Health Insurance for Informal Sector

Case Study of Gujarat

This pilot study explores the availability of health insurance coverage for the poor and especially women, their needs and expectations of a health insurance system, and the likely constraints in extending current health insurance benefits to workers in the informal sector. The ESIS has substantial scope for improvement of its services, particularly better utilisation of its facilities. The survey shows that the poor prefer public sector management of health care facilities.

ANIL GUMBER, VEENA KULKARNI

It is estimated that about two-fifths of India's GDP originates from the informal sector and almost 90 per cent of families depend on this sector for their livelihood. Despite this fact, a large number of workers engaged in the informal sector in both rural and urban areas are illiterate, poor and vulnerable. They live and work in unhygienic conditions and are susceptible to many infectious and chronic diseases. These workers neither have fixed employer-employee relationship nor do they obtain statutory social security benefits [Ahmad et al 1991]. They do not have the bargaining power to fight discrimination and victimisation for protecting their right to a minimal standard of living.

The persistent poverty and disease syndromes have pushed the families of the unorganised sector workers into debt to meet their day-to-day contingencies, which certainly includes health care. The latter is the subject of this paper. The studies on the use of health care services show that the poor and other disadvantaged sections such as scheduled castes and tribes are forced to spend a higher proportion of their income on health care than the better off. The burden of treatment is unduly large on them when seeking inpatient care [Visaria and Gumber 1994; Gumber 1997]. The high incidence of morbidity cuts their household budget both ways, i e, not only do they have to spend a large amount of money and resources on medical care but are also unable to earn during the period of illness. Very often they have to borrow funds at very high interest rate to meet both medical expenditure and other household consumption needs. One possible consequence of this could be the pushing of these families into a zone of permanent poverty.

On the other hand, there are issues related to accessibility and use of subsidised public health facilities. A majority of the poor households, especially the rural ones, reside in backward, hilly and remote regions where neither government facilities nor private medical practitioners are available. They have to depend heavily on poor quality services provided by local, often unqualified practitioners and faith healers. Further, wherever accessibility is not a problem, the primary health centres are either dysfunctional or provide low quality services.

Overall about 6 per cent of the household income is spent on curative care which amounts to Rs 250 per capita per annum [Shariff et al]. The burden of expenditure on health care is however unduly heavy for households belonging to informal sector indicating a potential for voluntary comprehensive health insurance schemes for such sections of the society. It is estimated that only a small fraction (less than 9 per cent) of the Indian workforce is covered by some form of health insurance through central government health scheme, employees state insurance scheme and Mediclaim; a majority of the covered population belongs to the organised sector [Gumber 1998]. Further, the low level of health insurance coverage is due to the fact that government policies have been designed to provide free health services through the public sector. The reality however is that the public sector health agencies on the one hand charge for their services and on the other hand have a poor outreach both in terms of quantity and quality. Also, public insurance companies so far have paid very little attention to voluntary medical insurance because of low profitability and high risk coupled with deficient marketing and management strategies.

Hence a majority of the rural and urban slum population in India remains outside the health insurance system. This could be due to lack of information regarding available health insurance schemes or because the mechanisms used by the health insurance providers are not suitable to them. There is also a gender bias with men having better access to health care when compared to women due to socio-economic and cultural reasons. More specifically, poor women are most vulnerable to diseases and ill-health due to unhygienic living conditions, heavy burden of childbearing, low emphasis on their own health care needs and severe constraints in seeking health care for themselves. Institutional arrangements have so far been lacking in correcting these gender differentials. This study, undertaken on a pilot basis, attempts to explore some critical issues relating to the availability and needs of health insurance coverage for the poor and especially women, and the likely constraints in extending current health insurance benefits to workers in the informal sector.

The objectives of the study were: (i) to estimate the burden of health care expenditure on households, protected under varied health insurance environments; (ii) to assess the extent to which health insurance has helped in mitigating the burden; (iii) to estimate the demand for health insurance and willingness to pay for services; and (iv) to suggest an affordable health insurance plan for workers in the informal sector.

I
Methods and Materials

To achieve the objectives of the study, a primary survey of 1,200 households was undertaken in Ahmedabad district of Gujarat. The survey included households from four types of health insurance

enrolment status in rural and urban areas. About 360 households belonged to a contributory plan known as Employees' State Insurance Scheme (ESIS) for industrial workers. Another 120 households subscribed to a voluntary plan (Mediclaim) and 360 households were members of the community and self-financing scheme, which was run by a non-governmental organisation called Self-Employed Women's Association (SEWA).[1] The remaining 360 households were non-insured and were purchasing health care services directly from the market. This last subsample, namely, the non-insured households, was taken to serve as a control group. The idea of selecting such stratification was to understand the health care needs, use pattern and the types of benefits received by sample households protected under different health insurance environments. Also, the survey was designed to estimate the demand for health insurance and the willingness and capacity to pay for services across socio-economic categories of the households.

