation of Plan Sésame at the health post level. Finally, hospitals provided most of the services covered by Plan Sésame (MEF, 2009) and therefore captured most of the resources allocated to the plan. Interviews with stakeholders and older people show that this came at the expense of the older people residing in rural areas, especially those who live at a distance from a hospital.

> *- Do you have trouble getting to [the hospital]?*
>
> *- [The hospital] is very far from our village... The roads are not good, there is no car, there are only carts and bicycles and an ill person cannot ride a bike [...]. If you fall sick and that you do not receive any help, then you do not have the means to move, to go to the district, and then from there to go to Tamba [the regional headquarters], is difficult. It requires means and you have meagre resources from agriculture.” (Male, 69 years old, Rural)*

It is clear that the non-implementation of Plan Sésame at health posts caused differences in access at the expense of the older people who do not have easy access to hospitals, and rural dwellers in particular.

Irregular implementation of the Plan since 2009

Funding problems have seriously affected utilization of Plan Sésame. The initial allocated budget was quickly exhausted, and no budget allocation or earmarked financing were planned to ensure the continuity in financing (MEF[2], 2009). The document analysis shows that, after the first year of implementation, hospitals no longer received pre-financing but operated on a cost-recovery basis with no certainty to be paid in the end. By 2009, the Plan was highly indebted, owing a total amount of over 4 billion F CFA to the health facilities (MEF, 2009).

Inconsistent funding caused several dysfunctions in the Plan Sésame implementation at the health facility level (Leye et al., 2013; Mbaye et al., 2013). The benefit package covered by the Plan was reduced in 2009 (Ministry of Health, 2009), while many facilities had already rationed it implicitly. These procedures restricted the coverage to consultations only and excluded any further investigations or additional examinations to the provided services. At the same time, some facilities simply decided to put Plan Sésame on hold:

"We no longer have the means to meet the demand. Either there is lack of supply, drugs are not available, especially since money transfers are rare. [...] We continue to support them [older people] depending on our capacity, but if the old person comes here and we do not have inputs to cover him, we do not take care of him." Hospital Director, Rural

Thus, three years after it started, Plan Sésame worked in an irregular way in many hospitals and health centres. Interviews with actors show while some facilities partially used Plan Sésame, others simply chose to ignore it. This implicit termination of Plan Sésame was strongly felt by the older people who were using it:

"I know Plan Sésame, but they said that Plan Sésame is stopped. I went to the hospital "Nabil Choucair" in Dakar, the doctor told me that policies related to Plan Sésame were over." (Male, 83years old, Rural) .

Implementation of Plan Sésame was thus highly irregular. The "randomness" in coverage affected the perception of the main beneficiaries: most of the older people have a negative opinion about it. Many interviewed old persons showed a high level of distrust in the programme and in those who initiated it. Therefore some of them, although being informed of its existence, did not use Plan Sésame.

"I did not go since I have to pay prescriptions myself. People went and came back without getting anything, they were even asked to pay their bills, so I did not go. [...] I was not even tempted to give it a try." (Female, 63 years, Rural)

The halt in the implementation of Plan Sésame in many health facilities brought the financial barriers back to the forefront; the costs of health services being seen as a great obstacle for the older population to access health care. Financial barriers related to access to health care services therefore remain a central issue for many of the interviewees:

"If we don't have money, we cannot be treated! Currently, if doctors say they give you free [drugs], they misinform you, nobody gives free drugs. "(FGD, Group of beggars, urban)

It clearly appears that due to the numerous gaps in design and implementation, Plan Sésame suffered from a great deficit in communication and ineffective implementation. Yet, despite these facts, some groups succeeded in benefiting from Plan Sésame while the great majority was excluded. The following section aims to explain how and why.

Implicit strategies to gain information and access to Plan Sésame services

Data extracted from focus group discussions, interviews with stakeholders and older people shows that the absence of a formal communication strategy was compensated by inappropriate implicit strategies, mainly within health structures. Indeed, during consultation, health personnel were expected to inform the patient on the existence of Plan Sésame and on the paperwork it required. However, our study shows that not everyone received the same quality of "interpersonal communication" and support on the Plan. The levels of information received varied greatly according to the social connections of the patient, some even stating that the information given by the health staff was mostly provided to their relatives or friends.

- Is there any special kind of older persons who use Plan Sésame more than others?

- Yes of course [...] the nurse can inform his relatives who can thus benefit from it, whiles others have to pay to be cured. (Social Worker, Rural)

Thus, these implicit strategies seem to benefit more the older people who are able to gather resources thanks to their socio-professional status or through their social networks. Analysis shows that this profile refers to specific categories within the older population: those who retired from the formal sector and those with strong social networks.

The status of being a retiree of the formal sector

The results show that being retired from the formal sector constitutes a clear advantage in accessing Plan Sésame resources. First, it appears that pensioners from IPRES and FNR are widely privileged vis-à-vis information on the Plan. Group discussions with them show that they are often well informed on Plan Sésame and have good knowledge about it.

This advantage that the formal sector retirees have in terms of information is explained by the fact that the lobbying efforts for a reduction of health care costs for the older population, which eventually resulted in the launch of the Plan, were led by associations of formal sector pensioners (Ministry of Health, 2007). Moreover, their representatives were involved at the design stage of the programme and often invited to take part in the working groups in charge of preparing the plan. The interviews of these representatives show that their involvement at the design stage facilitated the spreading of information among members affiliated to IPRES and FNR.

> *"Pensioners of IPRES and FNR better understood [the Plan] because they are aware, they belong to organizations where information flows and they knew how to proceed [to benefit from the plan]." (Social Assistant, Urban)*

This category is also privileged in terms of utilization. Indeed, interviews with stakeholders show that the status of being a formal sector pensioner also increased the odds of benefiting from Plan Sésame:

> *"- It was always those who had IPRES and FNR cards [that used Plan Sésame most]. The older people who live in the rural world seemed not to be able to enjoy favors which were offered to them." (Doctor Head of a District, Rural)*

It is important to note that retirees from the formal sector, both from the public or the private sectors, already have a formal coverage. Therefore, contacts with health personnel are far more likely than for those who have always worked in the informal sector and have never benefited from any protection. Besides this better access, they have more experience of the standard administrative procedures. For example, during interviews and focus groups, they showed a certain experience in using their cards to claim for their rights to free health services, which they often did to benefit from Plan Sésame. This ability partly explains the higher utilization rates of the programme among FNR and IPRES pensioners.

> *"We have a card on where it is written FNR. All the retirees from the civil service have that. That is what we generally bring along to the facilities [...]. For example, when I go to the hospital, that is the card I show, they allow me to get in and say: "Here is a retired civil servant, he can be treated here." (Male, 65 years, Urban)*

Social networks

Social relations, through professional status, are also strong determinants of the utilization of Plan Sésame. Interviews with older people show that those who have a strong social network benefited more from services and therefore captured more resources allocated to the Plan. It seems, therefore, that benefiting from Plan Sésame requires either to have contacts within the health facilities or to be supported by a third person to activate entitlements to Plan Sésame:

> *[...] In my opinion, Plan Sésame is only for some people.*

Why do you say so?

Because if you do not know how to proceed it will be difficult to benefit from it. In addition, you need to have connections to access formal papers, which allow you to get treated at the hospital. But if you have no one to help you, things will be very difficult. This is my opinion on Plan Sésame: if you do not have connections you cannot benefit from it. (Chairman of an association of Imams -Rural)

"I have used it (Plan Sésame) twice but it was thanks to my contacts. I know a head of unit, a medical in-charge, who after having consulted me, told me: 'My dear, I will do a Plan Sésame for you.' I used it twice, but it was not easy. The other guy told me: 'We'll do it for you just because the boss asked us to.'" (FGD, Retirees of FNR, Rural)

Thus, IDIs with older people show that to enhance the chances of benefitting from the Plan, some resorted first to visiting facilities in which they had contacts that could guide them towards accessing Plan Sésame, hence bypassing the referral system.

"[...] I went to "Hôpital Principal" where my niece works. She consulted me the very same day and diagnosed stomach pains. She got me an appointment with another Medical Doctor. She then asked me if I was 60, and since I was, she suggested me to use Plan Sésame through which I could get free care. It is through Plan Sésame that I undertook the medical check-up that identified a problem in my colon. (FG, Health insurance, Urban)

IDIs and the key informant interviews show that the level of participation in community associations was also associated with better information and better access to the services of the Plan. Indeed, a member of an association (typically the leader), if conversant with the operating procedures of the Plan, can help the other members to use his/her own social network to benefit from it. Interviews with the civil society leaders show that members of community associations can thereby be informed and guided in the pathway leading to Plan Sésame benefits:

"One of our elders who came from one of our villages called me to say that his eyes hurt him. Being part of the association, I told him to come here, that I would help him get treated [...] I helped him to benefit from Plan Sésame and this improved our relations. I knew him via the association and thanks to the association he won my trust.

[...] So, do you manage to accompany the members of your association who are aged of 60 and over and who are sick? Do you help them to benefit from the Plan Sésame?

I help them to get treatment by driving them up there [to the hospital]. Or I direct them to their dispensary. Or I ask them to come here and I take them to our dispensary, I get an official document here and then we go to Matam." (Head of a Community Association, Rural)

Thus, it seems that opportunities to know about and to benefit from Plan Sésame vary according to people's socio-professional status and their social network. That explains why some older people benefit from Plan Sésame in some cases without even knowing about its existence previously.

Psychosocial and financial barriers to access

Internalized discrimination: an obstacle to care for the older person

In the previous paragraphs, we showed that belonging to a specific socio-professional group,, or having a strong social network, were both linked with greater benefits from Plan Sésame. What the data analysis also reveals is that there is a category of older people who rarely (if ever) use health services due to internalized discrimination. Internalized discrimination was identified as a process through which discriminative practices and attitudes towards

members of a group/category – in this case an age category – are gradually considered normal by the members of the group themselves. This discrimination thus becomes a strong internalized barrier that hampers full participation in social life. Our findings show that the development of such feeling is strongly linked to the combination of three factors: the serious impoverishment of the older population, a deteriorating social status, and a growing issue of loneliness enhanced by an increasing challenge to complete daily tasks without support from others (see chapter one).

Precarious economic power and social status

Interviews with the elderly emphasize the importance of socio-economic status in the internalization of discrimination, which in turn limits the expression of their needs in health care. Indeed, aging generally was accompanied by a loss of economic power (see chapter 1):

> *"If we do not have the means to pay, why would we go to the hospital? Who is going to treat you? You can have money and do not receive adequate care, so it will be even worse if you have no money." (Focus group, Delegates of district, urban)*

This feeling is also noted among those with a status of formal retirees. Their financial situation gradually deteriorates as a combined result of low pensions – hence lower income – and familial responsibilities that remain high:

> *"The day we perceive our pension is the day we feel sicker. That day all our hibernating pathologies re-emerge. We spend all day trying to arbitrate between the bills and food rations. (FG, member of IPRES, Rural)*

> *"These [difficulties] come out when you are in charge of the whole family with your pension. You have children at home. You cannot eat without your children, without your nephews or your grandchildren. Distress starts from then on. And all the while, the pensions are not being increased. (FGD, FNR, Rural)*

Even if this category is privileged in terms of information and use of the plan, they are facing similar problems of accessing services, as they no longer have economic capital and are no longer able to maintain a strong and extended social network.

As mentioned above, the loss of economic power goes along with a change in the social status (see Chapter 1). Traditionally, older generations were considered the guardians of knowledge and authority. Today, their social role and position are less valued. They feel they do not receive as much attention from the younger generations as it used to be. For them, they are given less consideration and respect (see Chapter 1), as it was mentioned in most of the interviews:

> *"Our society has changed fast, it is still changing by the way. It is a society that does no longer give a role to the old person. In some families, the old person lives in a corner, is no longer invited to the debates, his/her voice is no longer important when there are familial issues to be addressed, because it is always said "Dafa magett , dafa naax " (S/he is old , S/he is senile) (health worker , Urban).*

Difficulties arising from the degrading economic situation and social support lead the elderly to internalize a discrimination that keeps them away from health services where they are not sure to receive attention and treatment they think they must have. The fact that they did not receive the same care in health services is seen as quite normative by some of them. "People like me cannot access Plan Sésame" is a widely repeated assertion that reflects the same perception. "People like me" refers here to the most economically and socially vulnerable groups. Indeed, this feeling is mainly perceived among those with the lower level of education:

> *My view is that they do not take care of people.*

> *Why do not they take care of you?*

I do not know, as long as they are more educated than me. (Female, 63 years, Rural)

This feeling is also found among those who are not part of the formal sector:

"I thought Plan Sésame was just for people in the administration. I thought it was only for people who have worked for the State." (FG, Association of taxi drivers, Rural)

Even community leaders in the informal sector have these perceptions:

"The Imam and the old person from FNR do not receive the same treatment. There is a big difference. In general, the imam who falls sick receives prayers at his mosque and they contribute during two or three days to pay his drugs. Let's not be foolish, we [the imams] cannot be supported in the same way [as FNR pensioners] when we fall sick." (FG, Association of Imams, Rural)

All in all, it is a feeling widely shared by those who identify themselves as poor people:

"If we do not have financial means, we cannot go to be healed; we do what the poor do: once we are at the hospital, if you do not have resources or someone to help you, you can do absolutely nothing ". (FGD, GPF, Rural)

Physical impairment and loneliness

Physical impairment is also one of the basic criteria of internalized discrimination. It was considered a serious obstacle to accessing Plan Sésame services, which are conditional on fulfilling official procedures. These procedures were perceived as challenging by most of the older interviewees, particularly those with a poor physical condition:

"If you cannot walk, you cannot do anything. As you can see, I have no teeth anymore and I also have cataracts. Now if you cannot move, or you cannot see, there is a problem, because you might get informed [about Plan Sésame], but you won't go anywhere. In this case you are alive, but life does not need you anymore" (male, 80 years, Urban).

Physical impairment, sometimes coupled with a lack of appropriate assistance, is particularly felt when health care is needed. Elderly with physical impairments sometimes evoke a sense of powerlessness over their own condition; consequently, they often choose not to attend health services:

I do not often go to the hospital

Is it far?

Yes it is far for me because I walk there; I do not have the means to take a taxi. So it's hard for me because I cannot walk long distances. I am quickly out of breath when I walk (Male, 72 years, Urban)

This feeling of inability is a real constraint, especially as it mostly reinforces the isolation of the elderly:

"I can absolutely do nothing more. I'm just like that, I stay seated all day long and I lie all the night. (Female, 80 years, Rural)

It is worth noting that even the elderly with no physical impairment also mentioned a sense of isolation. Quotes made by older people – supported by the key informants – show that loneliness of the elderly is increasing. A vast majority of older people interviewed had the impression of being "forgotten" – another way to express a feeling of growing isolation – which in turn contributes to internalized discrimination.

"Do you feel alone?

Very alone! Sometimes I do not go out all day long, my wife… does not even greet me. She stays, she talks with the children and sometimes I am forgotten". (Male, age 65, Urban).

Lack of access to health care is thus the fruit of a complex ageing phenomenon, characterized by intertwined issues building upon precarious socio-economic conditions, physical disabilities and a feeling of loneliness. All these facts lead some older people to experience aging as social abandonment. This feeling discourages them from using health services. These deprivations lead to an internalized discrimination, which does not only put a stop to the older people's social participation, but also prevents them from fulfilling their most basic right: the right to health.

Discussion

The limited implementation of Plan Sésame without regular funding has affected accessibility to free or subsidised care for the elderly. This is largely explained by the organizational set-up and the implementation of the programme, leading to severe dysfunctions and low utilization. Several other studies support this finding and have also shown that poor results of an exemption policy are largely rooted in the implementation gaps (Gilson & Di McIntyre, 2005). In several similar programmes, lack of funding hindered the implementation of the programmes and exacerbated the access issue (Witter et al., 2010; De Sardan & Ridde, 2012).

This low utilization of Plan Sésame is also due to the absence of a structured information strategy tailored to the need of the targeted audience. Information was hardly relayed by health workers, whose behaviour turned into passive resistance. This behaviour is often noticed in other policies that provide care free at the point of use or exemption programmes because such programmes are often considered a threat to the financial equilibrium of the facilities (Ba, M., 2011). This in turn triggers implicit information and access strategies, which are directed only to groups with a certain level of economic and/or social capital. Other studies have also shown how important economic status and social networks are to access health services, especially where social connections are central in the operations of the health system (Hours, 2006).

Thereby, the elderly with strong social capital were better at capturing resources allocated to the Plan. Social capital, defined here as a "set of actual or potential resources linked to the possession of a durable network of more or less institutionalized relationships" (Bourdieu, 1980) is seen as a key factor to access information and services of the Plan. The role of social capital in facilitating the access to health services (Swann & Morgan, 2002) and social health protection mechanisms (Mladovsky et al., 2014) has also been demonstrated by other studies. For example, in Senegal, households with higher levels of social capital were more likely to enrol in community health insurance schemes that aim to provide risk pooling and financial protection from the cost of ill health.

Plan Sésame, therefore, ideally reveals the complexity of access to health care for groups – such as the elderly in Senegal – who face social exclusion processes. Indeed, this population is subject to a growing social vulnerability, mostly because of the poverty that strikes the households in which they live. In low- and middle-income countries, the traditional solidarity model relying on the kinship network – long seen as the "social care provider" for the elderly – is now showing several shortcomings (Jong, 2005) and social solidarity systems are failing to fill gaps in formal social protection in general (Vidal, 1994; Lloyd-Sherlock, 2000).

This situation is exacerbated by a decline in the social status of the elderly, increasing social isolation and physiological weakening, which interacts with each other to enhance poverty, which is socially built (Simmel et al., 1907). This leads older people to show a sense of resignation in the face of a situation that is increasingly perceived as fatal. This is interpreted in this study as a form of internalized discrimination that prevents older people from seeking care and using public programmes, including those especially targeting them.

As a result of these processes, Plan Sésame has not drastically reduced the financial risk related to the elderly's access to health services, especially for groups subject to social exclusion. It neither considered nor tackled some of the structural factors embedded in the social environment of implementation (the unequal distribution of power and resources) that lead to social exclusion. Indeed, in its formulation and implementation, it did not take into account

the specificity of the aging process, which combines poverty and vulnerabilities. Heavy and lengthy administrative procedures and a bias towards hospital care are among the design factors that translate to social exclusion from Plan Sésame. Plan Sésame in its current format does not therefore seem adequate to address the needs of a largely illiterate population who mainly live in rural areas and face physical limitations and lack of public support. Because of all these facts, Plan Sésame did not trigger the transformative process (Michielsen et al., 2010) that one should expect from a social protection programme in health that targets vulnerable groups.

Conclusion

Social exclusion from Plan Sésame is associated with multiple factors. This exclusion is structural, rooted in some central features of the programme – i.e. the lack of funding and hospital-centrism that further widens the rural/urban gap. It is also social: Plan Sésame is operated in a system in which social connections are determinant in accessing health services. Information on the Plan and its utilization are largely dependent on implicit strategies that have turned the programme into an initiative that favours the urban, educated categories and those belonging to the formal sector. The vast majority of the elderly are actually excluded from a health policy that is specifically intended for them. This study unravelled a worrying phenomenon: the acceptance of discrimination by the "socially excluded". This discrimination has become normative for them, a phenomenon that often prevents them from seeking out health services. Plan Sésame as a mechanism of social protection has hardly managed to stop this process, and has even exacerbated it. Therefore, strengthening the inclusive capacity of Plan Sésame should be a top priority to reverse the social exclusion of the elderly in Senegal.

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Endnotes

1 Details of the design of Plan Sésame are presented in chapter four

2 In 2013, there were 60 million individuals aged 60 years and more in Africa. According to the United Nations, 212 million Africans will belong to this age group by 2050. Source: United Nations, 2013.

3 Further information on the data collection process is provided in chapter four.

CHAPTER 12: Enrolment of older people in social health protection programs in West Africa: does social exclusion play a part? ***

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Introduction

In their 'manifesto for the world we want', The Lancet (2012) identified globally ageing population as a critical issue that must be addressed to help create sustainable improvements in health. By 2016 it is estimated that there will be more people older than 65 years than children under five, and 1.5 billion people over 60 will be added to the global population between now and 2050 (UN, 2009). Despite the demographic transition being more advanced in developed countries, between 1950 and 2000, 66% of the global increase in people over 60 occurred in low- and middle-income countries (LMIC); by 2050 it is projected that 80% of all older people (i.e. 1.6 billion) will be living in LMIC (Aboderin, 2012; Beard et al., 2011, pp. 4). This unprecedented and rapid demographic shift will have far-reaching consequences for health systems, and many LMIC already face immense challenges in providing adequate, age-appropriate healthcare and a decent standard of living for older people.

In Sub-Saharan Africa (SSA) the issue of ageing has so far received little attention from both policy makers and researchers. However, despite the low relative share of older people in the total SSA populations (below 10%), the subcontinent still hosts a significant aged population, which is expected to grow at a steady pace. With life expectancy of 16 years for 60 year olds, getting old is no longer an exception in Africa.

Ageing in Africa raises particular concerns because of its strong association with increased vulnerability. Several risk factors are associated with this heightened vulnerability (Crooks, 2009; Issahaku & Neysmith, 2013). First, older people in SSA usually retire in rural areas, characterized by poor infrastructures and acute problems of basic service provision. Second, many scholars point out the feminisation of the SSA aged population – 'a female society', according to Apt (2009). This makes Africa's older women twice as vulnerable: first, due to the biological process of ageing; and second, gender-related discrimination. Third, the majority of older people are illiterate (67% in Africa (UN, 2009)), which is associated with poor access to public resources. Furthermore, most of Africa's older people, especially women, have no formal employment records and thus no access to formal social security arrangements like pensions. It is estimated that only 17% of older people in SSA receive an old-age pension (International Labour Organization, 2014).

Historically, the extended family structure in Africa has mitigated the effect of these combined risk factors. However, evidence suggests that the situation is changing. Traditional respect and caring structures are facing substantial social challenges, hence refuting the widespread African myth of the "inexhaustible capacity of the extended family to withstand crisis" (Gysels et al., 2011).

Access to appropriate healthcare remains a major concern for the majority of the ageing population in SSA. Facts speak for themselves: not only do older people spend more per-capita on healthcare than others in LMIC, consequently bearing a heavy burden linked to user fees policies, they also face higher levels of unmet need for healthcare with a greater proportion of older people reporting forgone treatments for illness than younger groups (McIntyre, 2004; Saeed et al., 2012)economic, demographic and health variables in our analysis. Median household OOP healthcare in the year 2004-05 was Pakistani Rupees (PKR. The gap between needs and access is expected to grow further in the short term, especially due to the escalating epidemic of non-communicable diseases (NCDs) among the ageing population (Alam et al., 2010; George-Carey et al., 2012; Holmes & Joseph, 2011).

Recognising the increased vulnerability of older people in relation to illness and healthcare expenditures, two West African countries, Ghana and Senegal, have implemented Social Health Protection (SHP) programs that specifically target older people. These programs aim to reduce the financial barriers faced by older people in accessing healthcare services.

The Ghanaian National Health Insurance Scheme (NHIS)

The Ghanaian NHIS, launched in 2003, is a national health-financing system where all formal sector employees and their dependents are automatically enrolled. Self-employed individuals and informal sector workers need to enrol in NHIS. NHIS is largely funded by value-added tax (61% of the total NHIS revenue in 2009). Investment income (17%), and the Social Security and National Insurance Trust pensioners (SSNIT is a national pension scheme which is mandatory for formal sector employees but voluntary for self-employed) premiums (16%) constitute a small proportion of the NHIS budget. Children under 18, pregnant women, indigents (i.e. the poor and destitute), and all people over 70 are exempt from paying premiums, although they still need to register and renew their membership annually and pay a small fee at the time of renewal (National Health Insurance Authority, 2011). Membership can be renewed at the District Mutual Health Insurance Scheme office or by an agent of the scheme. For more details on the scheme, refer to Chapter three: Ghana Case Study.

