*Indus Journal of Management & Social Sciences*
Vol. 1, No. 2: 129-146 (Fall 2007)

# Health Insurance for the Poor in Informal Sector

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## ABSTRACT

The realization that mere existence of health care facilities does not necessarily mean that they are readily accessible to the poorest section in the informal economy, tend to the evolution of a unique health insurance scheme, with contribution according to individual capacity. This paper examines several health insurance schemes catering to the informal sector as well as some critical issues with regard to extending health insurance coverage to poor households in general and those working in the informal sector in particular.

**JEL. Classification**: E26;G22; H55; I10;I30; I38; J16; J71

**Keywords:** Health Insurance Schemes, Health Care Facilities, Social Security, Informal Sector

## 1. INTRODUCTION

The informal economy is vertically stratified. The concept has sufficient flexibility and content to provide a suitable framework of analysis for the non-formal sector. It is an imperative segment of the labor market in many developing and transition countries. Starting from complete neglect, then phenomenon of informal economic activity has grown to be a subject of study by many researchers, both governmental and non-governmental. The informal economy is a part of survival and household strategies; nevertheless its contribution to well-being remains inadequately understood and largely unnoticed by policy makers. The recent phenomenal intensification of the informal economy and the rising interaction and interdependence of the formal and informal economy lead to growing interest in

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IJMSS is published by Indus Institute of Higher Education (IIHE), Plot. # ST-2D, Block-17, Gulshan-e-Iqbal, Karachi, Pakistan

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studies of the informal economy among many researchers and policy makers. The term informal sector and informal economy are used interchangeably to specify that segment of the economy and labor market, which has absorbed significant numbers of job seekers and unemployed workers outside government regulations and formal systems of labor and social protection. Studying the existing literature on the informal economy rapidly makes it evident that there is no standardized conceptual framework wrapping the subject. An extensive range of terms is used for numerous definitions or less precise descriptions of the phenomenon. Sometimes the similar term is used for diverse concepts and sometimes several terms portray the same concept. Various methods of research have been used to attain information on different concepts of the informal economy. The choice of methodology often resolves which part of the informal economy can be covered. This delves into why institutions or researchers interested in a specific definition and a specific coverage of the informal economy tend to use related approach and methodology. The scholars of the informal sector are still grappling with developing a concrete theoretical framework for what is undoubtedly a multifarious subject. However a key achievement of existing work on the sector is the legitimizing of the informal sector as a theoretical concept that calls for further empirical consideration in insurance sector.

In India the informal sector employs more than 90 percent of workforce, most if not all, are covered by meaningful social security schemes. The term social security in developing countries is used in much broader sense than that used in developed countries (Ahmad, Dreze and Sen 1991; Guhan 1994; Prabhu 2001; Sarkar and Bhuimali 2005). It has been further recognized that the neglect of social opportunities due to lack of adequate progress in social security has been detrimental to the economic and social development in the developing countries including India (Datta 1998:L-2). The informalised workforce is unprotected labor, which implies labor that does not have any socio-economic safety. The protection that a society provides to individuals and households to ensure access to wage and working conditions in a comprehensive sense, in matters of security of employment, health care, maternity benefits, provident fund, retirement benefits, is an essential element of the safety nets that keeps working people and their families from falling into poverty (Sarkar 2004 a: 122).

The informal sector represents an important part of the economy and certainly of labor market in many countries, especially developing countries and poses a challenge to policy makers with regard to issues relating to improvement of the working condition and social protection of the workers engaged in the informal sector (Sarkar 2006a). In the developing economies a substantial share of employment is indeed in informal category and women in all age groups depend on the informal sector more heavily than men. Women are over represented in this sector in the sense that their share in the sector is higher than their share in total labor force. Most women tend to be own account workers and only a few are heads of micro enterprises. Relatively lower level of education among women, compared to men, seems to explain, in part, this gender differential in informal employment. Discrimination in the labor market also explains in part the disproportionate concentration as it limits women's access to

formal and wage employment. Women also face additional constraints because of their homemaking and childcare responsibilities, which limits their participation in formal employment. Even within the informal sector more women than men seem to be in poor quality employment. The causes for participation in the informal sector can be economic and non-economic. Economic reasons are related to unemployment and an inflexible formal labor market, a declining real price of capital and the high cost of formal production. Besides, non-economic causes are concerned with a greater flexibility and satisfaction in work, a complete use of workers professional qualifications and increased leisure time. There are two groups of factors, which determine the decision to become active in the informal sector, more specifically, the structural as well as opportunity factors. The structural factors consist of financial pressure, socio-psychological pressure and institutional constraints. The opportunity factors consist of individual background, skills, education, living condition or non-individual components, environment, values, standards etc. (Sarkar 2004 b: 366).