The survey was conducted in eight localities dominated by slum population in the city of Ahmedabad and six villages in the neighbourhood. On an average 60 households per village and 90 households per urban locality were selected. The selection criterion of a village or an urban locality was that the settlement should have a cluster of households benefiting from SEWA and ESIS plans. The sample canvassed from each of the settlements was such that it covered approximately equal number of households from the ESIS, SEWA and the non-insured categories (20 each from a village and 30 each from an urban locality). The sample was purposive and no house listing prior to the survey was carried out. On the other hand, the sample of Mediclaim/Jan Arogya beneficiaries belonging to Ahmedabad city was selected from the list of subscribers obtained from the offices of United India Insurance and New India Assurance.

The households subscribing to Mediclaim generally belong to the higher income strata and their average annual income was twice that of the households enrolled with SEWA and ESIS as well as that in the non-insured category. In the remaining categories the average household income of the ESIS households is marginally higher than SEWA and non-insured households in both rural and urban areas. Similar differentials are revealed in the average household monthly expenditure (Table 1).

In terms of major source of income a considerable proportion of both non-insured and SEWA households in rural as well as urban areas has earnings from self-employment and casual labour. As expected ESIS households are dependent on salary income mainly from the organised sector in both rural and urban areas. However, for Mediclaim households, beside salary income from the organised sector, self-employment and salaried jobs in the unorganised sector are equally important sources of income.

The literacy rate among the surveyed population is high in both rural and urban areas. The gender disparity in the literacy rates is much lower as compared to the 1991 census figures for the state as a whole for urban and rural areas. Interestingly, the literacy rate is very close to 100 per cent for both males and females among the Mediclaim households. In terms of economic activity, female participation is higher among the SEWA households in both rural and urban areas. As expected, the overall work participation rate is higher in rural than in urban areas.

II
Morbidity and Utilisation of Health Care Services

Before going into details of accessibility and use of health care services, let us discuss the health insurance coverage among the sampled households. The health insurance coverage is not mandatory for all the SEWA households. Only 47 per cent of rural and 66 per cent of urban SEWA households opted for the health insurance scheme. As the SEWA scheme is limited to woman members, the percentage of beneficiary population is just 11 in rural and 18 in urban areas. The proportion of sample population insured is between 82 and 86 per cent in the ESIS and 68 per cent in the Mediclaim categories (Table 2). Only a couple of households in the non-insured category benefit from medical reimbursement from their employers. On the average, insured persons among the SEWA households are paying an annual premium between Rs 70 and Rs 80; the figure for ESIS households is between Rs 126 and Rs 130 and for Mediclaim households it is Rs 221.

Table 1: Characteristics of Surveyed Population by Health Insurance Status

Characteristics	Rural			Urban			
	Non-Insured	SEWA	ESIS	Non-Insured	SEWA	ESIS	Mediclaim
Number of households	127	121	113	240	236	239	116
Main source of household income							
Self employed	37.0	43.9	2.7	26.2	22.9	0.4	29.3
Casual labour	36.2	35.6	1.8	28.8	18.7	–	0.9
Salaried – Organised	5.5	11.6	93.8	15.4	23.3	88.3	46.6
Salaried – Unorganised	19.7	8.3	1.8	27.5	34.7	11.3	20.7
Others	1.6	0.8	–	2.1	0.4	–	2.6
Mean household: annual income	31164	31182	36711	33537	37715	38197	79086
Mean household: monthly expenditure	2319	2299	2793	2484	2869	2887	5123
Mean household size	5.13	5.50	5.47	5.42	5.88	5.64	4.63
Literacy rate (aged 7+) (per cent)							
Males	89.3	86.3	94.0	87.7	87.1	90.0	99.6
Females	63.5	68.2	75.7	68.6	75.6	73.4	96.8
Total	76.6	77.0	85.1	77.9	81.4	81.8	98.2
Worker-population ratio (per cent)							
Males	54.0	53.7	48.8	49.5	50.5	50.8	56.1
Females	31.0	33.9	22.5	22.9	28.3	16.9	11.7
Total	42.8	43.9	36.7	36.2	39.4	33.8	34.1

Source: NCAER-SEWA Survey, 1999.