Senegal's Plan Sesame

Unlike NHIS, Plan Sesame directly and exclusively targets older people. Launched in 2006 during the presidential address to the nation, Plan Sesame aims to provide free access to public healthcare services to all citizens over 60 – an estimated 5.9% of the total population (ANSD, 2012). Although there is no specific registration process, older people who want to benefit from this exemption are required to present a national ID card at the point of service. The national ID card is mandatory for all citizens aged over 15 years. It can be obtained in person at police stations for a fee of approximately $2 and by presenting a birth certificate or an old ID card (the card is valid for ten years). According to our study, 89% of older people have the new national ID card. Plan Sesame is largely funded by taxation; some funds are also received from the Institut de Prévoyance Retraite du Sénégal (IPRES) and the Fonds National de Retraite (FNR), the national contingency/pension fund for formal employees in the private sector. Plan Sesame has suffered from under funding and short staffing, and no communication plan is implemented to promote the scheme (Mbaye et al., 2013; Leye et al., 2013). For more details on Plan Sesame refer to Chapter four: Senegal Case Study.

Although the demand for SHP has recently gained momentum in LMIC, evidence on whether SHP schemes have been successful in providing equitable healthcare to older people where they have access to healthcare on the basis of need, irrespective of their income, age, residency, or sociocultural factors, is limited. In Ghana, NHIS still struggles to overcome inequities in enrolment (Jehu-appiah et al., 2011; Sarpong et al., 2010) and evidence on whether NHIS has benefitted older people is rare (Lloyd-Sherlock, 2000). Enrolment in itself does not guarantee access to health services: there are likely to be barriers to accessing healthcare even for people who are insured (Biritwum et al., 2013). However, these schemes have been designed in such a way that enrolment is a prerequisite for accessing free care at the point of use for the populations covered; as such, enrolment constitutes an important first step (and potential barrier) to accessing care. It is therefore crucial to study this step to identify individuals at risk of inequities in enrolment.

This study tests the hypothesis that socially excluded older people are less likely to enrol in NHIS and Plan Sesame. This hypothesis is supported by wider literature, which points to social exclusion in the healthcare sector (Marmot et al., 2008) and in the social sector more broadly (Popay et al., 2008). To the best of our knowledge, this is the first study that investigates the role of social exclusion in SHP uptake among the ageing population in West Africa.

Methodology

The SPEC (Social, Political, Economic and Cultural) framework

We used the SEKN (Social Exclusion Knowledge Network) definition of social exclusion – 'dynamic, multidimensional processes driven by unequal power relationships interacting across four main dimensions – Social, Political, Economic and Cultural': SPEC (Popay et al., 2008). This definition was operationalized in two steps. First, we conducted an extensive literature review to develop a SPEC framework based on the SEKN framework of social exclusion and identified domains related to resources and participation that are important for understanding social exclusion. Resources are means such as wealth, assets, education or values that can be used to meet human needs, and participation refers to the power and ability people have to utilise the resources available to them (Popal et al., 2008). Within these domains, we identified measurable indicators or variables of social exclusion, which can be considered as risk factors of social exclusion. Having a risk factor does not indicate that the person is socially excluded; rather, it indicates that the person is vulnerable to social exclusion. Second, local expert teams in Ghana

and Senegal reviewed the SPEC framework and identified domains and variables they thought to be relevant and important in their contexts. Although all four SPEC dimensions are interdependent and interact to affect social exclusion, the social and cultural dimensions in particular were felt to be so intricately interlinked that they were combined into one dimension: sociocultural.

Domains and variables (as shown in Table 1) identified by local teams, common to both the settings and relevant for understanding social exclusion among older people, were used to construct an index for each dimension of social exclusion. All dimensions were given equal weightage (i.e. 100%). Each domain within the dimensions was also given equal weightage and adds up to 100%. Therefore, each index has a maximum value of 100%; and the higher the index, the greater the vulnerability of older persons within that dimension to be socially excluded.

Table 1. SPEC dimensions and variables

Dimension	Domain	Variables	Weightage
Sociocultural (SC)	Social and community participation	Not a member of any association or club; not participating in religious events	25%
	Social isolation	Single or living alone	25%
	Social discrimination	Feel that elders are not respected in society	25%
	Social dependence	Require help in undertaking activities of daily living	25%
Political (P)	Access to healthcare	Do not have a health facility close by	20%
	Access to information	Do not have access to a television or a radio	20%
	Political and civil participation	Do not exercise their voting rights; not a member of any political party	20%
	Decision making role	Do not have a decision making role in an association	20%
	Access to safe housing	Live in an unsafe neighbourhood (Feel that it is not safe to walk alone in the night in the neighbourhood)	20%
Economic (E)	Relative poverty	Belong to the poorest quartiles (Q1 & Q2)*	33%
	Economic dependence	Do not have an independent source of income	33%
	Precariousness of shelter	Not living in a family-owned household*	33%
Notes: Variables denoted by (*) are estimated at the household level; all other are individual level variables.			

Household surveys

We used data from cross-sectional household surveys conducted in 2012 in Senegal and Ghana. Since the target population for NHIS and Plan Sesame differs, we applied different sampling strategies in the two countries as described in Chapter three: Ghana Case Study and Chapter four: Senegal case study. In Ghana a total of 4050 households were selected; in Senegal, 2933 households were selected.

The household survey consisted of two parts. Part I was administered to the household head and collected data on basic demographics and socio-economic situation of the household and its members. For Ghana, this part also gathered information on health status, healthcare utilisation, and awareness and utilisation of NHIS. Part II included questions on social exclusion and was administered to those members that were eligible for NHIS and Plan Sesame in Ghana and Senegal respectively. In Ghana, the household head and his/her spouse were interviewed, while in

Senegal, a person over 60, and preferably the household head, was interviewed. In the event that the household head was under 60 or unavailable, another person over 60 from the household was interviewed. For Senegal, besides questions on social exclusion, Part II also covered questions on health status, healthcare utilisation, and awareness and utilisation of Plan Sesame.

Although efforts were made to include similar worded questions in both surveys, owing to the differences in contexts and scheme features, many questions were adapted to local settings. The survey was drafted in English in Ghana and French in Senegal, but interviews were conducted in local languages if the respondent was not fluent in the official language.

In Ghana, as the survey was administered to study social exclusion in NHIS, and since NHIS is offered to all Ghanaians and not only to people over 70, the respondents were not necessarily over 70. For Ghana we therefore used data on persons over 70 who had answered Part II of the questionnaire, i.e. 435 older people. In Senegal, all persons over 60 had answered Part II, so we used the entire sample, i.e. 2933. In both countries, the household head was interviewed if possible. Therefore, older people in our sample are more likely to be household heads.

For NHIS, although registration needs to be done once, membership needs to be renewed each year. People over 70 were considered enrolled if they had a valid card – they were registered and had renewed their NHIS membership that year. Those that had renewed their membership but had not received their cards were considered as not enrolled, as they did not possess a valid card to use NHIS.

In Senegal, people over 60 are not required to register for Plan Sesame. However, they are required to present their national biometric identity card (or IPRES or FNR cards) at health facilities to obtain exemptions. Hence, in Senegal, people over 60 require a valid card, and they should be aware of Plan Sesame to avail exemptions. We therefore considered persons as enrolled if they had a valid card and also knew about Plan Sesame.

In this study we wanted to compare older people who are eligible for free healthcare however they were defined differently as per the scheme's eligibility. For NHIS, people over 70 are eligible for exemptions; Plan Sesame exemptions are offered to people over 60. We therefore included persons who are benefitting from SHP as over 70 years in Ghana and over 60 years in Senegal.

Regression models

Our basic regression model for determinants of enrolment can be defined as:

$$\text{Logit}(p) = \log(p/1-p) = \beta 0 + Xi.\beta i1 + SEi.\beta i2 \quad (1)$$

Enrolled is a binary outcome variable indicating enrolment status as 0/1, and p is the probability that the individual has enrolled in the scheme, i.e. p = prob (Enrolled=1). SEi is a set of SPEC variables (as described in Table 1), Xi is a set of remaining variables that may influence enrolment, and βs are the model parameters.

We estimated three logistic regression models for each country. First, we estimated a simple regression model (Model A) with only Xi variables, we then ran the regression with all variables–Xi and SEi variables in Model B, and in the third model (Model C) we included Xi variables and the SPEC indices.

Since more than one older person could have answered Part II of the questionnaire in Ghana (for example if both the household head and his/her spouse were over 70), the standard errors for Ghana were adjusted for clustering at the household level. All models were estimated using Stata 12.

Variables

The variables used in this study are described in Table 2.

Table 2. Definition and descriptive statistics of variables, by country

Variables	Definition	Percentage	
		Ghana	Senegal
Enrolled	1 if enrolled; 0 otherwise	71.7%	47.7%
Core variables			
Male	1 if male; 0 otherwise	48.1%	53.4%
Educated	1 if education; 0 otherwise	32.6%	26.8%
Head	1 if elder is the household head; 0 otherwise	89.9%	68.1%
Majority_religion a	1 if belongs to the majority religion; 0 otherwise	66.7%	96.5%
Majority_ethnicity b	1 if belongs to the majority ethnicity; 0 otherwise	72.6%	47.6%
Urban	1 if living in an urban area; 0 otherwise	50.6%	48.8%
HHHmale	1 if household head is male; 0 otherwise	49.9%	73.9%
Chronic	1 if has any chronic illness; 0 otherwise	27.8%	25.1%
Hospitalised	1 if hospitalised in the past 12 months; 0 otherwise	11.5%	7.7%
Sociocultural (SC)			
Single	1 if single or living alone; 0 otherwise	56.1%	40.5%
No_respect	1 if feel elders are not respected these days; 0 otherwise	4.8%	30.7%
No_association	1 if not member of any association or club; 0 otherwise	64.4%	74.8%
Religious_participation	1 if does not regularly attend religious events; 0 otherwise	24.8%	46.4%
Needhelp_adl	1 if needs help in activities of daily living; 0 otherwise	7.6%	25.4%
Political (P)			
Lessaccess_info	1 if living in a household without a radio or TV; 0 otherwise	36.6%	8.9%
Decision_making	1 if not in any formal decision making position; 0 otherwise	81.6%	85.8%
Political_participation	1 if not part of any political party/group or did not vote in the previous general elections; 0 otherwise	4.1%	29.4%
Far	1 if PHC or health post is within 15 minutes' walk; 0 otherwise	48.5%	44.3%
NotSafe	1 if feel it is not safe to walk alone in the night in the neighbourhood; 0 otherwise	8.1%	30.6%
Economic (E)			
No_income	1 if does not have any independent source of income; 0 otherwise	29.0%	41.0%
Rented_house	1 if living in a rented house; 0 otherwise	24.8%	13.8%
Wealth quartiles	Q1-Q4, with Q1 referring to the poorest 25% households and Q4 to the richest 25% households.		
	Q1	25.3%	25.1%
	Q2	25.7%	24.6%
	Q3	23.9%	25.1%
	Q4	25.1%	25.1%

a Majority religion is Christianity in Ghana and Islam in Senegal.

b Majority ethnicity is Akan, Ga and Ewe in Ghana and Wolof in Senegal.

The dependent variable, Enrolled, is a binary variable indicating the enrolment status, i.e. having a valid NHIS card in Ghana. In Senegal there is no Plan Sesame specific card. Older people are required to show their national biometric ID, IPRES or FNR cards at health facilities to access free care. Hence, a person was considered enrolled if he/she had a valid card and had heard of Plan Sesame.

Core variables identified in Table 2 were included in all regressions. Since the majority of persons were illiterate, Education was constructed as a binary variable, and persons who had any formal education were coded as 1. Whether persons belong to majority or minority religious and ethnic groups could determine if they experience exclusion and discrimination. To capture this, two variables, Majority_religion and Majority_ethnicity, were included. In Ghana, majority religion was Christianity; in Senegal, Islam. Akan, Ga and Ewe were regarded as majority ethnicities in Ghana and Wolof in Senegal. Previous studies (Jehu-Appiah et al., 2011; Chankova et al., 2008) found that households in urban areas and female-headed households tend to have higher levels of enrolment and healthcare utilisation; we therefore included the variables, Urban and HHHmale. Presence of adverse selection (when high-risk individuals who have a higher probability of using healthcare services enrol more than lower-risk or healthier individuals) in voluntary schemes has been noted before (Parmar et al., 2012). This is captured by Chronic and Hospitalised. Respondents were asked if they have any chronic illness as diagnosed by a healthcare provider (e.g. doctor) or if they were hospitalised in the past 12 months. It is expected that older people suffering from chronic illnesses that require regular healthcare and those having hospitalisation needs will tend to enrol more.

Sociocultural variables: We created the variable, No_association, to reflect whether a person was a member of any association (e.g. social clubs, sports clubs, religious associations, women's groups). The variable, Religious_ participation, was included to reflect the intensity and regularity of participating in religious events. The variable, No_respect, indicates whether older people feel respected. The questionnaire included a statement ('Older people are respected these days') and responses were captured by a Likert scale (strongly agree to strongly disagree). Persons who require help with activities of daily living may have difficulties in participating in social and cultural events and Needhelp_adl captured this. Persons living alone or who are single may feel isolated and may be vulnerable to socially exclusion. We included the variable, Single, to investigate this.

Political variables: Some groups may not have access to necessary resources that are needed to participate in society – either due to the unavailability of resources or due to barriers that prevent these groups from accessing these resources. Variables that capture access to health facilities and safe housing and the ease of accessing information were included. For Ghana, clinics run by missions and NGOs could have NHIS accreditation and be entitled to provide free care to enrolled persons. For this reason, these two types of clinics were also considered while defining access to health facilities by the variable, Far. The variable, Political_participation, reflects participation in democratic processes. It includes two activities – participated in recent elections and being a member of a political party.

Economic variables: Relative wealth was estimated at the household level by using principle components analysis (PCA). Household ownership of durable goods (e.g. TV, radio and car), housing conditions (material of roof, number of rooms) and livestock were used. Based on their PCA scores, household were divided into quartiles with Q1 representing the poorest 25% and Q4 the richest 25% households. Since composition of household assets differ in rural and urban areas, quartiles were constructed separately for rural and urban households. As a result, quartiles for the whole sample (rural and urban combined) may not exactly consist of 25% of the persons. Economic dependence is reflected by the variable, No_income, which captures whether a person has any source of independent income, e.g. from pensions, salary or rent.

Ethical approval for this research was obtained from the Noguchi Memorial Institute for Medical Research Institutional Review Board, Ghana [069/11-12] and from the National Ethics Committee for Research in Health, Senegal [674/MSAS/DS/DER].

Results

Descriptive statistics

Table 2 shows the percentage or means of variables that were included in the regressions in the two countries. There were more older people enrolled in NHIS in Ghana than in Plan Sesame in Senegal (72% vs. 48%). The majority of older people were uneducated in both countries, although more were educated in Ghana than in Senegal, despite the fact that persons, as included in this study, were relatively older in Ghana than in Senegal. We have a higher proportion of older people who were household heads in both settings.

Around 1/4th of the older people reported having a chronic illness (28% in Ghana and 25% in Senegal) and 11% in Ghana vs. 8% in Senegal reported being hospitalised in the past 12 months. Access to health facilities was poor, as the majority of them lived more than 15 minutes' walk from any PHC or health post. For those that do not possess a car (90% of households in Senegal and 99% in Ghana as per our sample), reaching health facilities could be a challenge. A large proportion of older people are either single or live alone; most are not members of any association, but many regularly attend religious events, with attendance being higher in Ghana.

Determinants of enrolment

Results from the logistic regressions models, with enrolment status as the dependent variable, are presented in Table 3.

Table 3. Determinants of enrolment, 2012.

		Ghana - National Health Insurance Scheme									Senegal - Plan Sesame								
		Model A			Model B			Model C			Model A			Model B			Model C		
	VARIABLES	OR	SE	CI	OR	SE	CI	OR	SE	CI	OR	SE	CI	OR	SE	CI	OR	SE	CI
	Male	0.696	(0.511)	0.165 - 2.938	0.617	(0.405)	0.170 - 2.235	0.698	(0.573)	0.139 - 3.492	2.207	(0.307)***	1.680 - 2.900	2.141	(0.345)***	1.561 - 2.937	2.114	(0.306)***	1.592 - 2.808
	Educated	1.048	(0.301)	0.597 - 1.839	0.708	(0.222)	0.384 - 1.308	0.762	(0.223)	0.429 - 1.353	2.038	(0.202)***	1.679 - 2.474	1.596	(0.169)***	1.297 - 1.963	1.766	(0.181)***	1.445 - 2.157
	Head	1.250	(0.544)	0.533 - 2.936	1.636	(0.696)	0.710 - 3.767	1.309	(0.609)	0.526 - 3.259	1.735	(0.207)***	1.373 - 2.191	1.482	(0.197)***	1.142 - 1.923	1.378	(0.172)**	1.079 - 1.758
	Majority_religion	2.478	(0.913)**	1.204 - 5.102	1.439	(0.582)	0.651 - 3.180	1.852	(0.702)	0.882 - 3.892	0.997	(0.225)	0.640 - 1.551	1.086	(0.257)	0.683 - 1.727	1.003	(0.231)	0.638 - 1.576
	Majority_ethnicity	0.563	(0.228)	0.254 - 1.246	0.862	(0.412)	0.338 - 2.198	0.833	(0.355)	0.362 - 1.919	1.408	(0.115)***	1.198 - 1.653	1.212	(0.109)**	1.017 - 1.445	1.394	(0.119)***	1.180 - 1.647
	Urban	1.420	(0.329)	0.901 - 2.236	1.414	(0.402)	0.810 - 2.469	1.392	(0.355)	0.844 - 2.296	1.810	(0.169)***	1.507 - 2.173	1.953	(0.217)***	1.571 - 2.429	1.963	(0.191)***	1.621 - 2.376
	HHHmale	0.911	(0.645)	0.228 - 3.646	0.873	(0.597)	0.228 - 3.336	0.614	(0.488)	0.129 - 2.917	1.011	(0.146)	0.761 - 1.341	0.909	(0.140)	0.672 - 1.230	0.890	(0.133)	0.664 - 1.193
	Chronic	2.141	(0.650)**	1.181 - 3.882	2.044	(0.686)**	1.058 - 3.946	2.276	(0.725)***	1.219 - 4.249	1.686	(0.164)***	1.393 - 2.040	1.689	(0.175)***	1.378 - 2.069	1.731	(0.173)***	1.424 - 2.105
	Hospitalised	4.161	(2.262)***	1.434 - 12.077	3.841	(2.214)**	1.241 - 11.888	4.430	(2.482)***	1.477 - 13.284	1.596	(0.243)***	1.184 - 2.151	1.856	(0.298)***	1.354 - 2.544	1.788	(0.281)***	1.314 - 2.432
Sociocultural	Single				1.118	(0.393)	0.561 - 2.226							0.753	(0.089)**	0.598 - 0.949			
Sociocultural	No_respect				0.147	(0.076)***	0.053 - 0.403							0.963	(0.089)	0.804 - 1.153			
Sociocultural	No_association				0.785	(0.293)	0.378 - 1.633							0.494	(0.068)***	0.377 - 0.647			
Sociocultural	Religious_participation				0.744	(0.224)	0.412 - 1.344							1.027	(0.104)	0.842 - 1.252			
Sociocultural	Needhelp_adl				0.971	(0.478)	0.370 - 2.549							0.885	(0.090)	0.725 - 1.079			
Political	Lessaccess_info				0.956	(0.349)	0.467 - 1.956							0.671	(0.110)**	0.486 - 0.926			
Political	Decision_making				0.701	(0.347)	0.265 - 1.851							1.003	(0.173)	0.716 - 1.406			
Political	Political_participation				0.414	(0.215)*	0.149 - 1.148							0.522	(0.053)***	0.428 - 0.638			
Political	Far				0.559	(0.145)**	0.336 - 0.930							0.916	(0.081)	0.771 - 1.089			
Political	NotSafe				1.681	(0.886)	0.598 - 4.725							0.797	(0.079)**	0.657 - 0.967			
Economic	No_income				1.257	(0.366)	0.710 - 2.225							0.846	(0.079)*	0.705 - 1.016			
Economic	Rented_house				0.553	(0.170)*	0.302 - 1.009							0.950	(0.126)	0.733 - 1.233			
Economic	Wealth: Q2				1.287	(0.440)	0.659 - 2.514							1.237	(0.154)*	0.970 - 1.578			
Economic	Wealth: Q3				2.575	(1.120)**	1.098 - 6.041							1.557	(0.200)***	1.211 - 2.003			
Economic	Wealth: Q4				3.861	(1.771)***	1.572 - 9.486							2.286	(0.310)***	1.753 - 2.982			
	SC Index							0.993	(0.008)	0.978 - 1.009							0.991	(0.002)***	0.987 - 0.995
	P Index							0.978	(0.008)***	0.963 - 0.993							0.983	(0.002)***	0.978 - 0.987
	E Index							0.992	(0.005)	0.982 - 1.002							0.990	(0.002)***	0.987 - 0.994
	Observations	435			434			435			2,917			2,902			2,917		

Dependent variable: Binary choice variable for enrolment
Acronyms: Odds Ratio (OR); Standard Errors (SE); Confidence Interval (CI); Socio-cultural (SC); Political (P); Economic (E)
Robust SE in parenthesis
*** p<0.01, ** p<0.05, * p<0.1

With regard to the core variables, men, household heads, having some formal education and living in urban areas increased the odds of enrolling in Plan Sesame by almost twofold. This remained relatively consistent for all models even after other covariates and SPEC indices were introduced. For NHIS these variables were not found to be significant. Belonging to the majority ethnicity (i.e. Wolof) increased the odds of enrolling in Plan Sesame, while belonging to the majority religious group (i.e. Christianity) increased the odds for enrolling in NHIS, although found to be significant only in Model A for NHIS.

Strong evidence of adverse selection was found for both schemes with NHIS being associated with higher adverse selection. Older people who had a chronic illness were significantly more likely to enrol in NHIS and Plan Sesame. Being hospitalised in the last 12 months increased the odds of enrolling in NHIS fourfold and almost twofold in Plan Sesame.

With regard to sociocultural variables, those who were not members of sociocultural associations were less likely to enrol in Plan Sesame. Surprisingly, those who felt that older people are not generally respected in society were more likely to enrol in NHIS. This could be because a very small sample of them (4.8% as mentioned in Table 2) actually felt that older people are not respected.

Older people vulnerable to political exclusion as reflected from lower political and civic participation, living in relatively unsafe neighbours and having limited access to information channels, had lower odds of enrolling in Plan Sesame. For NHIS, lower political and civic participation (significant only at 10%) and living far from health facilities were found to lower the odds of enrolling.

The results show that older people belonging to richer households (Q3 and Q4) are 1.6 and 2.3 times more likely to enrol in Plan Sesame and 2.6 and 4 times in NHIS when compared to the poorest 25% households. This shows that both schemes have a pro-rich bias, with NHIS being more inequitable.

As mirrored in the odds ratio in Model B for both countries, those who were vulnerable in all dimensions of social exclusion had lower odds of enrolling in Plan Sesame, as seen from the SPEC indices in Model C. For NHIS, only the political dimension was found to significantly lower the odds of enrolling. However, it should be noted that the indices, although found to be highly significant, are very close to 1.

Discussion

The implementation of Plan Sesame and NHIS exemptions for people over 70 represent significant efforts to remove financial barriers to healthcare access for older people. There is currently limited evidence to show how successful these schemes have been at enrolling the ageing population and whether inequities in enrolment exist. Our study has addressed these issues by analysing data from household surveys in Ghana and Senegal to ascertain enrolment rates for targeted persons, to analyse determinants of enrolment, and to explore whether social exclusion is restricting access to these SHP schemes.

Our results show evidence of persisting inequities in enrolment for older people in NHIS and Plan Sesame caused by a combination of economic, political and sociocultural dimensions. The impact of each of these dimensions is discussed in turn in the remainder of this section.

Economic exclusion and enrolment

Pronounced economic inequalities are evident in both schemes with older people in the richest quartiles being more likely to enrol than those in the poorest quartile. In Ghana, older people who live in family-owned houses are more likely to enrol in NHIS than those living in rented houses (nearly 25%), while older people with their own source of income in Senegal (nearly 59%) were more likely to enrol in Plan Sesame than individuals with no income. These findings are consistent with existing literature that finds substantial evidence of low enrolment for the most economically vulnerable individuals in SHP schemes that are specifically targeted towards the poor in LMIC (Jehu-Appiah et al., 2011; Sarpong et al., 2010). Although both schemes have taken steps to reduce financial barriers to access, it is clear that richer individuals are more likely to activate their entitlements to access Plan Sesame or to receive exemptions from NHIS. In Ghana, potential financial barriers to enrolment for the poor still exist. Despite being exempt from paying the full premium, older people are required to pay a small registration to join. Removal of this registration fee may increase enrolment among the poor, as the existence of even a small fee has previously been shown to prevent the poor from enrolling (Wang et al., 2005).

