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HEALTH INSURANCE FOR THE INFORMAL SECTOR: PROBLEMS AND PROSPECTS

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Foreword

This paper formed part of a series of background papers prepared for the ICRIER India Health Study, "Changing the Indian Health System: Current Issues, Future Directions" by Rajiv L. Misra, Rachel Chatterjee, and Sujatha Rao. The India Health Study, prepared under the team leadership of Rajiv Misra, former Health Secretary, Government of India, was funded by the Bill and Melinda Gates Foundation.

This paper by Dr Anil Gumber, Senior Fellow, Warwick Business School, University of Warwick, UK and Senior Economist, National Council of Applied Economic Research, New Delhi, 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. A review of the existing health insurance schemes in India and select Asian and Latin American countries, such as China, Thailand, Sri Lanka, Chile, Uruguay, Colombia, Brazil, and Argentina, is undertaken with a view to drawing lessons for India. On the basis of a pilot study undertaken in Gujarat during 1999, the paper examines the feasibility of providing health insurance to poor people in terms of both willingness and capacity to pay for such services. The paper also suggests various options available to introduce an affordable health insurance plan for workers in the informal sector.

The issues discussed in this paper have assumed great importance in the current context of liberalisation of the insurance sector in India. Health insurance will continue to remain a high priority area in the years to come. I am confident that this paper by Dr Anil Gumber will provide an important contribution to the challenging task of developing and marketing of an affordable health insurance package for low-income people.

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I. Background

It is a well recognised fact that the contribution of the informal sector to the Indian economy is enormous. It is estimated that about two-fifths of the country's gross domestic product originates from and almost 90 per cent of families earn their livelihood from the informal sector. 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. A vast majority of them neither have fixed employer–employee relationships nor do they get any statutory social security benefits. This implies that workers in the informal sector do not get health care benefits, paid leave for illness, maternity benefits, insurance, old age pension, and other benefits. They receive very low wages; and, as own-account or self-employed workers, they obtain meagre piece-rated earnings. At the same time, most workers of the unorganised sector have not formed their unions or associations. They thus remain without their representative organisations, which could otherwise help them fight against the many injustices they face everyday. They also do not have the bargaining power or collective strength to demand just policies and laws, including laws for social protection and social security (Ahmad *et al*. 1991).

The persistent poverty and disease syndromes have pushed the families of the unorganised sector into the process of de-capitalisation and indebtedness to meet their day-to-day contingencies. Both macro and micro studies on the use of health care services show that the poor and 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 particularly 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 a 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.

There are also concerns about problems in the accessibility and use of subsidised public health facilities. A majority of the poor households, especially rural, 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 constraint, the primary health centres are usually either dysfunctional or provide services of low quality. The government's claim to provide free secondary and tertiary care does not hold; in reality the government is charging for various services (Gumber 1997).

Estimates based on a large-scale health care utilization survey of 1993 suggest that overall about six per cent of the household income is spent on curative care which amounts to Rs. 250 per capita per annum (Shariff *et al.* 1999). However, the burden of expenditure on health care is unduly heavy on households engaged in the informal sector, indicating the potential for voluntary comprehensive health insurance schemes for such sections of the society.

Overall, the health insurance coverage is very low. Only nine per cent of the Indian workforce is covered by some form of health insurance (through the Central Government Health Scheme (CGHS), Employees' State Insurance Scheme (ESIS) and *Mediclaim*), a majority of them belonging to organised sector (Gumber 1998). The low level of health insurance coverage is due to the fact that the government policies have been to provide free health services through the public hospitals/dispensaries/clinics. In reality, despite having a poor outreach, the public sector providers charge for various services. According to estimates based on the National Sample Survey (NSS) 1986–87, 42 and 30 per cent of inpatients and outpatients, respectively, using public sector facilities had paid for various services; the percentages varied substantially between rural and urban areas and amongst states (Gumber 1997). Further, over time the cost of health care has increased enormously. A comparison of NSS data for 1986–87 and 1995–96 suggest that the cost of inpatient care and outpatient care grew annually at 26–31 per cent and 15–16 per cent respectively, which in turn has put severe strains on achieving equity in health (Gumber 2001).

Non-governmental organisations (NGOs) and charitable institutions (not-for-profit) have played an important role in the delivery of affordable health services to the poor but their coverage has always remained small. The issue, which continues to bother us, is how to reach the unreached and more recently, how to insure the uninsured to get minimum affordable quality services.

The public insurance companies so far have paid very little attention to voluntary medical insurance because of low profitability and high risk together with lack of demand. From the consumer point of view, the insurance coverage is low because of lack of information about the private health insurance plans as well as the mechanisms used by the health insurance providers being not suitable to consumers. Further, in comparison to the ESIS and also to the community-based schemes, the private plans cover a modicum of benefits (see Statement I), i.e. only hospitalisation and with a lot of exclusions. One analysis suggests that the existing voluntary health insurance plans cover only 55–67 per cent of the total hospitalisation cost and in all just 10–20 per cent of the total outpatient care burden on households (Gumber 2000a).

Statement I
Type of Health Care Burden on Households Covered under Health Insurance Schemes

Type of Care/Cost		ESIS	SEWA	*Mediclaim*
Inpatient	Medical	✔	✔	✔
	Transport and other direct cost	✘	✘	✘
	Loss of earnings	✔	✘	✘
Outpatient	Medical	✔	✘	✘
	Transport and other direct cost	✘	✘	✘
	Loss of earnings	✔	✘	✘
Preventive and Promotive	Immunisation	✔	✘	✘
	Ante- and post-natal care	✔	✘	✘
	Maternity care	✔	✔	✘
	Family planning	✘	✘	✘

Note: SEWA and *Mediclaim* are reimbursement plans (subject to sum assured) whereas ESIS is a facility-based plan.

Gender bias in health care use continues to persist with men having better access to facility as compared to women due to various socio-economic and cultural reasons. More specifically, poor women are most vulnerable to diseases and ill-health due to living in unhygienic conditions, heavy burden of child bearing, 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. A pioneer study undertaken by Gumber and Kulkarni (2000) has carefully looked into issues related to the availability and needs of health insurance coverage for the poor, especially the women, and the likely constraints in extending current health insurance benefits to workers of the informal sector.

This paper attempts to review the existing health insurance schemes both in India and a few other developing countries catering to the general population as well as addressing the needs of the informal sector and the poor section of the society. The critical issues of accessibility and use of health care services, the out-of-pocket expenditure on health care, and the need for health insurance for poor households pursuing varied occupations in both rural and urban areas are discussed in the subsequent section. The discussion is based on a pilot study undertaken in Gujarat (Gumber and Kulkarni 2000). The paper also examines the feasibility for health insurance to poor people in terms of both willingness and capacity to pay for the services, including the mechanism for delivery of such type of services. The final section suggests the various options available to introduce an affordable health insurance plan for workers in the informal sector.

II. Review of Existing Health Insurance Schemes in India

Prior to assessing the need for health insurance as a social security measure for workers in the informal sector, a critical review of the existing health insurance schemes in India is attempted in this section. Subsequently lessons learnt from similar efforts undertaken by other developing countries are drawn to explore and consolidate various options of extending health insurance coverage to workers engaged in the informal sector.

Following a review of the health insurance schemes of some of the developing countries, it may be worthwhile to do a similar exercise for the Indian case. Such a description would aid in putting forward the suggestion for a new or a modified package of health insurance for workers in the informal sector. However, the review does not cover a few private sector companies who have recently been granted license to introduce health insurance schemes and they aimed at catering to middle and higher income people.

The various health care programmes presently operating in India can be categorised as follows:

(a) State-run schemes for formal sector employees;

(b) Public sector health insurance schemes;

(c) Corporate sector health care programmes;

(d) Community and self-financing schemes, primarily for workers outside the formal sector; and

(e) Micro-credit linked health insurance schemes.

(a) Schemes for Organised and Government Sector Employees

There are two schemes, the Central Government Health Scheme (CGHS) and the Employees' State Insurance Scheme (ESIS), sponsored by the central and state governments, respectively, which extend free medical care for both inpatient and outpatient services on co-payment basis to the organised workforce. ESIS also extends cash benefits towards loss of wages due to sickness as well as cash compensation towards permanent physical impairments.

Employees' State Insurance Scheme

The Employee State Insurance Corporation (ESIC) runs the ESIS, which provides both cash and medical benefits. The scheme (launched in 1948) is essentially a compulsory social security benefit to workers in the industrial sector. The original legislation required it to cover only factories using power and employing 10 or more employees, and was later extended to cover factories not using power and employing 20 or more persons. Persons working in mines and plantations are specifically excluded from the ESIS coverage. Any organisation offering benefits as good or better than the ESIS is obviously excluded from the coverage.