Table 2: Health Insurance Coverage among Surveyed Households

Characteristics	Rural			Urban			
	Non-Insured	SEWA	ESIS	Non-Insured	SEWA	ESIS	Mediclaim
Health insurance coverage							
Households (per cent)	3.1	47.1	100.0	4.6	66.1	100.0	100.0
Population (per cent)	2.5	10.8	82.5	3.3	17.7	86.1	67.6
Males	1.8	3.6	81.5	2.9	6.1	85.3	71.2
Females	3.2	18.1	83.7	3.7	29.6	86.8	63.9
Annual premium (Rs)							
Per household	4	44	525	5	77	540	648
Per capita	1	8	96	1	13	96	140
Per insured person	41	70	150	25	80	126	221

Source: NCAER-SEWA Survey, 1999.

To understand the health-seeking behaviour of the surveyed population, information was collected on three types of morbidity: acute morbidity (using 30 days recall period), chronic morbidity and hospitalisation (using 365 days recall period).[2] The incidence of acute morbidity is the highest for SEWA households among the three categories of SEWA, ESIS and non-insured for both males and females in rural and urban areas. The incidence of acute morbidity is the lowest among the Mediclaim households. All the three types of morbidity rates are higher for females as compared to males in almost all the population groups. For a meaningful comparison we have converted three types of morbidity into annual illness rate. On an average, the population is experiencing about two episodes of illnesses per year; the rate however is higher for SEWA households and lower for Mediclaim households. We have also asked the surveyed population how they rate their 'overall health status' in a scale ranging from very poor to excellent. As compared to rural, a higher percentage of urban population (very close to 90 per cent) has perceived their health status to be good or excellent. The rural-urban differentials are sharper for perceived health status than that emerged from the empirical morbidity rate (Table 3).

As expected, both in rural and urban areas the private sector has played a dominant role in providing services for ambulatory care (acute and chronic morbidity). Surprisingly, even the households covered under ESIS facility particularly in rural areas have relied heavily on the private facility for treatment of acute illnesses. The results clearly highlight the poor outreach of ESIS panel doctor, dispensary and hospital facilities for the rural insured households. In urban areas too, only a little over 50 per cent of both acute and chronic cases of the insured population are handled by the ESIS facilities. For rest of the population groups, there is some reliance on government hospitals for inpatient care (Table 4).

To estimate the total burden of treatment three types of cost are computed – medical cost, other direct cost and indirect cost. The medical cost includes expenses towards fees and consultations, medicines, diagnostic charges and other hospital payments. There are other kinds of out-of-pocket expenditures, which relate to accessing health care facility such as transportation, special diet, etc. While under-

Table 3: Morbidity Profile by Health Insurance Status of Household

Type of Morbidity	Rural			Urban			
	Non-Insured	SEWA	ESIS	Non-Insured	SEWA	ESIS	Mediclaim
Acute morbidity (last 30 days)							
Male	131	170	146	130	149	140	55
Female	152	209	145	165	181	167	94
Total	141	189	146	147	165	154	75
Chronic morbidity							
Male	45	33	37	38	53	53	37
Female	57	70	76	64	63	72	45
Total	51	51	55	50	58	62	41
Hospitalisation (last 365 days)							
Male	42	72	58	52	43	62	19
Female	57	48	87	67	74	54	19
Total	49	60	71	59	59	58	19
Annual morbidity rate*							
Male	1663	2146	1845	1652	1888	1799	720
Female	1937	2619	1907	2106	2305	2129	1192
Total	1796	2381	1874	1877	2095	1965	953
Percent reporting their overall health status as good/excellent	77.3	78.1	82.4	90.5	88.2	86.2	90.9

Notes: Morbidity rates are per 1,000 population.
* Annual morbidity rate = (Acute morbidity rate × 12) + Chronic rate + Hospitalisation rate.
Source: NCAER-SEWA Survey, 1999.

Table 4: Source of Treatment by Health Insurance Status of Household
(*Per cent*)

Type of Morbidity	Rural			Urban			
	Non-Insured	SEWA	ESIS	Non-Insured	SEWA	ESIS	Mediclaim
Acute morbidity							
Government	10.3	6.1	3.5	9.2	15.2	3.1	–
ESI facility	–	–	15.1	1.1	1.3	54.1	–
Private	89.7	93.9	81.4	89.7	83.5	42.9	100.0
Chronic morbidity							
Government	21.9	20.0	9.1	40.3	31.6	7.7	9.5
ESI facility	–	–	30.3	1.6	–	53.8	–
Private	78.1	80.0	60.6	58.1	68.4	38.5	90.5
Hospitalisation							
Government	40.6	27.5	29.5	51.9	50.6	14.5	10.0
ESI facility	–	–	20.5	1.3	2.4	64.5	–
Private	59.4	72.5	50.0	46.8	47.1	21.1	90.0

Source: NCAER-SEWA Survey, 1999.

