Women organizing for social protection

The Self-employed Women's Association's Integrated Insurance Scheme, India

STEP Programme
Social Protection Sector
International Labour Office

4, route des Morillons
CH-1211 Geneva 22, Switzerland
Tel.: (41 22) 799 65 44 – Fax: (41 22) 799 66 44
e-mail: step@ilo.org – INTERNET: www.ilo.org/step/publs

The programme "Strategies and Tools against Social Exclusion and Poverty" (STEP) of the International Labour Office is an instrument for extending the coverage and effectiveness of social protection throughout the world.

Following the conclusions of the World Summit for Social Development in Copenhagen, the STEP programme promotes the design and the implementation of innovative systems of social protection for excluded populations. Based on the principles of equity, efficiency and solidarity, these systems contribute to social justice and cohesion.

In its work, STEP combines different types of activities: concrete actions in the field, research, production of methodological tools, reference documents and technical assistance for policy development and implementation.

Women organizing for social protection

The Self-employed Women's Association's Integrated Insurance Scheme, India

International Labour Office

ILO
Women organizing for social protection. The Self-employed Women's Association's Integrated Insurance Scheme, India
Geneva, International Labour Office, Strategies and Tools against social Exclusion and Poverty Programme (STEP), 2001

Social protection, woman worker, self employed, womens organization, informal sector, health insurance, India. 02.03.1

ISBN 92-2-112627-7

ILO Cataloguing in Publication Data

This publication can be obtained, free of charge from:

ILO-STEP Programme
Social Protection Sector,
International Labour Office
4, route des Morillons
CH-1211 Geneva 22,
Switzerland
Tel.: (+41 22) 799 6544
Fax: (+41 22) 799 6644
E-mail: step@ilo.org
http://www.ilo.org/step/publs

Printed in Italy

CONTENTS

ACRONYMS

ACCORD	Action for Community Organization, Rehabilitation and Development
ASSEFA	Association of Sarwa SEWA Farms
CHC	Community Health Centre
ESI	Employee's State Insurance
EPF/MP	Employee's Provident Fund/ Miscellaneous Provisions
FD	Fixed deposit
GDP	Gross Domestic Product
GIC	General Insurance Corporation of India
GIS	Group Insurance Scheme
GoI	Government of India
GTZ	Gesellschaft für technische Zusammenarbeit (German Technical Development Agency)
HDI	Human Development Index
ILO	International Labour Office
IIS	Integrated Insurance Scheme
IRDP	Integrated Rural Development Programme
LALGI	Landless Agriculture Labourers' Group Insurance
LIC	Life Insurance Corporation of India
NGO	Non-governmental organization
NIACL	New Indian Assurance Company Ltd
NSAP	National Social Assistance Programme
PHC	Primary Health Care Centre
RBI	Reserve Bank of India
RGLIS	Rural Group Life Insurance Scheme
SAAT	South Asia Advisory Team
SEWA	Self-employed Women's Association
SPARC	Society for Promotion of Area Resources Centre
STEP	Strategies and Tools against Social Exclusion and Poverty Programme

Rs.	Indian rupees
UIIC	United Indian Insurance Company
UNDP	United Nations Development Programme
WHO	World Health Organization

Exchange rate in 1998
Rs.41.3 = US$1

Exchange rate in 2000
Rs.46.0 = US$1

INTRODUCTION

Several international declarations and conventions claim social protection as a universal right. Most countries in the world mention the individual's right to social protection in their constitution or in their legislation. Nevertheless, today, the majority of the world's population has no access to this kind of protection. For example in the case of health, over 80 per cent of the population in most countries in sub-Saharan Africa and in southern Asia are estimated to be without social protection. In the rest of Asia and much of Latin America the figure is still as high as 50 per cent. If social protection is first of all an individual's legitimate right, it is also a condition for economic and social progress. In this sense the lack of social protection not only affects the well-being of a large part of humanity, but also contributes to the persistence of poverty and social exclusion.

In a great number of cases, insufficient financial resources and institutional capacities considerably limit the possibilities of extending social protection through the effort of the state alone. Sometimes the state simply does not pay enough attention to this question. To complement the state's effort, new local initiatives, creating insurance schemes adapted to the poorer population, are appearing in many countries. These schemes, grouped under the term micro-insurance, take diverse forms. There are still few of them worldwide, but their number is increasing rapidly.

The Self-employed Women's Association's (SEWA) insurance scheme is one of the oldest schemes of this type. Since its foundation in 1972, SEWA has carried out other activities for its members. In particular, SEWA is active in the field of self-employed women's rights, cooperatives, banking, health and capacity building and it is one of the few registered trade unions for self-employed women workers in India. Through these activities, its members have expressed a special need, the need for social protection. In 1992 SEWA set up an insurance scheme to address this need. The insurance scheme has developed from a simple life insurance to a more comprehensive insurance, its Integrated Insurance Scheme (IIS), which now comprises health, life and assets components and a maternity benefit. Today more than 26,000 SEWA members belong to the Integrated Insurance Scheme.

This study has been undertaken in order to better understand and to share the lessons of this experience. Its aim is not an evaluation of the scheme. It discusses

issues relevant to a better understanding of the insurance scheme, such as information about the SEWA movement and the environment in which the scheme operates, and provides a brief overview of social protection schemes in India. The study examines the key stages in the development of the scheme,[1] the roles of the main parties involved and the structure of the benefit package and premiums. Furthermore, it takes a detailed look at certain aspects of the health component of the benefits package. The final part deals with the financial aspects of the scheme.

The STEP programme, which conducted the present study, had previously undertaken another study intended to address SEWA's own internal statistical needs, carried out by Smita Srinivas in 1999. The present study uses data and information from the STEP-Srinivas study, as well as further information provided by SEWA's IIS and SEWA Bank staff and drawn from SEWA internal documents. The financial analysis within the chapter about the financial operation of the scheme was prepared by John Woodall, Senior Social Security specialist with ILO-SAAT, the South Asia Advisory Team, based in New Delhi. Some of the data on the health component come from a survey by Kent Ranson, as part of his doctoral research at the London School of Hygiene and Tropical Medicine.

1 The study had been finalized before the earthquake hit Gujarat State in January 2001. Therefore the consequences of the earthquake on the SEWA members and on the Integrated Insurance Scheme have not been considered.

Chapter 1

CONTEXT OF THE INTEGRATED INSURANCE SCHEME

1. The SEWA movement

As a background to this study, this section looks at the origins of the SEWA movement, its ideology, goals and the individual elements of the SEWA family of organizations and programmes as a whole, focussing on the issues relevant to a better understanding of the insurance scheme.[2]

1.1 *SEWA's origins*

The SEWA movement goes back to 1972, when it was founded by Ela Bhatt in Ahmedabad, the principal city of Gujarat State in India, and today still the main centre of SEWA's activities. SEWA has grown from a small group of women into a major social movement with more than 200,000 women members, working in the informal economy. Such workers include the self-employed, employees without a formal contract or unpaid family members.

The SEWA movement was inspired by the example of M.K. Gandhi, later to become the *Mahatma*. He himself hailed from Gujarat State, among other things, campaigning to reverse the decline of the textile industry in Ahmedabad, once home to many factories and textile workers. Textile production in cities like Ahmedabad nevertheless began to slow down, textile mills were shut down and workers were laid off. Poverty and unemployment began to spread rapidly, leading to a growing informal economy. SEWA, with offices on the Sabarmati River, near the Gandhi Ashram, seeks to pursue its activities in the spirit of Gandhi.

2 Further information about the SEWA movement is available in SEWA' s own reports.

1.2 *SEWA's philosophy, goals and membership*

Philosophy and goals

SEWA's philosophy and origins, with their fundamental inspiration of the Gandhian principles of *satya* (truth), *ahimsa* (non-violence), *sarvardharma* (integrating all faiths, all people) and *khadi* (propagation of local employment and self-reliance), lie at the core of SEWA's administration and planning (SEWA, 1999).

SEWA has two main goals. The first is to organize women workers to achieve full employment, i.e. work security, income security, food security and social security. The second is to make them individually and collectively self-reliant, economically independent and capable of making their own decisions.

SEWA sees itself both as a movement specifically concerned with workers' problems and as an organization committed to integrating the distinct but convergent needs of women workers. It can be seen as a confluence of the women's movement, the labour movement, for the self-employed especially, and the cooperative movement. It draws its strength from all three (SEWA, 1999).

In recent years SEWA has adopted an integrated approach to eradicating poverty. According to SEWA in its 1999 report, it consists of:

- *organizing* for collective strength, bargaining power and representation on committees and boards at district, state, national and international level;
- *capital formation* at household level to allow women in their own right to have access to financial services, such as savings, credit and insurance, to build and develop property, including land, house and workshop;
- *capacity building* through education, information and training, to allow women to run their own businesses and compete in the market place by giving them access to market facilities;
- *social security* based on the principles of dignity of labour and "work security". For SEWA, the concept of work security means simultaneously addressing the multiple risks of ill health, loss of assets, unforeseen calamities, death and disability, and child-bearing with their attendant economic and social effects. Any one or a combination of these factors may keep women workers in poverty.

No one of these four components alone, SEWA believes, can deliver the desired results. They must be viably combined in a way that the workers can manage for themselves.

SEWA's membership

SEWA has almost a quarter of a million women members in total (215,234 in 1999), predominantly in rural areas, and the bulk of them (over 147,000) in Gujarat State alone. SEWA is also active in six other states in India, with 42,000 members in Madhya Pradesh and almost 10,000 in Uttar Pradesh. SEWA's activities also extend abroad, to countries such as Turkey, Yemen and South Africa.

Table 1. SEWA Membership
(whole of India and Gujarat State)

Year	India	Gujarat State
1990	25 911	25 911
1991	46 076	46 076
1992	45 936	38 136
1993	53 570	42 280
1994	143 702	75 615
1995	218 797	158 152
1996	212 016	162 781
1997	211 124	159 204
1998	209 250	142 810
1999	215 234	147 618

Source: SEWA, 1999.

SEWA works mainly with women in the informal economy, broken down into the following three categories: *self-employed, regular wage workers* and *casual labourers.* SEWA works with all three, and within those categories, lays special emphasis on *home-workers.*

The three categories may be further characterized as follows:

- the *self-employed* include small farmers (owners or tenant farmers), livestock farmers, household industries, those working in fisheries or forestry and trading. The category also includes hawkers, street vendors, sellers of fruit, flowers, vegetables, and prepared foods and makers and/or sellers of clothes, utensils and other metalwork;

- *regular wage workers* are mainly construction and industrial workers in urban areas, rather fewer in agriculture. They also include domestic servants, mostly women workers in middle- and upper-class urban households;
- *casual labour* is found in the same sectors as regular wage workers and in other labour-intensive tasks, especially construction, agriculture, pulling carts and other transport, portering, street-sweeping, mining and quarrying. The vast majority of women construction workers are casual and daily wage labourers.

All three categories include *home-workers*, mostly women and children working in home-based occupations, often under piece-rate contracts, which may also come into the self-employed, regular wage workers or casual labourers category. They include makers of *beedi* (indigenous cigarettes) and *agarbatti* (incense sticks), garment workers, rag collectors, assemblers and craft-workers other than workers in cottage industries. Most home-workers in urban areas are industrial outworkers and have direct or indirect links to the formal economy.