The monthly wage limit for enrolment in the ESIS has been raised from Rs. 3500 to Rs. 6500. The contribution is paid in the form of a payroll tax of 4 per cent by the employer and 1.4 per cent by the employee. Medical benefits comprise cash payment for sickness, maternity, temporary or permanent disablement, survivorship and funeral expenses. Expenditure for medical benefits constitutes 70 per cent of the total benefits paid under the ESIS. These medical benefits are provided primarily through hospitals and dispensaries. As on 31 March 1997, there were 32.8 million beneficiaries spread over 617 ESI centres across states. Under the ESIC, there were 125 hospitals, 42 annexes, and 1443 dispensaries with over 23,334 beds facility. The total state government expenditure on ESIS was about Rs. 3300 million and the expenditure per insured person worked out to be a little under Rs. 400.

There has been a steady rise in the share of total government medical expenditure on the ESIS as also an increase in the number of beneficiaries. However, the latter has not been commensurate with the increase the number of workers in the organised sector. In fact, over the period 1955–56 to 1984–85, there has been a decline in the percentage of the total organised sector employees covered by ESIS from 38.2 to 29.3. This implies that the ESIS could not keep pace with even the slow growth of the organised sector.

ESIS has, however, not been as successful in terms of both coverage and quality of services. The issue of coverage is related to that of equity. The states with a higher share of the total expenditure on ESIS are also the ones with a higher share of organised workforce. Such states are also invariably better placed in terms of other development indicators. Barring a few exceptions, it can therefore be stated that the expenditure share for ESIS is in relation to the size of the organised sector as well as the level of industrialisation and development of the states. Only around 30 per cent of the workforce is covered by the benefit though the government spends 12 per cent of the total medical expenditure on ESIC. The larger question is, of course, that less than 10 per cent of the country's total workforce is engaged in the organised sector. This kind of subsidisation of services for one section of the workforce almost amounts to creating a two-tier health care system. Regarding the other aspect of quality of services, the ESIS hospitals are perceived to be of poor quality. There have been studies showing that the hospital equipment was in a state of disorder and there was a shortage of medicines and drugs (Shariff 1994). The

available drugs and medicines are more often found to be of substandard quality. Over and above, there also have been reports of negligence and corruption in the system. Instances include the employers depriving workers their right of coverage by not informing the employees of their coverage, disallowing injury claims by changing eligibility, and manipulation of part-time employees' work schedules so as to make them non-eligible for ESIS coverage.

Central Government Health Scheme

The scheme, introduced in 1954 as a contributory plan, was aimed at providing comprehensive medical care to the central government employees (both in service and retired) and their families to replace the cumbersome and expensive system of reimbursement. The contribution by the employees is nominal but progressive with salary scales (the contribution starts at an amount as low as Rs. 20 per month). Separate dispensaries are maintained for the exclusive use of central government workers. There are also central government run hospitals where the CGHS beneficiaries are treated. Over the years, the coverage has grown spatially and also in terms of beneficiaries. By covering all systems of medicines, it delivers services through 320 dispensaries in 17 major cities of most of states. In addition, there are 108 polyclinics, laboratories, and dental units. The total number of beneficiaries was 4.2 million in 1997. Besides providing medical services, the CGHS provides reimbursement for out-of-pocket expenditure for availing treatment in government hospitals and approved private facilities. The list of beneficiaries contains all current as well as ex-government employees, including Members of Parliament, Supreme and High Court judges, and Central Government bureaucrats.

The CGHS is widely criticized for its quality and accessibility (NCAER 1993). As the CGHS services are confined to regular government employees, the better-off section of the population as compared to the general masses is enjoying the benefits. Apart from this, for those availing the services the waiting time is long, out-of-pocket costs of treatment are high (Rs. 1507 in 1994), supplies of medicine, equipment, and staff are inadequate, and conditions are often unhygienic.

Various research studies show that both CGHS and ESIS are not serving their basic purpose. The quality of services is poor. Long waiting period, non-availability of drugs,

inadequacy of staff and non-functioning of equipment are the most common problems encountered by the users. Though the number of beneficiaries is increasing the actual use of facility is declining due to switching over to private facility.

Employer Managed Facilities and Reimbursable Schemes

The government also provides direct health services for employees of a large number of state-owned departments like Railways and Defence and Police services. These departments have set up their own system of dispensaries, hospitals, and personnel and the services are provided free of charge. Railways alone provide health care services through 110 hospitals and 665 dispensaries to nearly 8.6 million beneficiaries (Annex I). An industrial sector that offers similar kinds of services is the mining sector. Employers in schools and universities too have their network of hospitals and dispensaries.

There are numerous reimbursement plans offered by the employers for private medical expenses. Many private sector companies, in addition to ESIS and other health insurance schemes, reimburse the expenses. There are normally two kinds of reimbursement:

(a) Employers contribute towards a medical grant/fund, which is annually disbursed as medical allowances to their employees.

(b) Employees incurring medical expenses submit their claims to their employer for reimbursement and reimbursements are linked to individual contributions.

(b) **Mediclaim** ***Health Insurance Plan***

The currently prevalent public insurance scheme in India is the *Mediclaim* plan, which is run by the General Insurance Corporation (GIC), a public-sector undertaking. There are four subsidiary companies of GIC, namely National Insurance Corporation, New India Assurance Company, Oriental Insurance Company, and United Insurance Company. All these four companies operate nationally and are controlled by the GIC. Though a full range of insurance cover is offered by GIC, such as on property, liability, casualty, and business, health insurance is also a part. Since the merger of the various private insurance companies into one apex body in

1973, there has been a uniformity in the provision of medical benefits. The *Mediclaim* policy, as it is called, covers hospital care and domicilary hospitalisation benefits, which means specified outpatient treatment provided in place of inpatient treatment. Premiums, eligibility, and benefit coverage for all the subsidiaries are as prescribed by the GIC.

In the light of the cumbersome procedure to reimburse the hospitalisation expenses, certain changes were made in the *Mediclaim* policy and accordingly, the premia was revised from 1 September 1996. The salient revisions are as follows.

(a) Sum insured was raised from Rs. 83,000 to Rs. 300,000[1].

(b) Fixation of premium according to the category of hospital/ward was removed, and now it varies according to five age groups, viz. up to 45 years, 46–55 years, 56–65 years, 66–70 years and 71–75 years.

(c) Rate of premium was reduced (and it became almost half of the previous rate in the higher categories of sum insured). The premium varies between a low of Rs. 175 (up to 45 years age group) and Rs. 330 (71–75 years age group) for Rs. 15,000 coverage to a high of between Rs. 2825 and Rs. 5770 for Rs. 300,000 coverage.

(d) Extending coverage to children between the age of 3 months to 5 years, provided one of the parents is concurrently enrolled.

(e) Extending reimbursement of cost of health check-up once at the end of a block of every four underwriting years.

(f) This plan also provides family discount and cumulative bonus.

However, changes were not made with regard to pre-existing diseases and exclusion of certain conditions during the first year of coverage. Also, the *Mediclaim* policy does not allow reimbursement of expenses against AIDS, venereal diseases, pregnancy, dental treatment, hearing aids, spectacles, and contact lenses. The only good aspect of the plan is that the premium has been reduced considerably, thereby raising its affordability.

[1] Recently it has been further raised to Rs. 500,000.

The GIC also floats a group medical policy along the same lines as the individual or family *Mediclaim* policy. Due to risk pooling, the premium gets reduced in the Group *Mediclaim* policy.

The response to the *Mediclaim* policy, unlike that for ESIS, is quite favourable. There has been a tremendous increase in the enrolment for the *Mediclaim policy*. There has been a 174 per cent increase in the beneficiaries of *Mediclaim* over the period between 1986 and 1995 (Ellis et al. 2000). A major shortcoming of the programme is, however, that only hospitalisation expenses are covered while routine outpatient care is not covered. The hospitalisation coverage is also subject to numerous exclusions, coverage limits, and restrictions on eligibility, etc. Also claim payments are higher than premiums, thus questioning its viability.

The GIC, in its efforts to expand coverage, introduced a new policy called *Jan Arogya Bima Policy* on 15 August 1996 to cater the health care needs of people belonging to middle and lower income groups. The annual premium ranges between Rs. 70 and Rs. 140 by age, and it is just Rs. 50 for dependent children against a coverage limit of Rs. 5000 in a year. It is expected that this plan would certainly be affordable to large section of India's population. In a short span of about six months, about 400,000 individuals (till March 1997) opted for this plan as against 1.6 million under the *Mediclaim*.