Table 5: Cost of Treatment by Health Insurance Status of Household

Type of Morbidity	Rural			Urban			
	Non-Insured	SEWA	ESIS	Non-Insured	SEWA	ESIS	Mediclaim
Acute morbidity							
Medical cost	233	200	224	234	228	97	686
Other direct expenditure	77	62	69	48	54	49	152
Indirect cost	90	33	93	50	54	55	85
Net total cost	401	295	380	331	336	202	923
Chronic morbidity							
Medical cost	347	284	214	210	261	135	216
Other direct expenditure	115	81	215	56	51	74	43
Indirect cost	236	86	225	98	60	25	5
Net total cost	697	451	644	364	371	234	263
Hospitalisation							
Medical cost	2427	3072	2200	3246	2099	621	4045
Other direct expenditure	444	557	589	431	780	318	935
Indirect cost	631	694	305	439	413	206	464
Net total cost	3502	4323	3076	2954	3280	1146	4034

Note: Medical cost includes expenses towards fees, medicine, diagnostic and other hospital charges.
Other direct expenditure includes expenses on transport, special diet, etc.
Indirect cost includes loss of income of the ailing person as well as of the caring person and one year interest payment (at 24 per cent) on the amount borrowed during the course of treatment.
Net total cost is direct cost plus Indirect cost less reimbursement.
Source: NCAER-SEWA Survey, 1999.

going treatment there is a loss of income of the patient (if working) and/or of the caring person (if working). Sometimes the household has to borrow money at very high interest rate to meet treatment-related exigencies. All these account for indirect cost of treatment.

As nearly 90 per cent of rural households have used private facilities for the treatment of acute morbidity, the direct medical cost does not vary much by insurance status of households. However, the total cost of treatment varies within a range of Rs 295 and Rs 401 mainly due to differences in indirect costs of treatment (Table 5). The non-insured and SEWA households in urban areas have spent in a similar manner. However, the urban ESIS households are spending much less on treatment, because of availing of ESIS facility to a greater extent than their rural counterparts. The Mediclaim beneficiaries are spending three times more than the non-insured or SEWA households.

In the case of treatment of chronic illnesses, the expenditure per episode is higher than that of acute illnesses in both rural and urban households. Surprisingly, the rural households have spent about 50 per cent more on treatment of chromic illnesses compared to acute illnesses whereas for urban households it is just 10 per cent higher. The reason for such differences could be delays in seeking treatment by the rural households and thus raising the indirect cost of treatment. This fact is also reflected in the case of hospitalisation. Further, the indirect cost of treatment for both chronic and hospitalisation episodes is higher among rural patients as a relatively higher percentage of them have reported loss of income as well as amount borrowed in the course of treatment than their urban counterparts. Thus, in several population groups indirect cost of treatment turns out to be substantial (between one-fifth to one-third of the total cost) for seeking ambulatory and/or inpatient care. Another observation worth noting is that the average cost of treatment is lower among the urban than the rural patients irrespective of health insurance status.

In the survey the details of use of maternal and child health services (antenatal care, delivery, postnatal care and child immunisation) were recorded from a married woman who had reported delivery during the two years before the date of survey. About 98 per cent of urban women and 93 per cent of rural women used antenatal services. Here once again the private sector has played a significant role in providing such services. More than 50 per cent of women had incurred expenditure while seeking antenatal care. On an average the expenditure per reporting case was Rs 679 for a rural woman and Rs 691 for an urban woman (Table 6).

The share of institutional delivery was only about 47 per cent among the rural women as compared to 77 per cent among urban women. In the latter cases, it is the government hospital where the highest proportion of deliveries took place. For rural women, however the percentage of deliveries taking place in government hospitals was 20.8 per cent, lower than the private hospital where the corresponding figure was 26.4 per cent. Also, 54 per cent of the deliveries in the rural sample were assisted by a trained mid-wife or a nurse. The average expenditure on delivery was higher for urban than rural woman. The difference in expenditure is larger in the 'other expenses' category than the 'institutional payments' category.