There are high rates of poverty among rural people, indigenous South Asian and some groups of immigrants. It negatively affects the life chances and opportunities of women and children. Children are vulnerable and dependent, and the effects and impacts of poverty can so easily stultify and distort women and children future lives by robbing them of opportunities to develop their potential. In addressing women's poverty, many studies measure the incidence of income or consumption poverty among female-headed households and compare it to that of male-headed counterparts. The unit of analysis is the household and the incidence of women's poverty is conflated with the poverty of female-headed households. On a priori grounds, there are reasons to be concerned about the welfare of female-headed households, since women are subject to discrimination in labor, credit and a variety of other markets and they own less property compared to men. In some societies, widows, divorced or abandoned women may be subject to social exclusion, isolation and harassment, making it very difficult for them to maintain a livelihood for themselves or their children. Women heads of households with young children may face great time constraints and may have to limit their work hours. Even though female-headed households are a relatively small proportion of households. This has been seen as evidence that women are becoming poorer over time relative to men. The comparative poverty of female-headed households' vis-à-vis male-headed counterparts is not universal. It has also been argued that it may be more meaningful to study female-maintained households as opposed to those headed by women. Female-maintained households are those in which women are the primary providers of the family. What is also necessary to understand is the process through which households become women-headed or female-maintained rather than viewing headship as a static indicator. When programmes targeting female-headed households analyze the reasons for the rise, nature and vulnerability of such households, it has been possible to design effective anti-poverty programmes that target female headship (Sarkar 2006b).

The vulnerable women suffer from the larger level of bribes than the non-poor households. With the difficult economic conditions of transition, a number of women

no longer value edification as much as they did before the transition; their pinnacle priority is mere survival. In most ethnicity, women and men have differing roles and responsibilities according to socially defined division of labor based on gender. This gender inequity is reflected in a variety of social and economic dimensions. In terms of reproductive activities, women generally have primary responsibility for the care and feeding of children and families, as well as health care and education. In many developing countries, it is the women who perform most of the work related to subsistence agriculture, plus gathering and managing fuel and water as a part of the household responsibility. Their productive activities are often unpaid and labor-intensive. When women in rural areas do generate income, it tends to be within the informal sector, and not adequately reflected in national accounting systems. This serves to under-represent the importance of energy as an input to women's economic activities. Because they operate mostly in the informal and unpaid sectors, poor women have less access to financial resources, credit and equipment than do men, and less of a voice in household, or community-level, decision making. Gender-poverty is a problem that has a disproportionate effect on women and girls, especially in rural areas. The most obvious factors relate to time and physical effort. Many women in developing countries have to spend long hours gathering fuel and hauling water, using their own labor to carry heavy loads over long distances in addition to other informal work. When women are overburdened, they are more likely to keep their daughters home from school to assist with own household activities, including fuel and water collection, thereby limiting opportunities for girls to move forward through education, and rising the likelihood that their families will remain in poverty.

The realization that mere existence of health care facilities does not necessarily mean that they are readily accessible to the poorest section in the informal economy, tend to the evolution of a unique health insurance scheme, with contribution according to individual capacity. Health insurance protects against the cost of illness, mobilizes funds for health services, enhances the efficiency of mobilization of funds and provision of health services, and achieves certain equity objectives by continuously benchmarking. Previously insurance was not considered as an option for the poor in informal sector. They were regarded to be too poor to save and pay premium. It is being gradually recognized that even low-income group can make tiny contribution to health insurance schemes. Health insurance for the poor can take different forms namely, community based or non-community based insurance policy of the government. In recent years community health insurance has gained as a possible means of improving access to health care among the poor and protecting the poor from indebtedness and hardship resulting from medical expenditures. Non-governmental organizations (NGOs) play an important role in the delivery of affordable health services to the poor but their coverage has always remained diminutive (Table 1 and 2). This paper examines several health insurance schemes catering to the informal sector as well as some critical issues with regard to extending health insurance coverage to poor households in general and those working in the informal sector in particular.

