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Health Insurance for Informal Sector Workers

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Background

Vulnerability and risk among informal sector workers

Work and social security are the central concerns of the poor in our country. Most of our nation's poor or almost 400 million workers are engaged in the informal economy, also called the informal or unorganized sector.
Among these workers, women are the poorest and most vulnerable of all. Their lives are marked by a struggle to attain basic security of employment and livelihood with social security.

The quest to overcome vulnerability and obtain some protection from the many risks and shocks they face has to be understood all across women's life cycles, as at any time they face one or more risks. Some of these are described as below.

Childhood :

In the Indian context, being a female foetus is itself a risk. The women's and community health movements have been trying to ensure that, first and foremost, the girl child is born. This involves working with women, men and indeed families to change age-old cultural norms and deeply-held beliefs, a slow but essential aspect of social change.

Sickness is the biggest risk faced by all infants and young children in India. High levels of morbidity and mortality continue to characterise the nation's health patterns. And accidents, particularly in the absence of proper child care, also take their toll.

Adolescents :

After the critical first five years, sickness and accidents are risks faced by all children and adolescents. The girl child has a particularly low nutritional level for various socio-cultural reasons, and is often anaemic. This low nutritional status puts her at higher risk than her male counterparts, especially as most girls still marry early and become young mothers.

Adulthood :

As adults, women face a number of risks, both acute and chronic. Their menfolk also suffer from these as well, but country wide experience points to the fact that women have to suffer the impact of these to a greater extent, as they are poorer and more socially disadvantaged than their men.

For the purposes of clarity, in this analysis it is advisable to separate acute and chronic risks. In reality, however, these may not be so easily teased apart, and generally have a synergistic effect.

Examples of acute risks: sickness, maternity, death, accident, natural disasters like floods and earthquakes, human-made crises like ethnic violence.

Examples of chronic risks: sickness, physical disability, unemployment.

There are many more that could be added to the list, including, in particular, the vagaries of the marketplace with fluctuating demand and prices for the products and services offered by the poor.

Old age :

Old age is another period fraught with risk. With little to fall back upon in terms of savings and pension, older women (and men) with a life-time of hard labour behind them have to confront sickness and the cumulative effect of occupational hazards like dust or chemical-related illnesses like cancers. They are dependent on the earning members of their families for support and assistance to counter such risks.

We have seen over the years that these risks are frequent, and often occur simultaneously, increasing a woman's vulnerability manifold. And always it is the poorest and most vulnerable who have to bear the consequences of the multiple risks they face to a greater extent. The women who are heads of their households, including widows and single mothers, most often face the greatest risks.

To sum it up then, among poor working people, and especially women, risks are varied and frequent at all stages of their lives, contributing to their vulnerability and continuing poverty.

Coping with shocks and women's risk management strategies :

Women workers have devised their own systems to cope with the many risks in their lives. Some of them may be mentioned, others will be added as a result of the exposure experience. The first and now most well-known of these is savings. Contrary to what was widely believed a few decades ago, all women save and use their savings for a variety of purposes, including coping with risk – paying for medical expenses, funeral costs, or a leaking roof.

The system of "Vishi", or contributing to a central pool of money which is then drawn upon by a few of the contributors in times of need, is yet another kind of risk management, developed by women themselves.

Borrowing from family, neighbours, friends and moneylenders is also part of women's crisis management strategies, though often at a high social and economic cost.

Finally, payment in kind for risk management services provided by midwives or traditional healers, for example, as per the traditional jajmani system, is also part of coping strategies. Often these payments are deferred to the post-harvest period with the unwritten understanding of all concerned.

Insurance :

- **National insurance programmes**

  One of the relatively new systems of risk management among and for the poor in India is insurance. For some years now, the government has been trying to provide some risk coverage for poor families, especially those below the poverty line. This coverage with subsidised premiums has been through the nationalised insurance companies and both for life and non-life coverage. The Life Insurance Corporation of India (LIC) has even developed a corpus of Rs. 800 Crores to be used for insurance for the poor.