Majority of women were not availing of the postnatal care services and surprisingly the number was higher among urban women. In the sample villages, government dispensary/clinic seemed to be most sought after followed by primary health centre or community health centre. In urban areas, it was the private hospital where a higher number of women used the facility. As far as the immunisation status is concerned, most of the children were immunised against six diseases and almost all against five diseases (excluding measles) in both rural and urban areas. Here government clearly dominated in providing such services free of cost.

The average total expenditure on using various MCH services during the last two years turned out to be Rs 2,128 per rural woman and Rs 2,653 per urban woman. The higher total expenditure for the urban woman was mainly due to other out-of-pocket expenditures (Rs 1,066 per urban woman as opposed to only Rs 668 per rural woman).

The total burden of out-of-pocket expenditure on households is estimated while taking into account three types of expenditures namely, per capita annual expenditure on treatment of illnesses, use of MCH services and health insurance premium. The per capita expenditure on treatment was higher for rural households irrespective of health insurance status. In urban areas the per capita out-of-pocket expenditure among both ESIS and Mediclaim beneficiaries was lower than that among the non-insured and SEWA households (Table 7). Among three categories of households common to rural and urban areas, the average expenditure

Table 6: Use Pattern of Maternal and Child Health Care Services

Type of Service	Rural	Urban
Number of women reported delivery during last two years	87	213
I Antenatal Services		
Source: Public	43.7	51.7
Private	49.4	46.0
Did not use	6.9	2.3
Expenditure on antenatal services		
Per cent reported institutional payment	57.5	61.5
Per cent reported other expenses	50.6	62.9
Average institutional payments per reporting case	608	640
Average other expenses per reporting case	266	323
Average total expenses per reporting case	679	691
II Delivery		
Place: Home	40.2	17.4
Government institution	20.8	42.7
Private institution	26.4	34.7
Other places	12.6	5.2
Expenditure on delivery		
Per cent reporting institutional payment	71.3	69.5
Per cent reported other expenses	75.9	81.2
Average institutional payments per reporting case	1366	1628
Average other expenses per reporting case	595	1017
Average total expenses per reporting case	1494	2004
III Postnatal services		
Source: Public	26.5	9.4
Private	11.4	10.8
Did not use	62.1	79.8
Expenditure on postnatal care		
Per cent reporting institutional payment	24.1	10.3
Per cent reported other expenses	21.8	12.7
Average institutional payments per reporting case	533	492
Average other expenses per reporting case	371	290
Average total expenses per reporting case	730	518
IV Immunisation of children		
Number of surviving children	82	210
Per cent immunised for: DPT	92.6	94.8
Polio	100.0	97.6
BCG	96.4	96.1
Measles	74.4	85.7
Per cent used private facility for:		
DPT	3.6	14.7
Polio	3.6	14.2
BCG	3.6	14.7
Measles	2.4	13.3
Per cent reported expenditure		
Average expenses per reporting case	2.4	7.1
Average expenditure on MCH	360	154
Institutional payments	1460	1587
Other expenses	668	1066
Total expenses	2128	2653

Source: NCAER-SEWA Survey, 1999.

on treatment of morbidity for rural households in the non-insured, SEWA and ESIS categories was higher by 27, 7 and 102 per cent, respectively, than their urban counterparts. When one converts the average expenditure on treatment as proportion of income (burden of treatment), the rural-urban differences increase further (because of lower levels of income in the rural areas).

The burden of treatment ranged between 16 and 19.1 per cent for rural households and between 4.7 and 17 per cent for urban households. Overall, the burden of treatment turned out to be the lowest for Mediclaim and the highest for rural SEWA households. If we include the expenditure on MCH and insurance premium then the burden increases further. The increase was higher among ESIS households mainly due to regular contribution towards health insurance. The burden of total health care costs varied between 18 and 21 per cent in three categories of rural households and the corresponding range for urban households was 10 and 18 per cent. Although the Mediclaim households have spent the highest amount per illness episode, as having reported the lowest incidence of illness, the annual per capita expenditure turned out to be small; and as a result the burden was just 6 per cent of their income. On the contrary, the SEWA households were bearing the highest burden in both rural and urban areas.

III
Expectations

Over 92 per cent of the non-insured households in both rural and urban areas have no awareness about the existing health insurance schemes (Table 8). This is despite living in the neighbourhood of ESIS and SEWA households. Further only a minuscule number of insured households were aware of other insurance plans available in the market. When we told them about the various plans, almost all of them showed interest in joining it. The SEWA plan turns out to be very appealing not only among the non-insured but also among the insured households. Further, the Jan Arogya plan was preferred over the Mediclaim plan mainly because of lower premium.