## 2. EXISTING HEALTH INSURANCE SCHEMES

The various health care programmes are presently operating for the informal sector in developing countries. In India community and self-financing schemes, and micro-credit linked health insurance schemes are the important intermediate steps in the evolution of an equitable health financing mechanism for the workers in informal sector.

**Table-1**
**Salient Characteristics of Select NGO Managed Health Insurance Schemes**

| Voluntary Organizations / Location | Date Started | Service Provided | Health Service Delivery/Organis-ation | 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<br>• Outpatient pediatric 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.<br>• health centres staffed by nurse provide outpatient care run MCH clinic<br>• 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, gynecology, surgery, ophthalmology | - | 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]

Various other terms are used with regards to community health insurance (CHI), including micro health insurance and local health insurance. The benefit of CHI lies in keeping transaction cost low, in formulating a scheme suited to community needs, in influencing health behavior through health education, and affecting the supply health care. CHI programmes offer best aspiration for cutting down financial burden caused by sickness to a large segment of the low-income groups. This scheme is purely based on non-profit making motive, which is intended for the workers of informal sector and involves repayment and the pooling of resources to cover the cost of health related matters. Often the schemes are operated by a hospital and intended at households of the surrounding area and membership is voluntary rather than compulsory. A survey of existing literature on health insurance suggested approaches to community financing. The conventional method to community financing was considered to be inapt and forced *Sewagram* to fashion its responses in the light of its own observations and experiences (Table 3).

**Table- 2**

**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 | 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 | Community care: free CHW services and drugs. Free health centre services including MCH clinic. Hospital: | 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 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | illness episodes, 25% subsidy for anticipated illness episodes, e.g., pregnancy and chronic ailments | free care after paying entrance fee up to ceiling of Rs. 1000 | | | | |
| 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 entitled 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 enroll 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]

**Table- 3**
**Approaches to Community Financing**

| Conventional Approach | Sewagram Experience |
|---|---|
| It does little to promote equally, can place great burden on the poor and the sick, and suffers from poor selection.<br><br>It lacks stability and needs some external support to mobilize and sustain | The principle of contribution according to capacity, but services according to need, developed an egalitarian system, which does not suffer from poor selection.<br>The acceptability and affordability of the |

| | |
|---|---|
| community efforts.<br><br>It favors the creation of those health facilities for which there is high local demand, rather than meeting professionally perceived needs.<br><br>It carries the danger of an excessive use of facilities.<br><br>It is never easy to sell the concept among poor people.<br>It tends to benefit the community more than individual and hence there could be greater reluctance to participate. | scheme resulted in stability of revenue and willing community involvement on a sustainable basis.<br>Doctors prefer not to over-medicate, as the hospital has to raise 25 per cent of its own expenditure.<br>Also as the remaining 75 per cent of the funds is assured to the professionals, they do not succumb to whimsical local demands for tonics and injections.<br>The facilities are primarily controlled by professionals and not by the people, thus avoiding chance of excessive use.<br>The need for and affordability of the scheme are strong selling points.<br>Sewagram's insurance scheme is oriented more towards individual as there is an element of risk sharing and hence there is little reluctance to participate. |

*Source:* Jajoo [2000]

Several NGOs and governments have initiated micro-credit schemes for vulnerable groups to crash 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 creates 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 initiated 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 petty 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 informal sector. It organizes 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. 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 major motivation behind the initiation of a health insurance scheme for women is that maintenance of an active health seeking behavior 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, hospitalization coverage for a wide range of diseases, and insurance for occupational health related illnesses and other diseases specific to women (Table 4).

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 premium.

The comprehensive review of the existing health insurance schemes for informal sector in India describes that several programmes indulge to economically lower segment of the population (Sarkar 2006c). The voluntary health insurance plan, which

**Table- 4**
**Type of Coverage under SEWA Scheme**

| Provider | Description of Coverage | Coverage Amount (Rs.) | Premium (Rs.) |
|---|---|---|---|
| New India Assurance | Accidental death of the woman member<br>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.:<br>(a) of work equipment<br>(b) of the housing unit | <br><br>2000<br>3000 | 8.00 |
| | Health Insurance (Including coverage for:<br>(a) gynecological ailments<br>(b) occupational health related diseases) | 1200 | 30.00<br><br>(10)<br><br>(5) |
| | Maternity Benefits | 300 | - |
| Life Insurance Corporation of India | Natural death<br>Accidental death | 3000<br>25,000 | 15.00 |

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

covers only hospitalization 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 minute, let alone those employed in informal sector. The market for health insurance is growing at a substantial rate, though. At this stage, it may be worthwhile to abridge the experience with health insurance of selected Asian and Latin American countries to understand 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 worth mentioning.