The GIC also offers medical benefits and compensation under personal accident policies for individuals and groups. If an injury results in total disablement of the insured and thereby prevents him/her from engaging in any activity or occupation, then 100 per cent of the sum insured will be paid. In other cases like irrevocable loss of eyesight, hearing, and different parts of limbs, different percentages of the sum insured are being paid.

Bhavishya Arogya Policy (old age medical insurance), also introduced by GIC in 1991, was designed to enable a person to plan for medical needs during old age out of savings during his/her current earning phase, as an old age security. Under this scheme medical expenses to be incurred over the balance life span after a predetermined age of retirement will be reimbursed up

to the amount of sum insured. The advantage of this plan is that it assures coverage of all types of conditions from the effective date of benefits.

Other Public Sector Health Insurance Schemes

Similarly, the Unit Trust of India (UTI), a public-sector undertaking launched the Senior Citizens Unit Plan (SCUP) in April 1993 to provide coverage for hospitalisation expenses up to Rs. 500,000 for the investors after attaining the age of 58 years. Anyone in the 18–54 years age group can join the scheme by a one-time investment and his/her spouse can also become eligible for the medical insurance benefits.

The Life Insurance Corporation (LIC) introduced a special policy known as *Asha Deep II* in 1995 to cover insurance against four major ailments, namely cancer, paralytic stroke, renal failure, and coronary artery diseases. Anyone between 18 and 50 years can opt for an insurance coverage between Rs. 50,000 and Rs. 300,000. This is basically an endowment policy with three terms — 15, 20 and 25 years — with maximum age at maturity fixed at 65 years. The benefits can be claimed only once out of four specified diseases. It includes an immediate payment of 50 per cent of the sum assured, waiver of subsequent premiums; subsequently annual payment up to 10 per cent of sum assured till the policy matures or the insured dies, whichever is earlier; the payment of balance 50 per cent of the sum assured and vesting bonuses are on maturity or death, whichever is earlier. The bonus will be paid on full sum assured even though half of the sum assured has already been paid. Though it is not primarily a medical insurance policy, it became popular by selling 175,000 polices during 1995–96 with total sum assured of Rs 13,620 million.

Statement II
Salient Features of Important Health Insurance Schemes in India, 1998

Type of Health Insurance Scheme and Commencement Year	Coverage Age/Sum Insured	Estimated Enrolment ('000)	Remarks
1. General Insurance Corporation			
Mediclaim, 1986 (Individual/Family/Group)	Individual aged 5–75/ Family-3 months to 75 yr., Rs. 15000–300000*	1600	Only hospitalisation coverage with exclusion of pre-existing conditions and dental coverage
Jan Arogya, 1996 (Individual/Family)	Age group up to 70 yr., Rs. 5000	400	Same as above without group coverage benefits
Bhavishya Arogya, 1991 (Old-age Security, Individual/ Spouse)	Individual/spouse aged 18–55 years for post-retirement benefits up to Rs. 500000	100	Hospitalisation coverage after the age of retirement
2. Life Insurance Corporation Asha Deep II, 1995	Individual aged 18–50 years, Rs. 50,000–300,000	175	Endowment policy with coverage of four ailments — cancer, paralytic strokes, renal failure, and coronary artery diseases
3. Unit Trust of India Senior Citizens, Unit Plan	Individual/spouse aged 18-54 years for post retirement benefits up to Rs. 500,000	100	Medical benefits with one-time investment after the age of retirement
4. Central Government Health Scheme Medical and Health Care Services	Central government employees (current or retired) and families, all types of medical services	4249	Though providing coverage for both inpatient and outpatient care, the quality and delivery of services are poor
5. Railways Health Insurance Scheme Medical and Health Care Services along with other Benefits	Railways employees (current or retired) and families, all types of medical services	8600	Delivery through hospitals and dispensaries which are highly skewed (located in Grade A stations)
6. Employees' State Insurance Scheme, 1948 Medical and Health Care Services along with Cash Benefits	Any employee and his/her family in an organised sector with monthly wages under Rs. 6500, both cash and medical benefits	32,766	Poor quality and delivery of services; delay in enrolment and disbursement of cash benefits; non-coverage of temporary workers and their families

Source: Gumber (2000b).

Note: * Recently the limit of sum insured has been raised to Rs.500,000.

An interesting aspect of all these policies (as listed in Statement II) is that the premium qualifies for income tax benefits. However, all these schemes cover partial medical benefits by limiting to hospitalisation coverage for mainly communicable diseases and selected non-communicable diseases. Not a single policy has allowed reimbursement of expenses for outpatient care. Nevertheless, the health insurance market is growing faster than that for general insurance (in terms of premium collected by GIC, the latter grew annually at 14 per cent while the former grew at 26 per cent annually during the last five years). These facts clearly highlight that there is much potential to tap the health insurance market. As both the public health delivery

and health insurance package are far below the quality, the increasing role of private facilities, especially corporate hospitals, would be warranted.

(c) Corporate Sector Health Care Programmes

Major corporate houses, given the limitation of the state-owned and ESIS health care services, have developed their own systems for the benefit of their employees. There are broadly two approaches: the first one can be called as *empanelment* and second one is *direct provision of services*. Empanelment refers to the arrangement where the employer develops a panel of private hospitals/clinics and/or group *Mediclaim* coverage. In the context of the second approach, there are instances of emergency services and dispensaries. Some major corporates like the Hindujas and the Tatas have even developed hospitals as trusts or societies. These hospitals more often than not possess the latest state-of-the-art technology.

Apart from this, there are big corporate hospitals, like the Apollo Hospitals, which are characterised by high quality exhaustive hospital benefits but very little outpatient coverage. The delivery of health care services by such hospitals is obviously extremely expensive. Apollo Hospital, to make the availability of its services more viable, has tied up with major insurance companies like New India Assurance and United India Insurance (Baru 1998).

A negative consequence of this rapid expansion is the further skewing of the health sector resources in the urban areas. There is an emphasis in these hospitals on expensive medical equipment and therefore leads to escalation in the costs of delivering medical care. The growth of this kind of high-tech health care service has been very rapid and unchecked. The government needs to review and initiate measures to regulate it (Naylor *et al*. 1999).

(d) Community-based and Self-financing Programmes

Community and self-generated financing programmes are those usually run by non-governmental organisations (NGOs) or non-profit making organisations. These organisations rely on finances from various sources, including government, donor agencies, and community and self-generated sources. Also many innovative methods of financing health care services have been used, like progressive premium scales, community-based pre-payment/insurance schemes,

and income-generating schemes. The target population for provision of health care services by such organisations is primarily workers and families outside the formal sector. The sources of revenue for the programmes can be categorised as:

(a) User fees defined as the payment made by the beneficiaries directly to the health care provider, such as fees for services or prices paid for drugs/immunisation. This mode of financing is not common.

(b) Prepayment/insurance schemes, including payment by members for drugs either at subsidised rate or at cost price.

(c) Commercial schemes for-profit actively run by organisations to finance health care.

(d) Fund raising activities by organisations for financing health care services. In some cases the revenue raised in this manner constitutes more than 5 per cent of the total funds of the organisations.

(e) System of making contributions in kind (such as rice, sorghum, community labour, etc.). This method is not very popular due to difficulty in management.

(f) Other sources of community-based and self-financing include instances like Tribhovandas Foundation providing health care through village milk cooperatives and Amul Union (the milk cooperative organisation) contributing significantly towards health services through putting a cess on milk collection.

Statements III and IV provide a description of some select schemes. Most of the successful case studies as documented by Dave (1991) happen to be in the states of Assam, Gujarat, Maharshtra, Orissa, Tamil Nadu, and West Bengal. Therefore, the experience of such schemes could be illustrative to understand their merits and demerits and potential for replication in other states. The most pertinent point about these schemes is their rural orientation and ability to mobilize resources in a village community. However, most of these schemes have catered to a small section of population with limited health coverage restricted to elementary, preventive, and maternal and child health (MCH) care.