Political exclusion and enrolment

Our results show that the political dimension is an important determinant of enrolment in NHIS and Plan Sesame. Older people that take an active role in civic society by voting were shown to have higher odds of enrolment. For Plan Sesame, this is partly explained by individuals who intend to vote being required to have the same ID card to obtain a voter registration ID as they need to access Plan Sesame; an individual that intends to vote therefore has an additional incentive to acquire an ID card. Voting may also be significant, as individuals who take an interest in politics are more likely to have heard of these financing schemes and be influenced by the opinions of political and local leaders. Additionally, people who participate in the democratic system may have a higher level of trust in the democratic system and political structures and may be more likely to participate in government initiatives such as Plan Sesame and NHIS (Ottone, 2007). Geographical inequities are shown to exist for individuals living in remote areas, with individuals living close to a health facility in Ghana having significantly increased odds of enrolling in NHIS and urban individuals more likely to enrol in Plan Sesame. Links between lack of physical access to healthcare and lower enrolment has been well established (Schneider & Diop, 2004). This apparent geographical segregation and exclusion suggests that further investment in health centres is needed in Ghana. In Senegal, distance to a health facility is not significantly related to enrolment, suggesting that low enrolment among rural individuals may instead be due to barriers to accessing administrative offices to apply for an ID card. Efforts should therefore be taken to create ID card centres in remote areas of Senegal.

Sociocultural exclusion and enrolment

Our results also show the importance of social support networks and solidarity in influencing enrolment patterns in Plan Sesame. SHP schemes are founded on the principle of social solidarity, and we initially hypothesized that greater feelings of solidarity would increase odds of enrolment (Barrientos & Lloyd-Sherlock, 2000). In our regression models, respect afforded to older people were included as proxy measures for solidarity felt with fellow citizens. Having a positive perception on the respect afforded to older people in Ghana increased the odds of being enrolled in NHIS, confirming our initial hypothesis. Being a member of an association significantly increased the odds of being covered by Plan Sesame, while being single decreased odds of enrolment. These variables signify the existence of a social support network and indicate that an individual is not isolated from the community. Social support networks are important in ensuring that individuals are able to actively participate in society and benefit from opportunities that are afforded to them, as networks with many social connections are more likely to introduce new ideas and opportunities to their members (Putman, 1993). Being a member of an association is therefore likely to enhance the probability of having heard of Plan Sesame and an individual's ability to register for an ID card.

The SEKN and Commission on Social Determinants of Health have both affirmed that health inequalities and access to SHP are affected by hierarchical systems of social stratification based on gender, class, education, age, ethnicity, and religion (Marmot et al., 2008; Popay, 2008). Unsurprisingly, a number of these sociocultural variables are shown to be significant determinants of enrolment in Plan Sesame and NHIS. In Senegal, being male, educated, household head or belonging to the majority ethnicity increases the odds of being covered. In Ghana, although these variables are not significant, belonging to the majority religion significantly increases the odds of enrolment. The significance of these variables may indicate that discriminatory processes are present, and religious minorities in Ghana and ethnic minorities and women in Senegal are being excluded from SHP. Efforts should be made to target older women and minorities to ensure they are fully aware of their entitlements. As highlighted in previous literature, education is unsurprisingly significant, as higher education leads to a greater understanding of the scheme and therefore a higher tendency to enrol (Chankova et al., 2008; Jehu-Appiah et al., 2011).

SPEC indices of social exclusion

A similar pattern to the above results is seen when looking more closely at the SPEC indices of social exclusion. In our third regression model (Model C), sociocultural, political and economic indices are all significantly related to enrolment in Plan Sesame, indicating that individuals at risk of social exclusion are less likely to enrol. Results from Ghana suggest that individuals at risk of social exclusion in the political domain are less likely to enrol in NHIS, although the economic and sociocultural indices are not significant. These results confirm our initial hypothesis and indicate that access to SHP schemes can be restricted by social exclusion. Efforts to reform both schemes should be undertaken to ensure that socially excluded individuals are aware of their entitlements and to ensure that all older people enjoy the same rights and ability to access these schemes.

More research on NHIS and Plan Sesame is needed to explore the underlying causes or pathways that explain the results presented in this study. A number of non-financial indicators, such as access to information and administrative processes, may be preventing older people from enrolling. Richer and educated individuals are likely to have better access to media, giving them greater exposure to scheme-related information and education campaigns that enhance their awareness and understanding of SHP (Schneider & Diop, 2004). Indeed, results from our regression analysis indicate that older people with access to a TV or radio were more likely to enrol. Although general awareness of NHIS is high in Ghana, we are not aware of any study that has looked at the awareness of exemptions among older people.

In addition to lack of awareness, complex administrative procedures may be discouraging vulnerable older people from enrolling. In Senegal, older people are required to obtain an ID card from officials by either presenting a birth certificate or taking three Senegalese witnesses to confirm their Senegalese nationality. These requirements may be difficult for some persons to fulfil, particularly those that are socially isolated, in poor health or living in remote communities.

Limitations

Our results are based on an analysis of quantitative data on social exclusion and thus capture social exclusion as a set of binary/dichotomous variables. Although a quantitative assessment of the multiple indicators of disadvantage presents important insights into the analysis of social exclusion, further research is needed to fully capture the complexity and dynamics of social exclusion processes. In addition, the survey in Ghana was part of a larger study exploring enrolment of all individuals in NHIS and was not specifically targeted towards the ageing population. In comparison, our Senegalese survey was targeted towards older people, ensuring the sample size in Ghana was far smaller (435) than in Senegal (2933). This may have been responsible for some variables to be insignificant in the regression models for Ghana. Practical considerations ensured that interviews were primarily conducted with

older persons who were household heads. We therefore miss the experience of those who are not household heads and who may be more likely to experience social exclusion and barriers to accessing SHP and healthcare. Furthermore, due to the differing design of the schemes, our analysis of NHIS was conducted on persons over 70, while our analysis of Plan Sesame was for over 60s. This should be taken into consideration when comparing the results between these two schemes. It was also not possible to explore all possible variables influencing enrolment. More research is needed to explore whether prior experience of enrolling in SHP schemes and utilizing healthcare services, and perceptions on quality of healthcare can further explain the differences in enrolment rates among the socially excluded groups in these countries. Since NHIS has been operational for nine years and Plan Sesame for almost six years, there is a need to understand program-level barriers faced by older people and how these barriers can be removed so that the most vulnerable are not left out. Finally, we did not study the impact of either scheme on utilization of healthcare or health outcomes, as this was beyond the scope of the study. Previous studies have shown that although SHP schemes often increase utilization and reduce the risk of catastrophic health payments, these benefits are often unequally distributed amongst vulnerable groups, particularly those in the lowest quintile (Lu et al., 2012; Lioyd-Sherlock et al., 2012). It is therefore important for future research to determine if these SHP schemes benefit the most vulnerable older people.

Conclusion

Our study makes a valuable contribution to the evaluation of SHP for older people in LMIC. Plan Sesame and exemptions for older people in NHIS are both significant policies that have taken steps to address the inequities experienced by older people in relation to healthcare access. However, results from our study indicate that older people at risk of social exclusion are currently disadvantaged in enrolment and neither scheme has yet achieved the goal of equity in access for older people. Although these schemes aim to reduce financial barriers to enrolment, economically vulnerable persons still suffer from inequities in enrolment and efforts should be taken to identify the very poorest to ensure they are aware of and enrol in SHP schemes. Simply targeting the removal or reduction of financial barriers may not be enough. Enhanced efforts should also be made to reach older populations in remote areas, those who belong to ethnic minorities, women, and those isolated due to a lack of social support. Consideration should also be paid to modifying scheme features such as eliminating the registration fee for older people in NHIS and creating administration offices for ID cards in remote communities in Senegal. Recognising and taking steps to address factors hindering enrolment of older people at risk of social exclusion will ultimately improve the prospect of achieving equity and universal coverage in older populations.

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CHAPTER 13: Are women excluded from social protection programmes in Ghana? A case study of the National Health Insurance Scheme

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Introduction

Globally, there is a strong link between gender, vulnerability and social exclusion. Women and girls are disproportionately exposed to poverty, vulnerability and exclusion than men and boys (UNRISD, 2010; UNDP-Ghana, 2007; Kabeer, 2008). Generally, women occupy a disadvantaged status in relation to work opportunities compared to men (Sabates-Wheeler & Kabeer, 2003; Luttrell & Moser, 2004). Working on gender dimensions of risk, vulnerability and shocks, Luttrell & Moser (2004) explain that men and women are exposed to different risks, and even where the risks are the same, men and women experience them differently. This is because some of the constraints men and women face are 'gender-specific', while others are either 'gender-intensified' or 'gender-imposed' (Sabates-Wheeler & Kabeer, 2003). Applying the lens proposed by Sabates-Wheeler & Kabeer (2003), and later reused by Luttrell & Moser (2004), the gender-specific constraints relate to 'societal norms and practices that apply to women or men by virtue of their gender', and for women these constraints are mostly as a result of their biological and social roles in reproduction and family care. Fagan et al. (2006) report of gender differences in health and the incidences of a range of health problems. For instance, women in developing countries are exposed to more health risks associated with pregnancy, delivery and postpartum complications. In Ghana, maternal mortality is quite high (485/100,000 live births) with about 31% of women aged 15-49 years still delivering at home without skilled attendants (GSS, 2012; GSS, 2011). There are wide inequalities in the allocation of time between paid and unpaid work for men and women, which tend to disadvantage women (Antonopoulos, 2013). Antonopoulos (2013) has explained that because women spend a higher proportion of their time performing household chores, the available time they can

potentially devote to paid work is severely curtailed. Globally, more than 50% of economically active women are deemed most vulnerable workers because they engaged in own-account and unpaid family work and are more likely to lack social pensions (Antonopoulos, 2013). This situation is not very different from Ghana where 24.6% of males compared to only 10.6% of females were engaged in paid employment (GSS, 2013).

The gender-intensified constraints, on the other hand, are inequalities in opportunities and resources between men and women because of the norms and customs in the society or within the household (Sabates-Wheeler & Kabeer, 2003; Luttrell & Moser, 2004). Generally, women have limited access to formal education, health care services, property and political power (Antonopoulos, 2013; Fagan et al., 2006). According to Ghana's NSPS, women suffer the brunt of extreme poverty and remain at the top of the list of excluded and vulnerable groups in society (MMYE, 2007). This is largely due to their weak control over resources, power and their sexuality and the persistent male biased socio-cultural norms and practices (UNDP-Ghana, 2007). Women in Ghana have lower educational levels, low working capital and are more likely to work in the informal economy and engaged in subsistence agriculture where poverty is more pronounced. They are also more likely to suffer from unemployment compared to men (UNDP-Ghana, 2007). The literacy rate for females is 49.6% compared to 67.3% for males in Ghana with a national average of 56.3% (GSS, 2013). The literacy rate in rural Ghana is even worse for women, where only 29% of women compared to 52% of men are literate (FAO, 2012).

The gender-imposed contraints are explained to include the forms of gender disadvantage that reflect discrimination in the wider public domain outside the household or community (Sabates-Wheeler & Kabeer, 2003; Thakur et al., 2009). These biases include the gender differentiation of jobs, which stereotype certain jobs for women and instances where employers refuse to recruit women (Wheeler & Kabeer, 2003). Fagan et al. (2006) report that 'women are less likely to secure a decent individual income through employment because of their 'lower employment rate, greater exposure to low pay and more broadly by their lower average earnings'. In rural Ghana, the wages of men in employment is five times more than that of women (FAO, 2012).

The above gender-related vulnerabilities, inequalities and social exclusion justify why mainstreaming gender in social protection interventions, especially for the informal sector, is of paramount importance (Kabeer, 2008). According to Sabates-Wheeler & Kabeer (2003), social protection interventions are there to 'assist individuals, households and communities to better manage the income risks that leave people vulnerable'. From a rights-based approach, social protection as a framework for promoting social justice could be a tool for the empowerment of women (ILO, 2011). This is expected to offer women the opportunity to participate fully in economic, social, political and cultural structures within which they live their lives (Antonopoulos, 2013). It is known that improving women's access to decent jobs, vocational training and enabling social services are necessary to providing them with a sustainable route out of poverty and access to personal income (UNRISD, 2010). This makes improving women's access to quality health care service imperative because good health is a necessary requirement for increased productivity and wealth creation. Lund & Srinivas (2000) have argued that strategies which mitigate or lessen risks, and those which help in coping with them, especially for women, are important because such risks adversely affect their income flow while increasing their expenditures. A typical example of such risks is health shocks, which sometimes can have catastrophic consequences for low-income households. As emphasised by the UN System Task Team on the Post-2015 UN Development Agenda (2012), social protection should ensure that all people have access to essential goods and services by removing social and economic barriers to access. By viewing social protection as an investment in workforce, DFID (2006) argues that in developing countries, many potentially productive people cannot participate effectively in the labour market or as entrepreneurs due to ill health and a lack of education. To this effect, Lund & Srinivas (2000), sharing their experiences on a gendered approach to social protection for

workers in the informal sector, identified health coverage and health insurance as some of the main objectives and scope of social protection of direct relevance to women. This is because among other things, health insurance enables them to reduce the risks associated with pregnancy, childbirth, postpartum complications, and also enables them to access affordable primary health care (Lund & Srinivas, 2000; Luttrell & Moser, 2004).

In Ghana, governments over the years have initiated a number of social protection programmes to reduce poverty and tackle inequalities. One strategy has been to provide safety nets that can be used to cushion the most vulnerable groups from unexpected economic and environmental shocks, as envisaged by the United Nations in Ghana (The United Nations in Ghana, 2014). In 2007, the Ghanaian government adopted a National Social Protection Strategy (NSPS). It makes provision for both social protection and social assistance mechanisms aimed at enhancing an individual's capacity to manage their socio-economic risks – e.g. unemployment, sickness, disability and old age (MMYE, 2007). Over the years, Ghana's social protection programmes have been organised to cover six main intervention areas: (i) child protection, survival and development, (ii) labour market policies and programmes, (iii) health programmes, (iv) social insurance programmes, (v) microfinance, and (vi) social welfare programmes. The extent to which these interventions impact on the most vulnerable in society, especially on women and children, therefore requires an investigation.

One of Ghana's flagship social protection interventions in the area of social insurance is the National Health Insurance Scheme (NHIS), which is described in-depth in chapter three. All categories of members in the NHIS have to pay an initial registration fee and then renew their membership annually, except pregnant women and indigents who are exempted from paying the registration fee. The scheme has a comprehensive benefits package that covers about 95% of the disease conditions in the country. However, expensive health services, such as treatment of cancers other than breast and cervical cancers, dialysis for chronic renal failure and organ transplantation, are excluded.

After a decade of implementation, only 36% of the national population of 24.6 million is covered by the NHIS as active members (meaning their membership is up-to-date). Studies have attributed this low coverage to an unaffordable insurance premium/registration fee, low incomes, apathy, perceived poor quality of health services, lack of trust in insurers, and confusion over the basic details of the scheme among others (Asante &Aikins, 2008, Jehu-Appiah et al., 2011; Sarpong et al., 2010; Chankova et al., 2010; Kotoh, 2013; Alfers, 2009). It has been found that certain groups of persons, especially the poor, are systematically excluded from the NHIS (Asante & Aikins, 2008; Alfers, 2009; Sarpong et al., 2010; Jehu-Appiah et al., 2011).

Notwithstanding the generally low enrolment of the population, coverage is relatively higher among the female population. According to the recent national Multiple Indicator Cluster Survey (MICS), 69% of women aged 15-49 years and 56% of men aged 15-59 years have ever been registered with the National Health Insurance Scheme (GSS, 2011). Another report also shows that 58% of new registrants and renewals in 2012 were females (NDPC, 2012). The increasing enrolment for women is perhaps due to the free delivery policy (from 2005), followed by the free insurance enrolment (i.e. the premium exemption policy) for pregnant women (since 2008), which have been effective measures to lift up some of the gender-specific constraints to access to healthcare (Dzakpasu et al., 2012) including Ghana, have introduced policies to provide free medical care to pregnant women. The impact of these policies, particularly on access to health services among the poor, has not been evaluated using rigorous methods, and so the empirical basis for defending these policies is weak. In Ghana, a recent report also cast doubt on the current mechanism of delivering free care—the National Health Insurance Scheme. Longitudinal surveillance data from two randomized controlled trials conducted in the Brong Ahafo Region provided a unique opportunity to assess the impact of Ghana's policies.\n\nMETHODS: We used time-series methods to assess the impact of Ghana's 2005 policy on free delivery care and its 2008 policy on free national health insurance for pregnant women. We estimated their impacts on facility delivery and insurance coverage, and on socioeconomic differentials in these outcomes after controlling for temporal trends and seasonality.\n\nRESULTS: Facility delivery has been increasing

significantly over time. The 2005 and 2008 policies were associated with significant jumps in coverage of 2.3% (p\ u200a=\u200a0.015. In most of the studies that have looked at equity issues, they focused on one dimension of vulnerability (i.e. poverty) by comparing enrolment by wealth quintiles (e.g. Asante & Aikins, 2008; Sarpong et al., 2010; Jehu-Appiah et al., 2011). As clearly demonstrated by Dixon (2014), poverty is just one of the many factors driving inequality in enrolment in the NHIS. For those who have looked at NHIS and gender have also done so by comparing enrolment by males and females (Dixon, 2014) or enrolment of women in the reproductive age of 15 – 49 years (Kumi-Kyereme & Amo-Adjei, 2013). While the higher enrolment of females is encouraging, more scrutiny is required to identify groups of women who are left out of NHIS and how they could be assisted. In this study, we try to fill this gap. By using a social exclusion lens, we explore whether Ghanaian women (i.e. 15-years and above) are participating in the NHIS. We further discuss the processes by which exclusion occurs, why it occurs and whether social exclusion can explain the patterns observed.

Methods

Study design

The study uses data from a cross-sectional household survey conducted in five districts of Ghana in 2012. Further details on the study locations and sampling strategy can be found in chapter three.

Trained field assistants administered a structured household quantitative questionnaire to the household head. The aim of the household survey was to obtain data on household members who were socially excluded from the NHIS using a Social, Political, Economic and Cultural (SPEC) framework based on the Social Exclusion Knowledge Network's (SEKN) concept of social exclusion (SEKN, 2008). The household questionnaire was made up of two modules, with the first part focused on general information about the household and its members. Information collected included socio-economic and demographic characteristics of the household members, their health status, NHIS membership status, reasons for non-membership, access to social services and ownership of assets, among others. The second module assessed the awareness and opinions of the household head or the spouse on specific social, political, economic and cultural factors that are likely to act as drivers of social exclusion. It also assessed their opinions on the NHIS. While the household head answered the first module, the household head and the spouse, if available, answered the second separately. A total of 5,292 social exclusion (i.e. module 2) questionnaires were administered, of which 60% (3,173) of the respondents were women. The analysis is limited to 3,165 women and their households with complete data.

Statistical analysis

We assessed the determinants of enrolment in the NHIS for women aged 15-years and above by estimating a binary logistic regression model. The dependent variable is the current health insurance status of a woman, which is treated as a binary variable where the probability (P) of enrolment in the NHIS is specified as: $P(y=1|x) = \exp(\beta'x) / 1 + \exp(\beta'x)$, where y=1 if a woman is currently enrolled in the NHIS (i.e. those with valid membership cards) and y=0 if the woman is not; x is vector of the independent variables while β is the coefficients to be estimated. The choice of the independent variables is informed by recent studies in assessing the determinants of enrolment in the NHIS (Asante & Aikins, 2008; Jehu-Appiah et al., 2011; Chankova et al., 2010; Mensah et al., 2010; Parmar et al., 2014; Dixon, 2014).

The independent variables included in the estimation were grouped into personal characteristics of the women (e.g. age, religion affiliation, marital status, relationship to the household head and health status) and selected social exclusion variables. Using the definition of social exclusion as the systematic denial of particular groups of people from fully enjoying a set of social opportunities, such as the right to "participate on equal terms in social relationships in economic, social, cultural or political arenas" (GSDRC, University of Birmingham 2006), a number

of SPEC variables were used to construct an index for each of the four SPEC dimensions using principal component analysis (PCA). The construction of the index for each of the four SPEC dimensions followed a similar approach by Parmar et al. (2014). The PCA was performed using the correlation matrix method, while the first component of each index with an eigenvalue greater than 1 was maintained as an index for each dimension.

These four SPEC dimensions can be considered as "risk factors" of social exclusion; exposure to them therefore makes the person more vulnerable to social exclusion (Parmar et al., 2014). The social and cultural dimensions were combined to obtain the socio-cultural variables that mainly looked at proximal relationships of support and solidarity that generate a sense of belonging within social systems. The socio-cultural variables included in the regression were, place of residence, social capital (e.g. whether they belong to any social organisation), social participation (e.g. whether they are able to participate in social activities in the community), perceptions about the NHIS and gender-specific variables relating to domestic violence and sexual abuse. Though most of the socio-cultural variables were generated from responses captured by a Likert-scale (i.e. strongly agree to strongly disagree), they were analysed as binary responses (i.e. 0=disagree, 1=agree). In a few cases, the scoring of the responses was reversed (i.e. 0=agree, 1=agree) depending on the direction of the question.

The political dimension, on the other hand, is constituted by power dynamics in relationships that generate unequal patterns for both formal rights embedded in legislation, constitution, policies and practices and the conditions in which rights are exercised, including access to social services (e.g. health and education services), administrative, transport and communication infrastructure, to enable individuals to fully participate in their communities. They also included the educational background of women and their level of political participation in their communities as proxy indicators for empowerment. The responses were analysed as binary responses.

Finally, the economic dimension is constituted by access to, and distribution of, material resources necessary to sustain life and participation in society (e.g. income, employment, housing, land, working conditions, livelihoods, assets, etc.). The economic variables considered in this study included whether the women worked in the last six months for pay or profit and the wealth status of their households. The household wealth status was also generated using PCA based on asset indicators ranging from households' dwelling characteristics to access to utilities and sanitation facilities, as well as households ownership of consumer durables such as refrigerator, bicycle, television, radio and mobile phone (Filmer & Pritchett, 2001).

The specific SPEC variables employed in the study are outlined in Table 1. They included individual characteristics and household level variables. Two logistic regression models were estimated. Model 1 contains personal characteristics of the women surveyed and variables representing the four SPEC dimensions. Model 2 contains the personal characteristics and the three indices representing the social-cultural dimension, political dimension and the economic dimension of social exclusion.

Table 1: SPEC variables used to analyse the exclusion of women from the NHIS

Domains	Variable description
Personal characteristics	Age categories (1=15-45years, 2=46-69years, 5=≥70years)
	Religion (1=Christian, 2=Muslim, 3=Other)
	Marital status (1=Never married, 2=Married/in-union, 3=Divorced/separated, 4=Widowed)
	Relationship to household head (1=Head, 2=Spouse, 3=Child, 4=Other)
	Self-reported chronic illness (0=No, 1.Yes)
	Self-assessed health status (1=Poor, 2= fair, 3=good)
Socio-cultural variables	Residence (0=Rural, 1=Urban)
	A member of a social organization (0=No, 1=Yes)
	Able to participate in social activities in community (0=No, 1=Yes)
	Satisfied with social life lately (0=Disagree, 1=Agree)
	A person's fate is determined by God (0=Disagree, 1=Agree)
	Spending money on health insurance is not a priority (0=Disagree, 1=Agree)
	Health insurance is for the poor (0=Agree, 1=Disagree)
	It is good to be a member of the NHIS even when I don't fall sick (0=Disagree, 1=Agree)
	A good wife obeys her husband even if she disagrees with him (0=Disagree, 1=Agree)
	A man has a good reason to hit his wife if she does not complete housework to his satisfaction (0=Agree, 1=Disagree)
	A man has a good reason to hit his wife if she refuses to have sexual relations with him (0=Agree, 1=Disagree)
Political variables	Within 15 minutes distance to the nearest public health centre (0=No, 1=Yes)
	Within 15 minutes distance to the nearest all-seasoned road (0=No, 1=Yes)
	Within 60 minutes distance to the district capital (0=No, 1=Yes)
	Household owns a radio or television (0=No, 1=Yes)
	Years of schooling
	Voted in any recent elections (0=No, 1=Yes)
	Free to express personal opinion in the family (0=No, 1=Yes)
	Free to express personal opinion in group meeting (0=No, 1=Yes)
Economic variables	Work (Did any work for pay, profit or family gain in the past 12 months, 0=No, 1=Yes)
	Wealth quintiles (1=First, 2=Second, 3=Third, 4=Fourth, 5=Fifth)

Results

Descriptive statistics

About 78% of the 3,165 women had ever registered with the NHIS. With regards to their currently health insurance status, 58.3% (1,862) of the women were categorised as insured (i.e. active members) because they had valid NHIS membership cards at the time of the survey, while the remaining 41.7% (1,303) were uninsured (Table 2). The majority (64.9%) of the women were in their reproductive age (15-45 years), with a higher proportion of them among the uninsured women (63.1 % vs. 67.4%, p=0.000). There were more elderly women among the insured

(9.3%) compared to the uninsured (4.1%). This notwithstanding, a further analysis of the 53 uninsured elderly women revealed that they were widowed (69.8%), had never been to school (75.5%), with 82.7% of them being in the two lowest wealth quintiles (Results not shown in Table 2). About 76% of the insured women and 72.3% of the uninsured were Christians with equal representation of Muslims in the two groups (about 22%).