  However, the nationalised insurers have, for their part, been unable to cover a sizeable number of India's working poor. With an informal and largely uncovered workforce of almost 400 million, the task is a formidable one indeed.

- **Health Insurance**

  Health insurance is the most urgently required of all insurance coverage for the poor. Women workers across the country time and again express it as the cause of the maximum stress in their lives—i.e. sickness is the number one stressor. It also causes indebtedness and leads to decapitalisation. And among the poor sickness is a common event leading to expenditures ranging from Rs 300 per month in urban slums (Source: Study by SEWA's Social Security Team) to Rs 800 per episode of illness(Source: SEWA Academy Research Team).

  While some coverage for sickness mainly hospitalization, is the most pressing need of the poor, it is also the most complex risk to cover. There are many reasons for this including their access to health care (whether they have access at all both for geographical and economic reasons), the high cost of private health care which has a bearing on the viability of health insurance, and the fact that the world over, health insurance is prone to fraud.

  Small but significant experiences of health insurance for the poor, both in India and abroad, reveal that coverage is indeed possible, if certain critical issues are taken in to account. The most important of these issues is developing a mechanism of implementation that is specially tailored to the reality of the poor, and organized according to their convenience.

  Another contentious issue is the fact that most of our people 80% seek care with private providers. And the private health sector is unregulated especially in terms of standardizing regimens, fees and diagnostic tests. It is a growing sector. And costs are escalating in a manner that is leading to greater indebtedness of the mass of our nation's people.

  SEWA's experience based on insuring over 106,000 workers and their families over fourteen years (See Appendix) suggests that for health insurance to be viable, it has to be controlled and run by the users themselves, the very women who are the insureds. Their organization then negotiates fees, treatment regimens etc.with providers, both public and private. And those providers that adopt poor quality of

care or fraudulent practices are black-listed. This has already had the effect of providers improving the quality of their care and revising some of their prices.

It has also resulted in the public health system gearing itself up to provide the care required, with the public charitable trust hospitals serving as a back up or alternative to the public and private-for-profit health providers.

Finally, our experience with health insurance has encouraged us to develop "cashless" systems with providers, both public and private, enabling women and their families to seek quality care of their choice without having to pay upfront immediately. This new system will soon be tested out in eight talukas in Gujarat, as well as two working class neighbourhoods of Ahmedabad city.

All of the above experiences point to the need to develop appropriate mechanisms to reach health insurance to the poorest. But first let us see what package we can suggest, based on affordability for both workers and the government.

Our experience points to the need for a comprehensive insurance package covering both life and non-life. This is advisable both because a holistic approach to risks and shocks faced by the poor is required, and also because this will lead to overall viability of insurance for the poor.

Further, maternity benefits of Rs.500 per pregnancy and for all pregnancies must be provided to all poor women. No extra premium is required. It is built into the package outlined below.

Finally, the health coverage should include hospitalization for complications during pregnancy. Caesarian section, however, may not be covered at this stage.

Health insurance and life package is suggested below:

HEALTH & OTHER INSURANCE FOR BPL (Per insured)

Cover	Worker contribution in Rs. towards premium	GOI contribution in Rs. towards premium	Total Premium (Rs.)	Sum Insured (Rs.)
Life	-	24	24	5000
Health (Hospitalization)	-	130	130	14000
Asset	-	15	15	10000
Personal Accident (PA)	-	6	6	40000
Administration & Marketing	25	25	50	-
Total	25	200	225	-

N.B :

- The above is based on discussion and rates offered by some insurers (Life and Non - Life)
- In case of BPL families, a worker will contribute only Rs. 25/- towards Administration and Marketing.