Statement III
Salient Characteristics of Select NGO Managed Health Insurance Schemes

Voluntary Organizations/ Location	Date Started	Service Provided	Health Service Delivery/Organization	Population Served	Total Annual Cost (Rs.)
Sevagram/ Wardha, Maharasthra	Hospital, 1945 Community health programme 1972	1. 500 bed hospital 2. Out reach community health programme	-- Trained male VHW provides basic curative, preventive and promotive health care. Mobile with doctor and ANM provides care every 2 months	-- 19,457	-- 69,459
Bombay Mother and Child Welfare Society (BMCWS)/ Chawl in Bombay	1947	Health activities, Two maternity hospitals (40 beds each) with child welfare centres, Non-health activities, Day care centres, convalescent home	• Outpatient and inpatient maternity care • Outpatient paediatric care including immunization		120175 (health and non health combined)
Raigarh Ambikapur Health Association (RAHA)/ Raigarh, Madhya Pradesh	1969 Community health services started 1974	Federation of 3 referral hospitals and 65 independent health centres with outreach community care	• RAHA functions include management of insurance scheme, training and support for health centres. • health centres staffed by nurse provide outpatient care run MCH clinic • VHWs provide community based care	400,000	30,000-50,000 (cost range of individual health centres of which there are 65)
Christian Hospital/ Bissamaucuttak, Orissa	Hospital 1954, out reach community care 1980	120 bed hospital, community project currently not operational	Outpatient/inpatient care, specialties include obstetrics, gyneacology, surgery, opthalmology	--	1,911,740 (hospital only)
UPASI Coonoor, Tamil Nadu	19th century CLWS - 1971	Association of tea growers run comprehensive labour welfare scheme (CLWS)	CLWS provides training, management support to health programmes of individual tea estates. Tea estates have small cottage hospital and outreach care provided by local workers	250,000	300,000
Goalpur Co-operative Health Society/ Shantiniketan, West Bengal	1964	Dispensary, periodic community health services	Doctor provides outpatient care twice weekly	1,247	32,000
Students health home/ West Bengal	1955	Polyclinic plus 28 regional clinics	Polyclinic has 20 beds provides outpatient and inpatient care; Regional clinics, outpatient care only, health education campaigns, blood donation camps	550,000	2,950,745
Saheed Shabsankar Saba Samithi (SSSS)/ Burdwan, West Bengal	1978	Dispensary occupational health activities, rural health programme, school health programme, fair price medicine shop	Doctors provide outpatient care weekly MCH clinic	--	87,780
Arvind eye hospital/ Madurai, Tamil Nadu	1976	2 urban hospitals (100 beds), 2 rural hospitals (500 beds), outreach programme	Outpatient and inpatient eye care Regular eye camps organized	--	10,987,700
Tribovandas Foundation/ Anand, Gujarat	1980	Community based health programme linked with milk cooperatives, regional rehabilitation centres, Balwadis women's income generating scheme	Community health workers (CHWs) Ws provide basic curative, preventive, and promotive care; field, supervisors provide support to CHWs milk society building used as base for coordinating health services.	300,000	1,080,000 (health and non-health combined)
SEWA/ Ahmedabad, Gujarat	Union 1972, health programme 1984	Union of self-employed women. Helps organize women into cooperatives of various traders, provides credit facilities. Provides health care as a support which stocks rational generic drugs.	Health centres in urban slums and rural villages. CHWs provide basic care, doctors provide support twice weekly.	63,000	391,850 (health programme only)
CINI/ Daulatpur, West Bengal	1975	Community based health programmes, dispensary and outreach rehabilitation centre. Other activities: income generating schemes, farm, health training, research	CHWs provide MCH care through Mahila Mandals, doctors run daily OPD, weekly MCH clinic, supplementary feeding	70,000 (Community health project)	1,900,000

Source: Dave (1991).

Statement IV
Prepayment and Insurance Mechanisms in Select NGO Managed Health Insurance Schemes

Features	Sevagram	RAHA	Tribovandas Foundation	Goalpara	Students health home	SSSS
Coverage provided	Household	Individual	Household	Household	Institutional and individual	Individual
Annual subscription fee	8 payali sorgham (landless) and 2 payali sorgham per acre extra (land holders), or equivalent cash	Rs. 5 or Rs. 2 rice	Rs. 10	Rs. 18 in cash or in kind (rice or labour)	Rs. 2 Institutions Rs. 6- Individuals	Rs. 2 or Rs. 5
Number of members	At least 75% of households (23 villages covered) Total insured 14,390	75,000	Approximately 1/5 to 1/6 of all households in villages, (319 villages covered)	150 out of 175 households in village	630 institutes total 350,000 students covered	6800
Member entitlement	Community care: free CHW services, drugs, and mobile (doctor +ANM) services. Hospital: free care for unphased illness episodes, 25% subsidy for anticipated illness episodes, e.g., pregnancy and chronic ailments	Community care: free CHW services and drugs. Free health centre services including MCH clinic. Hospital: free care after paying entrance fee up to ceiling of Rs. 1000	Community care : free services , subsidized drugs. Hospital: 50% subsidy	Dispensary: Free doctor consultations, drugs at cost. Free periodic public health activities	Polyclinic/ regional clinics: free consultations, drugs, diagnostic tests, operations, bed stay at nominal charges	outpatient clinic: free consultations, drugs at cost, free MCH care
Non-member entitlement	Non-members not entitled to use community health services	Non-members charged for drugs (over cost), not entitled to attend MCH clinic	Non-members have same emoluments to community services as members but not hospital care	Non-members charged for drugs (over cost)	Non-members not entitled to avail of services	Non-members are not entiltled to avail the services
Management of fund	VHW responsible for membership collections, Collections once a year at harvest time. Compulsory that 75% of villages covered.	Individual health centres responsible for membership collections. Collections once a year. New members waiting period 2 months before services entitlements Rs. 3 retained by centre, Rs. 2 to RAHA for referral fund.	VHW services responsible for membership collections. Collected once a year at times- bonus payments distributed (non-adult society members can also enrol in scheme)	Village health communities -- funds collections once a year.	Institutions enrolled once a year. Individuals ongoing (no waiting period)	Able to enroll through the year. No waiting period between enrollment and service entitlements.

Source: Dave (1991).

(e) Micro Credit Linked Health Insurance Schemes

Several NGOs and governments worldwide have started micro-credit schemes for vulnerable groups to break the vicious circle of poverty, malnutrition, disease, low productivity, and low income. Micro-credit is now considered not only an effective tool for poverty reduction but also used as an instrument for empowerment of the poor, particularly the women. This operation generates income to the poor by extending them small credits for self-employment and other economic activities. However, it was soon realized that loan repayments by these groups were much below the expected level. The experience suggested that ill-health and expenditure on treatment and associated consumption needs were the prime reasons for defaulting on repayments. To plug the erosion of income of borrowers on health care needs, some NGOs (such as Grameen Bank in Bangladesh and the Self-Employed Women Association (SEWA) in India) have introduced health insurance schemes for their members. The Grameen Bank Health Programme was started in 1994 with the objectives to adopt preventive measures against diseases, to arrange for treatment at minimum cost, and to build a non-profit primary health care system. Under this scheme the borrowers pay a fixed annual amount of 60 Taka per family as premium and a very trivial sum at the time of using the facility. The scheme over time has proven to meet the desired objectives (Rahman 2000).

In India, SEWA is a trade union of 215,000 women workers of the unorganised sector. It organises them towards the goals of full employment and self-reliance at the household level. Full employment includes social security, which in turn incorporates insurance. SEWA's experience repeatedly revealed that despite women's efforts to come out of poverty through enhanced employment opportunities and increased income, they were still vulnerable to various crises in their lives. These prevented them from leading a life free of poverty. The crises they continue to face are death of a breadwinner, accidental damage to and destruction of their homes and work equipment, and sickness. Maternity too often becomes a crisis for a woman, especially if she is poor, malnourished, and lives in a remote area. One of the SEWA studies observed that women identified sickness of themselves or a family member as the major stress event in their lives (Chatterjee and Vyas 1997). It was also a major cause of indebtedness among women.

The health insurance programme was, from the start, linked to SEWA's primary health care programme, which include occupational health services. Thus, insured members also have access to preventive and curative health care with health education. Health insurance accounts for the majority of claims and for 50 per cent of the premium paid out to the insurance programme by SEWA members. The scheme was introduced by the SEWA Bank in March 1992 with an initial enrolment of 7000 women from Ahmedabad city (Chatterjee and Vyas 1997). Later on it was extended to cover rural woman members from nine districts of Gujarat. Now its enrolment is 30,000 women, of which 50 per cent is from rural areas.

Health insurance is an integral part of the insurance programme of SEWA. The main motivation behind the initiation of a health insurance scheme for women is that maintenance of an active health seeking behaviour is a vital component for ensuring a good quality life and women tend to place a low priority to their health care needs. The poor women's health is most vulnerable both because of their unhygienic living conditions as well as the burden of bearing children. And persistent poor health of such workers costs them in terms of loss of working days and the corresponding incomes.