About 63% of the women were married with no significant difference between insured and uninsured with respect to their marital status (p=0.133). There was no significant difference between the insured and uninsured women with respect to their relationship with their head of households (p=0.407). About 40% of the women were heads of their households with the majority (49.9%) being spouses of the household head. On health, the insured women were more likely to report a chronic health problem (10.9 vs. 4.5, p=0.000). A lower proportion of the insured (86.4%) compared to the uninsured (90.9%) assessed their health status as good (p=0.000).

On the social-cultural dimension, the results show that the insured women were more likely to be urban dwellers (56.5% vs.44.8%, p=0.000). There was no statistical difference in the proportion of insured and uninsured women with respect to their social capital and their participation in social activities in the communities. A significant proportion of the insured women (65.1% vs. 58.5%, p=0.000) felt that health insurance is for poor people. They however believed that it was good for people who do not often get sick to become members of the NHIS. On the gender-specific variables, there were significant differences in how the women responded to the questions. While a higher proportion of the uninsured women (86% vs. 83%, p=0.000) agreed that a good wife obeys her husband even if she disagrees with him, a higher proportion of the insured women agreed that a man has a good reason to hit his wife if she does not complete housework to his satisfaction (87% vs. 84%, p=0.005) or if she refuses to have sexual relations with him (86% vs. 79%, p<0.000).

In terms of education, the insured women seemed better educated than their uninsured counterparts. A significant proportion of the insured women reported to have ever been to school and also had a higher proportion of women with more years of education (p=0.000). The insured women were relatively closer to the nearest public health facility, the district capital, and were more likely have a radio or television in the household (p=0.000). There was, however, no statistical difference with respect to access to the nearest all-seasoned road (p=0.744). The results show a significant difference between the insured and uninsured women with respect to their political participation.

Economically, about 41% of the women were in agriculture, engaging mainly in food crop production, with a higher proportion among the uninsured (45% vs. 38%). This is followed by about third of the women in sales and services with a higher proportion among the insured (35%) compared to the uninsured (32%). About 22% of all the women were unemployed. The results also show a significant difference between the insured and uninsured women with respect to their wealth status (p=0.000). There were a higher proportion of uninsured women in the first (26.6% vs. 18.1%) and second (25.6% vs. 17.5%) wealth quintiles.

Table 2: Descriptive statistics of selected variables by health insurance status of women in Ghana, 2012

Variable	Insured (%)	Uninsured (%)	Total (%)	p-valuea
Personal characteristics				
Age (years)				
15-45	63.2	67.4	64.9	0.000
46-69	27.6	28.6	28.0	
≥70 years	9.3	4.1	3.2	
Religion				
Christian	76.1	72.3	74.5	0.000
Muslim	22.6	22.4	23.7	
Other	1.3	2.4	1.8	
Marital status				
Never married	11.0	11.0	11.0	0.133
Married/in-union	63.0	64.2	63.5	
Divorced/separated	11.2	12.7	11.8	
Widowed	14.8	12.1	13.7	
Relationship to household head				
Head	41.5	38.5	40.3	0.407
Spouse	48.9	51.2	49.9	
Child	7.0	7.5	7.2	
Other	2.5	2.8	2.6	
Health status				
Presence of chronic illness	10.9	4.5	8.3	0.000
Self-assessed health	2.7	5	2.2	0.000
Poor	11.0	7.7	9.6	
Fair	86.4	90.9	88.2	
Good				
Socio-cultural dimension				
Residence				
Urban	56.5	44.8	51.7	0.000
Rural	43.5	55.2	48.3	
Social capital/social participation				
Member of a social organization	38.7	37.6	38.2	0.586
Able to participate in social activities in community	28.3	22.2	27.8	0.535
Satisfied with social life lately	63.4	61.2	62.5	0.240
A person's fate is determined by God	67.8	68.2	68.0	0.814
Perception about the NHIS				
Spending money on health insurance is not a priority	10.9	11.1	11.0	0.804
Health insurance is for the poor	65.1	58.5	62.4	0.000
It is good to be a member of the NHIS even when you don't fall sick	94.5	91.1	93.1	0.000
Gender-specific variables				
A good wife obeys her husband even if she disagrees with him (% agree)	82.8	85.9	84.1	0.000
A man has a good reason to hit his wife if she does not complete housework to his satisfaction (% disagree)	87.2	83.7	85.72	0.005
A man has a good reason to hit his wife if she refuses to have sexual relations with him (% disagree)	86.3	78.8	83.2	0.000

Political dimension				
Education				
% ever being to school	65.8	56.5	62.0	0.000
Years of schooling	34.3	43.6	38.1	0.000
No formal education	10.2	13.6	11.6	
Less than 6 years	45.8	37.9	42.5	
6-10 years	9.8	5.0	7.8	
Secondary or higher				
Access to services and information				
Within 15 minutes distance to the nearest public health centre	52.8	43.3	48.9	0.000
Within 15 minutes distance to the nearest all-seasoned road	87.5	87.9	87.7	0.744
Within 60 minutes distance to the district capital	87.5	80.7	84.7	0.000
Household owns a radio or television	77.6	66.5	73.0	0.000
Political participation				
Voted in any recent elections (% yes)	90.9	87.1	89.4	0.001
Free to express personal opinion in the family (% yes)	88.6	84.3	86.8	0.001
Free to express personal opinion in group meeting (% yes)	68.9	61.8	66.0	0.000
Economic dimension				
Occupation				
Professional/tech/mgt/clerical	3.1	1.5	2.5	0.001
Sales and Service	34.9	31.9	33.7	
Agriculture	38.3	44.6	40.9	
Unemployed	23.3	21.3	22.4	
Other	0.4	0.69	0.5	
Wealth status				
First	18.1	26.6	21.6	0.000
Second	17.5	25.6	20.8	
Third	19.6	20.2	19.8	
Fourth	20.4	16.2	18.7	
Fifth	24.4	11.4	19.0	
Total (n)	**1,862**	**1,303**	**3,165**	

Pearson's chi-square ($\chi 2$) for categorical variables

Reasons for non-membership in the NHIS

When uninsured women were asked to state their reasons for non-enrolment in the NHIS, the results did not show any significant difference between rural and urban women in their views (p=0.251). The main reason cited was economic, as the majority (53.6%) felt the NHIS premium/registration charges were too expensive for them with a little higher (54.3%) complaining from urban women (Table 3). Close to 18% of all the women had not enrolled in the NHIS because they considered themselves as healthy (not falling sick) and as such do not need health insurance. This proportion was higher among rural uninsured women (18.4% vs. 17.2%). Socio-culturally, this notion of some women that they are not members of the NHIS because they do not fall sick suggests that not all of them appreciate or understand the risk-sharing principle underlying the NHIS. Relationally (politically), few of the women (1.4%) did

not trust the scheme's officials. About 8.0% (urban=6.7%, rural=8.4%) of the women, though, had registered with the NHIS but never received their cards, while others (5.8%) had no reason for their non-membership. A few others (5.3%) attributed their non-membership to a lack of time to go to the registration centre, lack of interest in orthodox medicine and introduction of the capitation policy.

Table 3: Reasons for non-membership in the NHIS (%)

Reason	Urban	Rural	Total
Premium/registration fee is too expensive/no money	54.3	53.0	53.6
Does not fall sick	17.2	18.4	17.9
Never benefited from it	1.2	1.1	1.2
Does not trust the NHIS	1.2	1.5	1.4
Poor services to NHIS members	0.9	1.0	0.9
Heard bad news about the NHIS	1.0	1.4	1.2
Registration centre is too far from community	1.4	0.8	1.1
Ignorant about the scheme	0.8	0.3	0.6
Did not know card had expired	3.9	2.4	3.1
Registered but card never came	6.7	8.4	7.6
No reason	7.7	4.7	5.8
Other	4.8	5.7	5.3
n	586	717	1303

Determinants of enrolment in the NHIS by women

Table 4 presents the estimates of the determinants of enrolment in the NHIS by women. Results from model 1 show that elderly women aged 70 years or more were nearly three times more likely to enrol in the NHIS relative to women in their reproductive years (15-45 years). Muslim women were 1.3 times more likely to insured with the NHIS, while women with no religious affiliation or those belonging to a minority religious group were less likely to enrol in the NHIS relative to their Christian counterparts. The result (model 2) shows that divorced or separated women were 1.6 times less likely to enrol in the NHIS compared to their never married counterparts. Women with chronic health problems were about 2.3 times more likely to be members of the NHIS.

Socio-cultural variables likely to increase the likelihood of women's enrolment in the NHIS included being an urban dweller or having a positive perception about the NHIS. For instance, women who agreed that the NHIS is not for the poor were 1.3 times more likely to be members of the NHIS, while those who agreed that it was good to be a member of the NHIS even if one does not get sick often were 1.7 times more likely to enrol. Surprisingly, women who belonged to a social organisation were 1.2 times less likely to enrol. Women who disagreed that a man has a good reason to hit his wife if she does not complete housework to his satisfaction were 1.3 times less likely to enrol in the NHIS. On the other hand, those who disagreed that a man has a good reason to hit his wife if she refuses to have sexual relations with him were 1.7 times more likely to enrol.

Politically, the results show that lack of women's formal education reduces the likelihood of enrolment. For instance, women who had between 6-10 years of formal education are 1.7 times more likely to enrol in the NHIS relative to those without formal education. The likelihood of enrolment is 2.0 times more likely for women with more than 10 years of formal education. Better access to a public health centre or the district capital increases the probability of women's enrolment in the NHIS. The probability of enrolment is about 23% higher for women living within 15 minutes away from a public health centre and 49% higher for women living within 60 minutes from the district capital compared to those living further away. Unexpectedly, close proximity to an all-seasoned road significantly

reduces the likelihood of enrolling in the NHIS. Interestingly, women with higher political participation in their communities were more likely to enrol in the NHIS. Women who voted in the recent elections in their communities were 1.4 times more likely to enrol in the NHIS, while those who were free to express their personal opinions in community group meetings were also 1.2 times more likely to enrol.

From an economic perspective, household's wealth status has a positive and significant effect on a woman's insurance status. The probability of enrolling in the NHIS increases with an increase in household's wealth status. Women in the third wealth quintile are 1.4 times more likely to enrol in the NHIS compared to women in the first wealth quintile. This increases to 1.6 times and 2.6 times for women in the fourth and fifth wealth quintiles respectively.

Results from model 2 also show that in addition to the significant personal characteristics, the political and economic drivers of social exclusion have a positive and significant influence on a woman's enrolment status in the NHIS. Women with higher scores on the political and economic dimensions are more likely to enrol in the NHIS. Politically, improvement in educational levels and improved access to social services increase the likelihood of NHIS membership. The same observation applies to improvement in the wealth status of the women.

Table 4: Logistic regression estimates of the determinants of enrolment in the NHIS by women in Ghana, 2012

Variables	Model 1		Model 2	
	Odds ratio	Std. Err	Odds ratio	Std. Err
Age (in years) (Ref=15-45)				
46-69	1.006	0.103	0.897	0.087
≥70 years	2.994***	0.624	2.516***	0.505
Religion (Ref=Christian)				
Muslim	1.247*	0.145	1.117	0.108
Other	0.688	0.209	0.572*	0.166
Marital status (Ref=Never married)				
Married/in-union	1.037	0.176	0.826	0.132
Divorced/separated	0.842	0.163	0.623***	0.115
Widowed	1.119	0.228	0.767	0.148
Relation to household head (Ref=Head)				
Spouse	0.955	0.126	0.937	0.112
Child	0.965	0.183	1.126	0.204
Other	0.876	0.228	1.026	0.255
Health status				
Presence of chronic illness	2.266***	0.394	2.273***	0.386
Self-assessed health (Ref=Poor)				
Fair	0.894	0.290	0.896	0.283
Good	0.777	0.242	0.706	0.214
Socio-cultural dimension				
Residence (Ref=Rural) Urban				
Urban	1.474***	0.128		
Social capital/social participation				
A member of a social organisation	0.854*	0.075		
Able to participate in social activities	0.986	0.088		
Satisfied with social life late	1.105	0.127		
A person's fate is determined by God	1.006	0.127		
Perception about the NHIS				
NHIS is for the poor	1.259***	0.103		
It is good to be a member of the NHIS even when you don't fall sick	1.679***	0.256		

Spending money on health insurance is not a priority	0.975	0.126		
Gender-specific variables				
A good wife obeys her husband even if she disagrees with him	0.970	0.108		
A man has a good reason to hit his wife if she does not complete housework to his satisfaction	0.773*	0.114		
A man has a good reason to hit his wife if she refuses to have sexual relations with him	1.654***	0.227		
Political dimension				
Education				
Less than 6 years	1.012	0.138		
6-10 years	1.655***	0.177		
Secondary or higher	2.048***	0.393		
Access to services and information				
Within 15 minutes distance to the nearest public health centre	1.226**	0.101		
Within 15 minutes distance to the nearest all-seasoned road	0.649***	0.081		
Within 60 minutes distance to the district capital	1.492***	0.168		
Household owns a radio or television	1.191	0.138		
Political participation				
Voted in any recent elections	1.384**	0.187		
Free to express personal opinion in the family	1.229	0.156		
Free to express personal opinion in group meeting	1.170*	0.111		
Economic dimension				
Do any work for pay, profit or family gain in the last 12 months	0.951	0.100		
Wealth quintile				
Second	1.085	0.143		
Third	1.399**	0.197		
Fourth	1.632***	0.249		
Fifth	2.648***	0.440		
SPEC indices				
Social-cultural index			1.040	0.032
Political index			1.211***	0.039
Economic index			1.290***	0.054
No. of observations	3118		3118	

Dependent variable: NHIS enrolment status (1=Enrolled, 0=Otherwise)

*** p<0.01, ** p<0.05, * p<0.1

Discussion

This study sought to assess the determinants of women's enrolment in the NHIS in order to identify the groups of women who are not participating in the NHIS and whether this could be attributed to social exclusion. It is important to understand that not all uninsured women can be described as being socially excluded from the NHIS. The analysis of the determinants of enrolment in the NHIS paves the way for a critical assessment with a social exclusion lens. As explained by Soors et al (2013), using the social exclusion lens is relevant in identifying causes of poverty and equity and possibly to understand why certain groups of women are socially excluded from the NHIS.

The significant importance of factors such as age, health status, education, spatial factors and wealth influencing enrolment in the NHIS found in our study are in line with the existing literature on enrolment in Ghana and in other Sub-Saharan African countries (Chankova et al., 2008; Jehu-Appiah et al., 2011; Asante and Aikins, 2008; Kirigia et al., 2005; Sarpong et al., 2010; Dixon, 2014; Kumi-Kyeremeh & Amo-Kumi, 2013). The results show that age is a significant determinant of enrolment in the NHIS. Though pregnant women are exempted from premium payment, women in their reproductive years were less likely to enrol in the NHIS. The significant enrolment of older women may suggest that those who are aware of the age-related premium exemption policy are making good use of it. This is encouraging given the fact that aging is associated with a decline in health status and the need for more health care, but the profile of the uninsured older women being rural, widowed, uneducated and from poor households is of much concern. Though older women are exempted from paying the premium, they still have to pay a registration fee, which many may not be able to afford and may not also be aware of the exemption package, a concern raised by Parmar et al. (2014) in a study of enrolment of older people in the NHIS. According to Luttrell & Moser (2004), women generally have higher life expectancy than men and are therefore more likely to be in poverty in old age. This is why they will require special attention to cater for their health needs.

Socially, results from our regression analysis (model 1) also show that individuals with no religious affiliation or are followers of minority religions were less likely to enrol in the NHIS. This may be because their social participation in the community may be low, leading to social isolation and may therefore be missing out on opportunities of gaining adequate information about the NHIS from potential social sources and may also lack solidarity support. The observation that women with positive perceptions about the NHIS are more likely to enrol can clearly be situated in the social dimension of social exclusion, which is about the proximal relationships of support and solidarity that generate a sense of belonging within social systems (Popay et al. 2008). Women accepting that the NHIS is not for the poor and that it is good to enrol in it even if one perceives himself/herself as healthy fit well in the solidarity concept underlying the NHIS. Being a member of a social organisation (social capital) is expected to increase enrolment, but this was not the case with our result. This observation is, however, difficult to explain.

The Ghana Human Development Report (HDR) of 2007 (UNDP-Ghana, 2007), which was dedicated to social exclusion, profiled the excluded in Ghana to include residents of urban slums, extremely poor people in the northern regions of Ghana and people who are geographically isolated due to lack of road access. This brings to focus the issue of territorial discrimination and deprivation between rural-urban communities and broadly between northern and southern Ghana. Our results show that rural women were less likely to enrol in the NHIS. NHIS registration centres could be far from their communities and/or may have limited information about the NHIS. Long distances to registration centres, registration process rigidities and activities of unscrupulous NHIS registration agents could exclude rural women from enrolling in the NHIS (Jehu-Appiah et al., 2011; Gobah & Liang, 2011). Kumi-Kyeremeh & Amo-Kumi (2013) also observed a positive and significant effect of wealth and spatial location of women in their reproduction age enrolling in the NHIS.

Explaining the issue of territorial discrimination and deprivation through the relational approach to social exclusion (Popay et al., 2008), the unjust and unequal distribution of national resources due to unequal power relationships is reflected in the positive and significant effect of the political variables affecting enrolment into the NHIS. Limited or poor access to social services, including education, health and administrative services excluding women from enrolling in the NHIS, is confirmed by our results. Women with no or low formal education are less likely to enrol in the NHIS. While the effects of these gender-intensified factors may adversely impact on the enrolment of both men and women in the same community, it could be enormous for women (Luttrell and Moser, 2004). Women who live far away from a public health centre and the district capital are less likely to enrol in the NHIS. Rationally, people would not pay for a service that is not available to them. It is known that excluded groups tend to have low access to both public and private goods and services, and when they do, the quality of the services available to them

is relatively low (UNDP-Ghana, 2007). Longer distances to health facilities means that the cost of transportation in seeking health care could sometimes exceed the cost of enrolling in the NHIS. This could discourage people from enrolling in the scheme. It is common knowledge that access to higher education increases enrolment in the NHIS and other insurance schemes in SSA (Jehu-Appiah et al., 2011; Dixon, 2014; Chankova et al., 2008). But the fact that the girl-child is less likely to receive adequate quality education due to unequal distribution of resources in the household (Antonopoulos, 2013), many more women grow into adulthood without education. This affects women's intra-household bargaining power in male dominated societies in Ghana and, therefore, their access to health insurance and access to health care (Dixon, 2014).

The importance of the relational approach is again highlighted in the significance of political participation variables influencing women's participation in the NHIS. Participation in the recent elections and freedom of expression relating to expression of personal opinions in the community can ensure equality of opportunities for these women. It has been observed that community participation can increase the effectiveness of initiatives seeking to address exclusionary processes and that 'promoting community participation can improve relationships between local people and service providers and improve people's perceptions of the areas in which they live' (Popay et al., 2008). It is possible that these women might have had the voice and the opportunity to interact with officials of the NHIS and therefore easy for them to enrol.

The results further show that economic factors are important determinants of enrolment in the NHIS. From the descriptive statistics, insured and uninsured women differed significantly in their economic activities. Only a few women engaged in professional activities, with the majority in sales and services as well as in small-scale food crop production. Women dominate the informal economy of Ghana with small businesses and low incomes. As observed by Alfers (2009), there are a significant number of informal workers who do not earn enough to be able to afford the NHIS premium. The UNDP-Ghana 2007 HDR on social exclusion identifies rural agricultural producers, particularly migrant farm labourers and settlers, as well as traditional fishermen and food crop farmers, as more prone to social exclusion. Patriarchal gender relations in many societies in Ghana place women in a position subordinate to men in decision-making (UNDP-Ghana, 2007). Women generally have limited access to, and control over, productive resources, especially capital, labour and land (Duncan, 2004; UNDP-Ghana, 2007). They tend to have smaller farm sizes and cultivate mainly food crops (FAO, 2012). Poverty is endemic in the food crop sub-sector of the agriculture sector, and with many women involved, they are more likely to be economically excluded from many spheres of life. Our results further show a positive relationship between wealth status and enrolment in the NHIS, which has been observed by other studies on the NHIS (Asante & Aikins, 2008: Jehu-Appiah et al., 2011; Sarpong et al., 2010). Understandably, women from poorly resourced households were more likely to be excluded from enrolling in the NHIS. About 57% of the uninsured women complained about the expensive NHIS premium/registration fee. Many of these women may have to depend on their spouses to be enrolled in the NHIS, because even where these women work and earn incomes, many may not have full control over the use of the cash earnings (GSS, 2008).

Conclusion

By conceptualising social exclusion as the multi-dimensional processes driven by unequal power relationships that lead to differential inclusion and exclusion in social systems, this study provides evidence to show that certain groups of women are systemically excluded from participating in the NHIS. With women dominating the informal sector of Ghana's economy, the NHIS is seen as an important social protection intervention for informal workers, especially women. This is because the cost of health care constitutes one of the most serious threats to the economic security of the poor (Norton et al., 2001). While not all the uninsured women could be described as socially excluded from the NHIS, the results suggest that certain categories of women are socially excluded from enrolling in the NHIS. They include the poor uneducated elderly women, women with no religious affiliation or are in minority religious groups,

women in remote rural communities with limited access to education, health and administrative services, as well as women in small-scale food crop production who are also more likely to come from less wealthy households. While the findings from our study are not entirely different from that of other studies on enrolment and equity in the NHIS, it offers the opportunity to explore the other dimensions of vulnerability and exclusion from the NHIS apart from poverty.

As explained by Norton and colleagues (2001) if the rationale for a social protection policy is to 'ensure continuity of access for all to the basic services necessary for developing human capital and meeting basic needs' in order to improve on livelihood, then the socio-cultural, political and economic factors responsible for social exclusion need critical attention. Policy should aim at identifying these excluded women so that they could be assisted to benefit from the exemption package where they qualify. Improvement in general rural infrastructure with emphasis on reducing the physical barriers to health care (e.g. Expansion in the Community Health Planning Services) would be beneficial.

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CHAPTER 14: What generative mechanisms excluded indigenous people from social health protection? A study of RSBY in Karnataka

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Introduction

The status of tribal communities in India

Indigenous people, the world over, suffer violations of human rights and experience deprivations in basic human necessities, including health. According to the recent census, 8.6% of the Indian population (104,545,716 individuals) are tribal people (Census of India, 2011). Following independence, the Indian Constitution granted special provisions to the indigenous people classified as Scheduled Tribes (ST), of which reservation of seats in higher education, public employment and legal representation have since been a constant (Louis, 2003; Xaxa, 2001). Protective measures (Protection against Atrocities Act, 1989) and participation in planning for development (Provisions of the Panchayats (Extension to Scheduled Areas) Act 1997) – also mandated by the Constitution – are much less developed (Heredia, 2011; Louis, 2003; Xaxa, 2001). Studies have shown that the implementation of these measures has been weak and that the indigenous population have not been made aware of the rights accorded to them (Rout & Patnaik, 2013).