1.3 *SEWA: A profile of its organizations and activities*

SEWA's philosophy and approaches are reflected in its organizational structure:

- SEWA Union;
- SEWA cooperatives;
- SEWA Bank;
- SEWA Academy;
- SEWA social security.

SEWA Union

SEWA is one of the few trade unions in India for workers in the informal economy. The traditional trade unions in India mainly represent workers in the formal economy, most notably in the public sector. Informal workers in India still have a low profile and are under-represented at state or national level.

SEWA Union builds member solidarity around common causes and campaigns for workers' basic needs. This falls comfortably within the framework of SEWA's tradition of campaigning for workers' rights within the broader field of human rights generally. Campaigns are organized at grassroots, state and national level as

well as internationally. The most famous of these campaigns were the street vendors' campaign[3] for basic selling space under municipal law, the home-based workers' campaign and campaigns for a minimum wage and child care. Others included the water campaign, construction workers and food security campaigns (SEWA, 1999).

The underlying motive for these campaigns is the long-term goal of integrating women workers into the economy. Nor is it just a question of securing legal and statistical recognition of their contribution to India's GDP. It is also about alleviating the extremely hard physical and mental conditions which they face in their everyday working lives.

SEWA cooperatives

SEWA has 84 cooperatives with over 11,000 members, including 4,000 in nine service and labour cooperatives. These cooperatives aim to allow women workers to raise their economic profile by pooling their resources and providing them with facilities for collective negotiation of contracts, joint sourcing, production and marketing of goods and services at optimal prices.

SEWA also has health care cooperatives, which are of particular relevance to the health component of the Integrated Insurance Scheme, examined below, as well as credit cooperatives and a cooperative bank, SEWA Bank.

SEWA Bank

SEWA, with its understanding of the economic constraints, limited assets, the need for rational choices and the effects of social pressure, is also heavily involved in banking and credit, micro-finance in particular. This was what led to the creation of a cooperative bank, the SEWA Bank, which, among other things, has a crucial role in the management of the Integrated Insurance Scheme.

In the early days between 1974 and 1977, SEWA Bank was mainly concerned with attracting deposits and serving as an intermediary between the national banks and self-employed women. As it gradually built up its own funds, it moved away from its role as intermediary and began to lend directly to its depositors.

3 Hawkers and vendors have a special place in SEWA's history. The Supreme Court of India, in a historic judgement, upheld SEWA's presumption that workers, and municipal vendors in particular, had rights, when it ruled that municipal authorities had a fundamental obligation to provide them with working space.

The SEWA Bank network of rural savings and credit groups operates at district level. The strategy is to provide access to credit and to finance agricultural cooperatives supplying seed and fertilizer for sale. The operation of the insurance scheme is heavily dependent on this network.

SEWA itself is now 27 years old and SEWA Bank celebrated its 25th year of operations in 1999. The bank is run by professional managers appointed by the Board of Directors. The Board consists of self-employed SEWA members and professional bank staff. All banking activities are subject to supervision by the Reserve Bank of India (RBI), India's Central Bank. Borrowing and lending are at the rates for cooperative banks set by the RBI. SEWA Bank only lends to poor women, thus the majority of loans are unsecured, i.e. without any physical collateral. Loans are intended primarily for an economic activity, usually working capital for business, purchase of tools, building or repairing houses, a small store or developing a work space, not for consumption.

SEWA Academy

SEWA Academy is the focal point for members' education and capacity building. The Academy stresses self-employment to encourage and develop women workers' talents, self-confidence and leadership skills. It is also a way for SEWA to unite its large and diverse membership in a common vision of the SEWA movement.

SEWA Academy's activities are centred on:

- training;
- literacy;
- research and policy development;
- communication through print and the electronic media.

A new members' education programme was launched in 1999, covering issues such as organization, women's role in the economy, the women's movement, as well as the sharing of experience by SEWA leaders in different districts (SEWA, 1999).

SEWA social security

For SEWA, therefore, social security means providing for health care, child care, housing and shelter, and insurance through the Integrated Insurance Scheme to cover the risks faced by members and their families, thus enhancing well-being and productivity and ensuring that sickness or sudden crisis are not a drain on their fragile finances.[4] SEWA's health care network is examined in detail below, since it is relevant to the Integrated Insurance Scheme in two ways. First, the health component of the Integrated Insurance Scheme was designed to complement the existing SEWA health care network by only covering hospitalisation. Second, the health care network plays a crucial role in the decentralized administration of the Integrated Insurance Scheme, including the processing of claims and collection of premiums.

SEWA health and child care

SEWA emphasizes the importance of *health care*, especially occupational health, because experience over the years and the evidence of several studies have shown health concerns to be the main cause of stress, driving women into a vicious circle of falling productivity and thus declining income, growing indebtedness, deteriorating health and increasing poverty. Ill health is one of the reasons why women are unable to pay back their loans.

Another reason was that diagnostic and basic treatment services provided in the past under existing health care provision (public and private clinics, hospitals, doctors) were often of questionable quality. Public hospitals were considered to offer poor levels of care, while private health care was expensive. The cost of hospitalization or surgery was prohibitive for most workers in the informal economy.

Furthermore, many women workers tended to neglect their own health until the last possible instance in order to save money. In some cases, social taboos made it hard for women to seek proper and timely gynaecological or maternity care.

Initially, SEWA focused on providing curative services to its members, because it enhanced confidence in the health care facilities. As Mirai Chatterjee[5] put it, "First, you have to save the lives of their children. Then they will listen to what you have to say about health promotion and disease prevention." SEWA nowadays combines preventative and curative services with a strong education and training component. It also works in partnership with public health services on immunization, micronutrient supplementation, family planning, tuberculosis control and referral care at public hospitals, dispensaries and primary health centres.

4 See Chapter 1, section 3 for ILO definition of social security.
5 Mirai Chatterjee, former General Secretary of SEWA, quoted in Hauck, 1998.

SEWA's health care network operates in all the nine districts of Gujarat State where SEWA members live and work as well as in Ahmedabad. The activities are decentralized, being carried out by district-level health teams of SEWA members. These teams are either part of the midwives' cooperatives (see below) or part of their own district associations.

The health care network consists of:

(a) health and midwives' cooperatives;

(b) health centres;

(c) dispensaries.

(*a) Health and midwives' cooperatives*

There are four health cooperatives, founded in 1986: the *Shri Swashrayi Mahila-Lok Swasthya* cooperative (people's health and well-being), *Shramshakti Dayan* cooperative, the *Shri Krishna Dayan* cooperative (midwives) and the *Sangini* cooperative (child care). The formation of the SEWA health and midwives' cooperatives was financed from general SEWA revenues and fees for services provided. Most of the services are available to SEWA members and non-members. Certain services are also provided for men.

Under SEWA's integrated health approach, the cooperatives provide a combination of preventative and curative health care and health education. The health care encompasses primary health care, drug therapy and referrals, especially for tuberculosis, immunization and micronutrient supplementation. Health education covers basic nutrition, hygiene, sanitation, occupational health (mainly the *Swasthya* cooperative) and family planning, as well as women's physical well-being. It is provided in tandem with SEWA's basic literacy classes.

SEWA puts a strong emphasis on the training of *health workers* and *dais* (midwives). The health workers are active in all areas of preventative health, treatment and education. In addition to providing basic treatment, health care workers in Ahmedabad tend to act as intermediaries between SEWA members and health care providers. However, their rural counterparts shoulder greater responsibility, because they are chiefly responsible for the first contact with primary health care services in most SEWA-staffed areas, providing direct assistance to community health services where the public or private health care infrastructure is limited. They also staff SEWA dispensaries. Health workers are paid a staff honorarium by SEWA as well as charging fees for services.

Training health workers allows SEWA to decentralize its own health care work aimed at improving members' well-being. It's objective is to provide women with the authority and credibility to take over health-related decisions for the community. By providing reproductive and family planning services in addition to curative services, it aims to give men a greater say in the family's health, thus lifting some of the burden of health care from the shoulders of its women members. Finally, it aims to create an effective basic awareness to underpin its preventative health mandate.

Dais (midwives) are traditional birth attendants with significant knowledge regarding pregnancy, delivery and maternal and child care. They have traditionally been community health care providers and often come from the lower castes. Different communities often have *dais* of similar backgrounds. The form of payment is not fixed and can vary with the perceived value of the service rendered and can be in cash or in kind.

SEWA is one of many Indian organizations that have tried to build on the skills of *dais* by raising their status within the community and supplementing their traditional skills with modern techniques. SEWA has also attempted to link the services of the *dais* formally to the primary health care referral system. This allows the *dais* to upgrade their skills and their incomes while improving the health of their local communities, especially that of women. The *Krishna* cooperative is active in the training of *dais*.

Especially active in child care is the *Sangini* cooperative, based in Ahmedabad. It was founded and is managed by women child care workers. The Integrated Child Development Scheme of India, which was pioneered in the 1960s in one of the first integrated approaches to the care and development of children, linked up with *Sangini* to provide child care, in the form of creches and nutrition, in parts of Ahmedabad. The fact that *Sangini* has taken over the operation of the government programme is seen as testimony to SEWA's effectiveness through its cooperatives.[6]

6 In many rural areas of Gujarat State, SEWA registered child care cooperatives have been working with state government and district agencies to provide maternal and child health care. SEWA carried out a study to assess the impact of child care provision on the lives and productivity of women tobacco workers in the district of Kheda. The findings were positive and, where possible, child care cooperatives continue to be registered and function. Through concerted lobbying of employers, community leaders and officials by its members at local level, SEWA is attempting to make child care financially viable. It is moving steadily to a fee-for-service approach in most service provision, looking for novel ways to build upon the skills of trained SEWA members and studying demand for such services in the local community.

(b) Health centres

The number of health centres rose from five in 1986-87, when they were introduced, to 95 centres in both urban and rural areas by 1997. Since 1992, the health centres have directly complemented the activities of the health component of the insurance scheme, but they function as autonomous entities. The main activities of the health centres are providing advice on basic health problems, accompanying patients to hospital and assisting them in their dealings with medical personnel, transferring centrally purchased drugs from the SEWA office to dispensaries and supervising the sale of non-prescription drugs. Health workers at health centres provide information about the insurance scheme and advise on the processing of claims and reimbursement (see Chapter 3). It is important to note that SEWA health centre services are open to all SEWA members and non-members alike.

(c) Dispensaries

Aware that expenditure by women members on prescription drugs was extremely high, SEWA opened three additional specialized dispensaries in Ahmedabad in 1986–87. One was at the SEWA office itself and two at municipal hospitals[7] in Ahmedabad. SEWA dispensaries buy drugs directly from wholesalers and then pass on the savings to members.[8] These dispensaries are licensed to sell more sophisticated prescription drugs.[9] The sale of drugs indirectly has implications for the insurance scheme because when members are hospitalized, they can obtain their medicines more cheaply. Despite bulk purchases, however, and the sale of generic rather than branded drugs whenever possible, prices cannot always be kept down. SEWA also comes into direct competition with other retailers. The hospital system, however, does support the SEWA initiative.