The coverage of the SEWA health insurance programme includes maternity coverage, hospitalisation coverage for a wide range of diseases, and insurance for occupational health related illnesses and other diseases specific to women (Statement V). More specifically, its main features are:

- Occupational health coverage
- Coverage for women specific diseases
- Maternity benefit
- Coverage for a much broader range of diseases (which are not covered by the GIC's *Mediclaim* plan)
- Simplified administrative procedures
- Life and asset insurance coverage of the woman member
- Life coverage for members' husband or other members of household (in case of widowhood and separation)

Statement V
Type of Coverage under SEWA Scheme

Provider	Description of Coverage	Coverage Amount (Rs.)	Premium (Rs.)
New India Assurance	Accidental death of the woman member Loss of assets	10,000	3.50
	Accidental death of a member's husband	10,000	3.50
SEWA	Loss during riots, fire, floods, theft, etc.: (a) of work equipment (b) of the housing unit	 2000 3000	8.00
	Health Insurance (Including coverage for: (a) gynaecological ailments (b) occupational health related diseases)	1200	30.00 (10) (5)
	Maternity benefits	300	--
Life Insurance Corporation of India	Natural death Accidental death	3000 25,000	15.00

Note: Total premium for the entire package is Rs. 60 plus Rs. 5 as service charge.

SEWA's health insurance scheme functions in co-ordination with Life Insurance Corporation of India (LIC) and New India Assurance Company (NIAC). SEWA has integrated the schemes of LIC and NIAC into a comprehensive health insurance package to address women's basic needs. The claimants are the needy health-benefits seekers and as the insurance is an additional benefit, the beneficiaries willingly pay the premium. Most of the insurers opt for fixed deposit of Rs. 500 or Rs. 700 (depending upon the type of coverage) with the SEWA Bank and the interest accrual goes towards annual payment of premium. It is the large membership and assets of the SEWA Bank that has made possible the provision of the insurance coverage at low premiums.

III. Review of Other Developing Countries' Health Insurance Schemes

The comprehensive review of the existing health insurance schemes in India as presented above points to the fact that almost all the programmes cater either to the organised workforce or to the economically upper section of the population. The private health care expenditure is more than four times that of public expenditure and there is very little preference for the government health delivery system *vis-à-vis* the private system. The latter is primarily because of poor quality service in the government-managed facilities. There is coverage of both inpatient and outpatient care in the government-sponsored health insurance schemes – CGHS and ESIS. The

quality of services under the ambit of both is poor. The voluntary health insurance plan (*Mediclaim*), which covers only hospitalisation expenses, is too expensive for the informal sector workers to get enrolled. There are various community-based and self-financing schemes but, given the massive health care needs, the coverage of population by them is just not adequate. The proportion of population covered by any health insurance scheme is minuscule, let alone those employed in informal sector. The market for health insurance is growing at a substantial rate, though.

At this juncture, it may be worthwhile to summarise the experience with health insurance of select Asian and Latin American countries to know what lessons can be learnt by India. There have been commendable efforts in developing health insurance models by these countries whose per capita incomes are well below those of the developed countries. The specific experiences of China, Thailand, Indonesia, Sri Lanka, Chile, Uruguay, Colombia, Brazil, and Argentina are discussed below.

China stands out as an example where insurance has been successful in covering a large part of the population both in rural and urban areas. The Chinese expenditure is characterised by high total expenditure, low government expenditure and heavy dependence on insurance financing. There are two kinds of coverage which are in practice in China: (a) labour insurance medical coverage for state-owned enterprise workers and retired persons, and (b) free medical service which caters to workers and retired persons of government agencies and parties and non-profit institutions. A noteworthy feature of China's health care system is the coverage of rural population through various kinds of schemes, which have been designed in accordance with the local economic conditions and public opinion. China's system of health care certainly scores better *vis-à-vis* some of its Asian counterparts like India and Indonesia.

Thailand has four different kinds of health care financing programmes: voluntary health schemes, mandatory schemes, social welfare schemes, and fringe benefit schemes. Statement VI presents the coverage of these programmes with their important features. The target population of each of these schemes varies in terms of their place of residence (rural/urban) and employment status (formal sector/informal sector). The coverage of population in the informal sector,

especially in rural areas is, however, far from a desirable level. In fact, 41 per cent of the population, which is not covered by health insurance scheme largely, consists of subsistence farmers, self-employed, rural workers, and urban dwellers engaged in informal sector activity such as street vending and small-scale commercial undertakings. Despite this under-coverage, the experiment with the health card scheme seems to have worked. The health-card scheme is designed for delivering health care services to the workers in the informal sector where assessing incomes is problematic. The health-card scheme was initiated primarily with the objective of improving health among the rural population.

Indonesia, with a very low level of government expenditure and negligible insurance spending, fares the worst (among the countries under comparison) as far as health outcomes are concerned. In the Asian group of countries, Sri Lanka too (like China) emerges as a good performer. However, the pattern of health care expenditure between the two greatly varies. While China relies substantially on insurance spending, Sri Lanka's health care expenditure is characterised by high government, low private, and low insurance expenditures.

The pattern of health care expenditure in Latin American countries varies according to the size of the country (both in terms of population and geographical size) and the income level. Taking a larger perspective, there are mainly two types of managed competition, which are emerging in this region: (a) where government is the sponsor and (b) where private employers are playing the role of sponsor. The former type is followed in countries like Chile, Uruguay, and Colombia. In Chile, for instance, 73 per cent of the population is covered by public health care whereas the remaining 27 per cent are enrolled into the ISPRAE, a private insurance plan. Colombia too has a system of mixed public funding and managed competition, which has not only increased the coverage but also made the system more equitable. In fact, Colombia's health care system has been hailed as one of the most successful ones in the region. Brazil has three distinct systems being availed of by three different income classes – public system primarily by informal sector and low-income workers, private supplementary medicine by formal sector and middle-income workers, and direct out-of-pocket payments by high-income workers. Argentina's health delivery system is mixed – *Obra Social* (statutory sickness fund) and a large number of private insurance plans.

Statement VI
Coverage of Health Schemes in Thailand

Scheme	Target Population	Population Coverage, 1992		Source of Finance	Subsidy per head 1992
		Number (million)	%		
Voluntary Health Insurance					
Health Card	Mainly rural	1.3	2.3	Card holder and government (MOPH)	63 baht
Private Insurance	Mainly urban	0.9	1.6	Insurer	-
Mandatory Schemes					
Worker's Compensation	Formal sector employees	2.5	4.4	Employers and government (MOLW)	--
Social Security	Formal sector employees	2.5 (1992) 4.5 (1995)	4.4 7.6	Employers, employees, and government (MOLW)	541 baht
Social Welfare Schemes					
Low Income Support	Low income Mainly rural	11.7	20.7	Government (MOI)	214 baht
Support for the Elderly	Population Over 60	3.5	6.2	Government (MOPH)	72 baht
School Children	Primary school children	5.1	9.0	Government (MOE)	--
Government Fringe Benefits					
Government Reimbursement	Government employees & families	5.6	9.9	Government (various agencies)	916 baht
State Enterprise Benefits	State enterprise employees & families	0.8	1.4	Government (various agencies)	815 baht
Total Insured		33.2	58.7		
Total Uninsured		23.3	41.3		

Notes: Other welfare recipients include veterans, monks and those deemed truly needy.
MOPH - Ministry of Public Health, MOI - Ministry of Interior, MOLW - Ministry of Labour and Welfare, MOE - Ministry of Education.
Source: Khoman (1998).

While the broad goals and objectives of the health care system in the reviewed countries remain equity and efficiency in the delivery of health care, yet there are variations in the design of programmes, role of government, etc. In the Asian group of countries, China and Sri Lanka, with their success in the health arena, do pose as examples worth emulating but it needs to be noted that each of them follows a different pattern. In Sri Lanka, there is a dominance of government spending in the health sector whereas insurance spending is substantial in China. In the Indian case, the effort can be two-directional. Government health spending can be improved

in terms of the amount spent as well as efficacy of expenditure. The latter is, however, more important. The widespread introduction of low user fees in government hospitals can improve the provision of basic health services. A mix of government expenditure as well private insurance is possible but the amount of premium to be collected from workers in the informal sector remains a moot question. This becomes all the more important when the share of informal sector workers is more than 90 per cent and it is not easy to make an assessment of their income. The Chinese model throws some light on how risk sharing can be made workable even in rural areas where incomes are not too low. The India–China comparison has always been a subject of debate because of their similarities in terms of geographical size, population, and low levels of income. China has surpassed India as far as the achievements in the area of health are concerned. China's basic indicators of well-being – infant mortality rate, life expectancy, maternal mortality – are far more favourably placed as compared to those of India. Thailand's health-card scheme has been another innovative attempt towards fostering grass root participation and management skills.

IV. Key Findings from the Pilot Study on Feasibility of Health Insurance for Informal Sector

This section discusses some of the principal findings that emerged from the pilot study undertaken in Gujarat (Gumber and Kulkarni 2000). The objectives of the study were: (i) to review the existing health insurance schemes both in India and few developing countries with respect to efficacy and equity; (ii) to examine the health seeking behaviour, health expenditure, and morbidity pattern of households protected under different health insurance environments; (iii) to estimate the demand for health insurance; and (iv) to suggest an affordable health insurance plan for workers in the informal sector.