Despite over six decades of affirmative policies, India's ST communities still face hardship and inequities. For instance, the proportion of tribal people living Below the Poverty Line (BPL) is nearly twice as high as among the rest of the population (43.8% vs. 22.7%) (Planning Commission, 2007). Although some improvements have been made, literacy levels for the tribal population is abysmally low (47%) compared with the rest of the population (67%) (World Bank, 2011). These failures in substantial improvement for tribal communities has arisen out of low fund allocation for

tribal development, violation of protective land measures and displacement from land/forests and livelihoods due to forest clearance policies, mining, construction of dams, fraudulent land transfers, forcible evictions from areas designated as national parks and other abuses of their land rights, and often by the federal government itself (Xaxa, 2012).

Essentially, tribal people have been displaced from their lands in the name of development but have been denied the fruits of that development with inadequate compensation in land or restoring their livelihoods. For example, two states, Orissa and Jharkhand, have experienced rapid infrastructure development but have the largest percentage of tribal population living below the poverty line. Tribal people also face discrimination from larger society because of their societal structure, cultural practices, religious beliefs, and language (Xaxa, 2005). Overt poverty, displacement, difficulties adapting their lifestyle to a new environment, inability to enter forests to collect food and medical resources, discrimination, and deficient provision of health services all add to their predicament (Sundarajan et al., 2013; Ministry of Tribal Affairs, 2004).

Health of tribal communities in India

Few ST-targeted public health interventions have been introduced to complement the reservation policies (Mohindra & Labonté, 2010). ST health indicators are abysmal, with higher rates of mortality (for all ages), malnutrition, anaemia, malaria and tuberculosis than the rest of the population (Mohindra & Labonté, 2010; Subramanian, Smith & Subramanyam, 2006). The under-five child mortality of tribal children is particularly stark with nearly 96 deaths for every 1000 live births, well above the national average of 74 deaths per 1000 live births; around 53% of tribal children are stunted (lower height-for-age) (NFH3-3, 2006). However, the health and economic status of tribal communities vary considerably by where they live in India: tribal communities in rural areas of the states of Orissa, Chhattisgarh, Jharkhand, Maharashtra and Rajasthan have seen far lower declines in poverty relative to other groups; incidentally, the World Bank notes a high correlation between poverty and concentration of tribal populations (World Bank 2011).

Tribal communities in Karnataka

In the southern state of Karnataka, tribal people constitute about 7% of the population (4,248,987 people) (Census of India, 2011). The ST literacy rate is considerably lower than the average literacy rate in the state (53.9% vs. 75.6%) (Census of India, 2011). According to the 2005 Karnataka Human Development Report, “The human development status of the Scheduled Tribes is more than a decade behind the rest of the population of the state and they are the poorest and most deprived of all sub-populations in the state”. Decades of alarming health indicators have seen little or no improvement. While the proportion of institutional deliveries among ST women in Karnataka increased from 26.8% in 1993 to 41.5 % in 2005-06, the proportion of pregnant tribal women not receiving antenatal care has seen only slight improvement, from from 21.4 in 1993 to 17.8 in 2005 (Planning and Statistics Department, 2006; NFHS 3, 2006). In Mysore district – home to the state’s historic and touristic capital and a study district – ST women are still twice as unlikely to have an institutional delivery than non-ST women (Adamson et al., 2012). Considering the state programmes targeting the ST population (electricity, free housing, drinking water supply, midday school meals and free text books and school uniforms), the 2005 Karnataka Human Development Report concludes that while some programmes have been successful, most suffer from poor implementation and low effectiveness – particularly in the areas of poverty reduction, education and health (Planning and Statistics Department, 2006). The report also states that state functionaries have given insufficient attention to this vulnerable group and resources allocated for tribal development are under utilised. Skilled practitioners are unavailable to tribal people and a combination of distance from public services and neglect by the state in ensuring access to health services has contributed to the poor health indicators of tribal people.

In the absence of a health programme specifically targeting tribal people, studying the implementation of social health protection (SHP) schemes in tribal areas provides an opportunity to understand if and how tribal people are excluded despite being eligible according to the programme design. In our study, we focused on a social health protection scheme, Rashtriya Swasthya Bima Yojana (RSBY), instituted by the Indian federal government in 2008, targeting the BPL population and described in detail in Chapter 6.

While some studies have examined rates of awareness, enrolment and utilisation among different social categories including ST (Nandi et al., 2013; Devadasan et al, 2013) in RSBY, there is a paucity of studies exploring RSBY or any similar SHP scheme through the lens of social exclusion to explore who gets excluded from the scheme and how and why this occurs. We attempt at filling this gap by unfolding the process of social exclusion – as manifest in experiences and events – through its underlying generative mechanisms (Demetriou, 2009; Bunge, 1997; Tilly, 2001; Marchal et al., 2010). Given historical reasons for the apparent social exclusion of tribal people in India, we aim to examine if rural ST communities are also excluded from RSBY; and if so, to understand the mechanisms of their exclusion.

Methods

A full description of the study approach can be found in chapter 6. In this chapter, we focus on the experience of tribal households (n=553, 9.2% of total) across all four sites/districts in engaging with RSBY.

A mixed-method approach was used for the overall study comprising of household surveys along with focus group discussions and in-depth interviews with community and different stakeholders. It is important to note that the household surveys were designed to provide estimates of the general population and not any specific group, like the tribal population. While the proportion of tribal households identified in the study is similar to the state proportion, the number of households captured was relatively small in size and not representative of the tribal population in the state. Hence, while the quantitative findings do provide valuable insights about the RSBY experience of tribal households in relation to the rest of the study households, we are cautious about generalising findings from these households. Furthermore, when surveyed on aspects such as 'participating in local political activities', what constituted those activities was not specified and only later explored in the qualitative approach.

At every stage, we explore the experience of the tribal households in relation to the rest of the study households. We also chose multivariate analysis (logistic regression) to study the interaction between key variables both within and across SPEC dimensions and their influence on the odds of enrolling into the scheme (see chapter 8). In this chapter, we take the analysis forward by conducting multivariate analysis within the ST households to explore the influence of key SPEC variables on a household's chances of enrolment within this community (described later).

Eight of the focus group discussions were conducted specifically with tribal communities in two districts with a relatively higher proportion of tribal population, namely Mysore and Belgaum. These aimed at capturing information related to health seeking behaviour, access to RSBY and other welfare schemes and their experiences of exclusion. Findings from all sources were triangulated with each other to present a comprehensive picture of the tribal households' experience in accessing RSBY in our study.

Regression model

The simple logistic model used for estimating the determinants of enrolment in RSBY among the ST households was defined by the following relationship (adapted from Parmar et al., 2014):

$$Enrolled_i = \beta_0 + \beta_{i1} X_i + \beta_{i2} SE_i + \epsilon_i$$

$Enrolled_i$ is a binary variable that denotes the enrolment status of a household;

X_i is a set of general variables;

SE_i is a set of key variables selected across social, political, economic and cultural (SPEC) dimensions;

ϵ_i is the random error.

The different variables included in regression analysis are shown in Table 2. The dependent variable, Enrolled, is a binary variable that indicates the enrolment status in RSBY of a tribal household in our study. A household is considered enrolled only if they enrolled in the enrolment camp conducted in their village/area.

General variables *(*X_i set*):* Since we looked for characteristics of the head of household that could determine its odds of being enrolled, we used gender*,* age, literacy status, and income dependence (coding explained in Table 2). The household size of the eligible household was also included, as only smaller households (5 or less members) can be fully covered under RSBY while larger households will always be partly covered given the design.

SPEC variables*:* Following preliminary analysis, we identified key variables across social, political, econominc and cultural (SPEC) dimensions guided by the SPEC framework and literature review. A few variables that were found to be significant at the general population level were skewed or made irrelevant when focusing within the tribal households. For instance, all ST households were Hindu and nearly all of them were native-Kannada speakers (Table 1). The variables included in Model B (chapter 8) were adapted to be relevant to this community. Migration for work captured households where any member needed to migrate out for work. This is important due to the higher proportions of casual labourers in this community and, as such, households are explicitly targeted by the scheme. Food security reflects if a household reported having adequate food for at least 3 meals a day throughout the past year. Given the higher proportions of relatively economic poor households in this community (Table 2), this variable was included to supplement the wealth index. Forced to vote included any household where a member was reported to have been forced to vote in the recent elections.

Results

We present our results in three main sections. We first describe and compare the profile of tribal households in the study with non-tribal households. We then explore the tribal households' experience in accessing RSBY in terms of receiving information and enrolling in the scheme in relation to other study households, and then amongst the tribal households. In the end, we attempt to describe possible exclusionary processes in society due to which tribal households are excluded from accessing the schemes.

Profile of the tribal households

Tribal households constitute 9% (n=553) of our study households. More than half of these households belong to Mysore district, constituting 20% of total households from the district. Tribal households were largely Hindu, native-Kannada speaking, nuclear families with a median household size of 5 (Table 1). The adult literacy rate was significantly lower than for the rest of the study population, with one in two adults never having gone to school. The proportion of adults with an education above primary school was one-third that of the non-tribal population with nearly half of all tribal adults engaged in casual labour. The socio-economic disadvantage is further reflected by the proportion of households with the 'poorest of the poor' BPL ration card (Antyodaya or poorest of the poor card, a card distributed by the government to households that received the lowest scores among the BPL census to avail food subsidies) among tribal households, which is twice that of the non-tribal households (Table 1).

Table 1. General profile of tribal and non-tribal households

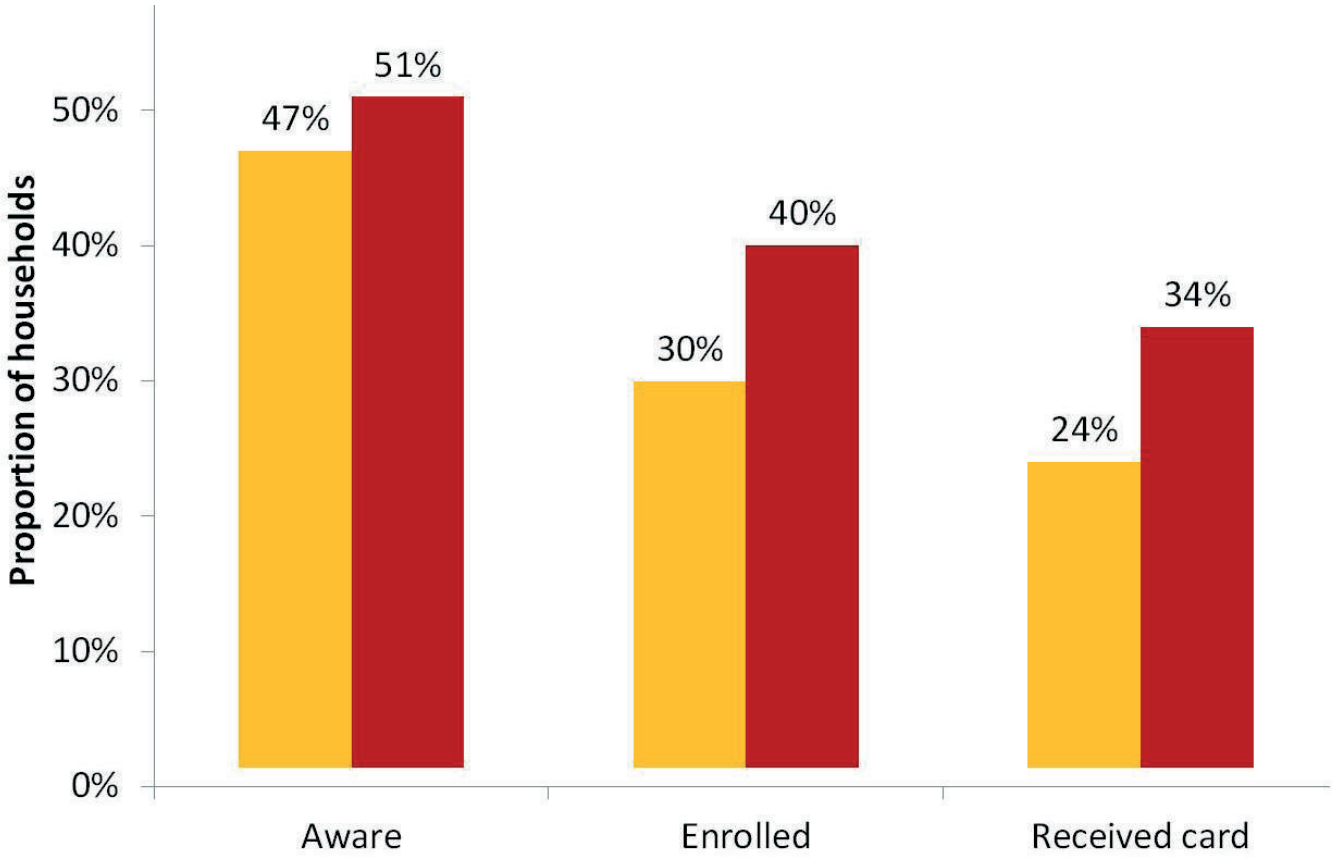
Characteristics		Tribal households		Non-tribal households	
		Frequency	Per cent (%)	Frequency	Per cent (%)
Total number of households		553		5487	
Total population included		2879		30238	
District	Bangalore rural	17	3.1	482	8.8
	Belgaum	185	33.5	2833	51.6
	Mysore	305	55.2	1199	21.9
	Shimoga	46	8.3	973	17.7
Religion	Hindu	553	100.0	4934	89.9
	Muslim	0	-	431	7.9
	Christian	0	-	17	0.3
	Others	0	-	105	1.9
Median household size		5 (1-23)		5 (1-30)	
Type of households	Single	12	2.2	92	1.7
	Nuclear	262	47.4	2379	43.4
	Joint/Extended	279	50.5	3016	55.0
Age group	Less than 18 years	877	30.5	9,190	30.4
	18 – 59 years	1,712	59.5	17,803	58.9
	60 years & above	290	10.1	3,245	10.7
Sex ratio (No. of females per 1000 males)		952		969	
Adult literacy rate*			44.8		59.0
Education* (18 years & above)	Never Went to School	1,010	50.4	7,487	35.6
	Upto primary school	520	26.0	3,126	14.9
	Upto high school	141	7.0	6,967	33.1
	Above high school	200	10.0	3,468	16.5
Occupation* (18 years & above)	Not earning	737	36.8	9,325	44.3
	Casual wage labourer	924	46.2	5,929	28.2
	Self employed	271	13.5	4,692	22.3
	Salaried	70	3.5	1,102	5.2
Kannada speaking households		489	88.4	3923	71.5
Household has a ration card		533	96.4	5268	96.0
Type of ration card	'Poorest of poor' BPL Card	86	15.6	441	8.0
	BPL Card	421	76.1	3974	72.4
	APL Card	22	4.0	810	14.8

* 18 years & above, n = 2,002 people among tribal households, n= 21,048 people among non-tribal households

Experience with accessing RSBY

Tribal households reported poor awareness with one in two households having never heard about the scheme or seen the RSBY card, similar to other households. However, the enrolment rate and the proportion that finally received the cards were significantly lower among tribal households than their counterparts (Figure 1). Similar to other households, the main sources of information about the scheme for the aware tribal households were Gram Panchayat (GP) members (36% v 41%), and local health workers (15% v 18%). Finding out about the scheme from friends/relatives was higher for the tribal households than others (34% v 20%).

Figure 1. RSBY experience of tribal and non-tribal households (n = 553, 5487)



While the proportions of enrolment and receiving the smart card among tribal households was significantly lower than the others, the experience at the camp was better in respect of having their thumbprints and photographs taken (98% v 91%), paying the correct amount of Rs. 30 at the camp (85% v 73%) and receiving the hospital information booklet (11% v 11%). Even the proportion of cardholding households that were fully covered (up to 5 members for large households) was higher among tribal households when compared to others (57% v 40%). While reviewing the interaction between RSBY and ST households, it becomes clear that the bulk of ST households are excluded at one particular step: enrolment (Figure 1). While other social categories including Scheduled Castes have an enrolment rate of 40%, only 30% per cent of ST households pass enrolment – the lowest score among all social categories. Approximately half (47%) of ST households that did not enrol reported that they were unaware of the enrolment camp venue and timings.

In chapter 8, we identified key determinants for enrolment in to RSBY for the study households. Social category appears to be a key determinant to predict a household's odds for enrolment. Among the different categories, the odds of an ST household being enrolled was 40% less than those of the other backward class (OBC) category while independent of other SPEC variables. We next explore various SPEC variables within the tribal households to try and understand why some households were able to be enrolled while some did not. A description of the different variables included in the analysis is given in Table 2. It is important to note here that 71% of the head of tribal households were illiterate, with 77% engaged in generating income (mostly casual labour) (Table 2). Around two-thirds of the tribal households reported to have members associated with some local social organisation, like women's groups, youth groups, or self-help groups. It is also important to point out that 52% of the tribal households belonged to the lowest wealth index quintiles, reflecting the higher relative economic poverty.

Table 2. Definition and description of variables used

Variables		Definition		Tribal households	
				Frequency	Per cent
Enrolled		1 if enrolled, 0 otherwise		165	30%
General					
Head of household	Female	1 if female, 0 otherwise		94	17%
	Elderly	1 if elderly (age 60 years and above), 0 otherwise		139	25%
	Illiterate	1 if illiterate, 0 otherwise		393	71%
	Income dependent	1 if not an earning member, 0 otherwise		125	23%
Large household		1 if the household has more than 5 members, 0 otherwise		180	33%
SPEC					
Social participation		1 if no household member is part of any local social organisation, 0 otherwise		223	40%
Socio-political contacts		1 if no socio-political contacts, 0 otherwise		353	64%
Political participation		1 if no household member participates in local political activities, 0 otherwise		449	81%
Access to health services		1 if distance from nearest PHC >5 km, 0 otherwise		171	31%
Migration for work		1 if migrant in household, 0 otherwise		62	11%
Food security		1 if household did not have enough food for 3 meals a day in the past year, 0 if otherwise		59	11%
Forced to vote		1 if any household member was forced to vote in the elections for a given candidate, 0 if otherwise		22	4%
Wealth index		Q 1 to Q 5; Q 1 refers to the wealthiest 20% households while Q 5 refers to the poorest 20% households.	Q 1	70	13%
			Q 2	81	15%
			Q 3	103	19%
			Q 4	124	23%
			Q 5	155	29%

Acronyms used: Q – Quintile, PHC – Primary Health Centre, SPEC – Social, Political, Economic and Cultural

Within tribal households, having an elderly-headed household and belonging to a small household increased the odds of the household being enrolled, similar to a pattern seen overall in chapter 8. When studying why tribal households fare poorly when compared to non-tribal households, socio-political exclusionary processes were clearly identified and outlined in chapter 8. However, when looking within the community of tribal households, it is the relative economic poverty that appears to decrease the odds of getting into the scheme. The socio-political processes hence appear to mainly operate at the societal level between tribal and non-tribal households.

Table 3. Determinants of enrolment in RSBY within tribal households (n=553)

Key variables		OR	SE
General			
Head of household	Female	0.616	(0.295)
	Elderly	0.513	(0.339)**
	Illiterate	0.694	(0.234)
	Income dependent	1.634	(0.350)
Large household		0.496	(0.228)***
SPEC			
Social participation		0.780	(0.207)
Socio-political contacts		1.340	(0.226)
Political participation		0.781	(0.275)
Access to health services		0.861	(0.219)
Migration for work		1.102	(0.330)
Food security		1.691	(0.354)
Forced to vote		0.915	(0.514)
Wealth index	Q 2	0.599	(0.352)
	Q 3	0.412	(0.342)**
	Q 4	0.355	(0.332)***
	Q 5	0.507	(0.316)**
No of observations		5827	

Acronyms used: Q – Quintile, SPEC – Social, Political, Economic and Cultural

Robust SE in parenthesis, *p<0.1, **p<0.05, ***p<0.01

Mechanisms of exclusion

Description of ST households' characteristics and the incidence of their exclusion from RSBY are of little value without knowledge on how and why exclusion actually occurs in a particular context. Building upon a critical realist rationale (Demetriou, 2009; Bunge, 1997; Tilly, 2001; Marchal, 2010), in the present section we explore the process of social exclusion as the interplay between individuals and institutions, the interaction between social structure and agency. Concretely, we move from description to the identification of generative mechanisms – which we will then resume in the discussion section – applying the iterative abstraction known as retroduction (Astbury & Leeuw, 2010).

In the FGDs, tribal respondents reported that information about welfare schemes does not reach them directly. A few people who are literate or semi-literate get to know about welfare schemes (sometimes through NGOs) and they spread the information among the rest of the settlement (usually through the tribal leader). For some elders, such information appears to be accessible through the younger generations due to their frequent travels outside the settlement for education or work:

> *Directly they [local government functionaries] will not come tell us anything. They circulate the information among themselves only. Three or four of our literate people they will come to know, maybe through organisations like yours [NGOs] and they will inform the tribal leader...Our children will go mix with others in the village and they will tell us about the different schemes going on. (FGD, Tribal member, Mysore)*

Lack of political networks

By far the most pronounced form of exclusion was exclusion from information about welfare schemes by Gram Panchayat members. In the case of RSBY, it is the insurance company's responsibility to conduct information and education campaigns. They in turn rely on local Gram Panchayat members and health workers to identify eligible households, at times issue them a token for participating in the enrolment camp and to inform them about the scheme and camp timings. RSBY actors state that since these local players are better informed and able to take on this role compared to external organisers, they are given the responsibility at their village level. FGDs with tribal beneficiaries revealed repeated accounts of Gram Panchayat members providing information (on RSBY and other welfare schemes) only to their relatives, friends and others who favour them politically or contribute to their campaigns.

ST respondents' perception of being "useful" to a political leader ranged from being a patron of a local politician to being hired for political rallies and odd jobs. In addition, ST respondents also state that the requirements of daily subsistence gave them no time to "run after" politicians to do their bidding. They also believed that the lack of clout and inability to contribute to campaign funds by tribal communities lead to their overall neglect by politicians of any kind:

> *The government will introduce some schemes and that will reach the panchayat, what he will do is only give the information to people whom he wants, but not for us poor people...If you are good to the leaders, running behind them, doing their work, then they will do your work [processing welfare applications or giving information about schemes]. But I am a daily wage [worker], I am of no use to him and I have to work everyday or my family will have no food. (FGD, Tribal member, Mysore)*

Gram Panchayat members admitted to giving information to their friends and others who frequently visited the GP office more often because it was convenient. Some reported that the time provided to them by the insurance companies and third-party administrators (TPA) was too short (a day to a week) to inform all those eligible, and to organise an enrolment camp. Faced with this short timeline, they then resorted to at least gathering some beneficiaries on the list.

Political neglect

Tribal respondents reported that Gram Panchayat members seldom visited their settlements, only doing so during election time. In times of natural disasters like forest fire or heavy rains, the local politicians are conspicuous by their absence. Therefore, they tend to believe that if a welfare scheme is targeted explicitly for tribal communities, then they will more likely see some benefits.

ST respondents also expressed trust in NGOs working for the organisation of self-help groups and specifically for development of tribal communities, who they believe are genuinely concerned for the wellbeing of tribal communities. In contrast, they perceive local government officials to be "middlemen", more focused on amassing profits and exploiting forest resources than helping tribal communities:

> *Schemes do not directly reach us. Always the government people, panchayat people, forest officials are there to take their cut from us. If we sell an ox, they will take 70% of what we get for it. Only the NGOs… those who help us with selling forest-made items, they should be given the money to give to us directly. (FGD, Tribal member, Belgaum)*

Neglect of ST communities seems to impact also at a higher level of programme implementation. During the enrolment period prior to our research, the tribal settlements around HD Kote in Mysore district and Khanapur in Belgaum district, and sharing the worst social indicators of the state – were the last to be enrolled, and enrolment could not be completed before the policy period took off. When the enrolment camps were prematurely shut down, enrolment rates were a mere 9% and 15% in HD Kote and Khanapur respectively. The following year, it was decided to start enrolment not where it had left off but in the better performing districts, leaving the ST populations in wait.

Lack of political voice

Interviews with tribal representatives, like women self-help group leaders and former tribal leaders, revealed their helplessness in mobilising other leaders among the tribal community to come together for protests to the district administrative headquarters, even to demand for essential public services. They acknowledged that other vulnerable social categories, particularly SC, were much more able to voice their demands, due to better political mobilisation.