In addition, SEWA Union subsidizes about 30 per cent of the cost of medicines through SEWA Union funds and occasionally provides grants.

7 These hospitals are located in poor localities of Ahmedabad and a large number of SEWA members go there for treatment.

8 Savings of up to 25 per cent off the standard retail price are available to members through SEWA's bulk-buying of the drugs.

9 They sell 1,500 different medicines covering both chronic and acute diseases. The dispensaries are open 24 hours a day and are managed by a professional pharmacist and two assistants.

Housing and shelter

The third element of SEWA *social security* is the provision for housing and shelter through the SEWA Gujarat State Mahila Housing Trust, a technical body, that sees housing as a basic need for poor women workers. The house is not only their shelter, but also their work place since many of these women are self-employed or home-based workers. A house is, therefore, one of their few assets and needs to be protected.

The Housing Trust's links to health come from the fact that with better living conditions, a significant number of ailments can be prevented. Better ventilation, lighting and clean water mean better health for both the working woman and her family. Furthermore, occupational hazards, especially those related to working in very cramped spaces, with poor lighting, lack of fresh air and often in contact with toxic substances, can be reduced. By developing housing as an asset, the SEWA Bank also helps women workers to safeguard their investments.

The SEWA Integrated Insurance Scheme

The last major element of SEWA *social security* is the Integrated Insurance Scheme, which is the subject of this study and which will be presented in detail in the following chapters.

Additional services

SEWA also provides legal services and other forms of education and training for its staff and members. Under its basic legal training programme, SEWA members learn how to prepare briefs and make appearances in court on behalf of other members facing lawsuits. The underlying strategy is to educate workers on their rights under the law as it stands and the need for legislative reform.

2. Environment in which the Integrated Insurance Scheme operates

This section provides some background information about India and the state of Gujarat and gives an overview of the environment in which the Integrated Insurance Scheme (IIS) operates.

2.1 *Demographic aspects*

In 1999, India's total population was 984 million (844 million in 1991) (EIU, 2000). The population of Gujarat State was 41 million in 1991 (EIU, 2000), of which 3.3 million lived in Ahmedabad, the principal city of Gujarat State. Table 2 compares some features of the state's population to India as a whole.

Table 2. Demographic data

	India	**Gujarat State**
Population 1991 (millions)	844 (1999: 984)	41
Growth rate 1981-91 (%)	2.14	1.92
Urban proportion (%)	26	34
Female proportion (%)	48.1	48.7
Female proportion of urban population (%)	47.2	47.6

Sources: Government of Gujarat State, 2000 and EIU, 2000.

2.2 *Economic aspects*

India's GDP per capita in 1998 (EIU, 2000) was US$444. India is predominantly an agricultural economy, with over 60 per cent of the population living in rural areas. However, agriculture accounted for only about 30 per cent of India's GDP in 1998. Industry has been growing and now accounts for about 30 per cent of GDP. The biggest share of GDP is provided by the service sector, which has been growing rapidly, reaching 40 per cent of GDP in 1998. Gujarat State, SEWA's heartland, has India's second largest industrial economy.

In terms of poverty in India as a whole, 37.27 per cent of rural and 32.36 per cent of urban dwellers had incomes below the national poverty line in 1998 (44 per cent of them earning less than US$1 per day). In Gujarat State, only 22.18 per cent of the rural population and 27.89 per cent of the urban population had incomes below the poverty line in 1998 (Government of Gujarat State, 2000). According to the Human Development Index (HDI) for 1999/2000, India ranked 128 out of 174 states in the world (UNDP, 2000).

2.3 *Labour market aspects*

The Indian labour force overall was some 372.1 million in 1994, of which, according to some estimates, the informal economy accounted for more than 90 per cent (about 344.7 million) (EIU, 2000). That means that most Indians live and work in the informal economy. The majority of them provide support for the relatively small *organized*[10] manufacturing and industrial sector, small, that is, relative to the non-industrial labour force, and increasingly the service sector. This support does not involve direct employment, but mostly operates through an extensive network of informal contracts, outsourcing, casual labour or piece-work. Out of the main occupational categories (the *self-employed, regular wage workers, casual workers* and *home-workers*),[11] only 13 per cent were in regular paid employment in 1994, while the majority, 54 per cent, were self-employed or casual workers, 32 per cent. Only 6.2 per cent of regular wage workers were women, while women made up 56 per cent of self-employed workers and 37 per cent of casual workers (Visaria, 1996). No statistics are available for home-workers.

In 1999, the unemployment rate for India as a whole was 21.5 per cent (AIG/Winterthur Alliance, 1999).

2.4 *Educational aspects*

The literate population for the whole of India in 1998, defined by educational level rather than absolute literacy rates, was 55.7 per cent. The discrepancy between male and female illiteracy is high: in 1998, 67.7 per cent of male adults were literate, compared to 43.5 per cent of female. Rural females are much more likely to be illiterate (75.1 per cent) than urban females (46.1 per cent), while 52.9 per cent of

10 The definition of the organized worker refers in Indian statistics to people engaged in a regular employment with an assured source of income. It encompasses especially those working in government, all public sector enterprises and other enterprises: (a) using electrical power and employing ten or more persons or (b) not using power but employing 20 or more persons (Subrahmanya 1998; van Ginneken, 1998).

11 See above, Chapter 1, section 1.2.

rural males and only 31.2 per cent of urban males are illiterate (Government of Gujarat State, 2000).

Literacy rates for 1991 show that 48.6 per cent of all Gujarat State females were literate. Figures for girls in general education show that 62 per cent are enrolled at primary level in India as a whole. There is a sharp decrease to 21 per cent at middle school level and only 8.5 per cent at secondary school or high school. The corresponding figures for Gujarat State are 60 per cent, 21.2 per cent and 9.1 per cent, respectively in 1991 (Government of Gujarat State, 2000).

2.5 *Health aspects*

Table 3 summarizes the basic health indicators for India compared to Gujarat State. Since only data from 1993 are available for Gujarat State, the data for India as a whole are also taken from 1993 for the purposes of comparison.

Table 3. Health indicators

	India	**Gujarat State**
Crude birth rate (per 1000)	28.7	28.0
Crude mortality rate (per 1000)	9.3	8.2
Infant mortality rate (per 1000)	74	58 (64 in 1998)
Life expectancy (years)	58.7	59.5

Source: Sample Registration System Estimates 1993 (Jain, 1999).

For India as a whole, life expectancy is rising and slightly higher for females than for males. In 1996, life expectancy was 63 years for women and 62 years for men. The mortality for under five year olds fell significantly from 173 per 1000 in 1980 to 85 per 1000 in 1996. The mortality for male children is significantly lower than for female children, reflecting female infanticide and neglect of unwanted female children (EIU, 2000).

The major causes of **morbidity** in India as a whole (1993) are: malaria (13 per cent); tuberculosis (7 per cent) and pneumonia (3 per cent).

Other leading causes of illness include tetanus, meningitis, enteric fever and viral hepatitis.

The major causes of **mortality** in India (1993) are: diarrhoeal diseases; acute respiratory infections; malaria; tuberculosis and pneumonia.

Others include tetanus, enteric fever, and hepatitis. In addition, there is a growing number of deaths caused by HIV/AIDS.[12]

In India as a whole, 26 per cent of the population were without access to safe drinking water in 1998, 47 per cent were without access to sanitation, and 57 per cent without access to basic health facilities (ACHAN, 2000).

The total expenditure on health in 1997 was 5.2 per cent of GDP.[13] In the same year, public expenditure as a percentage of total health expenditure was only 13 per cent, and private expenditure was 87 per cent[14] (WHO, 2000). Although a rudimentary system of free public health care does exist, in general, health care and medicines must be bought. Doctors in India are generally concentrated in urban areas. Levels of medical support staff are low. In 1990, there was one nurse for every 2,220 people (EIU, 2000) and in 1998, 48 doctors per 100,000 inhabitants (ACHAN, 2000).

In Gujarat State, the average number of people served by each government doctor was 11,404 in 1994. In the same year there were 7,274 sub-centres, 960 PHCs (primary health care centres) and 186 CHCs (community health centres with higher-grade facilities). The average rural population served was 3,721 per sub-centre, 28,191 per PHC, and 146,000 per CHC, respectively (Government of Gujarat State, 2000).

3. Social protection for people working in the informal economy in India

This section contains a brief overview of social protection schemes and other arrangements in India for people working in the informal economy. Here, and throughout the study, the definitions of *social security, social protection, social insurance* and *social assistance* contained in the current World Labour Report 2000 (ILO, 2000) will be used.

12 In 1997, 4,100,000 people between the age of 0 and 49 were infected by HIV/AIDS (ACHAN, 2000).

13 Compared with France 9.8 per cent, Germany 10.5 per cent, UK 5.8 per cent and USA 13.7 per cent in the same year.

14 Compared with the public/private ratio for France 76.9/23.1, Germany 77.5/22.5, the UK 96.6/3.4 and the USA 44.1/55.9 in the same year.

Social security is understood as:

> … the protection the society provides for its members, through a series of public measures:
>
> - to offset the absence or substantial reduction of income from work resulting from various contingencies (notably sickness, maternity, employment injury, unemployment, invalidity, old age and death of the breadwinner);
> - to provide them with health care, and
> - to provide benefits for families with children.

Social protection is understood as:

> … to include not only public social security schemes, but also private or non-statutory schemes with a similar objective, such as mutual benefit societies, occupational pension schemes. It includes all sorts of non-statutory schemes, formal or informal, provided that contributions to these schemes are not wholly determined by market forces. These schemes may feature, for example, group solidarity, or an employer subsidy, or perhaps a subsidy from the government.

The same Report further notes that these contingencies correspond to those covered by the ILO Social Security (Minimum Standards) Convention, 1952 (No. 102), reflecting the social security schemes existing at that time. With the partial exception of unemployment, these contingencies affect individuals rather than communities. So collective (co-variate) risk, such as occurs especially in developing countries, e.g. drought, bad harvests, natural disasters, and war, is not included. Social security here includes *social insurance*, which is understood as contributory schemes, *social assistance*, defined as tax-financed benefits provided only to those with low incomes and *universal benefits* i.e. tax-financed benefits, provided without income or means testing.

SEWA takes social security to be the combination of provision for health and child care, housing and shelter and insurance through the Integrated Insurance Scheme. SEWA also calls its scheme a "work insurance scheme". Like the ILO definition, it includes insurance in case of illness, including occupational disease, widowhood due to natural or accidental death and disability. In addition, SEWA's insurance package also includes "collective risk" such as fire, communal riots, floods, other natural or human-made calamities which result in loss of work or assets such as land and house (SEWA, 1999).

3.1 *The major Indian social security schemes*

Social security schemes since India's independence have been structured along lines appropriate to a relatively formalized economy. They are provided by the Indian Central Government as well as by the Indian states. It is mainly people working in the formal economy,[15] who are entitled to benefits under a series of social security laws (acts). Table 4 gives an overview of the major legislation, the benefits covered, who is entitled to them and by whom it is administered.