We asked the respondents about their expectation from a new health insurance scheme in terms of influencing factors to subscribe, types of benefits coverage, type of management preferred, types of costs coverage, types of additional benefits, amount of premium willing to pay for each additional benefit, and mode of premium payment.

As far as broad expectations from a new health insurance scheme are concerned, among rural households the coverage of all illnesses and timely attention seem to be paramount (Table 9). Among the urban households, however it is the price of insurance scheme that seems to be the most important factor considered for determining enrolment. Among the specific medical care benefits, coverage of hospitalisation expenditure is desired by more than 90 per cent of the respondents in both rural and urban areas. Hospitalisation being expensive, there is strong demand for the coverage of the costs among the respondents. To quantify, coverage of hospitalisation expenditure is desired by more than 90 per cent of the respondents in both rural and urban areas. The coverage includes fees, medicines, diagnostic services and hospital charges in rural areas. The urban respondents expect specialist consultation (as part of the coverage of hospital expenses).

Also about 50 per cent of households expressed the coverage of expenses for transport in the plan. The expectation of coverage of outpatient department (OPD) services and MCH follows next. The availability of OPD facilities at government hospitals rather than at dispensaries and clinics is a better way of providing coverage towards expenses incurred for OPD health care. Among the coverage of additional benefits, life insurance coverage was desired most by households in both rural and urban locations. Personal accident, permanent disability compensation, provision of cash benefits, and reimbursement of wage/income loss follows this. It is worth noting that all three household types and Mediclaim subscribers follow this preference pattern, the figures pertaining to the latter vary significantly. There are 73.3 per cent of responses which want inclusion of the life insurance coverage as an additional benefit whereas for the rest of the urban households the corresponding figure hovers around 87 per cent.

It is not that the respondents expect the above mentioned health insurance services free of charge. The rural respondents are willing to pay an annual per capita premium between Rs 80 and Rs 95 for the

Table 7: Out-of-Pocket Expenditure on Health-Care by Health Insurance Status

Indicator	Rural			Urban			
	Non-Insured	SEWA	ESIS	Non-Insured	SEWA	ESIS	Mediclaim
As per cent of per capita income	968	1036	868	888	966	438	855
Direct	280	196	286	167	191	131	87
Total (net)	1247	1232	1149	981	1156	569	905
As per cent of per capita income	19.1	20.4	16.0	14.6	17.0	7.9	4.7
Average annual health insurance premium by household	9	44	523	7	74	538	648
Average expenditure on MCH	492	577	466	722	659	709	576
Burden of total healthcare costs on households (per cent)	19.9	21.4	17.9	15.6	18.0	10.1	5.7

Notes: Expenditure on MCH has been incurred during the last two years.
Burden is estimated as the sum of per capita expenditures on (a) treatment of morbidity; (b) maternal and child health care; and (c) health insurance premium, and divided by per capita income.
Source: NCAER-SEWA Survey, 1999.

Table 8: Health Insurance Awareness by Health Insurance Status of Household

Indicator	Rural			Urban			
	Non-Insured	SEWA	ESIS	Non-Insured	SEWA	ESIS	Mediclaim
Per cent reporting awareness							
None	93.0	43.0	0	91.7	26.7	0	0
Mediclaim	2.3	2.5	1.8	0	0	0.8	98.3
ESIS	1.6	4.1	100.0	1.7	3.8	97.9	1.7
SEWA	1.6	54.6	1.8	2.9	71.2	2.1	0
Other plan	1.6	2.5	0.9	5.0	2.5	0	0.9
Per cent willing to join							
None	8.1	13.9	–	6.1	5.3	–	–
SEWA	79.8	80.0	53.1	82.6	80.0	66.5	37.1
Mediclaim	24.2	10.8	25.7	26.5	26.7	37.7	58.6
Jan Arogya	30.7	18.5	30.1	43.5	46.7	43.1	31.0

Note: Percentages do not add to 100 because of multiple response.
Source: NCAER-SEWA Survey, 1999.

coverage of services of hospitalisation, chronic ailment, specialist consultation and the like (Table 10). Further, with the coverage of the costs (such as fees, medicine, diagnostic charges, transportation, etc) the respondents are willing to pay an amount that is higher by 16 per cent. For additional benefits (such as life coverage, personal accident, etc) however the respondents are willing to pay an additional amount that is higher by around 7 per cent when compared to the amount that they are willing to pay for coverage of costs. The urban respondents (barring Mediclaim beneficiaries) are willing to pay an amount ranging from Rs 82 to Rs 84 by type of coverage of services. In addition to the above services, the respondents are willing to pay an amount higher by 13 to 25 per cent for the coverage of costs and further 11 to 14 per cent more for the coverage of additional benefits. The corresponding percentages for the Mediclaim beneficiaries are 23.5 and 19.5.