CHILDREN'S HEALTH INSURANCE FOR BPL (as an option)

Cover	Worker contribution in Rs. towards premium	GOI contribution in Rs. towards premium	Total Premium (Rs.)	Sum Insured (Rs.)
Health (Hospitalization)	20	80	100	2000
Administration & Marketing	-	-	-	-

N.B :

- Children between 3 months– 18 years of age only will be covered.
- Covers all children in the family with one sum insured limit (i.e. Rs.2000)

HEALTH & OTHER INSURANCE FOR APL (Per insured)

Cover	Worker contribution in Rs. towards premium	GOI contribution in Rs. towards premium	Total Premium (Rs.)	Sum Insured (Rs.)
Life	24	-	24	5000
Health (Hospitalization)	30	100	130	14000
Asset	15	-	15	10000
Personal Accident (PA)	6	-	6	40000
Administration & Marketing	25	25	50	-
Total	100	125	225	-

N.B :

- The above is based on discussion and rates offered by some insurers (Life and Non - Life)

CHILDREN'S HEALTH INSURANCE FOR APL (as an option)

Cover	Worker contribution in Rs. towards premium	GOI contribution in Rs. towards premium	Total Premium (Rs.)	Sum Insured (Rs.)
Health	100	-	100	2000
Administration & Marketing	-	-	-	-

N.B :

- Children between 3 months– 18 years of age only will be covered.
- Covers all children in the family with one sum insured limit (i.e. Rs.2000)

- **Implementation mechanism**

Despite the several insurance schemes developed by both government and private insurers, the outreach of these has remained very limited. There are various reasons for this including the appropriateness and affordability of the schemes. But in our experience, the most important reason is that appropriate mechanisms for both premium collection and claims servicing have not been developed. These have to be developed, as was mentioned earlier, according to the needs and suitability to local people, especially women.

The main issue is one of trust—the poor will not part with their hard-earned money as premium unless they are sure that this amount is in safe hands, and will deliver the service that they so desperately need. Even if premium is not collected, as in many government insurance schemes, the poor have great difficulty in navigating the various procedures and providing the documents required. Even after they carefully collect all the documents, the actual receipt of claims payments may or may not occur for a whole host of reasons. Often it is too difficult for them to spare the time and money to comply with insurers' requirements. And then frequent follow-up visits and even leakages are a problem.

For all these reasons then, we suggest that the government link up with local organizations: unions, self-help group associations, mahila mandals, cooperatives, farmers' or youth clubs and NGOs to ensure that the health insurance service actually reaches the poor, and at their very door-steps.

The government should consider pilot-testing this new, door-step approach to health insurance with a few organizations mentioned above and in a few select districts or states in the country. Criteria will have to be developed to ensure the reliability and accountability of partners. These could be worked out by a small, experienced working group like the one currently set up by the Ministry of Finance (financial sector). This group has already developed some criteria to ensure that "fly-by-nighters" are kept out.

We suggest the following implementation mechanism based on practical experience, and our ongoing discussions with the government of Gujarat's health department.

1. The list of BPL families will be provided to the organisation by the concerned district and municipal authorities. Based on the above numbers, the Government of India, GOI, will give the organisation a fund to cover these families' premium at the rate of Rs. 200 per individual. The organisation will meanwhile collect premium from these and other APL women and their families. The GOI's contribution for APL families will be Rs.125 per person. Receipts to each and every insured woman will be given by the organisation.

   The organisation will retain copies of the receipts for its own computerized data base and provide one to the government.

2. The organisation will offer the coverage shown earlier through insurers.

3. The organisation will forward the lists of insured members and the required premium to the insurance companies, both private and government. It will negotiate for the best possible price of premium from these insurers, in

consultation with the GOI's and state health departments. The local organisation will liaise regularly with the insurers.

4. The local organisation will take the responsibility of educating the insured families about insurance and the benefits available, procedures involved and the documents required. It will undertake all the promotional work like gram sabhas, small meetings and workshops on insurance, preparing literature and posters, video films and street theatre teams to promote insurance.