In the opinion of the interviewed representatives, most tribal people were unable to see the world beyond their settlement and were ignorant of their entitlements. On the other hand, several ST respondents explained that their elected representatives to the Gram Panchayat were more often than not "weak" and "ineffective", with a lack of focus on the legal ST entitlements, and unable able to question administrators and policymakers for the flawed implementation of existing welfare schemes. In general, they saw their representatives as excluded themselves from local political clout.

> *They don't tell him [representative] anything. They don't give him any information. They don't call him also for the meeting. What can he do if they don't allow him to find out anything for his people? (Interview, ST woman's self help group leader, Mysore)*

For those few beneficiaries who do make it to the village council and request information, the perception is that they are often ignored or treated without respect. Instances of verbal abuse by Gram Panchayat members referring to the beneficiaries' "poor physical appearance" and "illiteracy" were reported. ST respondents' state that they are often made to wait long hours, told to come back later, or that the concerned person is unavailable and are ultimately prevented from meeting a higher official. They point out that it can take all day to get information, and again they emphasise that for daily wageworkers this is problematic:

> *They will not allow us to go into the office and ask [information]… They say, "You people stay outside". If we want to see a higher official they will say things like "How can you see [him], look at your clothes!" or "He is not here, you have to wait". We will be waiting whole day but they will not let us see anyone. (FGD, Tribal member, Belgaum)*

Low literacy and education

Literacy rates and educational levels are low in tribal communities, and even lower among the women (see Table 1 and Table 2). As a series of communications on RSBY are in written form – benefits, eligibility, camp schedule, and list of empaneled hospitals–it is tempting to consider lack of literacy and education as a mechanism of (involuntary or passive) exclusion:

> *Uneducated people, they do not know to ask anything. They just come when we tell them to come; they take the photo and go. They do not know why they came also. We also don't tell the information because they are not asking. They don't know they have to ask. (Interview, GP, Mysore)*

However, low literacy rates and educational levels can also be interpreted as outcomes of a long-lasting exclusionary process. In tribal tradition, oral culture has always been more important than written culture, as recognised by the Ministry of Tribal Affairs (2013) and evidenced in other literature (Bhukiya, 2010). While both government and tribal people express a need for improved education, the near absence of efforts to bring this about is an exclusionary process in itself. The fact that ST respondents frequently testify to being blamed for being illiterate reinforces the latter interpretation.

Spatial and social isolation

Mainstream literature describes spatial isolation, or distance, as an important explanation of involuntary exclusion of ST communities (The World Bank, 2011). While, historically, this is largely true and still the case in Central India's tribal belt, it is far from always the case in South India. In Karnataka, most ST households' cluster in tribal settlements often located at the edge of a larger village or in relocated villages outside their original forest environment. Isolation then becomes much more social than spatial, and distance is not the real issue (Thorat, et al. 2007). A critical incident during our data collection can illustrate this: while conducting FGDs in HD Kote, Mysore district, we were confronted with three villages within sight of each other and at equal distance from the main road to which they were equally well connected. In village one and three, the TPA had come by to inform them about RSBY and enrol them, but not so in village two. What distinguished village two was that is was entirely tribal.

ST respondents confirm that camp organisers usually aim at the Gram Panchayat headquarters for conducting camps to ensure maximum participation in terms of numbers, making no extra efforts to reach out to tribal settlements. Gram Panchayat members, in turn, are perceived to ignore tribal settlements and villages for day-to-day matters and to only acknowledge their existence and issues for election campaigns.

Discussion

According to the World Health Organisation's Social Exclusion Knowledge Network (SEKN, 2012), "(Social) exclusion consists of dynamic, multi-dimensional processes driven by unequal power relationships. These operate along and interact across four dimensions – cultural, economic, political and social – and at different levels including individuals, groups, households, communities, countries and global regions. Exclusionary processes contribute to health inequalities by creating a continuum of inclusion/exclusion. This continuum is characterised by an unjust distribution of resources and unequal capabilities and rights". In this paper, we examined whether tribal households face social exclusion from RSBY, and if so, how and why. Our results show that tribal communities have lower rates of awareness and enrolment in RSBY when compared with non-tribal households in the areas studied. We identified that the process of exclusion includes the following – possibly overlapping – generative mechanisms: lack of political networks, political neglect, lack of a political voice, low literacy and education, and socio-spatial isolation.

Using T.H Marshall's (1977) classic work, these mechanisms can be grouped under one umbrella, i.e. be interpreted as a denial of citizenship. Marshall defines citizenship as, "...a status bestowed on those who are full members of a community. All who possess the status are equal with respect to the rights and duties with which the status is endowed". As he traces the evolution of civil rights (right to justice, rights to property and free speech), political rights (voting freely in fair elections) and social rights (equal membership in a community), it is clear that citizenship is not a given fact but a slow and arduous journey (Betteille, 1999). While the ST community of India may have been conferred their legal or political rights as citizens by the state (and certain protections in the Constitution), their civil rights are often trampled on, and their social rights as equal members of a society are far from realised in everyday living.

While citizenship demands equality before the law and equity in society, the relationships of tribal communities with mainstream society are characterised by inequity. Being denied citizenship is to have civil rights without the power to enforce them (as when tribal households are excluded from information about welfare), political rights without political effectiveness (when political representatives are absent or weak) and social rights without recognition from the rest of society of their equal worth. We have looked at social exclusion as a complex process for which we identified three sub-mechanisms, which we hypothesise are encompassed in a larger common mechanism, i.e. denial of full citizenship which, in this case prevents tribal households from benefiting from social health financing schemes.

Nathan and Xaxa (2012), commenting on the exclusions of tribal communities in India, state that "Exclusions are of two forms. One is exclusion from access to or denial of rights to various services, such as health, education, housing, and water, with sanitation also being more recently included as an essential service. The other form of exclusion is that of deprivation of the right to express one's views, of representation and voice in terms made famous by Hirschman. These two forms of exclusion often go together, with lack of representation and voice being manifested in inadequate provision of services". It is precisely this 'going together' which we refer to using the term 'denied citizenship' and have evidenced in this study.

We found that a vital conduit to gain access to information about welfare programmes, including RSBY, is the local political network. This echoes the wider sociological literature that finds that those with political power control information (as a resource) and divert it towards restricted groups that they prefer to be in the know (Murphy 1988). Exclusion occurs through 'social closure' (Weber, 1978), defined as monopolisation of resources by individuals and groups using rules of exclusion to dominate others in society, which in turn propels social inequalities.

ST households lack an entry point into these political networks, as they are usually poor and are not considered to have much leverage in the wider community (status) that a local politician could gain from. The institutional bias against tribal communities manifests in the larger neglect of tribal welfare and the disrespect (such as verbal abuse, failure to answer queries, delaying applications for welfare schemes, criticism of physical appearance and shunned from meeting with public officers) reported at the local government structures. This denial of recognition of tribal people as equal members of society reduces their life chances – a term we borrow from Max Weber (1978) meaning the probability an individual has to improve his or her quality of life through access to important social resources, including healthcare. The chance of access to information about welfare schemes for tribal households is under the influence of the inequitable power relationships that dominate everyday interactions with authorities, one that has persisted for generations. Our results suggest that this bias extends to the tribal representative in local government, who is sidelined by the dominant members, making their representation ineffective and muting the tribal voice. While the concept of social closure has been used in the sociology of organisations (and professions), the political exclusion of tribal communities could be built in to understand how institutional bias is constructed and maintained through everyday interactions (Rosigno et al., 2007) between tribal people and local government.

The world inhabited by the tribal households we studied in Karnataka was not the isolated forest dwelling abode that the life of tribal people is often portrayed to be in India. Many tribes have been forced out of the forest to re-settle near or in villages with limited access to the forests. In our study, 92% of the tribal households had permanent houses (most constructed via government welfare schemes), 82% had electricity and 79% had a drinking water facility nearby (Table 1), figures similar to the rest of the rural study population. While the literature on tribal communities (Planning Commission, 2007; Stephans et al., 2005; Ministry of Tribal Affairs, 2004; Betteille, 1991) talks of the geographical isolation of tribal community as a determinant for their lack of access to resources, more and more tribal communities are being shifted out of forests and are relocated outside. We argue that for the latter: their lack of access arises not from geographical remoteness per se but from social isolation due to differences in

social and cultural customs from larger society (Xaxa, 2001) and thus excluded even when at arms length. Regarding tribal settlements in remote areas or at the edges of larger villages, Nathan and Xaxa (2012) comment that the lack of infrastructure (be it roads, schools, or primary health centres) is not only due to higher cost but also due to persistent marginalisation: "remoteness (…) is not just a matter of geography".

Instead of tailoring welfare programmes to the particularities of tribal communities and targeting them specifically, the common strategy has been to consider ST communities as not having specific needs when entering modern society. According to Xaxa (2005), contact and exposure to modern society by some tribal communities has not necessarily benefitted them more than those with minimal exposure.

For the implementers of RSBY, a social exclusion lens unveils certain challenges. The implementation of the scheme is bound up today with these existing mechanisms that exclude tribal communities. For instance delegating responsibility to create awareness and organise enrolment camps for RSBY in a village to Gram Panchayat members and health workers is one way of involving the community; however, lack of sensitisation of those involved in reaching out to the vulnerable allows existing perceptions and exclusionary processes to continue unchallenged. In terms of overall numbers, this may go largely undetected until the policy maker asks the question specifically in relation to tribal communities and then reflects on processes to offset the control of information by local political networks, like bringing in additional focused monitoring systems, incentives to include tribal settlements, etc. Our study points to an urgent need for implementers of RSBY to reflect on the exclusion faced by tribal households and develop such processes.

In terms of overall numbers, their scattered settlements and increase in effort in terms of resources – financial, manpower and time – to reach out to them, tribal households are largely 'unattractive' in terms of the business model of implementation of RSBY (the government pays premiums per household enrolled to the insurance companies thereby making the companies responsible for creating awareness and enrolling households). However, it is of great significance given the social mandate of RSBY, and hence, the implementers need to bring in processes that negotiate between the mandate and the scheme's model of implementation. As Kabeer (2000) points out: "The rationale for social policy lies in the recognition that neither individual need nor the collective good can be left solely to private initiative and that there is a case for purposive public action to be taken".

These misaligned priorities (between a business and social model) can pose a moral hazard. Frazer (1989) and Gore (1993) discuss exclusion occurring through 'unruly practices' where, despite institutional rules, there is a gap in implementing them as intended. According to Kabeer (2000), there are likely to be unofficial norms that shape the actual provision of goods and resources to which groups are officially entitled. She stipulates that 'unruly practices' are more likely to occur in the public sector because the public provisioning is meant to deliver/cater to social need and curtail exclusions in communities. As a result, 'unruly practices' are more likely to occur because the rules clearly instruct otherwise. As the private sector is concerned with the business end of the scheme, discrimination is likely to occur only if it interferes with this pursuit as it seems to do in the case of RSBY and tribal communities. With stricter regulation by the state, positive incentives to motivate or penalties for not enrolling tribal populations should be considered for insurance companies; and with a clearer focus on groups that face social exclusion, the state might begin to meet its goals of health protection for the most vulnerable.

Currently, ST households (as well as others) have no forum to air their grievances about RSBY. The state needs to provide a transparent avenue for them to register their complaints and get information about their entitlements. One way forward would be to enlist trusted civil society or non-governmental organisations as independent regulators to ensure that information and welfare schemes reach the tribal people, building an effective partnership between the state and civil society without the state taking a back seat.

Limitations: Our study is not free of limitations. Firstly, our study did not cover the Chamarajanagar area of Karnataka where the largest tribal population resides, mainly within hilly forest reserves, hence limiting the generalisability of our findings to the tribal population across the state of Karnataka. Secondly, tribal communities were not asked prior to the survey who they thought were important socio-political contacts or what they understood as political participation (Table 2). These perceptions were more clearly examined during the qualitative discussions which followed the survey. Thirdly, since the findings of this paper are part of a larger study on social exclusion in access to health services vis-à-vis health-financing scheme, the study as a whole did not focus on the particular exclusion of tribal households. Therefore, interviews with implementers are not specific to the tribal condition alone. Fourth, some processes of exclusion identified were also seen to affect other vulnerable groups like scheduled caste households, woman-headed households, casual wage labourers, etc. to different degrees, influenced by the particular relational exclusions those groups face. Further research is required to explore the validity of the discovered mechanism within these groups.

Conclusion

Our findings suggest that ST households face exclusion from awareness about, and enrolment into, RSBY when compared with the rest of the population. By using local political networks to spread information about RSBY, tribal households are affected by the unequal power relations that govern their interactions with the local authority. The mechanism of their exclusion is what we call 'denied citizenship': a combination of a lack of political networks, a lack of a political voice in the existing climate of political neglect, cultural discrimination and social-spatial isolation. This study is the first of its kind to document the experience of tribal households in accessing a health-financing scheme in India and to explore possible mechanisms of their exclusion. Our study has relevance for policymakers and implementers of RSBY and similar welfare schemes that need to recognise that social inequities deny tribal communities access to the schemes that they are entitled to. Also, the policy implications have relevance to implementers outside of India to consider a social exclusion lens, the particular exclusions and discriminations that sections of the population might face, anticipate practical impediments and the gaps between policy or scheme guidelines and the ways in which they are implemented in reality.

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PART V: Mechanisms of social exclusion and final recommendations

CHAPTER 15: Mechanisms of social exclusion in social health protection schemes

Paul Peter Vermeiren & Werner Soors

Introduction

Social Health Protection (SHP) is considered to be a crucial factor in enhancing access to needed health services while providing financial protection, but it is clear that there is no general layout for a successful SHP policy. Consequently, we are faced with distinct SHP programmes and schemes in different countries, tailor-made to the felt needs of a specific context, but also building on earlier experience and now and again co-defined by donors' preferences. Apart from distinct characteristics due to context and path dependence, SHP programmes and schemes also differ in outcomes, in terms of both access and protection.

Today, the limited success of a number of SHP programmes and schemes in various countries is well documented. This limited success is usually described and analysed on the basis of outcome measures. However, presenting the success or failure of a scheme merely by means of outcomes doesn't say much about how and why the scheme produced that limited success. What happens between the setup of a scheme and its outcomes often remains clouded. The process that leads the scheme to perform poorly remains hidden: as long as that process is not well understood and explained, steering the scheme towards more successful results can only follow a path of calculated guesses, or at best trial and error.

A different way of analysing an SHP programme or scheme is by focusing on explanation, as a basic form of social theory formation. Having identified social exclusion as a core process restraining the success of SHP efforts in previous chapters, we attempt to delve deeper into the process of social exclusion by seeking out its mechanisms.

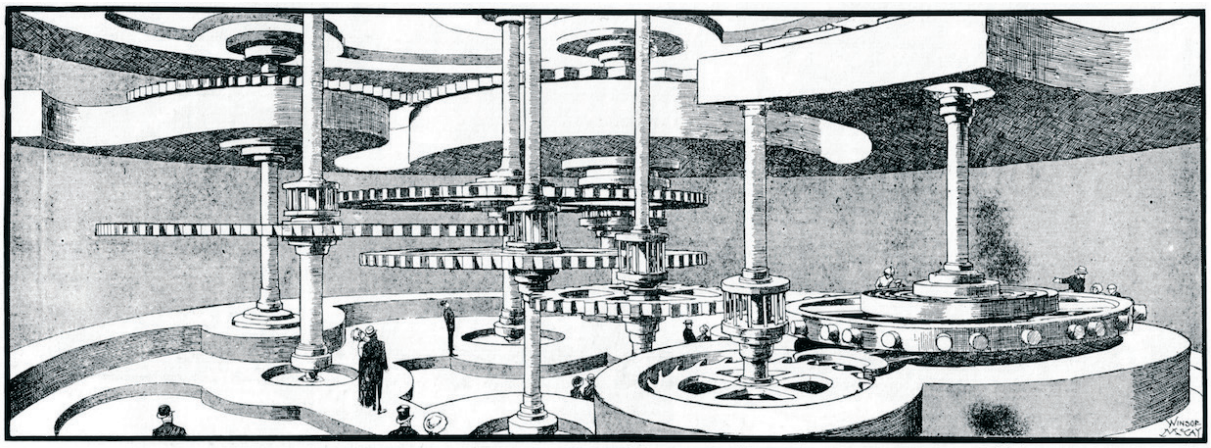
On process and its underlying mechanisms

A perennial flaw in evaluation of all kinds of social programmes–and in comparison within and between social programmes for that matter–has been lack of attention to what happens between inputs and outcomes. As Scott and Sechrest (1989) worded it: “We may know that an intervention is in place and that it has some effects, but as long as we lack further understanding of it, we will be helpless to improve on it in any way. In fact, without greater understanding of it, efforts to change and improve the intervention may actually have adverse consequences.” Or as Chen and Rossi (1989) viewed it: “Most so-called evaluations currently conducted are at best social accounting studies that enumerate clients, describe programmes, and sometimes count outcomes.” Such evaluations were critically termed ‘black-box evaluations’, consistent with experimental design and strong in internal validity, yet of little utility when one aims at improving a programme or policy.

Throughout the 1980s, Chen and Rossi (and Sechrest, and others) insisted on programme evaluation “to move (...) from the black box evaluation, which is concerned primarily with the relationship between input and output of a program, to the theory oriented evaluation, which emphasizes an understanding of the transformational relations between treatment and outcomes, as well as contextual factors under which the transformation processes occur” (Chen & Rossi, 1989). By 1990, they had put theory-driven evaluation on the map once and for all. In the next decade, Weiss (1995) would make an even stronger case for a theory-based approach.

When researchers unseal the black box of a social programme – as we attempt in Health Inc – chances are that opening the box leaves the researchers agape. The image of cogs and wheels comes to mind, as beautifully depicted nearly a century ago by Winsor McCay who subtitled his cartoon “Do you know what this is?” (see Figure 1).

Figure 1. “Do you know what this is? (Wheels and cogs)” by Winsor McCay



Source: ‘Do you know what this is? (Wheels and cogs)’ by Winsor McCay, 1920 (Wikimedia Commons)

Tangled up in complexity, we don’t know the answer until we discover mechanisms across the paths and patterns, and thus develop theory: “a framework of interconnected concepts that gives meaning and explanation” (Lipsey, 1990). Theory then transcends the theoretical: it actually allows us to give sound advice to policymakers, specifically on the conditions required for interventions to work.

As the critical realist Sayer (1992) puts it, theory becomes part of the method to link explanans and explanandum. It encompasses the recognition of stratified social reality in which actors and structures interact, the identification of structures – defined as sets of internally related objects or practices, and retroduction – defined as the identification of causal mechanisms through iterative abstraction.

Bunge, scientific realist par excellence, provides yet another scholarly rationale for the need for a theory of explanation. Central to Bunge's approach are systems, which are omnipresent: "everything in the universe is, was, or will be a system or a component of one". He defines a system as "a complex object whose parts and components are held together by bonds of some kind" and a mechanism as "a process (or sequence of states, or pathway) in a concrete system, natural or social (...) that makes a system what it is" (Bunge, 2004) and that "makes a concrete system tick" (Bunge, 1997). Most importantly, Bunge reminds us that "highly complex systems (...) have several concurrent mechanisms. That is, that is they undergo several more or less intertwined processes at the same time and on different levels. (...) The coexistence of parallel systems is particularly noticeable in social systems" (Bunge, 2004).

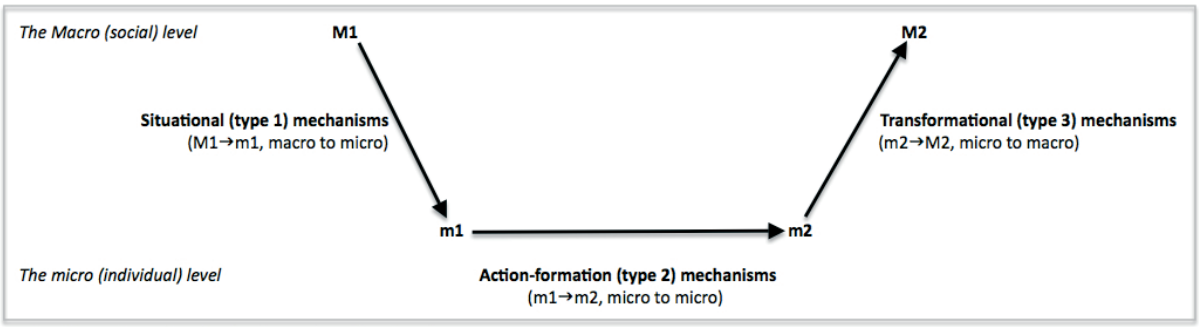
In our research context, health being a complex social system, we cannot but expect plural mechanisms.

Linking explanans and explanandum

Hedström and Swedberg (1998), based on Jon Elster's work, state that "the search for mechanisms means that we are not satisfied with merely establishing systematic covariation between variables or events; a satisfactory explanation requires that we are also able to specify the social 'cogs and wheels' (…) that have brought the relationship into existence." Schelling adds that mechanisms should be conceived as the systematic sets of statements that provide a plausible account of how inputs and outputs are linked (Hedström & Swedberg, 1998).

Following Elster's and Hedström and Swedberg's reasoning, explanation should be distinguished from labelling, relabeling and description. Looking for generative mechanisms allows us to make a distinction between genuine causality and coincidental association. To explain tangible social events we must rely on a number of elementary mechanisms, as one is not enough in real-life, complex processes. Often the mechanisms counteract one another; sometimes they work together. This multiplicity of mechanisms requires a typology to sort them out. We therefore make use of Hedström and Swedberg's (1998) typology that is based on Coleman's macro-micro-macro model (1986), commonly known in social science as 'Coleman's bathtub' (see Figure 2).

Figure 2. Coleman's bathtub



Adapted from Coleman (1986) and Hedström and Swedberg (1998)

This model provides an explanation of change at the macro level (M1gM2) by showing how macro states at a given moment in time influence the behaviour of individual actors and how these actions shape new macro states at a later time. In the type 1 (situational) mechanism, individual actors are exposed to a specific social situation at the macro level (M1), which affects them in a particular way. In the type 2 (action-formation) mechanism, a specific action is generated by a particular combination of individual desires, beliefs and action opportunities. Then, in the type 3 (transformational) mechanism, individuals interact with one another and the individual actions are transformed into an intended or unintended collective outcome (M2). What makes the model particularly attractive is its intertwining of structure and agency, thereby emphasizing the importance of both.

One early and clear example of an explanation following Coleman's 'bathtub' is provided in Bunge's 'Mechanism and explanation' (1997). He argues that it is hard to explain how rise in income (M1) leads to decline in fertility (M2) if one restricts the analysis to the societal level. Taking into account, however, what happens at the individual level, a plausible explanation becomes apparent (see Figure 3).

Figure 3. Bunge's 'Mechanism and explanation'

Source: Bunge (1997), p 453

Linking mechanisms and SHP

When looking for mechanisms that might lead to social exclusion in SHP schemes it is necessary to look for mechanisms in society as a whole that can lead to social exclusion. Social health protection doesn't operate in a vacuum but is fully embedded in social reality. The mechanisms that function in the social realm apply to SHP just as well. Actors within a programme or scheme are actors in the whole social reality; their actions within the SHP cannot be isolated from that larger reality. It can also be argued that the mechanisms of the larger social reality are actually reproduced in the implementation of the SHP scheme.

Based on the work of Hedström and Swedberg, we identified a number of crucial, prototypical mechanisms that can be framed and categorised within Coleman's 'bathtub' model:

1. Belief-formation mechanisms that can be categorised as type 1 situational mechanisms as described above

Self-fulfilling prophecy (Merton, 1948): an initially false definition of a situation evokes behaviour that eventually makes the false conception come true;

Network diffusion (various authors in Hedström & Swedberg, 1998): networks are important because information about innovations diffuse through them and an individual's propensity to adopt to innovation is influenced by what others do, particularly when there is a great deal of uncertainty about the true value of the innovation;

Threshold theory of collective behaviour (Granovetter, 1978): an individual's decision whether or not to participate in collective behaviour often depends (in part) on how many other actors already have decided to participate. Actors differ in terms of the number of other actors who already must participate before they decide to do the same. An actor's threshold denotes the proportion of the group that must have joined before the actor in question is willing to do so. According to Granovetter, even slight differences in thresholds can produce vastly different collective outcomes.

2. Opportunity-generating mechanisms, also part of type 1 situational mechanisms

Vacancy chains (White in Chase, 1991): a social structure through which resources are distributed to consumers (or beneficiaries). In a vacancy chain, a new resource unit that arrives into a population is taken by the first individual in line, who then leaves his/her old unit behind, this old unit is taken by a second individual, leaving his/her old unit behind, and so on;

Reference groups (and role models) (Paynton, 1966): social groups to which individuals refer when making decisions and judgments. The individual's choice is or can be determined by the reference group.