The preference for the type of management for a new health insurance scheme varied by the place of residence. A substantial proportion of the rural respondents preferred management by non-governmental organisations (NGOs); the next to follow was public hospital based management. Also, a section of the rural respondents are of the opinion that village level institutions such as panchayat should be delegated the responsibility of running the new heath insurance scheme. In the urban locations too, with the exception of Mediclaim beneficiaries, management by NGOs is most preferred. Public insurance company management follows it. Thus, it is quite clear that most of the low income households have faith in the public system for delivering of services.

Among the factors which determine the success of the scheme, the 'coverage of additional benefits' scores the most both in rural and urban samples. The SEWA beneficiaries are in particular interested in coverage of additional household members. The other factors are 'better delivery and management' and 'premium related' factors. In urban areas, more than the 'premium related' factors, it is the provision of 'better benefits' which determines the success.

IV
Policy Implications

This study addresses some critical issues with regard to extending health insurance coverage to poor households in general and those working in the informal sector in particular. These issues have become extremely important in the current context of liberalisation of the insurance sector in India. There is no doubt that health insurance will be one of the high priority areas as far as consumers, providers, and insurance companies are concerned. However, developing and marketing of unique and affordable health insurance package for low income people would be a great challenge.

First of all, there is strongly expressed need for health insurance among low income households in both rural and urban areas. This need has arisen primarily because of heavy burden of out-of-pocket expenditure on them while seeking health care. Despite a significant reliance on public health facilities, the poor households tend to spend

Table 9: Expectation from New Health Insurance Scheme

Types of Expectations/ Preferences	Rural			Urban			
	Non-Insured	SEWA	ESIS	Non-Insured	SEWA	ESIS	Mediclaim
Per cent of households reported	91.3	96.7	96.5	100.0	100.0	99.6	87.1
Influencing factors to subscribe							
Cheaper	48.8	49.6	41.6	75.8	74.2	79.5	57.8
Quality	35.4	37.2	41.6	64.6	63.1	57.7	37.9
Nearby/accessibility	40.9	37.2	37.2	60.4	59.7	64.0	59.5
Timely attention	51.2	49.6	52.2	49.6	57.2	50.6	41.4
Coverage of all illnesses	67.7	61.2	58.4	60.0	64.0	64.9	62.1
Coverage of all services	27.6	24.0	33.6	25.0	30.5	25.9	22.4
Community managed services	1.6	0.8	–	1.7	2.1	1.3	–
Coverage of Benefits							
Hospitalisation	90.6	93.4	91.2	100.0	100.0	99.6	85.3
Chronic ailment	82.7	88.4	83.2	99.6	98.7	99.2	82.8
General OPD	76.4	78.5	79.6	99.2	99.2	99.2	84.5
Specialist consultation	75.6	74.4	70.8	99.6	98.7	99.2	83.6
Reproductive and maternity care	68.5	79.3	62.8	95.8	97.5	97.1	81.0
Per cent reporting mode of premium payment on an annual basis	77.6	65.8	73.6	67.1	64.3	69.7	78.8
Type of management preferred							
Public hospital based	29.9	29.8	25.7	14.2	11.4	17.6	25.0
Private hospital based	2.4	9.9	8.0	0.8	–	–	15.5
Public insurance company	12.6	12.4	21.2	25.0	17.4	26.8	13.8
Private insurance company	2.4	2.5	3.5	8.3	–	0.8	11.2
Through bank/financial institution	20.5	25.6	23.9	18.3	19.5	24.7	23.3
Village level/panchayat	9.5	6.6	8.0	–	–	–	–
NGOs	33.1	38.8	27.4	45.4	54.2	40.2	5.2
Factors for Success of the Plan							
Coverage of all benefits	23.6	28.9	22.1	25.4	21.6	32.6	22.4
Coverage of additional benefits	6.3	20.7	15.0	7.1	8.9	5.9	0.9
Better delivery and management	15.0	17.4	21.2	9.6	10.6	13.0	0.9
Premium related	15.8	18.2	18.6	13.8	12.3	13.4	13.8
Quick settlement of claims	3.9	2.5	7.1	3.3	2.1	1.3	4.3
Better benefits	10.2	8.3	8.0	29.6	24.6	21.8	22.4
Others	15.8	14.9	13.3	15.8	19.9	20.9	16.4

Source: NCAER-SEWA Survey, 1999.