5. The organisation will cover all the children from BPL and APL families as an option. The organisations will encourage adolescent girls and boys, women and men to adopt the small family norm and to avail of the government's public health services, including immunization.

6. The collection of claims papers and all relevant documents and their timely processing will be the responsibility of the organisation. The organisation will forward claims promptly to insurers. Alternatively, if experienced, it will have its own claims committee. Periodically, insurers and government representatives will participate in the claims-processing and also audit all records. Disbursement preferably by cheque will be undertaken at women's very doorsteps. Their signatures will be taken for the records. The GOI and state governments will instruct local banks to make special arrangements for encashing cheques, so that the time and money of poor, working people is not wasted. Post offices can also be pressed into service for disbursing claims.

7. The GOI and state governments auditors and functionaries of the health department will have full access to records pertaining to this collaboration. Meanwhile, all the organisations records will be subject to internal as well as external audit.

8. The data base for this collaboration will be maintained by the local organisation and will be assisted by the insurers and the GOI and state government.

9. Monthly reports on coverage, claims disbursed time taken and all financial statements will be provided to GOI and the state government. Quarterly progess meetings will be held with the GOI and the state government.

10. This collaboration can be reviewed after a period of a year, with a view to making the necessary amendments and extending it to other districts, so that within the shortest possible period, all of our nation's poorest citizens have health insurance coverage.

If the above collaboration mechanism is approved of by the GOI and the states, then an MOU to this effect will be signed with a definite work plan and time schedule for release of funds from the GOI and the states.

The partnership will be the first of its kind, and by building on the strengths of each partner, will help reduce risk due to sickness for our country's poorest citizens.

Appendix

VimoSEWA (SEWA Insurance) – a case study

The Self-Employed Women's Association (SEWA) has been organizing women workers into their own union for over three decades now. Our combined, all – India strength is 7,00,000. SEWA has also established its own cooperative bank, SEWA Bank, in 1974.Our Bank then developed insurance in partnership with the insurance companies in 1992.Both life and non-life coverage has been offered to women, and they also have the option of insuring their husbands and children.

In the year 2000,with the steady growth of SEWA Insurance, SEWA decided to develop this as a separate unit within our union. Our goal was to build an insurance cooperative on the lines of SEWA Bank. Further, with the deregulation of the insurance sector from 1999 onwards, we sensed an opportunity to develop an insurance cooperative owned and managed by women workers themselves, on the lines of several already well-established cooperatives and producers' associations promoted by SEWA.

Since the year 2000, we have also initiated an ongoing dialogue with the government of India and the Insurance Regulatory and Development Authority (IRDA),on the extension of insurance services to the poor, and through their own organization—an insurance company or cooperative. Elaben Bhatt, SEWA's Founder, has been on the IRDA's advisory committee for several years now. In recent years, the IRDA has agreed to permit cooperatives to undertake insurance.

Since the year 2000,SEWA's insured membership has more than trebled from 29,000 to the current 1,06,000 today. Of our current insureds, 70,000 are women and the rest are their husbands and children, insured for sickness (hospitalization coverage). Most of our members are in the state of Gujarat, Madhya Pradesh, Bihar and Delhi. Sixty percent of them are rural members. This year, we will be including members from Uttar Pradesh, Rajasthan and Tamil Nadu. A steady annual increase in outreach of 15% is projected over the next ten years.