The study was based on a primary household survey undertaken in Ahmedabad district of Gujarat during 1999. The survey included about 1200 households in rural and urban areas classified into four categories according to their health insurance status. About 360 households belonged to 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-financing scheme, which was run by an NGO

called SEWA. Since 1994, SEWA has been extending a unique plan (covering health insurance, maternity benefits, life coverage, and asset insurance) to poor women engaged in petty occupations. The remaining 360 households were non-insured and were purchasing health care services directly from the market. This last sub-sample was taken to serve as a control group. The idea of selecting such stratification was to understand the health care needs, use pattern, and types of benefits received by sample households in different health insurance environment.

The main results of the study are discussed below and the salient statistics in tabular format are presented in Annex II.

(a) Morbidity Pattern: The health seeking behaviour examined against this backdrop in the current pilot study shows that the annual incidence of morbidity is around two episodes per capita which does not vary substantially among the households having different health insurance status except those subscribing to *Mediclaim*. However, the female morbidity turns out to be higher than that for their male counterparts in all the seven population groups studied.[2] 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). Even among the ESIS households, particularly in rural areas, there is greater reliance on the private facility for the treatment of acute illnesses. The survey results clearly pinpoint the poor outreach of ESIS empanelled doctors, dispensaries, and hospital facilities for the rural insured households. In urban areas too, only 54 per cent of acute and chronic ailments of the insured population were treated at the ESIS facility. However, for inpatient care, there is some reliance on government hospitals by all categories of households (except *Mediclaim* beneficiaries).

(b) Expenditure on Treatment: A special effort was made to collect information on three types of expenditures on treatment: (a) direct or medical costs (fees, medicine, diagnostic charges, and hospital charges), (b) other direct costs (transportation and special diet), and (c) indirect costs that included loss of income of the ailing and caring person and interest payments on amount borrowed for treatment. The share of medical costs in the total costs is about two-

[2] The detailed analysis has been attempted separately for seven groups of households namely, rural ESIS, rural SEWA, rural non-insured, urban ESIS, urban SEWA, urban *Mediclaim,* and urban non-insured.

thirds in most of the population groups. Even among urban ESIS households who have used ESIS facility to a greater extent, the share of medical costs in the total costs has remained at around 50 per cent. The average total expenditure on treatment, irrespective of health insurance status, turns out to be higher for rural than urban households. Getting insured has helped in mitigating the expenditure on treatment only for the urban ESIS households. Their out-of-pocket expenditure on treatment for acute and chronic ailments turns out to be about 30 per cent lower and for hospitalisation about 60 per cent lower, as compared to SEWA and other 'non-insured' households, or compared to their rural counterparts. *Mediclaim* beneficiaries indicate high level of expenditures for all the three types of illnesses.

(c) Burden of Health Care Expenditure: The burden of out-of-pocket expenditure on households is computed after estimating the annual per capita expenditure on treatment of illnesses, use of MCH services, and health insurance premium. The per capita expenditure on treatment turns out to be higher for the rural population. In urban areas, the per capita out-of-pocket expenditure among both ESIS and *Mediclaim* is lower than in SEWA and 'non-insured' households. The expenditure as a proportion of income (burden of treatment) was the lowest for *Mediclaim* households and the highest for rural SEWA households. If one includes the expenditures by households on MCH and insurance premium then the burden increases further. The burden of total health care costs varies between 18 and 21 per cent in three categories of rural households, and the corresponding range for urban households is 10 to 18 per cent. Although the *Mediclaim* households have spent the highest amount per illness episode, having reported lower incidence of illness as well as higher level of annual income, the burden is just 6 per cent.

(d) Users' Perceptions on the Delivery of Health Insurance Services: On the subject concerning satisfaction with the schemes, the subscribers of the three insurance schemes under study responded differently. SEWA beneficiaries are largely satisfied with the various aspects of the working of the scheme. SEWA beneficiaries feel that the low premium and maternity benefits are the most positive aspects of the SEWA scheme. The point of dissatisfaction worth mentioning is with the coverage of family members. In the same vein, the dissatisfaction expressed by the ESIS beneficiaries is the distance and inconvenient locations of dispensaries in

the case of rural households, and the time taken to seek treatment in the case of urban households. *Mediclaim* beneficiaries (30 per cent) feel that the process of filing claims should be made simpler and settlement of claims should be done quickly. About 26 per cent of the respondents expect the coverage of OPD (Outpatient Department) expenses/domicilary hospitalisation in the *Mediclaim* plan.

(e) Demand for Health Insurance: The responses indicate a strong inclination towards subscription to health insurance schemes by the households in general and specifically by workers in the informal sector. A majority of the low-income households wish to get enrolled to any health insurance scheme, despite the perception of many, in both rural and urban areas, that their health status is 'good' or 'excellent'. The demand for the SEWA health insurance scheme is the highest both among the SEWA members who are not enrolled as well as the 'non-insured'. About two-fourths of *Mediclaim* households have also expressed interest in joining the SEWA health insurance scheme. The next to follow in the preference order is the *Jan Arogya*. There is a substantial percentage of 'non-insured' and ESIS households in the urban areas, which are willing to enrol in the *Jan Arogya* scheme. The main reason for preference towards both SEWA and *Jan Arogya* is its low premium. It may be worthwhile to point out that there is a substantial percentage of non-enrolment among the SEWA members (42 per cent). The reason put forward by the majority of both SEWA members and those belonging to the 'non-insured' category is the 'no knowledge of insurance'. The knowledge of insurance is also very limited among those who have subscribed to one of the schemes. They have expressed very little knowledge about the alternative schemes. It is, therefore, not surprising that large sections of the sample whose income levels are not high are ignorant of the *Jan Arogya* scheme. *Jan Arogya* has been basically designed for those who cannot afford high levels of premium. The respondents suggested that those managing the scheme(s) should adopt more rigorous methods of spreading knowledge and awareness of the different health insurance schemes.

(f) Expectations from a New Health Insurance Scheme: 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. Among the urban households, however, it is the price of the insurance scheme that seems to be the most important factor considered for

determining the 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 a 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 wanted the coverage of expenses for transport to be included in the plan. The expectation of coverage of OPD and MCH follows next to that. 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. The room for improvement as suggested by the respondents lies in increasing the coverage of family members and coverage of services. The SEWA beneficiaries are, in particular, interested in the coverage of additional household members.

(g) Willingness-to-pay for the New Health Insurance Scheme: 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 coverage of services of hospitalisation, chronic ailment, specialist consultation, and the like. 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.), 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 extra 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 *panchayats,* 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 indicative that most of the low-income households have faith in the public system for delivering of services.

V. Designing an Affordable Scheme for the Informal Sector

The paper 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, the developing and marketing of a unique and affordable health insurance package for the low-income people would be a challenging task.

First of all, there is a strongly expressed need for health insurance among low-income households in both rural and urban areas. This need has arisen primarily because of the 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 nearly one-fifth of their income on treatment. Even among the fully insured households under ESIS, the burden is unduly large, particularly among rural ones. This clearly reflects upon a large-scale inefficiency operating in the delivery of services by both government and ESIS sectors.

While, innovative measures for improvement in ESIS and *Mediclaim* programmes are a necessity, nevertheless these will continue to cover a small proportion of the population. There are hence 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 the procedural aspects such as filing claims are critical in the decision to buy an insurance. A strong preference for the SEWA type of health insurance scheme reinforces the claim 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 includes hospitalisation, maternity and outpatient facilities.

There are several important issues regarding formulating, designing, operationalising, and managing an affordable health insurance scheme for low-income households. Before launching a novel and unique plan, varied designs in different settings can be tried out on a pilot basis, preferably at the district level because some of these would be having severe cost and management implications. The critical points and steps to be considered in this process are discussed below.

(a) Defining The Benefit Package

The types of benefits to be included are: (i) **Inpatient care:** the event is unpredictable but rare and the cost of treatment is either unaffordable or payment pushes people, even the better-off, into indebtedness and poverty. (ii) **Outpatient care**: Insurance is generally not well suited to routine ambulatory care because its requirements tend to be reasonably predictable and are of relatively low cost and people might be expected to meet these costs out of their pockets as they go along without too much hardship. Most people, however, do prefer the inclusion of at least those services (diagnostic and clinical) having a bearing on their pockets. (iii) **Chronic care**: Insurance is also poorly placed to meet the needs of chronic care as such conditions, although of high cost, are not unpredictable. As long as members of a scheme may be willing to subsidise others in rare times of extreme need, they may be unwilling to heavily subsidise them on a regular basis. This is not to say that providing protection for those with chronic illness is not important, but just that insurance is not the best way of doing it. (iv) **Maternity care:** Another area that generates considerable discussion is that of the possible inclusion of deliveries in the package. It is possible to argue that while mothers have nine months to plan to meet the financial costs of normal delivery and should be expected to do so themselves, a scheme might include emergency deliveries which are rarer but expensive.