3. Preference-formation mechanisms, belonging to type 2 action-formation mechanisms

Adaptive preference formation (Elster, 1982): often referred to as the 'sour grapes' mechanism: someone realizes that what he or she wants is unattainable, and then reduces his/her dissonance by criticizing what he/she wants. This is very closely related with the concept of cognitive dissonance (Festinger, 1957) and cognitive consequences of forced compliance (Festinger & Carlsmith, 1959). The latter proved that if a person is induced to do or say something against his/her will, that person will have a tendency to change his/her opinion in correspondence with what he/she did or said;

Discounting (Ainslie, 2002): inter-temporal choices are no different from other choices, except that some consequences are delayed and hence must be anticipated and discounted (i.e. reweighted to take into account the delay). Given two similar rewards, humans show a preference for one that arrives sooner rather than later. Humans are said to 'discount' the value of the later reward, by a factor that increases with the length of the delay.

4. Type 3 transformational mechanisms

Tipping (point) model: coined by Grodzins (1957) when studying racial segregation in American neighbourhoods, further developed and expanded by Schelling (1978, pp. 147-155). It is similar to Granovetter's threshold model, but usually used to explain sudden and more dramatic changes in social behaviour. A tipping point is a moment in time when a group, or a large number of its members, radically and rapidly changes its behaviour by adopting a practice that the same group previously seldom used;

Tragedy of the commons: individuals that act independently and rationally according to their own self-interest tend to behave contrary to the best interests of the whole population group in the long run by depleting common resources;

Matthew effect: "initial advantage tends to beget further advantage, and disadvantage further disadvantage, among individuals and groups through time, creating widening gaps between those who have more and those who have less" (Rigney, 2010).

This non-exhaustive list of mechanisms gives us an indication of the cogs and wheels that could explain why an SHP scheme performs poorly or not. The Health Inc research put forward the hypothesis that social exclusion is a significant cause for the limits of the success of recent social health protection initiatives in low- and middle-income countries (LMICs). It could therefore be revealing to see if the identified mechanisms also function as mechanisms of social exclusion. But before we do that, let us take a closer look at social exclusion itself.

The process of social exclusion

As reported in Chapter 1 – and expanded upon in detail in the case of Africa elsewhere (Soors et al., 2013) – adopting a social exclusion perspective where poverty is prevalent is not necessarily obvious. All too often, social exclusion is simply not considered, or taken for poverty as a state of deprivation, or at best narrowed down to exclusion from social networks, leaving an important part of the political, economic and cultural dimensions of the SEKN definition we adopted for the Health Inc research out of scope.

A frequently used argument is that the concept of social exclusion would be too 'European', its validity limited to European welfare states and thus hardly applicable in LMICs. Yet even the purely European initiative Medium-term Community action programme to foster the economic and social integration of the least privileged groups (EC, 1989), also known as EC Poverty 3 programme, brought forward strong arguments for social exclusion being a truly universal phenomenon. The programme conceptualised social exclusion as more comprehensive than poverty, "much more than money" (Bruto da Costa in Berghman, 1997), in terms of one's sense of belonging to society. Belonging to society was described as dependent on four societal systems:

- The family and community system, promoting interpersonal integration;
- The legal and democratic system, promoting civic integration;
- The labour market, promoting economic integration;
- The welfare-state system, promoting social integration.

Accordingly, Berghman (1997) describes social exclusion as "a breakdown or malfunctioning of the(se) major societal systems that should guarantee full citizenship". Clearly, this broad conceptualisation of social exclusion as withheld citizenship cannot be considered exclusively European.

The Poverty 3 programme also pointed out the rather important distinction between poverty as an outcome and social exclusion as a process. However, Berghman (1997) noted that on closer examination, both poverty and social exclusion can have a double connotation: a static one referring to outcome, which can be a lack of disposable income (poverty) or a multifaceted failure (social exclusion), and a dynamic one referring to process. Berghman therefore suggests "using poverty and deprivation to denote the outcome, the situation; and using impoverishment and social exclusion to refer to the process". This results in the following scheme (Figure 4).

Figure 4. Berghman's framework of poverty, impoverishment, deprivation and social exclusion

	Static Outcome	**Dynamic Outcome**
Income	Poverty	Impoverishment
Multidimensional	Deprivation	Social Exclusion

Source: Berghman (1997), p 7

From this scheme we can derive a concise, but more general definition of social exclusion: social exclusion is a dynamic, multidimensional process that leads to various forms of deprivation.

The definition of social exclusion as a process then provides us the link with the concept of mechanisms in the understanding of the same in social reality as a whole and in the SPH initiatives under scrutiny in particular.

But let us get one step closer to the social reality of social exclusion before having a look at the mechanisms that shape it as a process. We take this step by referring to the work of Jan Vranken, who studied poverty and social exclusion not so much at a theoretical level, but in its actual, daily life appearance for several decades. According to Vranken and De Boyser (2003), social exclusion occurs when 'units' (individuals, positions or groups) are hierarchically ordered and when on top of that clear fault lines appear. These fault lines are sudden 'drops' in the social continuum and take the (metaphorical) shape of chasms, walls or high thresholds. These fault lines indicate a qualitative difference between people, groups or areas, in terms of access to social benefits, political rights, formal and informal markets, and so on. Vranken also pointed out the important role of so-called 'gatekeepers'. These actors are people, but often also institutions that are situated on the strategic junctions of a network and have control over the social goods. They can decide whether people have access or not to networks or social goods.

Based on the work of Vranken, De Boyser (2003) identified five central areas or fields that produce and/or reproduce social exclusion:

- The labour market through unequal access, negative consequences of unemployment, inequalities between formal and informal labour and the unequal access to social benefits derived from labour;
- The education system through unequal access due to the social, economic and cultural situation of the households, impact of physical factors of the environment (distance to the school, quality of school buildings, etc.), unequal access accentuates unequal outcomes;
- Housing through unequal access to (social) housing market, poor housing areas deprived of basic services;

- Health through poorer health quality due to social and economical situation and the resulting inequality in life expectations, unequal access to health;
- Social services through various thresholds.

One might argue that in the Health Inc research we should only look at the fourth area, health, but it is clear that when looking at social exclusion in SHP programmes and schemes, it is necessary to take into consideration the other four areas too, as they all have an impact on the success (or lack thereof) of the programmes and schemes.

The labour market: often SHP schemes are 'reserved' for people in the formal labour market, excluding informal labourers, although in many LMICs people who work in the informal sector are the vast majority of the work force;

Education: low educational outcomes deprive people from knowledge/information-gathering capacities that are needed in order to be able to benefit from the SHP schemes. This disadvantage is even more accentuated when gatekeepers accommodate the schemes' campaigns to the ability of more educated people;

Housing: many deprived people live in poor areas that are remote or otherwise isolated and where decent information channels and social services are sparse;

Social services: often have high thresholds.

Berghman (1997), based on Bouget and Gachet (1996), points out the importance of the spatial dimension of social exclusion, as manifest in the isolation of 'island' communities, not necessarily based on distance. This refers to poor spaces in themselves rather than to spaces where there are poor persons. Such a space may be a poor region, village or neighbourhood surrounded by more 'developed' ones. As such it emphasises that the attempts to counteract social exclusion need to be universalistic and should not only focus on persons and/or groups. "The notion of target groups, though not necessarily inappropriate, becomes incomplete, since ultimately the target group is the community of the space as a whole" (Berghman, 1997). Clearly, the unbalanced reliance on targeting can be seen as an inherent inadequacy of many a social protection initiative, as was also elaborately argued by Mkandawire (2005) when comparing targeting and universalism in poverty reduction strategies.

Health Inc: bringing together mechanisms and the process of social exclusion in SHP

If we apply the model of Hedström and Swedberg to a Social Health Protection scheme that is intended to have a transformative outcome, putting in place the SHP scheme at the macro level should activate situational mechanisms to which people react through micro-level action-formation mechanisms. If these lead to a large enough number of people taking part in the scheme, transformational mechanisms can enter into motion that lead to the desired output at the macro level: an effective SHP scheme that redresses the health inequities and even leads to a more equitable society in general.

The previous description is of course an idealised scenario. In the real world quite a few elements can prevent the cogs in the mechanisms from turning in the right direction, or even put in motion other, counterproductive mechanisms that lead to the opposite of the effect the SHP scheme intended to achieve. The Health Inc research identified a number of such elements in the different steps of this model.

Gatekeeping

In the first step of Coleman's model, our research identified gatekeeping as the strongest mechanism to produce counterproductive effects, operating at various levels and in different forms or variations. In all four case studies, our research showed that from the highest ranking cabinet collaborator who is part of the 'design team' of an SHP scheme down to the local civil servant who has to enrol the members of the scheme's target group, these gatekeepers all can and do exert in one way or another a certain amount of power that decides who's in and who's out of the scheme. At the level of conception of the scheme, the 'designers' decide who the target group will be

and what are the rules that make one eligible for membership. This is heavily influenced by the political currents and policy priorities that are dominant at the moment of conception and can result in the political interest for or neglect of a certain population group (e.g.: a scheme might be aimed at elderly people while the handicapped and migrants are neglected by the authorities). But even when the scheme is being implemented, members of the targeted group might be denied access by various 'implementers': e.g., by planning an information campaign that, even involuntarily, is set up in a way that it cannot reach the target group. This can be because of a wrong choice of communication channel: choosing television when the target group owns few or no television sets, opting for textual advertisement when targeting a mostly illiterate population, etc. Another reason for denying access might be an almost unconscious 'ostracism' that is present in the cultural and social mind-set of the gatekeepers towards certain population groups. The Indian case studies provide us with very clear examples of this 'ostracism', especially towards the Scheduled Tribes (chapter 14). Given their position, the gatekeepers can, deliberately or not, manipulate the wants of other people by triggering the cognitive dissonance/adaptive preference formation mechanism (see below). As Elster (1982) put it: "if one only wants what little one can get, one's preferences are perhaps induced by other people in whose interests it is to keep one content with little."

The role the gatekeepers played in each of the four locations where the Health Inc research was conducted also shows the importance of what Lipsky (1969) called the 'street-level bureaucrats'. They can be identified as persons who are (directly or indirectly) working for the government, interacting with citizens in the course of their jobs in which they have significant independence in decision-making and an extensive impact on the lives of their clients. At the same time, these street-level bureaucrats often find themselves confronted with unavailability of resources and ambiguous, contradictory and sometimes even unattainable role expectations. Regarding the latter, we found that quite a few people working in health centres in Senegal or Ghana found themselves in that position, giving care, but not informing the patients/clients correctly or extensively about the SHP schemes, often because they themselves had not been informed well by their superiors. This results in two types of gatekeepers at 'street level': active ones who clearly decide who is in or who is out, based on a 'du ut des' principle (greed, corruption...) or the relationship of the receiver of the benefit with the gatekeeper; and passive ones who exclude on a more involuntary basis because these gatekeepers were not or were poorly informed themselves about the functioning of the scheme. A clear example of the latter were the poorly informed administrators in Karnataka and Maharashtra who had to organise enrolment camps, but were not able to inform the people about the advantages of the scheme; in Senegal a number of street-level bureaucrats were not sure about the advantages of the scheme because of a lack of information, and doubted the efficiency of the scheme. Because of this, they took the decision not to inform the potential beneficiaries. In India we also find a "stepped" structure from top to bottom, where in every step/delegation of the implementation task, an important amount of information about the scheme and its inclusive character was lost while at each step more existing social, political, economic and cultural mechanisms of exclusion came in motion.

Our analysis further revealed that the negative attitude of and the choices made by the gatekeepers were a main threshold that impeded collective behaviour of the targeted population, and created a strong atmosphere of distrust towards the state and government-related issues in general. This lack of trust is shared by a vast amount of the population that is targeted by the scheme and strengthens their doubts about whether or not to join the scheme, regardless of how much the improvements of taking part in it might be clear. The height of the thresholds shows the importance of social networks and the influence they have on the targeted, vulnerable population groups.

Network diffusion mechanisms

Gatekeeping as a mechanism is closely linked with network diffusion mechanisms that were clearly at work in all cases. People within the health services often did not inform the potential members of a scheme because they received negative or confusing information on the functioning of the scheme from within their professional network. At the same time, the social networks of the targeted population groups raised the thresholds for collective behaviour even further: "other people are not joining, so we don't either". Their compact networks are characterised by strong, but not very far-reaching ties that often don't provide the necessary, well-informed connections to convince them of the benefits of the SHP scheme. The qualitative data for West Africa show that people are strongly influenced in their decision to whether or not to enrol by the opinion of persons close to them in their social environment. The deteriorating social network of ageing people in Senegal contributes to their hesitations to join the scheme. A lack of trust in the institutional is often shared among the members of the community and even reinforced by the implementation of the SHP scheme.

Spatial isolation

The excluding power of the spatial isolation or seclusion mechanism is strongly present in all four studied locations. It is even strengthened when interacting with gatekeeping and adverse preference formation: isolated or poor spaces in rural and in urban areas are neglected by the political and administrative forces in power and this lack of political and institutional networks at the grassroots level enhances the feeling of the people living in the isolated areas that the SHP scheme "is not meant for people like them": there is no need to look for social benefits because these are seen as intended for 'other people'.

Adaptive preference formation

It is clear that the number of failures in the situational mechanisms is a serious impediment for entering in motion the following phase, the action-formation mechanisms at the individual, micro level. The Health Inc research, in particular the qualitative part of it, clearly demonstrated the importance of cognitive dissonance / adaptive preference formation as a mechanism. It was striking how in a number of interviews, the people who were targeted by the SHP scheme talked about it as 'something that is not meant for people like us' or 'When one is poor, one stays in the spot of the poor' (interview Senegal). It is important to point out, as Elster (1982) did, that this mechanism is an effect and not a cause. All too often this mechanism is interpreted as a deliberate act of the concerned actor, while in reality it is a way of coping with a situation of often prolonged deprivation over which the actor has very limited or no control or power at all. The analysis of the Senegalese qualitative data shows clearly how the older people, targeted by the SHP scheme, perceive themselves as such.

Discounting

A second important action-formation mechanism that is at work here in a negative sense for the scheme is the mechanism of discounting. Investing in the scheme is investing in something that might be advantageous in the near or far future. However, most people's daily needs are such that future benefits are strongly discounted in favour of more pressing, daily needs. When previous negative experiences with malfunctioning health (and other) services are added to the choice of using scarce resources for a possible advantage later in time compared to an immediate advantage of fulfilling a serious need now, the balance quickly tips towards the fulfilment of present-day needs. This is an active, deliberate decision not to participate in the scheme. It could be explained as self-exclusion from the scheme, but we can just as well conclude that these people actively take the decision to exclude the scheme from their lives.

Education

At this level, the effect of gatekeeping reinforces or is reinforced by another mechanism: education, or rather, the lack thereof. When information is given in an unintelligible way, people will not be able to grasp it and act accordingly. It is important to see the correct direction of the causality. In this case it is not the targeted group that doesn't look for the right information, but the fact that the information is out of their reach that explains the low awareness about the SHP scheme. The mechanism that is at work here, education, is not part of the implementation process, but was already in motion quite some time before the scheme was put in place. This shows, once again, that when looking at a particular fact, like putting in place an SHP scheme, and explaining it, it is paramount to look at the broader social context in which it is taking place.

Failure to transform

The failure of the situational mechanisms to put in motion the right action-formation mechanisms in the end leads to the transformational mechanisms not entering into action, or at least not in the direction intended. There is no tipping point reached that would result in the transformative effects desired as an outcome of putting in place the SHP scheme. As a matter of fact, our research discovered that often the opposite was achieved, namely that the implementation of the scheme created a Matthew effect: it advantaged those members of the population who already had certain advantages. In that sense the mechanisms turned in the opposite direction.

Labour Market

The labour market often accounts for people being excluded a priori from schemes that are directed at those who work in the formal sector, leaving out a majority of the labour force in LMICs. The combination of the labour market mechanism with the previously mentioned mechanisms strengthened the Matthew effect. This is shown by the Health Inc results. In Senegal the SHP scheme was put in place to benefit a specific target group of elderly people, regardless of their position in the labour market or geographical location. However, in the end it gave an advantage to people who already had another SHP scheme at their disposal because of their previous jobs in the formal sector and those who lived in urban areas and already had easier access to health services. Often they were also better educated with a larger network, so the educational and network diffusion mechanism turned in the positive sense for them and strengthened their access to the new SHP scheme. As such, the profile of an elderly person who received care through Plan Sesame was that of an educated man retired from the formal sector and residing in an urban area. In India the political and institutional gatekeeping mechanism also favoured those who already held an advantaged position.

Policy recommendations emerging from these findings are discussed in the following chapter.

Conclusion

Applied to Coleman's model, our research found that the initial lack of attention for the institutional and societal environment in which the SHP schemes are implemented gives them such a handicap from the start that any further development of the schemes towards a positive outcome is truncated. The SHP schemes that were under study in the Health Inc research are meant to promote inclusiveness, but are implemented using existing structures in which strong mechanisms of social exclusion are embedded, resulting in an ill-fated start for the schemes, no matter what their intended outcomes were. Contextual mechanisms external to the scheme were copied and or reproduced in the functioning of the scheme. It is striking that quite a few of the conditions for inclusion in the SHP scheme, like age, gender, Below Poverty Line-status or informal employment, are at the same time the determinants/drivers of exclusion from the scheme. This supports the point made by Berghman (1997) that a target group should include

the whole community: in this case also the institutional networks have to be targeted in the information and implementation phase of the SHP scheme. The institutional network should be made aware of the mechanisms of exclusion (in order to be able to create awareness with the targeted people about the schemes) and address them before starting the implementation of the scheme.

The initial wrong-footed start creates a situation that is not favourable for setting in motion the necessary mechanisms that make the cogs and wheels in Coleman's model turn in the right direction towards a positive and transformative outcome. Our research discovered that more often than not the mechanisms that are put in motion tend to exclude the targeted population. As a matter of fact this failure to 'tick the right boxes' is such that quite a few of these targeted people actively and deliberately exclude themselves from the scheme, making the intended, transformative outcome impossible to achieve or even exacerbating the already existing inequities.

The lack of trust the targeted groups express towards the SHP programmes, and the hesitation or even refusal to join the programme because of it, is a clear indication that the targeted groups don't consider themselves involved and have no intention of getting more involved. To them, the programme or scheme is just another one of those government initiatives that 'come from above' and, in their opinion, will not deliver what it promises. As Zakes Mda (2000) phrased it in his wonderful novel "The Heart of Redness": '... that is the danger of doing things for the people instead of doing things with the people.'

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CHAPTER 16: Health Inc: conclusions, lessons learnt and policy recommendations

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The Health Inc project studied social exclusion from social health protection (SHP) mechanisms in three different countries (Ghana, India and Senegal). It also covered several different contexts, including two states in India (Karnataka and Maharashtra) as well as both urban and rural study sites across the various countries and states. These diverse contexts were all studied using the Health Inc methodology, whose backbone is the SPEC-by-step tool. It proposes a step-wise approach to evaluate how inclusive/exclusive health financing arrangements are (see chapter 2) and identifies the mechanisms that shape and maintain the social exclusion (see chapter 15). This common methodology was designed to facilitate comparison across the various contexts studied.

In this final chapter, we seek to bring Health Inc results together to identify patterns that may apply across all the contexts studied, as well as findings that seem to be unique to specific contexts. Based on this, an attempt is made to highlight policy recommendations that may generally apply to low- and middle-income countries, while recognising that if they are to be implemented they must again be adapted to local context.

The chapter is structured in three sections. Section 1 summarises the results of Health Inc according to the "steps" in the SPEC-by-step tool, in terms of the limited effectiveness of each step in the SPEC-by-step cascade, e.g. socioeconomic determinants of low awareness of the SHP scheme and low enrolment. Section 2 explains how socially excluded groups and underlying processes of social exclusion interact with poor scheme design to cause the patterns observed in Section 1. The third section presents policy recommendations proposed in light of the results summarised in sections 1 and 2.

Section 1: Step-wise comparative summary of Health Inc results

As described in chapter 2, to construct the SPEC-by-step tool we broke up a hypothetical, generic SHP programme into a cascade of steps. In this section, we bring together the findings of the Health Inc project for each step.

The "awareness" step

Ideally, all targeted (or eligible) people become aware of an SHP programme. However, the Health Inc project found that in practice this is rarely the case. In several cases, much of the target population was completely unaware of the SHP programme. Furthermore, even among those who were aware or were enrolled, the depth of awareness was variable. Indeed, the project found that "awareness" has several different components or levels and that very few target beneficiaries were informed about the full range of benefits available to them. In general, the SPEC-by-step tool assumes awareness of the scheme to be a prerequisite for using the scheme and benefiting from it. However, it should be noted that although we use it as "step one", awareness of an SHP programme can also happen at a later step, for example at the time of utilisation when those who go to a hospital are informed of an exemption or insurance scheme by a health worker.

In Karnataka, 49% of eligible households were completely unaware of RSBY (had never heard about the scheme and never seen the RSBY card). Among those who had heard of the scheme, awareness about the details of the scheme was patchy, illustrating that the concept of "awareness" needs to be unpacked. Three broad levels were identified: those who were minimally aware (41%), those with broader or more comprehensive awareness (9%) and those with in-depth awareness of the scheme (<1%) (see chapter 6). Households belonging to Scheduled Tribe (ST) communities that did not speak the state's official language, resided far from government health centres, and reported poor local political participation were among those less likely to be aware of the scheme.

Awareness was even lower in Maharashtra, where 70% of the sample (again consisting only of eligible households) reported that they did not know about RSBY. Only 4% were found to be "fully aware" of all the components of the scheme. Urban households had a considerably lower level of knowledge than their rural counterparts, while female-headed households and households with an uneducated head were also less likely to receive information about RSBY (see chapter 5). Of enrolled households, 20.5% did not know anything about the provisions of expenditure allowed under the scheme, only 29.0% knew about hospitalisation benefit, 33.7% knew about hospitalisation benefit up to INR 30000 per year and only 16.8% were aware of the additional benefit of claiming travel expenses.

Seeking to understand this low level of awareness of RSBY, the Health Inc project found that although in principle the insurance companies and third party administrators (TPAs) are primarily responsible for awareness generation in the community, in practice they greatly relied on Gram Panchayat (local authority) members for making eligible beneficiaries aware of RSBY. In both Karnataka and Maharashtra, this over-reliance on Gram Panchayat members for IEC (information, education, communication) left enormous scope for exclusion of households from knowing about RSBY. Local officials at the Gram Panchayat office did not consider RSBY to be their department's work and therefore little priority was given to RSBY-related activities. Second, access to information about the RSBY enrolment camps largely depended on the political contacts and networks of households and hence the chances of getting information were low for those not associated with the Panchayati Raj Institutions (PRI). In part, this was because Gram Panchayats were given very little notice to inform beneficiaries (1-3 days instead of the 1 month that the guidelines stipulate). As a reaction to this they informed the people they knew, who lived close by and frequented the office. These issues are explored in more depth in Section 2 below. Other issues that are not related to social exclusion may also account for the low level of awareness (e.g. the relative newness of the RSBY scheme); these are discussed in previous chapters (e.g. chapter 7).

A similar pattern emerged in Senegal, with 49% of the elderly sampled not informed of the existence of Plan Sesame. Among those who were informed, 67% did not know basic details about Plan Sesame, such as the services offered by the Plan (chapter 4). However, those working in the formal sector were relatively advantaged in terms of awareness, for reasons discussed further in Section 2 of this chapter.

The NHIS in Ghana is ostensibly the exception in terms of awareness; the Health Inc survey revealed that awareness of the existence of the NHIS was 100% (chapter 3). However, when questioned about details of the scheme, similar issues emerged as in the other case studies, since many people did not understand the principles of the NHIS. For example, around a third of respondents to the household survey in Ghana agreed with the statement that "health insurance is something for the poor". Additionally, stakeholders interviewed about the NHIS said that men often believed that health insurance is meant for women and children. Yet the scheme is in principle mandatory and targeted at the entire Ghanaian population. However, this lack of awareness may not be related to social exclusion per se, and rather be caused by other limitations of the IEC campaign.