Current Outreach

Total Membership as on January 2004 – 106,479

a. Membership break-up

Annual members					
	Gujarat		Other states		Total
	Rural	Urban	Rural	Urban	
Women	28663	11610	5073	82	45428
Men	17237	6582	2234	15	26068
Total	**45900**	**18192**	**7307**	**97**	**71496**

Fixed-linked members					
	Gujarat		Other states		Total
	Rural	Urban	Rural	Urban	
Women	17665	8833	0	11	26509
Men	4342	2171	0	7	6520
Total	**22007**	**11004**	**0**	**18**	**33029**

Total Membership

Annual Membership	71496
Fixed-linked membership	33029
Total Membership	**104525**
Total Children	1954
Grand Total	**106479**

VimoSEWA's Integrated Insurance Schemes as on 1-1-2005

Scheme - 1				
	Member	**Spouse**	**Children**	**Total**
Annual Premium	100	70	100	**270**
Fixed Deposit	2,100	1,500	-	**3,600**
Natural Death	5,000	5,000	-	
Health (Hospitalization)	2,000	2,000	2,000	
Asset & Loss	10,000	-	-	
Accidental Death	40,000	25,000	-	
Accidental Death (spouse)	15,000	-	-	
Scheme - 2				
	Member	**Spouse**	**Children**	**Total**
Annual Premium	225	175	100	**500**
Fixed Deposit	5,000	4,000	-	**9,000**
Natural Death	20,000	20,000	-	
Health (Hospitalization)	6,000	6,000	2,000	
Asset & Loss	20,000	-	-	
Accidental Death	65,000	50,000	-	
Accidental Death (spouse)	15,000	-	-	

N.B :

1. Rs.20 discount would be given to member who are taking family package (member, spouse and child insurance).
2. Additional benefits for fixed deposit members:

(1) Maternity benefit : 300/- (2) Denture : 600/- (3) Hearing aid : 1000/-

3. Children's Health Insurance :
   a. Covers children of women members between 3 months to 18 years.
   b. Women and husband's is cover essential for taking children's insurance.
   c. Premium amount : Rs. 100/-
   d. Sum Insured : Rs. 2000/- for hospitalization (for total number of children and not per child)
   e. Premium covers all children in family irrespective of number of children per family.

VimoSEWA offers its insured members two different schemes, as shown above, from which they can choose, depending on their capacity to pay. Each covers a package of risks: sickness (hospitalization), personal accident, life, widowhood and asset loss. In both women are the policy-holders, and it is through them that their spouses and children are covered. The latter are optional and involve more payment of premium to cover the family members. Children's health insurance coverage is offered as an option since January 2003. Husbands' coverage includes sickness, life and accident.

To facilitate long-term coverage of our members, there is a special arrangement with SEWA Bank, whereby a woman makes a one-time payment which is put as a fixed deposit in her own name. The interest accrued then goes towards her insurance premium payment, both for herself and, if she so desires, for her husband. There are added incentives for the insured woman choosing this mode of premium payment. (See table above).

Engaging the services of an actuary well-versed in setting up insurance cooperatives, SEWA Insurance or VimoSEWA has developed a business plan for providing life coverage to the poor with women workers as the policy-holders. While our insurance services currently provide both life and non-life coverage through partnerships with nationalized and private insurers, the IRDA requires separate licenses for life and non-life business. For the present, we have decided to develop our business plan for life coverage, as this product has not only been viable but also generates profit for the insurer with whom we currently have a tie-up. We also plan to continue to provide non-life coverage through our current system of partnerships with insurance companies. Thus, poor women and their family members will get comprehensive life and non-life coverage and through one window.

Over the past year, and especially after cooperatives have been permitted to provide insurance, SEWA has stepped up its efforts to obtain permission for setting up its own cooperative. We have argued that:

a) our experience of over a decade shows that the poor, and especially women, are insurable;

b) insurance by and for the poor, and with women taking the lead, can be viable and

c) when poor women own, run and control their own organization, like a cooperative, then they ensure its viability by developing a system of checks and balances against fraud, moral hazard and adverse selection. Our experience with SEWA Bank, a cooperative, shows that women can develop their own organization into a vibrant, growing and sustainable enterprise, fully committed to the twin goals of serving the poor and being self-reliant.

Through our own registered cooperative, VimoSEWA, we hope to reach out to the poorest of women workers and their families, and in a viable manner.