If schemes do decide to include outpatient care and chronic care they must expect premiums to rise. Also, experience tends to suggest that women groups do want deliveries to be included. If so, the costs of the scheme may rise and again a future requirement might be to include all antenatal care.

Individual schemes may wish to deviate from these broad principles. One option might be to offer greater protection to the poorest in the group by perhaps offering them greater benefits, i.e. to cover the cost of ambulatory care where this benefit is not enjoyed by better off members. Alternatively, schemes could decide to meet the non-medical costs of treatment (e. g. transport costs) or they may even wish to extend benefits beyond just health care to cover loss of income, though this is unlikely and should only be considered when there is a demonstrated record of financial sustainability and ability to pay.

Another possible approach is to consider whether referrals to the more specialized facilities are to be included. Should a scheme's benefits be restricted to secondary hospitals or should referral for, say, specialist cancer treatment or heart surgery be allowed? This could potentially be very high cost and could drain the scheme, resources.

What is an appropriate role for the State? The government would presumably wish to give some freedom to determine the benefit package but may wish to insist that certain elements be included, e.g. inpatient and preventive care. Also a minimal benefit package should be defined so as to ensure delivery of only cost-effective services.

(b) Deciding on a Panel of Providers

If services are free there is little point in getting insurance. If most of the costs are in the form of unofficial fees, again health insurance can do little to help. Health insurance only makes sense when fees are being charged and this may rule out involvement with government facilities. However, fees may differ significantly from government facilities, where services may be free, to NGO providers to expensive for-profit providers. Obviously the higher the fees, the higher

will be the premiums needed for a scheme to break even, but also the greater are potential benefits from health insurance.

The question is whether the services should be restricted to just one provider or whether members should have choices. This depends largely on what members want and where they are currently getting their services but the decision does have some implications as set out below.

In some areas, especially rural and hilly areas, there may be little choice. Such an approach is perhaps easier to implement, although lack of competition reduces any pressure on the provider to improve the services. In urban areas, there may be a number of potential providers. Dealing with a larger number may be more difficult from a managerial point of view but does offer better potential for driving up quality. A scheme offering a choice of providers must include incentives for members to access the quality of care they need in the cheapest setting. One way to do this is to charge higher co-payments for higher cost providers.

(c) Type of Membership and Population Coverage

This includes whether the scheme would cover just the villagers, slum dwellers, poor, occupation groups, thrift and credit groups (e.g. DWCRA), select geographic unit, workers, women, or adult groups. Unit costs will differ if switching over from individual to household memberships because children and other dependents (elderly) have different health needs than the working population. Clearly, on the one hand the more are the people that are covered, the higher are the premiums per household, but on the other hand there is a reduction in adverse selection.

(d) Reducing Moral Hazard and Preventing Adverse Selection

Although the ultimate decision should be down to the group itself it is advisable that unless the majority of members join (ideally all) there are likely to be problems. Ideally one should cover the entire village or panchayat or settlement and make the scheme compulsory while covering minimal benefit package.

If services are free to members once they have paid a premium they have a strong incentive to use services even if their need is not great. One way of preventing such overuse (also called moral hazard) is to charge co-payments – a small amount charged when services are used. Although far less than the user fees, this would at least provide a deterrent to unnecessary use.

Also, on the provider side there are incentives for over-treatment and also the possibility of fraudulent practices as numbers and providers collaborate to falsify claims. One should aim at creating incentives for cost-effective treatment, i.e. preventing unnecessary use of services and ensuring services are of the appropriate quality provided at reasonable cost.

Approaches exist to contain, if not prevent, such practices totally. Members themselves would be expected to monitor the use themselves through peer pressure; it may also be possible to compare utilisation between groups to identify areas where overuse may be possible. Any managing organization could monitor this issue.

(e) Management Arrangements

Management will be important at all stages of preparation, design, implementation, and evaluation. One approach might be to contract an NGO to take on this role. They might carry out the initial groundwork and be responsible for monitoring schemes, perhaps even for negotiating special discounted rates with providers. If the groups are small, the managing agency may wish to introduce an additional element of risk pooling by taxing schemes and redistributing these funds to schemes in need. The role of evaluation would, of course, be given to another institution.

A managing institution, however, would require special skills in the areas of community participation/community liaison/ marketing, bookkeeping and financial analysis, monitoring, access to medical expertise (to validate treatment decisions), and possibly in providing preventive care directly (funded through premiums).

(f) Payment Mechanisms

There are a number of options here. In short, the approach should be as simple as possible and not open to fraud. Funds could be retained within the age group or held at the facility (if they can be trusted). Members might be given a card with their photograph on it and be exempted at the facility with the scheme reimbursing the provider afterwards. Alternatively, the member might be expected to make payment up front and be reimbursed by the scheme later–though this may present a significant barrier to some.

(g) The Role of Government

A number of important roles emerge for government in the development of a health insurance scheme, which include financing, management, training, monitoring, and evaluation.

First of all, it would be important to carry out a mapping exercise which would include the following: identifying the nature and activities of the target groups; assessing their knowledge of, and interest in, health insurance and carry out advocacy and training as necessary through workshops and door-to-door campaigns; identify interested groups for the pilot project; carry out willingness-to-pay survey and design the cost benefit package; carry out a baseline survey on current health practices in the pilot project area and also in control groups to obtain approximate initial administration costs.

It might be reasonable to provide schemes with government funds to meet the initial start-up costs. Those would not be significant as the approach would be paper based. Although an ongoing subsidy is probably unwarranted – schemes would be expected to be self supporting with the benefit package tailored to meet what people are willing to pay – in the short term a subsidy might be justified. Government can also stimulate the interest in the schemes and guarantee interest so that the people can learn the benefits of insurance, a concept many will be unfamiliar with. It can also provide an extra incentive to well designed schemes – the subsidies may be made available to schemes which incorporate elements of best practices. (One approach may be to cover 50 per cent of premiums for a fixed period of two years.)

If government wishes to evaluate schemes with a view to their replication it is important that the schemes are developed in a variety of settings (urban/rural with varied access to types of health facilities and socio-economic population groups). Otherwise they will leave themselves open to criticism that they only work in particular circumstances. It is also important to be clear about what the schemes are intended to achieve so that there can be some basis for evaluation.

VI. Conclusion: The Way Out

The above experiences suggest that there is much potential and scope to enhance the coverage of health insurance in general and, more specifically, to the poor. In view of the recent development in the insurance sector, by opening it to the private player, so far the license has been given to eight companies by the Insurance Regulatory and Development Authority (IRDA). It is good to note that now the IRDA has made the mandatory requirement for new companies to float a plan of health insurance as well. However, only HDFC and ICICI have come up with a health insurance plan and it is our assertion that only the upper and middle-income people are most likely to be benefited by these new plans. Therefore, the main thrust of the State should be in initiating schemes for the poor. For this purpose the discussion in the above sections suggests at looking towards options that could be explored through using the existing infrastructure, institutional arrangements, and networks in the public sector welfare programmes. It is presumed that the following options could be more suitable under the existing circumstances, that is, without putting much strain on both physical and financial resources of the State. It is of utmost importance that such options should be more cost- effective and the services be more responsive to people in the future. These viable options which encircle and involve the existing system pertain to: ESIS, crop insurance schemes, poverty alleviation programmes, safety nets, and Panchayat Raj institutions.

ESIS continues to have a poor outreach, especially in the rural areas. The exclusion of the poor in general and the rural people in particular from health schemes put a strain on scarce government finances. Further, even the urban poor are now finding it difficult to access the facilities of ESI hospitals and dispensaries because, with the urban growth and relocation of industries outside the cities, the habitat of the urban poor has moved away from these ESI hospitals and dispensaries. This has also meant underutilization of ESI facilities. In a couple of states, however, the ESI hospitals have opened up to the poor population located in the

catchment area on payment of a small charge for the services. There are of course quality issues that have to be addressed separately.

Tagging a new health insurance with the existing crop insurance scheme in the state could be another feasible alternative. Currently the government has started subsidizing the crop insurance scheme to the extent of 50 per cent. This has helped prevent farmers to commit suicide owing to crop failure. A health insurance scheme could be mounted using the existing network of crop insurance. This would save the task of creating a separate agency for initiating and implementing health insurance for the poor.