Coverage under these schemes[16]

The *Employees State Insurance (ESI)* covers about 6.75 million employees working in around 170,000 factories and establishments. With the inclusion of employees' family members, the scheme is available to almost 30 million people, or 2.2 per cent of India's workers and 3.5 per cent of the overall population. The highest numbers of insured persons are in the states of Maharashtra, West Bengal and Uttar Pradesh.

Roughly 20 million employees in about 264,000 establishments are covered under the *Employees' Provident Fund (EPF) (and Miscellaneous Provisions) Act,* 6.4 per cent of the overall working population. In terms of the National Industrial Classification, the most substantial share in overall coverage is in the manufacturing industries (over 51 per cent), followed by mining (20 per cent), then agricultural and allied fields (6 per cent). Benefits similar to those under the EPF Act are also available for workers in coal mines and the Assam tea plantations, covering some 1.25 million employees.

Workers in the informal economy as a whole account for 10 per cent of all EPF members' accounts, of whom the largest number are *beedi* workers (1.3 million people). Most members live in the states of Maharashtra, Tamil Nadu and West Bengal, followed by the states of Gujarat, Andhra Pradesh and Uttar Pradesh.

The coverage under the *Workmen's Compensation Act* and *Payment of Gratuity Act* is difficult to assess, as little data has been collected on the beneficiaries in general.

15 Employees in the government sector have their own social security schemes.
16 Based on Jain, 1999, in van Ginneken, 1999.

Table 4. Main social security schemes in India

Enactment/ law	Employees' State Insurance (ESI) Act, (1948)	Employees' Provident Funds (EPF) (and Miscellaneous Provisions) Act (1952)	Workmen's Compensation Act (1923)	Payment of Gratuity Act (1972)	Maternity Benefit Act (1961)	Gujarat State Shops and Establishment Employees Life Insurance Act (1980)	Other Workers Welfare Fund Acts
Contingency/ Benefits covered	Sickness, maternity, death or disablement due to employment injury	Old age and invalidity	Occupational injuries and diseases	End-of-service gratuity payments	Various maternity benefits before and after childbirth	Old age	Maternity benefits, health services, housing, life and scholarships
Eligible persons	1)Employees of power-using manufacturing establishments with over 10 and non-power establishments with over 20 workers 2)Areas with minimum 1000 eligible employees	Employees of factories and establishments with 20 or more workers	Employees and their survivors of factories, mines, plantations, railways and other scheduled employments	Employees of factories and establishments with 10 or more workers. Employees must have 5 years of continuous service	Women employees of factories, mines, and commercial establishments, landless agricultural workers in some state governments incl. Gujarat[17] State and Andhra Pradesh	Workers in specific sectors with 6 months of continuous service	Mainly workers in the informal economy: construction workers casual labourers, workers in specified sectors: e.g. *beedi* and cigar workers, fishing and agricultural workers
Administration	Employees' State Insurance Corporation; Ministry of Labour	Employees' Provident Funds Organization; Ministry of Labour	Self-administered: the employers themselves are liable to pay the benefits to eligible employees	Self-administered: the employers themselves are liable to pay the benefits to eligible employees	Self-administered: the employers themselves are liable to pay the benefits to eligible employees		Central and state governments

Sources: *Subrahmanya, 1998 and AIG/Winterthur Alliance, 1999.*

17 The Gujarat State Maternity scheme has been replaced by the National Maternity Benefit Scheme.

The take-up of claims under the *Maternity Benefit Act* has been estimated at only 0.5 per cent nation wide. Although the *Maternity Benefit Act* has been extended to shops and establishments since 1989, it is not known how many women have benefited from this extension. Some women workers, some *beedi* workers, for example, get maternity benefits through their common welfare fund.

When it comes to coverage under the *other welfare funds*, all that is known is that the Beedi Workers' Welfare Fund covers 425,000 *beedi* workers, primarily in Andhra Pradesh. Although statutory, the availability and level of benefits are quite modest, and the schemes are entirely directed towards general welfare rather than establishing individual rights and entitlements.

Overall, only some 10 per cent of the total Indian labour force of 372.1 million (1994) is covered by the Indian social security schemes. In principle, these social security schemes and the legislation behind them do not distinguish between workers in the informal or formal economy. In theory, therefore, they apply equally to casual and contract workers in the establishments covered as well to home-based contract workers in industries such as *beedi*-making, construction works, carpet manufacturing, *khadi* (homespun cloth) and village industries.

Furthermore, the Government of India has recently attempted to extend the coverage of these social security schemes to home-based workers, for example in the cigar and *beedi* sectors and the *agarbatti* industry. In addition, some modified maternity benefit schemes have been opened to women agricultural labourers in some states and other group insurance schemes are now available to fishing communities and agricultural groups.

Yet very few workers in the informal economy are covered under the above schemes. As we have seen in Table 4, the groups of persons or establishments defined as eligible to join these schemes exclude *de facto* the majority of informal workers.

Other factors which also prevent workers in the informal economy joining these schemes, or at least add to the difficulties, include:

(a) many workers in the informal economy, such as construction workers, and in India many of them are women, frequently change employers. When they do so, their account under the protection scheme has to be transferred from one employer to another. This often causes problems, sometimes because contributions have been lost or simply because it is a very time-consuming process. Until the contributions have been transferred, members cannot obtain benefits, and sometimes the account may even lapse. For this reason, many workers see no point in contributing to these schemes.

(b) work done by women, especially, is often invisible. In the case of construction workers, for example, often only the male head of household is hired, and it is he who then arranges to supply the labour of the rest of the household, including women and children. This means that the women workers do not receive a wage, and therefore do not acquire any entitlement to social security benefits as workers.

3.2 *Other arrangements for people in the informal economy*

Although coverage for workers in the informal economy under the main social security schemes is quite low, there are many other arrangements, too numerous to describe in detail here, which seek to provide them with social protection. The focus below is on social assistance schemes and group insurance schemes, whether subsidized, self-financing or a combination of both.

Social assistance schemes and programmes

Social assistance schemes and programmes are targeted at workers in the informal economy and those who are disadvantaged or excluded from other social protection arrangements (poor families, households headed by women, women and children, unemployed youth, etc.).

The most important of the social assistance programmes is the *National Social Assistance Programme (NSAP)*, which was introduced in 1995 by the central Government of India. It consists of three schemes: the *National Old Age Pension, National Maternity Benefit* and *National Family Benefit Scheme*. It is an attempt to go beyond basic formal sector social security and to cover a larger segment of the population. Under the NSAP, the central Government provides guaranteed funding to the state governments, which then supplement the funds to different degrees in accordance with their own priorities and financial capacities to provide:

- old age pensions to the very poor aged 65 years and over;
- benefit for survivors as a lump sum to families following the natural or accidental death of the breadwinner;
- maternity benefit with a cash component to poor women up to a maximum of two children.[18]

18 The old age pension funding is calculated on the assumption that 50 per cent of the population live below the poverty line and are over the age of 65; the other two benefits are available for all people below the poverty line.

Since the 1960s, social assistance programmes have been introduced at state level to avert or at least alleviate destitution due to incapacity. Although their conditions vary to some extent (benefits, eligibility, coverage), most of them include monthly pensions to various categories of the poor such as the aged, widows, the disabled, and family support and maternity benefit for women workers in different sectors.

Group insurance schemes

Besides the social assistance programmes, the Central Government of India has tried to reach a large number of poor workers in the informal economy through various group insurance schemes for different occupational groups and through development programmes. Some of those programmes were linked with two nationalized insurance companies, the Life Insurance Corporation (LIC)[19] and the General Insurance Corporation (GIC). There are variations, but the basic principle of the link between the Government and these companies is that the Indian Government finances a Social Security Fund, founded by the Government in 1988.[20] The Social Security Fund channels this financing to insurance companies to subsidize premiums for insurance policies offered by them to any social organization or cooperative working with certain occupational groups or poor communities within the informal economy, which wish to insure their members. For example, this subsidy enabled LIC to halve the premiums chargeable for life

19 Generally, since India's independence in 1947, the insurance sector has been structured along the lines of the British insurance system, which consists broadly of two main branches:
- life insurance;
- general insurance, such as health, assets and household.

In both branches there were about 70 private insurance companies. By the mid-1960/70s the Government of India had taken over their management and/or nationalized them, but the basic structure with two branches (life insurance and general insurance) still remains the same. The two main insurances companies are the above-mentioned Life Insurance Corporation (LIC) and the General Insurance Corporation (GIC).

Life Insurance Corporation of India (LIC)

The LIC is a statutory corporation formed under the Life Insurance Corporation Act of 1956. Under this act, the Government of India nationalized the business of life insurance and the newly formed LIC of India took over the assets and liabilities of all the existing insurance companies. LIC of India has since been the sole provider of life insurance in India. It has a strong network of 500,000 agents spread over the country.

General Insurance Corporation of India (GIC)

The GIC was incorporated under the Companies Act (1956) in 1972. Under the General Insurance (Business) Nationalizsation Act (1972), the undertakings of all insurance companies operating in the country were taken over by four companies, the New India Assurance Co. Ltd, the United India Insurance Co. Ltd, the National Insurance Co. Ltd and the Oriental Insurance Co. Ltd. The shareholdings of these four companies were taken over by GIC thus making it the holding company for the four general companies operating in India. GIC supervises and directs the activities of the subsidiary companies.

Sources: Unit Trust of India, 2000, interviews with Sayeeda Chauhan (GTZ/SEWA) and John Woodall (ILO-SAAT).

insurance coverage. At present, the subsidy supports life insurance policies for more than 2 million poor in India. SEWA's Integrated Insurance Scheme is one example where an organization linked to these two nationalized insurance companies receives a subsidy for its members in this way.

Another example of this linkage is the Indian Government's funding since the mid-1990s of four life insurance schemes, either partly in collaboration with LIC or in full. The schemes involved are the Landless Agriculture Labourers' Group Insurance (LALGI), one component of the Integrated Rural Development Programme (IRDP), the Group Insurance Scheme (GIS) and the Rural Group Life Insurance Scheme (RGLIS), providing a lump sum in the case of death of the beneficiary. In the first two schemes the Government pays the premium in full (via a subsidy to LIC) while in the case of the GIS and RGLIS only half of the contribution is paid by the Government (Jain, 1999).

Throughout India, there is a wide variety of social protection schemes for workers in the informal economy with varying degrees of self-financing. Many were developed in the absence of satisfactory state social protection provision. They range from wholly informal and unwritten systems within a small group to more formal ones catering to the needs of larger numbers and based on more complex arrangements, mostly offered by non-governmental organizations (NGOs) and self-help groups working in the fields of health, education and employment.

Apart from SEWA, the best known are ACCORD (Action for Community Organization, Rehabilitation and Development) or SPARC (Society for Promotion of Area Resources Centre), who have established direct links with the nationalized insurance companies through subsidized group insurance and/or the Indian Government's development programmes, as described above.

Others, notably the Cooperative Development Federation (Hyderabad), Pragati Thrift and Credit Society, Samakhya, Trivandrum District Fishermen Federation, ASSEFA (Association of Sarwa SEWA Farms) and the Voluntary Health Services in Tamil Nadu, provide insurance services covering death, disability, diseases, old age, or unemployment, independently or subsidized by foreign development agencies. They are often connected with credit/savings activities (Gupta,1994; Jain, 1999).