Table 10: Acceptable Average Per Capita Premium New Health Insurance Scheme

	Rural			Urban			
	Non-Insured	SEWA	ESIS	Non-Insured	SEWA	ESIS	Mediclaim
Stage 1: After asking type of service to be covered	80.4	82.6	95.3	82.1	83.3	84.1	206.5
Stage 2: After enlisting types of costs to be covered	93.5	98.2	111.0	93.1	95.8	105.1	255.1
Stage 3: After enlisting types of additional benefits to be covered	100.4	99.8	118.9	103.9	102.9	120.2	304.2
Percentage change from							
Stage 1 to 2	16.3	18.9	16.5	13.4	15.0	25.0	23.5
Stage 2 to 3	7.4	1.6	7.1	11.6	7.4	14.4	19.2
Stage 1 to 3	24.9	20.8	24.8	26.6	23.5	42.9	47.3

Notes: Types of services include coverage of hospitalisation, chronic disease, general OPD, specialist consultation and maternity care.
Types of costs include coverage of expenses towards fees, medicine, diagnostic service, hospital charges, specialist consultation and transportation.
Types of additional benefits include coverage of life insurance, personal accident, permanent disability benefits, reimbursement of wage/income loss, etc.

Source: NCAER-SEWA Survey, 1999.

nearly one-fifth of their income on treatment. Even among the fully insured households under the ESIS, the burden is unduly large particularly among rural households. This clearly reflects large scale inefficiency operating in the delivery of services by both government and ESIS sectors.

The ESIS with its large infrastructure has substantial scope for improvement, especially through the introduction of private initiatives. The latter can be of the nature of opening underutilised facilities to the general public against nominal charges, allowing private practitioners to use labs, radio-diagnostic services, operation theatres, evening OPDs, etc. The panel doctors can be replaced with mobile facilities. This will specially benefit the rural population since most of them are affiliated to the panel doctors who are very irregular in delivering the services. There are in fact, instances of such initiatives being undertaken in some of the ESIS hospitals. A recent World Bank study suggests some more drastic options too, like the separation of the health service delivery function (of ESIS) from the cash benefits component. Over time, the health service delivery elements of ESIS can be transferred to a separate state – owned entity, which may be privatised fully at a later point in time. These steps could both improve the quality of health care services as well reduce corruption in the area of issuing cash compensation [Naylor et al 1999].

The Mediclaim, which is at present the only public sector health insurance scheme, too will have to gear up if it wishes to remain in the race. There is ignorance regarding the scheme. Jan Arogya Bima policy, which is one of the schemes (of the General Insurance Corporation) specially designed for the low income group people, is not known to the majority. The other areas where there is scope for improvement is the coverage of problems such as those related to ophthalmic and dental care, making the process of filing claims easy, and quick settlement of claims.

While measures for improvement in the ESIS and the Mediclaim programmes are a necessity, these will continue to cover a small proportion of the population. There are many other emerging issues as far as future health insurance schemes are concerned. The expectations of low income households from a new scheme indicate that coverage of illnesses, coverage of services, amount of the premium to be paid as well as procedural aspects such as filing claims are critical in the decision to buy an insurance. A strong preference for SEWA type of health insurance scheme reinforces that the beneficiaries desire a system, which is not only affordable but also accessible in terms of easy settlement of claims and other related administrative procedures. The range of services expected to be covered include hospitalisation, maternal and outpatient facilities.

As far as the management of a health insurance scheme is concerned, the responses indicate a preference for some version of community financing. It appears that a scheme where the disbursement of services will take place from a public sector hospital with monetary contribution from the beneficiaries will be in demand. A privately managed health insurance scheme was among the least preferred ones. In rural areas, a preference for the management of health insurance schemes by panchayats was also cited.

Finally, the need for education for rural and urban populations alike on the concept of insurance and information on health insurance is a crucial aspect in extending health insurance coverage on a large scale. This study demonstrates that while there is great interest, the concept of health insurance and paying for a service which may or not be availed of is new to low income people. This calls for effective information, education and communication activities which will improve understanding of insurance by the public and hence help in developing a market for health insurance. EPW

Notes

1 Since 1992, SEWA has introduced a unique integrated insurance plan to their woman members mainly engaged in petty occupations. By just paying Rs 65 as premium, a poor woman gets coverage for health and maternity benefits, life coverage and asset insurance.

2 For a detailed discussion on measurement of self-perceived morbidity, see Gumber and Berman (1997).

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