These findings point to serious difficulties in designing and implementing effective IEC campaigns across all three SHP programmes studied. Health Inc research into who was excluded from the awareness step and why points to distinct patterns of inequity in both Senegal and India. This is discussed further in Section 2, in terms of social exclusion.

The "registration" or "enrolment" step

Health Inc results suggest that of those eligible for and aware of the programme, not all register (or enrol, according to the particular terminology).

In Karnataka, 77% of aware households were enrolled in RSBY. This implies that only 39% of the total 6040 households surveyed were enrolled in the scheme. A number of operational issues prevented people from enrolling, such as the short notice given to both local organisers and beneficiaries about the enrolment camp, misinformation spread about the enrolment procedure caused by a lack of training of organisers and, as in the awareness step, over-reliance on Gram Panchayats in the enrolment process (see chapter 6). Since the enrolment camp was organised on a particular day and time, people who were likely to be unavailable such as casual-wage workers or migrants had little opportunity to enter the scheme. Indeed, the one-time enrolment camp implicitly assumes that the beneficiaries don't have work, family or educational commitments. Perhaps therefore it is unsurprising that households headed by women, the elderly, households that are large in size (more than 5 members), in the lowest economic quintile, and households from Scheduled Caste and Scheduled Tribe communities were less likely to be enrolled (see chapter 8).

Similarly in Maharashtra, it was found that only 22% of households in the entire sample of eligible below poverty line (BPL) households were ever enrolled in RSBY. The results suggest that male-headed, non-labourer households, households belonging to majority religion and those residing in urban areas and from Vidharbha region were less likely to be included in RSBY. The results on rural / urban differences in Maharashtra are striking–the enrolment rate was considerably higher in rural areas (27%) than in urban areas (13%). This is contrary to the results from the other Health Inc research sites. One explanation might be that insurance companies have an incentive to focus on the rural areas (according to the Insurance Regulatory and Development Authority (IRDA) regulations they are supposed to meet the rural sector obligations by earning at least seven percent of their premium revenues from rural areas) (see chapter 9). The likelihood of reporting enrolment was much lower among single-member households than joint and extended families. Households that did not know any influential person were less likely to be enrolled in RSBY than those who did know such people. Those who expressed lack of trust in institutions were significantly less likely to be enrolled in RSBY. The qualitative evidence points to the following reasons for low enrolment rate:

flawed BPL lists, corruption and nepotism, death of the head of the household, movement of large population to other places, seasonal migration for work, lack of administrative support on the ground, cost of enrolment, no compulsive mandate on the insurance company to achieve a higher enrolment rate, limited and inflexible time span of enrolment process and ineffective oversight by the Department of Labour (see chapter 5).

Ghana again ostensibly seems to be the exception, with nearly 73% of household members in the sample having at some time registered with the NHIS. This can probably be attributed to the high level of awareness of the scheme, as compared to the other research settings. However, dropout was a major problem in the Ghanaian NHIS, with around 20% of those who had ever enrolled failing to renew their membership. Our survey found around 54% of household members were active NHIS members (currently insured) during the survey; official statistics report that active (current) membership is much lower, at only at 36% of the population (see chapter 3). We found that around 44% of those who had dropped out complained that the premium and the registration fees were expensive. The next most common reason cited was not falling sick and therefore not needing the insurance. Economic status was similarly a major determinant of why some people had never become insured. The never-insured also lived further away from educational, health and transport infrastructure and services than those who had ever been insured. Furthermore, a higher proportion of the never-insured felt their concerns, questions and feelings were not taken seriously by medical staff and a lower proportion of the never-insured strongly agreed that they were treated with respect at the health facility. Some individuals had withdrawn their membership from or decided not to enrol with the NHIS because of a lack of trust in the scheme and bad experiences with health professionals in the past (see chapter 3).

In Senegal elders are not required to “enrol” in Plan Sesame. However, they are required to present a national biometric identity at health facilities to get the exemption. We therefore considered elders to be enrolled if they had a valid card and also were aware of Plan Sesame. Health Inc found that the requirement to possess an ID card was not a major barrier to enrolling in Plan Sesame. Almost all those who had heard of the scheme also had a card (48% of the sample was “enrolled”). Being male, being a household head, having some formal education and living in urban areas all increased the odds of enrolling in Plan Sesame by almost twofold. Belonging to the majority ethnicity also increased the odds of enrolling. Strong evidence of adverse selection was found, with those hospitalised in the last 12 months being 1.8 times more likely to enrol. With regard to sociocultural variables, elders who were not members of sociocultural associations were less likely to enrol. The results show that elders belonging to richer households were significantly more likely to enrol in Plan Sesame. Also, elders who were vulnerable in all dimensions of social exclusion (using a social exclusion index) had lower odds of enrolling in Plan Sesame (chapter 12). These patterns point to social exclusion in Plan Sesame enrolment and are explained in more depth in Section 2 below.

In sum, current enrolment rates in all three schemes studied were low, never exceeding 55% of the sample. Difficulties with administrating the schemes were the main causes of these low enrolment rates; however, these difficulties seemed to affect some social groups more than others. The social patterns underlying these low enrolment rates are explored in more depth in Section 2 of this chapter.

The “membership card” step

Many SHP programmes, including RSBY and the NHIS, are supposed to provide those who enrol or register with a membership card. These programmes also require periodic renewal of the card. However, Health Inc found that not all people who register in a programme receive their card on time and that some people don’t receive it at all. As such, renewal confronts potential beneficiaries with the same difficulties as enrolment, again and again. However, compared to the previous steps (awareness and registration or enrolment), this step seemed to be a less serious barrier to roll-out of the SHP programmes studied.

In Ghana only around 6% of those who had registered had not received their card.

In Karnataka, 16% of registered households did not receive the smartcards needed for utilising the scheme (see chapter 6). Some local administrators or health workers reported poor incentives with high workload and at times, non-payment of incentives as reasons for being disinterested in actively distributing the cards. Known social contacts and those who proactively asked were given the cards, but those who did not seek out the cards often were not sought out. In some villages, beneficiaries reported that the local administrators used the cards as leverage to extract unpaid dues and, in some cases, bribes. Casual wage workers and those in Scheduled Caste and Scheduled Tribe communities also reported that at various instances local authorities verbally abused them (for being poorly dressed or illiterate) when they asked for their cards (see chapter 6).

In Maharashtra, of the currently enrolled households, 5% did not possess smart cards. The analysis of survey data reveals that technical problems were reported by 37% of the respondents as a reason for not getting the smart card. A third of respondents said that they did not know why they had not received the card. Delay in distribution of smart card was consistently reported in almost all focus group discussions (see chapter 5).

Furthermore, in RSBY our research revealed that in addition to problems obtaining cards, some households experienced problems enrolling all eligible members of the household onto the card. Overall, only 57.5% (6,140 out of 10,704) of household members belonging to card-holding households reported to be registered on the card. This is a limiting factor of the design of RSBY, as benefits can be availed only by those household members who have their name and relevant information (photographs and thumbprints) registered on the card (up to a maximum of five members per household). Only 51% of small sized households (up to 5 members) and 38% of large households (more than 5 members) were fully covered (all 5 members enrolled) (see chapter 6).

Our data suggest that gender, age and relationship to the head of household determine one's chances of being enrolled. Granddaughters and the daughter-in-law of the oldest male member were most often excluded from RSBY. In most instances, the highest earning member of the household (usually the oldest son) would take decisions on the family's expenses and inclusion in welfare schemes. These gender differentials are discussed further in Section 2 below.

These results suggest that specific procedures used for distributing membership cards created barriers to fully enrolling intended beneficiaries in SHP, particularly in the case of RSBY where, for example, the enrolment limit of five members per household was exclusionary in its very design. As in the previous steps, social drivers (such as gender and tribal status) and political drivers (such as lack of political networks) seem to play a role in preventing full implementation of the scheme. These issues are discussed further in Section 2.

The "accessing care" step

Being enrolled or registered in an SHP programme with a valid membership card should in principle ensure access to health care for the beneficiary. The "accessing care" step was difficult to study due to small sample sizes. However, Health Inc found that while the SHP schemes studied did improve access, in some cases cardholders did not visit a service provider and request services, despite having a health problem that merited them doing so.

In Karnataka, among registered members in card-holding households, the annual hospitalisation rate was calculated to be 42 per 1000 while that among the non-registered was 34 per 1000. This difference is statistically significant, and reflects higher access to hospitalisation among registered members (see chapter 6).

Similarly, in Ghana around two-thirds of the insured who reported ill in the last two weeks sought care from formal health care providers, compared with only around half of the never-insured (see chapter 10). One of the main aims of the NHIS scheme is to improve access to healthcare and this could be an early indication of the success of this policy intervention. Yet one-third of the insured did not seek formal care. The main reason given for this was that the illness was not considered serious, but a small percentage (around 5%) cited "high cost of seeking healthcare", suggesting that the insurance did not successfully remove all financial barriers.

In Senegal, some elders did not use Plan Sesame despite being informed of its existence. One reason given for this was a high level of distrust in Plan Sesame and in those who initiated it (see chapter 11).

In short, despite the numerous barriers encountered at each preceding step, overall the SHP programmes did seem to enhance access to health care for those who were registered or enrolled. However, even for members of the schemes who were in possession of the necessary ID card, the SHP programmes did not overcome all barriers to utilisation. The possible reasons for this are explored in more depth in Section 2 below.

The "benefiting from the scheme" step

When utilising health services, members of an SHP programme should receive care for free or at a greatly reduced cost. However, Health Inc found that not all those who claimed health services received the benefits as stipulated by the programme.

In Karnataka, a total of 264 hospitalisations were reported in six months among the registered members (see chapter 6). Only 33 (13%) of those hospitalised benefitted from the scheme. None among them reported a cashless experience implying that all the beneficiaries incurred some out-of-pocket health expenditure with a median of Rs. 5500 (approx. 100 USD, Rs. 30 – 34,500). The reported expenditure was mainly on medicines and diagnostic tests conducted outside the hospital. Nearly two-thirds of the hospitalised did not visit an RSBY-empanelled hospital, making this the main reason for not benefitting from the scheme. This can be explained in part by the finding that only 11% of households got the leaflet with the list of empanelled hospitals at the enrolment camp. Ten percent tried to use the card but the hospital refused it. Another 12% forgot to take the card with them in an emergency, while a few others went to an empanelled hospital that did not treat their particular illness. As per the results on awareness summarised above, most beneficiaries were unaware of where to go or how to use the scheme. For some beneficiaries, having social contacts in or related to the hospital facilitated accessing services and hence the scheme (see chapter 6).

Similarly, in Maharashtra, among the households with valid RSBY card with at least one hospitalisation case in the one year prior to the survey date, only 12% had used the cash-less services from the listed hospitals of RSBY. The qualitative interviews suggest that lack of information regarding the listed hospitals, inability to recognise the use of the smart card, non-availability of listed hospitals in their neighbourhood and invalid smart card were the leading causes of this poor performance (see chapter 5).

In Senegal, only around 10% of the sample was ever treated under Plan Sesame. In part, this low level of utilisation of the scheme was caused by inconsistent funding at the health facility level, which restricted the benefit package to consultations only. As a result, some facilities decided to put Plan Sesame on hold. Most of those who did manage to benefit from the scheme were male, living in urban areas, with higher education levels and having retired from the formal sector (see chapter 4).

Similarly in Ghana, there have been delays in reimbursement to service providers under the NHIS scheme, which in turn meant that hospitals experienced stock-outs and patients were not treated under the NHIS scheme as expected. However, only around 5% of those who reported a need for health services did not use care under the scheme (see chapter 3).

These results suggest that all three SHP programmes (especially RSBY and Plan Sesame) experienced serious difficulties in achieving their goal of providing health services that are free at the point of use, even for scheme members. This was attributable to inadequate funding and limitations of provider payment mechanisms, and overly complex programme rules and regulations. The following section further explores the barriers posed by social exclusion.

Section 2: Processes of exclusion and socially excluded groups

The previous section focused on the SPEC-by step cascade, in order to summarise findings on the social, political, economic and cultural inequities that characterise the schemes in terms of steps such as raising awareness, enrolment of the target population and utilising health services. This section seeks to summarise the mechanisms of social exclusion that help to explain these patterns. It provides examples from Health Inc results on socially excluded groups and processes of social exclusion, which interacted with weaknesses in SHP programme design to contribute to the implementation difficulties and inequities observed in Section 1. As explained earlier in this book, social exclusion is defined as dynamic, multi-dimensional processes driven by unequal power relationships that operate along and interact across four dimensions (cultural, economic, political and social) and at different levels (including individuals, groups, households and communities) (Popay et al., 2008).

In RSBY, the reliance on local socio-political networks to inform, organise and distribute cards often led to those without political connections to be excluded from the scheme. In both Maharashtra and Karnataka, tribal communities were a group that was particularly disadvantaged. In-depth analysis in Karnataka helps to explain this pattern. Health Inc identified that the process of exclusion includes the following, possibly overlapping, mechanisms: lack of political networks, political neglect, lack of a political voice, low literacy and education, and social-spatial isolation. The implementation of the scheme was embedded in existing social, economic, political and cultural structures that typically exclude tribal communities. For instance, delegating responsibility to Gram Panchayat members and health workers for creating awareness and organising enrolment camps for RSBY in a village allowed existing perceptions and exclusionary processes to continue unchallenged. In terms of their scattered settlements and small numbers there is a need for increased effort in terms of resources (financial, manpower and time) to reach out to ST households To insurance companies (that get paid a premium for every household enrolled), ST households were largely ‘unattractive’ in terms of the business model of implementation of RSBY (see chapter 14). Furthermore, the 5-person enrolment limit per household served to exclude women from RSBY. The women of the household had little to no say in whether they were enrolled. Women of the households accepted the legitimacy of the highest earning male member in making these types of decisions. Women were hardly ever allowed to work outside the home so they were stuck in a vicious cycle of not earning and therefore not feeling worthy enough to make decisions and demand their inclusion in welfare schemes.

In Senegal, being retired from the formal sector constituted a clear advantage to accessing Plan Sesame resources. This advantage is explained by the fact that the lobbying efforts for Plan Sesame were first led by associations of formal pensioners. Moreover, their representatives were involved at the design stage of the programme; this facilitated the spreading of information among the formal sector pensioners. This category was also privileged in the utilisation step. Retirees from the formal sector, both from the public and private sectors, had already experienced formal health coverage during their years of employment. As a result, they had more experience with the standard administrative procedures and personal contacts with health personnel (see chapter 6). The exclusion of the informal sector was also structural and rooted in some central features of the programme, i.e. the hospital-

centrism which further widened the rural / urban gap. This exclusion was also social: Plan Sesame operated in a system in which social connections are determinant to access health services. Finally, Health Inc also unravelled a worrying phenomenon: the acceptance of discrimination by the «socially excluded». This discrimination has become normative, a phenomenon that often prevented them from utilising health services (see chapter 4).

In Ghana, the NHIS premium payment exemption policy also has important limitations. Indigents are supposed to be exempted from making direct financial payments to enrol in the NHIS but, despite this, economic status continues to be a determinant of enrolment. This is in part because few indigents have been registered, due to the lack of a robust methodology for identifying the poor or defining "indigents" in the NHIS. Elders are also exempted from premium payment. However, there is strong evidence of inequity in enrolment of the elderly in the NHIS caused by a combination of economic, political and socio-cultural factors, with elders in the richest quartiles being more likely to enrol than those in the poorest quartile (see chapter 12). Women who lived in rural areas and were elderly, widowed, uneducated and from poor households were particularly unlikely to be insured. Though exempted from paying the premium, they still have to pay a registration fee which many may not be able to afford; women dominate the informal economy of Ghana with small businesses and low incomes and due to patriarchal gender relations are in a position subordinate to men in decision-making. They also may not be aware of the exemption package, due to lower levels of education (see chapter 13). These results suggest that, as with RSBY and Plan Sesame, the very design of a scheme (in this case a complex and incomplete exemption policy) may undermine the principles of SHP and cause exclusion of those who are most in need by failing to take into account underlying socially and culturally embedded barriers.

In sum, overall across all three schemes, we found that despite their intention to cover poor and vulnerable groups, the SHP schemes disproportionately benefited those who were socially, politically, economically and/or culturally privileged. Chapter 15 provides analysis of the mechanisms that cause the processes of social exclusion described. At the national or state level, these include the power of "gatekeepers" who are influenced by the political currents and policy priorities that are dominant at the moment of conception and can result in the political interest for or neglect of a certain population group. Meanwhile at the local level, "street level bureaucrats" confronted with unavailability of resources and ambiguous, contradictory and sometimes even unattainable role expectations decide who is in or who is out of the SHP programme, based on their relationship to the receiver of the benefit (social networks), passive exclusion on an unintentional basis due to poor information, or at worst, greed and corruption.

Another mechanism observed was "network diffusion" where the social networks of the targeted population groups raised the thresholds for collective behaviour, due for example to a lack of trust in the institutions providing the SHP programme. A further mechanism identified was "cognitive dissonance" or "adaptive preference formation", where the people who were targeted by the SHP scheme talked about it as "something that is not meant for people like us", as a way of coping with a situation of often prolonged deprivation over which they have very limited or no control or power. A further mechanism was "discounting"; in the target population, the future benefits of the SHP programme are strongly discounted in favour of the more pressing, daily needs. Therefore, even if the scheme has no direct cost such as a premium payment, due to badly designed enrolment processes the opportunity cost of enrolling was so great that it created an insurmountable barrier to those who relied on daily wage labour for example.

These results suggest that limitations in the design of SHP schemes inadvertently serve to reinforce rather than overcome deeply embedded processes of social exclusion. While SHP schemes cannot be expected to undertake profound social, political, economic and cultural transformations without broader inter-sectoral government and social action, there are specific reforms that SHP schemes could undertake to become more socially inclusive. To this end, Health Inc has developed a set of policy recommendations that apply to the three schemes studied, but may also apply to SHP more widely.

Section 3: International policy recommendations

Design more socially inclusive information, education and communication campaigns for SHP

Health Inc has highlighted the need for extensive educational and public awareness programmes to improve the perception of SHP programmes and the principles underlying them, to encourage more people to register or enrol, and remain registered or enrolled. These need to be tailored to specific sub-populations. They need to take into account illiteracy and other barriers experienced by socially excluded groups. Some ideas include:

- Developing creative and meaningful IEC campaigns that make the scheme relevant to people's lives with messages that resonate with the sociocultural context and take illiteracy into account. This approach recognises that the problem is not that the targeted group doesn't look for the right information, but rather that the information is out of their reach. This takes into account the underlying social context of a low level of education, rather than pointing to a lack of interest or understanding in the target population.
- Identifying and mapping known excluded groups will help target IEC initiatives. This will ensure that IEC campaigns are tailored to the specific community and, in special cases, even design new material and strategies to help include these groups or areas.
- Increasing the frequency of IEC campaigns, especially in areas of known excluded groups, making it part of the everyday conversation. Campaigns should become more detailed over time, to help ensure an appropriate depth of awareness about the objectives and functioning of the scheme (e.g. eligibility, benefits etc.).
- Designing multiple strategies and media channels for delivering the IEC campaigns to ensure that beneficiaries can access information about the scheme despite their social, political or educational profile. To this end, various relevant government ministries and departments should be involved in disseminating information about SHP to socially excluded groups with which they may interact (e.g. Department of Welfare).

Strengthen local scheme administration, focusing on socially excluded groups and areas

In each locality (e.g. district), designate an existing local centre such as the sub-centre or specific NGOs as a permanent resource centre for the SHP scheme where all relevant information is available throughout the year for beneficiaries.

District level stakeholders should come together and review the plan or guidelines set by the state and adapt it to their own district, taking social exclusion into account.

Geographical exclusion is a serious issue for the programmes studied. Therefore:

- registration centres should be more accessible and transportation facilities should be provided in areas excluded because of their physical distance.
- at the same time, in contexts where urban households are found to be disadvantaged, socially excluded groups in these areas also need to be targeted.

Increase the capacity of and incentives for scheme staff to enhance social inclusion

Provide training to stakeholders on the purpose of the programme and on existing structures and processes that cause social exclusion of the target group, in order to enhance the motivation of stakeholders to counteract social exclusion via SHP.

Employ relevant stakeholders such as civil society organisations, NGOs and researchers to help design programmes and implementation processes of an inclusive nature. This would involve providing the training and mandate to identify beneficiaries, assist in enrolment, liaise with the local authority on behalf of beneficiaries and so on.

Provide incentives and possibly penalties to local stakeholders to identify vulnerable households or communities and ensure their participation. These could be financial or non-financial.

Improve purchasing mechanisms and ensure SHP schemes are adequately resourced

Improved financial reimbursement systems and sufficient resources are needed to ensure that providers are able to deliver services, in order to ensure correct functioning of the scheme and prevent dropout. Without this, implicit rationing will take place, disadvantaging the socially excluded.

Improve targeting by focusing on social inclusion

If exemptions and targeting are to be used in SHP, there is a need for more robust definition and identification of who is eligible, using the conceptual framework of social exclusion.

Having established the target group, people who qualify for the SHP programme must be conscientiously identified and assisted to enrol and access care. Processes are needed to counteract existing structures that promote social exclusion. These might include:

- focused monitoring systems and financial incentives to include socially excluded groups.
- investment in more politically neutral processes which prevent local politicians and leaders from becoming the only gateway that determines who is enrolled and who is not. Instead, multiple channels are needed to allow the target groups access regardless of their local socio-political standing.
- enrolment centres should be conveniently located and open throughout the year, not just on certain days or annual events.

Devise socially inclusive complaints procedures

The state needs to provide transparent avenues for socially excluded groups to register complaints and get information about their entitlements. One possibility would be to enlist trusted civil society or non-governmental organisations as independent regulators to ensure that information and welfare schemes reach excluded groups.

Consider removing enrolment as a step in SHP programmes

Enrolment and awareness created the greatest barriers to health care utilisation in the SHP programmes studied. In light of this, policymakers should consider removing enrolment as a step in SHP programmes. Making inclusion an explicit objective and keeping the social mandate at its core would take SHP closer to fulfilling its overarching aim and negate the need for the enrolment step. Omitting this step would also allow resources and efforts to be channelled into creating much needed awareness about the schemes and improving monitoring processes. In SHP programmes where enrolment aims to raise revenue for the scheme, alternative revenue sources such as taxation should be considered. This has occurred in Ghana. In SHP programmes where enrolment is supposed to be used to identify eligible or exempted groups, other existing means of identification could be used, such as national ID cards (as in Senegal), existing membership of other types of social protection schemes, diagnosis of a particular disease or condition (e.g. exemption for pregnant women in Ghana), geographic area, profession / source of income, or attendance at another institution (such as schools).

Supply-side measures to improve the delivery of health services

Improvement in availability of high quality health services is needed, especially in rural communities. Without this, SHP programmes cannot achieve their goals.

Taken together, the proposed reforms represent a formidable challenge for SHP programmes. Indeed, the reforms needed to improve some steps, such as enrolment, may not be feasible. This is because reforms to strengthen SHP by increasing social inclusion in enrolment (e.g. registration processes that target vulnerable groups) may not be cost-effective when compared to alternative policies that require no enrolment. Indeed, improving enrolment may require local institutions to develop new capacities that are so demanding that alternative policies such as user-fee exemptions with no enrolment, investing more in more socially inclusive IEC, improved provider payment mechanisms and health service provision emerge as preferable alternatives. Improvements in the delivery of health services, including expanding geographical access and quality, are longstanding health system challenges in low- and middle-income countries and recommendations in these areas are beyond the scope of Health Inc. Yet without these improvements, SHP programmes such as the NHIS, RSBY and Plan Sesame will not succeed. Purchasing health services effectively to ensure that funds are available at the provider level is another key reform needed in all the schemes. Again, the details of these reforms are beyond the scope of Health Inc. Meanwhile, Health Inc has shown that socially inclusive, administratively simple forms of targeting as well as tailored IEC to inform targeted beneficiaries of free or subsidised services are crucial reforms needed to expand coverage which require considerable investment and capacity building. These should be key areas of intervention for policymakers, with the goal of contributing to profound social, political, economic and cultural transformations needed to overcome deeply embedded processes of social exclusion. If countries do decide to persevere with the steps of enrolment and providing SHP cards to beneficiaries, these processes similarly need to be underpinned by considerable investment and capacity building in order to overcome deeply embedded processes of social exclusion.

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Endnote

[i] This chapter draws extensively on and summarises the previous chapters in this book, as well as the broader work of the Health Inc project.

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