Coverage under these arrangements

It is estimated that just over 40 million workers are covered by these various central Government, State and NGO arrangements. Some 35 million of these are landless

20 In 1990, the Indian Government paid one billion Rs. (US$202 million) into the Fund.

agricultural labourers covered by life insurance policies offered through the group insurance and development schemes. Close on 5 million workers are covered under various central and state schemes and another half million or so by NGO schemes[21] in association with the nationalized insurance companies. In addition, approximately 5 million workers over the age of 60, and therefore counted as part of the labour force, are covered by various pension schemes (Jain, 1999).

Although, however, workers in the informal economy theoretically have access to these subsidized group insurance schemes and in some programmes the whole contribution is paid by the Government, relatively few have used their entitlement to claim. One reason might be lack of information. Often those insured are not informed and are therefore unaware that they are entitled to claim. Often, too, complicated and long-winded claim procedures make the schemes unattractive. Moreover, according to SEWA sources, although they provide access to certain components of social protection, they are still far from providing comprehensive social protection for workers in the informal economy.

21 For the NGO schemes no exact numbers were available.

Chapter 2

THE INTEGRATED INSURANCE SCHEME

1. Development of the Integrated Insurance Scheme

From the very beginning, SEWA adopted a pragmatic approach to the Integrated Insurance Scheme, frequently adapting it to reflect its members' needs. The following examination of the key stages and the changes that were introduced should provide the reader with an overview of the role of those chiefly involved and the structure of the benefits package.

1.1 *Birth of an idea: Access to social protection (1977-89)*

Back in 1977, some SEWA members raised with SEWA organizers and the SEWA Executive Committee their concerns that informal women workers did not have access to social protection. As the work of identifying members' needs progressed, SEWA began lobbying for basic social protection on behalf of its members. Later, in the early 1980s, SEWA asked one of the state insurance companies, the Life Insurance Corporation (LIC), to provide life insurance[22] for its members. The legislation at that time did not allow SEWA or any other private agency to enter the Indian insurance market themselves. In any case, SEWA did not have the necessary technical or management expertise.

22 The ILO Social Security (Minimum Standards) Convention, 1952 (No. 102), Article 59 *et seq.*, speaks of "survivors' benefit", i.e. payment to the widow or child of the breadwinner within the social security scheme. The term "life insurance" is used mainly in the private insurance sector, often connected to individual pension schemes. Since SEWA and its insurers, in their daily operations and documents, refer to the "life" component or "life insurance" in respect of insurance cover for death, this term will also be used in the rest of this work.

The LIC was sceptical about the ability of self-employed and other women workers in the informal economy to pay the premiums, not only because they had no regular income but because, due to the nature of self-employment, they would have to pay both the employees' and employers' share of the premiums. There was also concern about the administrative practicalities of collecting premiums from workers with whom they had little dealings and who were culturally far removed from their traditional client base. The poor were also regarded as a particularly high risk since their living and working conditions made them particularly vulnerable, and thus likely to make more frequent claims.

Although the LIC and SEWA did not come to a concrete agreement at that time, SEWA's extensive lobbying increased awareness within the LIC of the needs of workers in the informal economy. The stage was set for a simple life insurance scheme for SEWA members covering natural death.

1.2 *Introduction of the life insurance scheme (1989-91)*

In 1989, SEWA was invited to take part in a commission appointed by the Indian Government to explore the possibility of extending the existing government insurance schemes to workers in the informal economy. Prior to that, under an agreement struck in 1988 between the Indian Government and, notably, the Life Insurance Corporation (LIC) and the United Indian Insurance Company (UIIC), insurance policies at reduced premiums to social organizations wishing to insure poorer groups or communities in the informal economy, had been eligible for a subsidy from the State Social Security Fund. In 1991, SEWA reached an agreement with the LIC and the Indian Government to start such a scheme, with the following main features:

(a) *life insurance* with a benefit/sum insured of Rs.3,000 for natural death and a benefit of Rs.25,000 in the case of accidental death and permanent disability of women in the 18 to 58 age group. The beneficiary was the husband, no other family member.

(b) the scheme was based on *premiums*, set at Rs.30 per year. The members' share was Rs.15, the remaining Rs.15 being paid to the LIC from the State Social Security Fund.

(c) the scheme was *compulsory* for SEWA members, with SEWA paying the premium for all members in advance.

(d) SEWA was not involved in the overall administration of the scheme. It simply acted as an intermediary between its members and the Life Insurance Corporation, collecting premiums, receiving and disbursing claims. Where appropriate, it negotiated on behalf of claimants where claims were disallowed. The LIC insisted on retaining financial ownership.

1.3 *From life insurance to integrated insurance (1992)*

The reasons why

In 1992, SEWA decided to upgrade the scheme from life insurance only to an Integrated Insurance Scheme, with the addition to the benefits package of a health insurance component, covering hospitalization costs and an assets insurance component to compensate for loss of assets. There were a number of reasons for this decision.

First of all, SEWA members themselves expressed the need for a *health* component, covering the cost of hospitalization, because most self-employed women were excluded from the state social security schemes and SEWA's own health care network did not include hospitalization. The need was, in any case, obvious, since SEWA Bank research had shown that the main reason for irregular loan repayments and default was the ill health of the borrower or another family member. Loans were being used to pay high medical bills and indebtedness to money vendors was prevalent because women borrowed to cover health-related risks.

Second, an *asset* loss component was a way of covering another high risk area. Many of SEWA's members lived, as they still do, in slums on the banks of the Sabarmati River in Ahmedabad or in rural areas, and could not afford to move to safer areas. Consequently, there was a significant likelihood of the loss or destruction of assets, including work premises, tools, materials or living accommodation, through flooding and cyclones, fire, theft and civil unrest.

Third, it soon became apparent that although an insurance scheme with a *life* component alone, even when it covered both natural and accidental death, benefited the family, it actually threatened to add to the financial burdens of women workers who paid the premiums, while their husbands were the main beneficiaries. Some husbands even used the benefit paid on the death of their wives to pay for their next wedding, which hardly seemed fair.

Finally, adding the *health* and *assets components* to the benefits package was consistent with SEWA's promotion of comprehensive "work security", as described in Chapter 1.

The two insurance companies involved

Two insurance companies, the Life Insurance Corporation and the United India Insurance Company were involved with SEWA in designing an insurance scheme for its members which provided health and assets insurance. In UIIC, SEWA found itself an ally in the person of a woman staff member, who helped to set up the first pilot Integrated Insurance Scheme. UIIC entered into a formal partnership with SEWA to provide insurance for health (hospitalization expenses) and loss of assets. Additionally, it was agreed that UIIC would provide a set of benefits in the event of the natural or accidental death or permanent disability of the woman, as well as certain benefits for the accidental death of the husband.

The LIC, for its part, agreed to continue the life component, thus enhancing the benefits payable on the death of the insured (see Table 5).

SEWA's role, it was decided, was to continue to act as intermediary between its members and the two insurance companies.

Scheme design: benefits package and premiums

The basic design of the benefits package and premiums has been retained, with some modifications, up to the present.[23] A member was required to take the benefits package as a whole and was not allowed to pick and choose individual components.

The *life* component offered the following benefits. In the event of the woman's *accidental* death, her husband received a total sum of Rs.35,000 and Rs.3,000 for her *natural* death. In the event of the husband's accidental death, the woman received Rs.10,000. The breakdown is shown in Table 5.

The *health* component provided reimbursement of the expenses of hospitalization for general diseases[24] up to a ceiling of Rs.1,000[25] per year.

The *assets component* provided cover up to a ceiling of Rs.3,000 per year for loss of assets or equipment.

An additional element was the introduction of a maternity grant of Rs.300 for each child.

23 For an overview of the scheme in 2000, see Chapter 2, section 2.2.

24 General diseases are described in Chapter 3, section 1.1. Occupational and gynaecological ailments have also been covered since 1994.

25 Rs.1,200 since 1994.

Table 5. Life insurance benefits

	From LIC (Rs.)	From UIIC (Rs.)	Total
Accidental death of woman:	25 000	10 000	35 000
Natural death of woman:	3 000	0	3 000
Accidental death of husband:	0	10 000	10 000

Source: SEWA internal documents.

The full *premium* for the whole package was fixed at Rs.60 per year, Rs.45 payable by the insured member plus the subsidy of Rs.15 from the Social Security Fund paid to the LIC. Of the Rs.45 paid by the member, Rs.15 was paid to the LIC for life insurance and Rs.30 to the UIIC. The UIIC premium was broken down into Rs.15 for health insurance, Rs.8 for assets insurance, Rs.3.50 each for death of the woman and death of the husband.

In designing the benefits package, SEWA consulted its members through a combination of SEWA grassroots interviews and information campaigns and SEWA Bank estimates of members' incomes, debts and annual wage increases. For the health component, in particular, SEWA's extensive grassroots network was crucial in determining the cost of hospitalization and emergency treatment. The assets component was based on estimates of losses assessed by SEWA organizers on the ground.

When it came to setting premiums, the two insurance companies advised SEWA on the number and level of benefits available for a given amount of premium, based on their experience and actuarial projections. The basic premise behind the premium structure was that it should generally follow the pattern of existing social security schemes in the formal sector. Additionally, however, the insurance companies carried out their own calculations based on the size of the target group, estimates of SEWA members' incomes and the level of risk. SEWA did not carry out actuarial studies. Instead, drawing on its field workers' familiarity with their economic and social situation, it used its judgement to assess how much its members were willing and able to pay.

Conditions of membership

SEWA persuaded the LIC that the insurance should cease to be compulsory for its members, because when the scheme had originally been set up, many of them had

not agreed with the decision that it should be compulsory. Indeed, many of them had not even been informed. Consequently, they had not been aware of their entitlement to claim and thus were unwilling to pay the premium. The initial consequence, therefore, of the change from compulsory to voluntary membership of the insurance scheme was a mass exodus of members from the scheme.

The two insurance companies further agreed to provide the package for women up to the age of the age of 58, a compromise from SEWA's point of view, but in practice it covered the majority of SEWA's membership.

1.4 *Major changes in the Integrated Insurance Scheme between 1993 and 1999*

The period 1993 to 1999 was marked by a number of important changes to the Integrated Insurance Scheme. In 1993, the GTZ gave the IIS Rs.10 million as a capital fund.[26] It was decided to use the revenues from the investment of the fund to cover the costs of operating the scheme, the maternity grant and to constitute other reserves (see details in Chapter 4).

An improved benefits package was introduced in the same year. For an additional amount of Rs.15, a woman had the option of full life cover for her husband. Thus, in the case of accidental death or permanent disability of her *husband*, a woman would receive Rs.35,000,[27] and Rs.3,000 in the event of his natural death. Thereafter, she had a choice of two levels of premium: Rs.45 if she insured herself alone or Rs.60 if she included her husband.

Also in 1993, a second method of paying premiums via a fixed deposit was introduced. It involved depositing the sum of Rs.500 in a SEWA Bank account. The interest on the deposit was used to cover the annual premium (see section 2.2 for more details of the different ways of paying premiums).