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 characterized 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 namely, labor insurance medical coverage for state-owned enterprise workers and retired persons, and 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 compared to some of its Asian counterparts like India and Indonesia.

Thailand has four different kinds of health care financing programmes namely, voluntary health schemes, mandatory schemes, social welfare schemes, and fringe benefit schemes. 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 an enviable 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 characterized 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 where government is the sponsor and 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 namely, 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 and a large number of private insurance plans. 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 efficiency 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 exceeded India as far as the achievements in the area of health are concerned. China's basic indicators of infant mortality rate, life expectancy, and maternal mortality are far more favorably placed as compared to those of India. Thailand's health-card scheme has been another pioneering attempt towards promoting grass-root participation and management skills (Gumber 2002).

## 3. EXTENDING HEALTH INSURANCE COVERAGE

There are several important issues concerning formulating, designing and operationalizing an affordable health insurance scheme for the poor in informal sector. Before introducing a unique plan, wide-ranging designs in different settings can be tried out on a pilot basis. The critical points and steps to be considered in this process are as follows (Gumber 2002).

### 3.1 Defining 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 subsidize others in rare times of extreme need, they may be unwilling to heavily subsidize 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.

### 3.2 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.

### 3.3 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.

### 3.4 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 utilization between groups to identify areas where overuse may be possible. Any managing organization could monitor this issue.

### 3.5 Organizational 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).

### 3.6 Payment Systems

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.

### 3.7 The Task of Government

A number of important roles emerge for government in the development of a health insurance scheme, which includes 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.

## 4. CONCLDING REMARKS

Health insurance has gained amplified importance as a financing tool in meeting health care facilities to the poor in the informal sector. Community based health insurance is more useful mechanism for providing insurance to the poor. However the approach of the government is to support voluntary insurance rather than to widen the existing social insurance schemes. Social insurance may be better way of providing health protection to the low-income groups but alternative straightforward approaches to the people below the poverty line are needed. From a human poverty or capabilities perspective, makes it possible to see that women are indeed poorer in most societies in many dimensions of capabilities such education and health, but not necessarily in terms of life expectancy, although there are also societies in which women's life expectancy is shorter than men's due to maternal mortality or child mortality that may result from biases against girls' health and nutrition needs. Resource allocation within households is often biased against girls and women. In addition, it is harder for women to transform their capabilities into incomes or well being. Gender inequalities in the distribution of income, access to productive inputs such as credit, command over property or control over earned income, as well as gender biases in labor markets and social exclusion that women experience in a variety of economic and political institutions form the basis for the greater vulnerability of women to chronic poverty. Although it is often stated that labor is the poor most abundant asset, women are relatively time poor and much of their work is socially unrecognized since it is unpaid. Furthermore, when women are in paid work, the return to their labor is lower than the return to men's labor. Thus, women on average work more, but have less command over income as well as assets. Nor do they always have control or command over their own labor. In some cases, men may prohibit their wives from working outside the household and seclude them. In other cases, men may extract labor from women with the threat or actuality of violence, as for instance, in the case of unpaid women family laborers. Men tend to have more command over women's labor so that in crisis situations they may be able to mobilize the labor of women, while women generally do not have the reciprocal right or ability to mobilize men's labor. From a human poverty or capabilities perspective, makes it possible to see that women are indeed poorer in most societies in many dimensions of capabilities such education and health, but not necessarily in terms of life expectancy, although there are also societies in which women's life expectancy is shorter than men's due to maternal mortality or child mortality that may result from biases against girls' health and nutrition needs. Resource allocation within households is often biased against girls and women. In addition, it is harder for women to transform their capabilities into incomes or well being. Gender inequalities in the distribution of income, access to productive inputs such as credit, command over property or control over earned income, as well as gender biases in labor markets and social exclusion that women experience in a variety of economic and political institutions form the basis for the greater vulnerability of women to chronic poverty. Although it is often stated that labor is the poor most abundant asset, women are relatively time poor and much of their work is socially unrecognized since it is unpaid. Furthermore, when women are

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