Another way to increase or initiate health coverage to the poor could be to make health insurance a component of existing poverty alleviation programmes. This option may require additional staff for the purpose. However, other problems which come in the way of integrating insurance in the existing programmes need to be worked out in detail. In this regard, an interesting option proposed recently suggests that a rural hospitalization insurance scheme for people below the poverty line could be initiated as a part of the anti-poverty programme at a cost of Rs. 9000 million, presuming a low premium of Rs. 30 per head for the estimated 300 million poor in the country (Krishnan 1996). It is also estimated that there are nearly 300 million people in the country who are below the poverty line; at a particular point in time, only 6 per cent of this population will require hospitalization and therefore risk pooling will take place. Further, the insured persons under this scheme would be entitled for free hospital beds and other basic medical services. As suggested further by Krishnan, this scheme should be taken up as a part of the anti-poverty programme and, thus, resources should come from unspent savings under the programme or by a reallocation of government expenditure.

Another innovative approach could be built in a movement which empowers women to overcome their poverty. This could be in the form of creating thrift groups of women (Mahila Bank) and other safety nets (e.g. the Development of Women and Children in Rural Areas (DWCRA) programme). There are 15 Mahila banks in Andhra Pradesh which also provide loans for treatment of catastrophic illness at a very low rate of interest to women members.

Besides, there are a number of community risk pooling schemes, initiated by the NGOs. These generally target the poor, especially in the rural areas. SEWA is one example of such a

successful community based scheme, addressing itself to the health needs of the women in rural areas and small towns.

Learning from the initial experience of other countries, in due course of time, to cover the entire population, some of the mechanisms adopted in the other countries to cover the self-employed like farmers, fishermen, elderly dependent, disabled, and unemployed through various means including earmarked taxation and cesses could be deployed.

Finally, the Panchayat Raj institutions (PRIs) can play pivotal role in administering, coordinating, and managing new health insurance schemes. It is observed that in many states PRIs are successfully monitoring and implementing various health programmes (Gupta and Gumber 1999). Also, in Kerala, Tamil Nadu, and Rajasthan, many other intersectoral functions are being efficiently handled by the PRIs, some of which directly impact on the primary health component. For instance in Kerala, PRIs are carrying out a number of activities related to water, roads, street lighting, drainage, and solid waste in a coordinated manner. It may thus be worthwhile for the state to delegate power to PRIs to plan, manage, and run various welfare schemes, including community health insurance, to address the basic needs of the poor section of the society.

Annex I

Government Health Insurance Schemes: Infrastructure and Coverage

Infrastructure and Coverage	All India
CGHS (30.9.97)	
Dispensaries	320
Polyclinics	20
Labs	71
Dental Units	17
Coverage-Families (’000)	936
Coverage-Beneficiaries (’000)	4249
Annual visits per beneficiary (1994–95)	3.5
Posts & Telegraph	
Dispensaries	62
Railways (1987-88)	
Hospitals	110
Dispensaries	665
No. of Beds	12,644
Medical Staff	55,945
Beneficiaries (’000)	8600
Expenditure per beneficiary (Rs.)	31.59
ESIS Infrastructure (31.3.97)	
Hospitals	125
Dispensaries	1443
Beds	23,334
Doctors-Sanctioned	6220
Doctors-in-Position	5008
Practitioners	2900
Ambulances	287
ESIS Centres	632
Employers	200,471
Employees (’000)	7731
Insured Persons (’000)	8445
Beneficiaries (’000)	32,766

Annex II

Select Tables Based on Results of Pilot Study on Health Insurance for Informal Sector in Gujarat

Table 1: Select Characteristics of the Surveyed Population by Health Insurance Status

Characteristics	Rural			Urban			
	Non-insured	SEWA	ESIS	Non-insured	SEWA	ESIS	*Mediclaim*
Sampled Households	127	121	113	240	236	239	116
Population	651	666	618	1297	1437	1301	537
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 (Rs.)	31,164	31,182	36,711	33,537	37,715	38,197	79,086
Mean household monthly exp. (Rs.)	2319	2299	2793	2484	2869	2887	5123
Mean household size	5.13	5.50	5.47	5.42	5.88	5.64	4.63
Health Insurance Coverage							
Households (%)	3.1	47.1	100.0	4.6	66.1	100.0	100.0
Population (%)	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	41	70	130	25	80	126	221

Source: NCAER–SEWA Survey, 1999.

Table 2: Morbidity Profile of Population by Health Insurance Status

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
Both sexes	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
Both sexes	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
Both sexes	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
Both sexes	1796	2381	1874	1877	2095	1965	953

Note: Various morbidity rates are per 1000 population.
Annual morbidity rate = Acute morbidity rate* 12 + Chronic rate + Hospitalisation rate.

Source: NCAER–SEWA Survey, 1999.

Table 3: Source of Treatment by Health Insurance Status

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 4: Medical and Total Cost of Treatment by Facility Use and Health Insurance Status

(Amount in Rs.)

Type of Morbidity	Rural			Urban			
	Non-insured	SEWA	ESIS	Non-insured	SEWA	ESIS	*Mediclaim*
(a) Medical Cost							
Acute morbidity	246	218	234	241	233	99	686
Government	83	286	83	189	371	145	--
ESI Facility	--	--	2	NE	NE	8	--
Private	265*	213	284	245	212*	212	686
Chronic morbidity	357	322	221	223	274	142	220
Government	200	350	13	234	242	127	150
ESI Facility	--	--	0	NE	--	17	--
Private	401	315	362*	222	289	319*	227
Hospitalisation	2427	3072	2200	3246	2099	621	4045
Government	2200	4785	1896	1772	1196	900	1400
ESI Facility	--	--	33	NE	NE	64*	--
Private	2583	2422	3266	4970	3175*	2135*	4339
(b) Total Cost of Treatment							
Acute morbidity	424	317	398	341	344	206	923
Government	142	456	233	220	625	208	--
ESI Facility	--	--	191	NE	NE	127	--
Private	456	308	444	348	296*	304	923
Chronic morbidity	719	511	664	387	390	246	269
Government	476	621	620	553	374	262	225
ESI Facility	--	--	334	NE	--	124	--
Private	787	483	835	283*	398	412	274
Hospitalisation	3502	4323	3076	2954	3280	1146	4034
Government	3599	6151	3174	2161	2408	1467	1740
ESI Facility	--	--	961	NE	NE	469*	--
Private	3435	3630	3884	3908*	4321*	2996*	4289

Note: Medical cost includes expenses towards fees, medicine, diagnostic, and other hospital charges.
Total Cost = Medical cost + Other direct cost + Indirect cost – Reimbursement.
Other Direct cost 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 (@ 24 per cent) on the amount borrowed during the course of treatment.
* shows that the mean value is significantly different from that of government facility.
It excludes cases treated at home or not treated at all. NE – not estimated due to small no. of cases.

Source: NCAER–SEWA Survey, 1999.

Table 5: Total Health Care Burden on Households by Health Insurance Status

Indicator	Rural			Urban			
	Non-insured	**SEWA**	**ESIS**	**Non-insured**	**SEWA**	**ESIS**	***Mediclaim***
Annual Per Capita Health Exp. (Rs.)							
Direct	968	1036	868	888	966	438	855
Indirect	280	196	286	167	191	131	87
Total (Net)	1247	1232	1149	981	1156	569	905
As % of Per Capita Income	19.1	20.4	16.0	14.6	17.0	7.9	4.7
Av. Annual Health Insurance Premium by the Household (Rs.)	9	44	523	7	74	538	648
Av. Expenditure on MCH (Rs.)	492	577	466	722	659	709	576
Burden of Total Health Care Costs on Households (%)	19.9	21.4	17.9	15.6	18.0	10.1	5.7

Note: 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 6: Health Insurance Awareness by Health Insurance Status of the Household

Indicator	Rural			Urban			
	Non-insured	**SEWA**	**ESIS**	**Non-insured**	**SEWA**	**ESIS**	***Mediclaim***
% 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
% 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: Per centages do not add to 100 because of multiple response.

Source: NCAER–SEWA Survey, 1999.

Table 7: Expectation from a New Health Insurance Scheme by Health Insurance Status

Types of Expectations/ Preferences	Rural			Urban			
	Non-insured	SEWA	ESIS	Non-insured	SEWA	ESIS	*Mediclaim*
% 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 & maternity Care	68.5	79.3	62.8	95.8	97.5	97.1	81.0
% 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 inst.	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 & 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 8: Average Per Capita Premium Willing-to-pay for a 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 (Rs.)	80.4	82.6	95.3	82.1	83.3	84.1	206.5
Stage 2: After enlisting types of costs to be covered (Rs.)	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 (Rs.)	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

Note: **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.

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