The most important event in 1994 was that SEWA took over financial ownership of the health component from the UIIC and became responsible for its administration. A new branch, SEWA Mediclaim, was created within the IIS for the purpose. SEWA thus ceased to be simply an intermediary between the insurance companies and members of the scheme.

The year 1995 saw an increase in the benefits of the health component. Occupational diseases and gynaecological ailments were added to the general

26 US$250,000 in 1995.
27 Rs.25,000 from LIC, Rs.10,000 from UIIC.

diseases cover. This meant a rise of Rs.15 in the premium payable by members to Rs.60 (or Rs.75 if the husband was included in the life component).

The benefits for accidental death were improved in 1996 and again in 1999. For a woman, and her husband if included at the higher annual premium of Rs.75 or fixed deposit of Rs.700, the rise was from Rs.35,000 to Rs.40,000. For members who had not included their husband, the benefit in the event of the accidental death of the husband was increased from Rs.10,000 to Rs.15,000. Members using the fixed deposit payment method were entitled to additional benefits: cataract operations, hearing aids and dentures.

In 1998, SEWA also took over ownership and management of the assets component from UIIC, creating another new branch, the SEWA Emergency Fund within the IIS for the purpose.

2. Principal features of the Integrated Insurance Scheme in 2000

This section profiles the features, other than financial,[28] of the SEWA Integrated Insurance Scheme as it is constituted today, in particular:

- target group, members and beneficiaries;
- benefits and premiums;
- administration and management of the scheme.

2.1 *Target group, membership and beneficiaries*

The target group of the Integrated Insurance Scheme consists of present and potential members of SEWA. Its beneficiaries include the members of the IIS, defined as those persons who have subscribed to the scheme, and their husbands.

Size and general characteristics of the target group

SEWA's ideal target group would ultimately include every woman working in India's informal economy. In the immediate future, however, the target group is confined to SEWA members in Gujarat State. SEWA's other branches in India have not yet introduced an insurance scheme. The size of the target group is shown in Table 6, which indicates that the SEWA membership in Gujarat State

28 Covered in Chapter 4.

increased steadily from 25,911 members in 1990-91 to 162,781 in 1996-97, since when it has decreased slightly.

The characteristics of SEWA's target group are summarized in Table 7.

Table 6. Size of target group

Year	Target group (SEWA members Gujarat State)	Growth rate (%)
1990-91	25 911	
1991-92	46 076	78
1992-93	38 136	-17
1993-94	42 280	11
1994-95	75 615	79
1995-96	158 152	109
1996-97	162 781	3
1997-98	159 204	-2
1998-99	142 810	-10
1999-2000	147 618	3

Source: SEWA, 1999.

Members and beneficiaries of the IIS

As noted above, the full insurance package is only available to SEWA members in Gujarat State. Since only women can obtain SEWA membership, only a woman can become a member of the IIS. For the health and assets component she is also the only beneficiary, except that, in the insurance year 2000/2001, when the health component was extended to them on a trial basis, husbands were also beneficiaries.

With regard to the life component, it is the husband who is the direct beneficiary. It is in the nature of life insurance that in the event of death, the beneficiary is a person other than the life insured, in SEWA's case, the husband. If the woman has taken the additional life insurance policy on her husband's life, then she is the beneficiary in the event of her husband's death.

Table 7. Characteristics of the target group

Characteristic	Target group[29]
Location	SEWA membership in Gujarat State: 34% urban, 66% rural[30]
Age	Mainly members aged from 30 to 45 years[31]
Members' income	Annual average for all claimants[32]: Rs.18 396 Annual average for urban claimants: Rs.20 844 Annual average for rural claimants: Rs.13 236
Area of occupation	Services and labour[33]: 60% Home-based work: 34% Hawkers, vendors and traders: 6%
Religion/Caste	Predominantly Hindu, the largest population group, the majority among the lower castes; Muslims and other smaller minority groups
Literacy	51.4% female illiteracy in Gujarat State[34]
Housing	Kutcha[35]: urban: 4% rural: 19% Pucca: urban: 80% rural: 37% Semi-Pucca: urban: 16% rural: 44%

Sources: Various, see footnotes below.

29 Since data are not always separately available for the target group, some information is taken from the 1991 census of the whole of India and Gujarat State (Government of Gujarat State, 2000), which refers to the whole population of Gujarat State. SEWA does not have any more precise data.

30 SEWA, 1997, 1998, 1999.

31 Various SEWA sources.

32 In 1998 Rs.; income is not documented for members as a whole, but for the claimants of the insurance scheme. A figure mentioned in interviews with SEWA members was a minimum income of Rs.10-15 per day up to a maximum of Rs.60-80 per day.

33 SEWA, 1998. Note that in its report, SEWA includes both home-based and household workers under the heading of home-based worker.

34 Government of Gujarat State, 2000.

35 Kutcha houses are temporary, makeshift houses built of waste materials, plastic, etc. Pucca houses are more permanent housing brick, mortar, etc. (Government of Gujarat State, 2000).

Conditions of membership

To become a member of the IIS, it is necessary to be a member of SEWA in Gujarat State, paying the membership subscription of Rs.5. She must then pay an administrative fee of Rs.5 on joining a payment method, but only once on joining by users of the fixed deposit method (see section 2.2 for details of premium payment methods). A new member is required to open an account in SEWA Bank if she does not already have one, for a fee of Rs.10.

Until recently, membership of the IIS could only be registered at SEWA Bank[36] at SEWA headquarters in Ahmedabad, where the IIS has a counter with two insurance staff members in the main hall. However, since the decentralization of claims processing and premium collection, other SEWA branches in Gujarat State or IIS representatives can register membership.

Applications for admission to the scheme must be accompanied by the relevant supporting documents and the member's SEWA card. A register containing members' names, addresses, age and membership identification number is maintained by the insurance staff at SEWA Bank. A receipt for payment of the premium is given to the member, as evidence of membership of the IIS and identification for future claims.

All claims, even those relating to life insurance cover of the husband, must be submitted by the SEWA member herself (except, of course, in the event of her death or severe illness).

The number of IIS members and beneficiaries

Table 8 shows the number of IIS members and beneficiaries (husbands). It should be noted that membership increased in overall between 1994 until 2000. The sharp decline between 1993 and 1994 from 38,136 members to 7,000 members reflects the change from compulsory to voluntary membership of the scheme.

Growth in membership slowed in 2000, chiefly because of the severe drought which hit Gujarat State. Some members paying by the annual method did not have sufficient income to renew their insurance, because they had lost their main sources of income such as cattle and crops. Some still have not done so. Another indirect reason for the decline is that insurance representatives had less time to promote the IIS, collect premiums and process claims, because they were mainly occupied with drought relief work.

36 SEWA Bank plays an important role in the financial administration and management of the insurance scheme, as described in section 2.3 (administration and management).

Table 8. Members and beneficiaries of the IIS

Year	Total IIS members	Members without husbands included in life component (annual payment Rs.60/ fixed deposit Rs.500)	Members with husbands included in life component (annual payment Rs.75 / fixed deposit Rs.700)	Total beneficiaries of life component (IIS members + husbands, i.e. columns 2 + 4)	Growth rate of total IIS membership (based on column 2) (%)
1991-92	46 076	Insurance not available for husbands			
1992-93	38 136	Insurance not available for husbands			
1993-94	7 000	4 000	3 000	10 000	-82
1994-95	10 000	8 000	2 000	12 000	43
1995-96	12 784	10 569	2 215	14 999	28
1996-97	15 846	10 846	5 000	20 846	24
1997-98	19 515	14 515	5 000	24 515	23
1998-99	26 000	20 000	6 000	32 000	33
1999-2000	23 214	16 428	6 786	30 000	-11

Source: SEWA, 1999 and internal documents.
Note: Some numbers are only available rounded.

Table 8 also contains a breakdown of members who have included their husbands in the life component and those who have not. The latter pay an annual premium of Rs.60 or a fixed deposit of Rs.500, shown in column three. Those members who have included their husbands pay an annual premium of Rs.75 or a fixed deposit of Rs.700, shown in column four. By inference, the figure in column four also represents the number of husbands covered. The figure for total beneficiaries (column five) is significant, because it shows the largest number of people, members plus their husbands, who may receive one or other of the benefits in case of need.

Ratio of urban and rural members of the IIS

It is noteworthy that, up to 1997, the ratio of urban to rural members averaged 65 per cent urban to 35 per cent rural. Since 1998, the balance has shifted to an average ratio of 50:50, mainly due to SEWA's strenuous efforts to decentralize and promote the scheme in rural areas. In comparison, the urban-rural ratio within the target group (SEWA members in Gujarat State) is two-thirds rural and one-third urban.

Table 9. Membership of the IIS in rural and urban areas

Year	IIS membership	Urban members	Rural members
1991-92	46 076	n.a.	n.a.
1992-93	38 136	n.a.	n.a
1993-94	7 000	6 000 (85.7%)	1 000 (14.3%)
1994-95	10 000	8 000 (80.0%)	2 000 (20.0%)
1995-96	12 784	8 348 (65.3%)	4 436 (34.7%)
1996-97	15 846	10 346 (65.3%)	5 500 (34.7%)
1997-98	19 515	12 515 (64.1%)	7 000 (35.9%)
1998-99	26 000	13 000 (50.0%)	13 000 (50.0%)
1999-2000	23 214	n.a.	n.a.

Source: SEWA, 1999 and internal documents.
Note: Some numbers are only available rounded.

IIS penetration of the target group

Table 10 and Figure 1 show the correlation of the growth rate for the target group and that of IIS membership, while Table 11 and Figure 2 show percentage penetration.

Table 10. The growth rates of the target group and IIS membership

Year	Target group (SEWA Gujarat State)	Growth rate of target group (%)	IIS membership	Growth rate of IIS membership (%)
1990-91	25 911	-	-	-
1991-92	46 076	78	46 076	-
1992-93	38 136	-17	38 136	-17
1993-94	42 280	11	7 000	-82
1994-95	75 615	79	10 000	43
1995-96	158 152	109	12 784	28
1996-97	162 781	3	15 846	24
1997-98	159 204	-2	19 515	23
1998-99	142 810	-10	26 000	33
1999-2000	147 618	3	23 214	-11

Source: SEWA, 1999 and internal documents.
Note: Some numbers are only available rounded.

Figure 1.

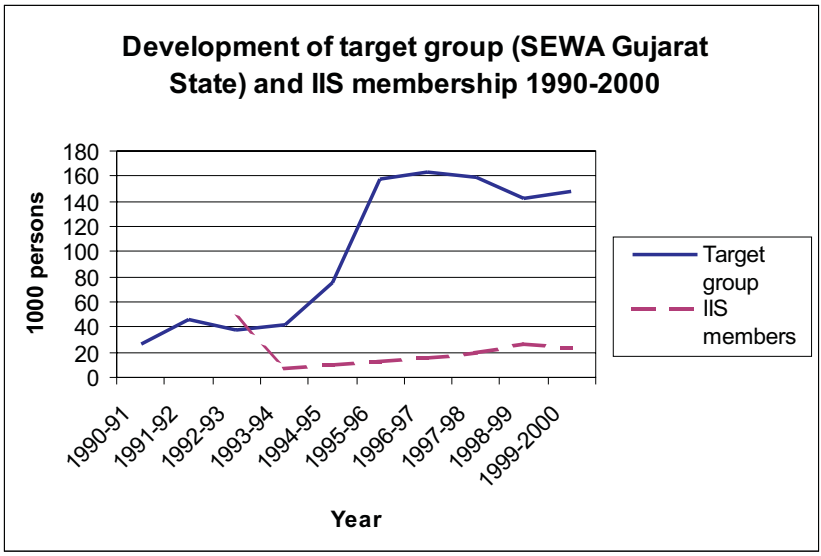
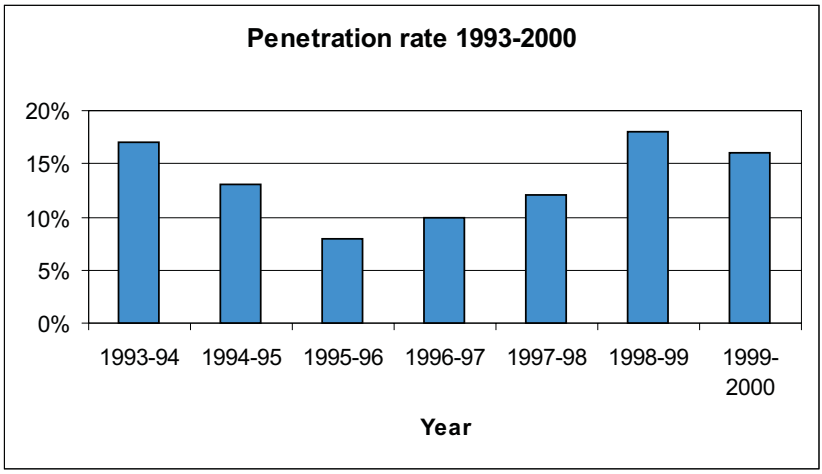


Table 11. IIS penetration rate[37]

Year	Target group (SEWA Gujarat State)	IIS membership	Penetration rate (%)
1990-91	25 911	n.a.	n.a.
1991-92	46 076	n.a.	n.a.
1992-93	38 136	n.a.	n.a.
1993-94	42 280	7 000	17
1994-95	75 615	10 000	13
1995-96	158 152	12 784	8
1996-97	162 781	15 846	10
1997-98	159 204	19 515	12
1998-99	142 810	26 000	18
1999-2000	147 618	23 214	16

Source: SEWA, 1999 and internal documents.

Figure 2.



37 The penetration rate is calculated as the number of members in the IIS divided by the number in the target group (SEWA members in Gujarat State).

Although the initial penetration rate declined sharply in 1995, it had recovered somewhat to 18 per cent in 1998, since when it has begun to decline again. Apart from the fact that SEWA membership as a whole is rising again, and the membership of the IIS itself is declining, the underlying causes are uncertain. One factor may be that while many SEWA members appreciate the value of coverage, they have little understanding of the principles and mechanics of insurance schemes. They are unfamiliar with the concept of paying out real money for annual premiums to protect themselves from the consequences of future events that may never occur.

2.2 *The benefits package and premiums*

Table 12 sets out the three components of the IIS benefits package, and the related premiums and payment methods in 2000. The table is based on an information leaflet which SEWA provides to its members. New IIS members are informed of their entitlements, privileges and obligations through local advertising, pamphlets, union meetings, SEWA Bank advertising or directly when they join the scheme.

As described earlier, there are two ways of paying the premium, giving entitlement to various kinds of benefit, as shown in Table 12. As with the level of the premium and the benefits package, SEWA consulted its members and the two insurance companies, LIC and UIIC, in order to develop payment methods suited to members' needs.

The original method is by annual payment, Rs.60 if the woman alone enters the scheme or Rs.75 if her husband is included, plus an annual administration charge of Rs.5. The former entitles the member to the benefits described in column two of Table 12, the second those listed in column three. Payment is due at any time between April and June.

Since 1993, members of the IIS have had the option of payment through the fixed deposit arrangement, involving a deposit of Rs.500 if the woman alone joins the scheme and Rs.700 if her husband is included, plus a one-off administration charge of Rs.5. The former entitles the member to the benefits described in column four of Table 12, the second those in column five. The fixed deposit, which can be paid at any time of the year, must be paid in cash into the member's account in SEWA Bank, where it remains. The annual interest, ranging from 11 to 13 per cent up to 1999, is used to pay the annual premium. The deposit is paid back to the woman when she reaches the age of 58.

Table 12. The IIS benefits package and premiums (April 2000)

Benefits	Rs.60 (annual)	Rs.75 (annual)	Rs.500 (fixed deposit)	Rs.700 (fixed deposit)
Death (via LIC + UIIC)				
Natural death of woman (Rs.3 000 via LIC)	✘	✘	✘	✘
Natural death of husband (Rs.3 000 via LIC)		✘		✘
Accidental death of woman (Rs.40 000 = Rs.25 000 via LIC + Rs.15 000 via UIIC)	✘	✘	✘	✘
Accidental death of husband (Rs.40 000 = Rs.25 000 via LIC + Rs.15 000 via UIIC)		✘		✘
Accidental death of husband (Rs.15 000 via UIIC)	✘		✘	
Health (SEWA Mediclaim)				
Hospitalization[38] of *woman* (Rs.1 200 ceiling)	✘	✘	✘	✘
- Cataract operation (Rs.1 200 ceiling) - Hearing aid (Rs.1 000 ceiling) - Dentures (Rs.600 ceiling)			✘ ✘ ✘	✘ ✘ ✘
Asset (SEWA Emergency Fund)				
Asset loss due to fire/flood/ riots for *woman* (Rs.5 000 ceiling)	✘	✘	✘	✘
Maternity benefit/GRANT				
Per childbirth (Rs.300 lump sum)			✘	✘

Source: SEWA IIS information leaflet.

38 For general diseases, special gynaecological ailments and occupational health-related diseases.

One of the reasons why the option of paying the annual premium via a fixed deposit account was introduced was that many members found the timing of the annual premium payment, which had been set by the insurance companies, inconvenient. October was preferred by many, since that was when they normally had higher income from increased business. Casual workers travelling between different districts or regions would often be away between April and June. Several members said that they might forget to renew the annual insurance contract when due and thus lose their cover. For some members, especially those who did not have to claim, saving a certain amount in the fixed deposit scheme seemed easier to accept than paying a premium each year, even though putting money into the fixed deposit meant that it was locked up and could not be used for other purposes.

For SEWA it brought greater security in its financial management, since it was assured of a known size of membership and avoided problems of collecting premiums. It also allowed streamlining of administrative procedures within the IIS by linking savings and insurance services. It gradually brought in incentives to use the fixed deposit method. From 1993, only those using the fixed deposit method were eligible for maternity benefit, and since 1999, for cataract operations, dentures and hearing aids.

As a further incentive to use the fixed deposit, on an experimental basis, SEWA launched a scheme allowing members to save up for the fixed deposit in monthly instalments of Rs.20. Meanwhile, SEWA paid part of the premium in advance to the insurance company, SEWA Mediclaim and SEWA Emergency Fund, so that members were already covered before they had saved the whole amount of the fixed deposit. Approximately 2,500 members signed up for this scheme, but many of them did not keep up the monthly payments and thus did not accumulate the amount of the fixed deposit. SEWA therefore ended the experiment in 1999, although some members are still paying the monthly amounts due.

A further improvement, being offered on a trial basis until June 2001, is that women who have already included their husbands in the life component can now include them in the health component for an additional premium of Rs.20 per year.

A precise breakdown of the number of members using the fixed deposit and annual payment methods respectively is not presently available. The fact, however, that up to 1999 some 11,000 women had opted for the fixed deposit method may be an indication of the success of the incentives offered. In fact, by 2000 the number had risen sharply to 16,000 members opting for that method.

2.3 Administration and management

The IIS belongs to SEWA social security, one of the five sub-programmes of the SEWA movement, the others being SEWA Bank, the SEWA cooperatives, SEWA Academy and SEWA Union. Although it maintains its own records and, in part, its own accounting system, it does not have a separate legal personality or separate constitution. It is not independent of the SEWA Executive Committee or SEWA Bank Committee (see below). However, the IIS does have its own internal rules, which are decided by the Insurance Committee, as described later in this section.

The principal agents and organs and their role in management and administration

Several institutions and agencies[39] are involved in the administration and day-to-day management, operation and organization of the Integrated Insurance Scheme:

(a) the insurance companies LIC and UIIC;

(b) the three organs of the IIS: The *Insurance Committee*, the *local insurance committees* and the local *spearhead teams*;

(c) SEWA Bank;

(d) SEWA health workers;

(e) external services and technical assistance.

(a) The insurance companies LIC and UIIC

Until 1994, the SEWA IIS was mainly an intermediary between its members and the two insurance companies LIC/UIIC for the three components of the scheme (life, health, assets). It handled the day-to-day processing of premiums and claims, but did not have financial ownership and was not responsible for the scheme's financial management and administration. In the case of the life component, that has not changed. The LIC and UIIC retain full financial and administrative ownership and management responsibility. However, SEWA Mediclaim took over financial ownership and the financial management and administration of the health component in 1994 and SEWA Emergency Fund similarly took over the assets component in 1998.

39 Since the relationships between these actors is complex and since their activities to some extent overlap, a strict separation of their roles is not always possible.

(b) The three organs of the IIS: The Insurance Committee, the local insurance committees and the local spearhead teams

The *Insurance Committee* is primarily responsible for monitoring the operation of the scheme: prompt payment of claims, dealing with complaints, service quality, deciding on changes needed, long-term policy, evaluation and review, as well as educational and promotional activities. Another core function is to conduct negotiations and ensure coordination with the two insurance companies. The Insurance Committee is, of course, inseparable from the financial management of the scheme, but that is not its main area of responsibility.

The Insurance Committee consists of SEWA members from the various districts, SEWA Bank staff and office holders, SEWA office holders and members of SEWA health cooperatives. All members of the Insurance Committee are nominated by the SEWA Executive Committee[40] and by the Board of SEWA Bank. The full Insurance Committee meets at least once a month.

The *local insurance committees* were formed, following the model of SEWA Union, to decentralize the administration of the scheme and deal with claims from outside Ahmedabad and in rural areas. The committees are made up of eight IIS members, advised by one insurance coordinator. They meet to take decisions on payment of claims every two weeks, or more frequently if required. SEWA Bank and SEWA Union in Ahmedabad have been working with insurance coordinators there to establish predetermined criteria to simplify claims decisions. Once the fully documented claim has been submitted and approved by the local insurance committee, payment is made immediately from local funds. It is hoped that this decentralization will lead to greater accountability and provide a better service to members.

Another decentralizing measure was the formation, in some of SEWA's branches, of local *spearhead teams* from local leaders specially trained in the SEWA Academy. Along the lines of the spearhead teams for savings, cooperatives and training, a spearhead team of 35 local leaders was formed for the insurance scheme in 1999. Its task was to promote the idea of insurance, advise people about premiums and ways of paying them, assist with claims, especially helping illiterate members to obtain all the documents required and inform them about changes to the scheme.

40 The SEWA Executive Committee represents all SEWA members in Gujarat State. The Committee has 25 elected members and the five heads of the five administrative divisions (one of which is social security). It is elected by the Council of SEWA (*Pratinidhi*), made up of 714 union representatives or village leaders. There are about 10,000 village leaders, for some 150,000 SEWA members in Gujarat State.

(c) SEWA Bank

The financial management and administration of the insurance scheme, described in more detail in Chapter 4, are mainly carried out by SEWA Bank staff at its Ahmedabad headquarters, in collaboration with the Insurance Committee and an extensive network of grassroots organizers, local representatives and health care workers.

As primary manager of the IIS, SEWA Bank is responsible for:

- day-to-day administration, financial management and investment of scheme funds;
- collection of premiums and claims payments;
- preparation of financial reports to the insurance companies;
- maintenance of the accounts of the fund established by the GTZ or "GTZ Fund" (investment of the fund, administrative costs, etc.) which are subject to external audit.

(d) SEWA health workers

As mentioned,[41] health workers are crucial for claims processing, as they constitute the central collection point for claims from several villages. These claims are taken to SEWA Bank, at its head office or branches, about once a week. The health worker from the area in question then discusses the claim with the doctor who makes a recommendation to the Committee on the admissibility and amount of the claim. The health worker collects the reimbursement from SEWA Bank and delivers it to village women in rural Gujarat State. Urban members collect the reimbursement directly from SEWA Bank or from mobile Bank staff within the city. Some health workers are also members of the Insurance Committee and health cooperative committees.

(e) External services and technical assistance

When required, technical assistance is provided for various purposes by the insurance companies UIIC and LIC and external donor agencies, such as the GTZ, which in 1993 financed the IIS to the tune of Rs.10 million. The GTZ is currently financing an insurance expert assigned to the IIS as coordinator for a project for the extension of the scheme, as well as its replication in other states of India. The expert formerly worked with the UIIC and advises on relations with the insurance companies. Technical assistance is also available from external researchers and consultants. External services include accountancy, computer support, photocopying and other reprographic services.

41 See Chapter 1, section 1.3 and Chapter 3.

Decision-making organs and procedure of the SEWA IIS

The IIS does not have a separate general assembly of its members, since it is included in the agenda of the main SEWA General Assembly. IIS members are represented in the Insurance Committee through union and village leaders.

The Integrated Insurance Scheme has been modified several times in recent years to reflect members' needs. Proposed amendments to the scheme are normally discussed and decided by the Insurance Committee. It decides on the choice of services covered, premium levels, premium payment methods, claims, complaints and suggestions concerning the general policy of the scheme. Members can submit their views to the Insurance Committee and the SEWA General Assembly through their local insurance committees or spearhead teams. Decisions taken by the Insurance Committee are discussed at meetings of the SEWA Executive Committee, SEWA Bank Board and the SEWA Council.

An alternative procedure, in the case of significant decisions, is to hold a workshop for members or their representatives to discuss various options for change. A recent example was the decision to include husbands in the health component. A number of members had argued for some years that health cover should be extended to the whole family. A workshop was held on the proposal with the participation of representatives of all the villages and of various occupations. The premiums for different scenarios were calculated and explained. One conclusion was that including the whole family would mean a big increase in the premium which members could not afford. On being asked to set priorities, the workshop recommended that husbands should come first. The Insurance Committee accepted the recommendation, drew up the terms of the new cover and notified all members. Other fundamental decisions, such as converting the Integrated Insurance Scheme into an insurance cooperative, were discussed at the SEWA Bank Assembly.

IIS members are informed of decisions taken by the Insurance Committee through a variety of channels: SEWA Bank, SEWA Insurance Committee itself, SEWA organizers and health care workers. All decisions by the Insurance Committee and recommendations of workshops are formally minuted, including the participants, dates and decisions. SEWA has introduced a number of measures to help illiterate members understand the changes and fully involve them in the decision-making process. These measures include pictorial presentations, videos, and dramatized discussions.

Claimants can appeal when a claim is disallowed or only allowed in part. Appeals against decisions by the SEWA IIS may be submitted to the Insurance Committee

by individuals or group representatives in respect of all components of the Integrated Insurance Scheme. Appeals against decisions concerning the life insurance component are submitted by SEWA organizers or the Insurance Committee to the LIC/UIIC. SEWA and the insurance companies meet periodically to discuss claims appeals, possible future extension of cover, or specific financial details of the scheme.

IIS staff

The IIS employs ten full-time salaried women staff and 35 volunteer village leaders in the day-to-day management of the scheme. The ten salaried staff include:

- two coordinators, one responsible for financial matters, coordination with SEWA Bank and the insurance companies, the other in charge of the expansion of the scheme, training, campaigns, coordination with rural districts and other SEWA activities;
- two employees in SEWA Bank, who deal with the day-to-day processing of claims and premiums at the accounts desk as well as financial matters;
- five local representatives.

The IIS office is also assisted by the insurance expert, funded by GTZ, who coordinates the GTZ project.

The volunteer workers are the 35 village or local SEWA members who form the spearhead team. These volunteers are specially trained in insurance issues so that they can explain them to new members, and help with submission of claims and collect premiums.

The members of the Insurance Committee are unpaid representatives and are chosen for their commitment to service.

The IIS is also supported by SEWA Bank and SEWA's own health care providers. SEWA Bank is crucial to the financial management of the different components of the IIS. SEWA does not keep separate costings of the time spent by SEWA Bank personnel or SEWA health workers on IIS work. They are paid for their health activities, but not for their insurance related work or their role in the Insurance Committee.

Information system and management tools

Accounting framework

Although SEWA Bank's activities are regulated, like any other commercial bank in India, the insurance scheme is not itself subject to any independent reporting requirements. However, some of the "GTZ Fund" accounts are audited externally, like all SEWA Bank programmes, by a firm of accountants.

SEWA only coordinates with and reports to the insurance companies LIC and UIIC for the life insurance and assets insurance components. Health insurance is managed entirely in-house. LIC and UIIC also share information with SEWA on total premiums received, claims paid out as well as programme updates.

Administrative procedures and management information

There are standard administrative procedures for information about members, premiums and processing of claims, either manual or computerized. There are standard forms for application to join the IIS, including information on benefits and obligations, claims, receipts for premiums and claims paid as well as advertising literature. Records are kept of membership, premiums, benefits paid, treatments sought and other relevant matters.

Other management tools

A combination of qualitative and quantitative methods is used to estimate future IIS growth, complaints, and new subscriptions and renewals. Premiums received and claims paid are monitored throughout the year, and a year-end balance is drawn up. A cash account is maintained for the IIS. Investment of premiums paid into SEWA Bank are also monitored. The IIS does not produce a separate annual report. Information about the scheme is included in SEWA's Annual Report.

Systems of control and verification

Periodic checks are carried out on cash accounts, membership numbers and trends, and patterns of premiums collected and claims paid. Benefits and expenditure invoiced direct to the IIS, types of benefit paid out (life, health, assets component) and specific sub-type (e.g. kind of disease, reason for loss of asset, etc.) are analysed periodically. SEWA ledgers are audited to check that the ceiling of Rs.1,200 has not been exceeded by a member claiming more than once during the reference period.

Equipment and infrastructure

The IIS relies mainly on the equipment and infrastructure of SEWA Bank and SEWA Union. The scheme uses the same premises in Ahmedabad rent-free, the same transport facilities for field work, auto-rickshaws and van, the same PCs, computer support, publishing and photocopying services. The health centres provide decentralized services, including premises for insurance committee meetings and submission of claims. The existing infrastructure of cooperatives and dispensaries helps to promote the scheme and recruit new members.

Chapter 3

SPECIFIC ASPECTS OF THE HEALTH COMPONENT

This chapter takes a more detailed look at certain aspects of the health component of the Integrated Insurance Scheme. The information comes mainly from two separate studies, one by Smita Srinivas for the STEP programme in 1999 (Srinivas, 1999) for SEWA's internal use and the second by Kent Ranson in 2000 (Ranson, 2000) in Gujarat State. The STEP-Srinivas study deals with a sample of 839 claims drawn from 1,309 claims between 1992 and 1998. The Ranson study analyses a total of 1,930 claims submitted in Gujarat State between July 1994 and June 2000. Additional information was provided by SEWA staff and documents.

It should be emphasized that much of the data collected was held in a variety of locally maintained ledgers, in many cases hand-written in Gujarat State. The following data may, therefore, be somewhat lacking in precision and should therefore be treated with caution. The statements made are based on the information available. SEWA Mediclaim is now working on a database containing full and easily updated information on each claimant in a single screen.

1. Health benefits

This section describes the benefits under the health component, the choice of services covered and the cover compared to the main reasons of morbidity and mortality in India.

1.1 Coverage

Table 13. Benefits

Premium payment method	Description of cover	Amount of cover
Annual premium (Rs.60/75) and fixed deposit (Rs.500/700)	Hospitalization (incl. hospital charges, medicines, lab/x-ray) for: • general diseases; • gynaecological ailments; • occupational health-related diseases.	Reimbursement up to the ceiling of Rs.1 200 per year
Fixed deposit only (Rs.500/700)	Maternity benefit/grant Per childbirth	Rs.300 lump sum paid out during or after 8th month of pregnancy
	Cataract operation	Reimbursement up to the ceiling of Rs.1 200 per year
	Hearing aid	Reimbursement up to the ceiling of Rs.1 000 per year
	Dentures	Reimbursement up to the ceiling of Rs.600 per year

Source: SEWA IIS information leaflet.

Normally outpatient treatment is not covered unless linked in some way to hospitalization charges.[42] Hospitalization refers to any in-patient admission to a hospital and can include any treatments the patient undergoes while actually admitted to the hospital.[43] It also includes all surgical operations. Only exceptions are the special services (described below), they are also covered when treated without hospitalization. There is *no* cover for diseases which are treated by the

42 Claims are sometimes paid, especially in rural areas, where patients are not hospitalized, e.g. for a fracture, because it is not possible for them to stay in hospital. The most common reasons are that there is no other female family member to take care of the children, the high cost of lost working days or the long distance to reach the hospital.

43 When the scheme was under UIIC management, one condition was that the hospital had to have a specified number of beds. Since SEWA took over, this is no longer a requirement.

SEWA health care network, which mainly provides primary health care and basic diagnostic services, but not hospital treatment.

The cost of hospitalization, including hospital fees, medicines, laboratory tests and x-rays related to the hospital stay, are covered up to a ceiling of Rs.1,200. The cost of transport and food is not included. Until June 1994, when the health component was managed by UIIC, the ceiling of reimbursement was set at Rs.1,000. In 1995, when administration of the component was taken over by SEWA Mediclaim, the ceiling was raised to Rs.1,200. The ceiling applied to *all claims combined in any one year* in respect of general, gynaecological or occupational health-related diseases or of the special services (cataract, dentures and hearing aid), and not to each separate claim in the case of more than one illness in the year.

Normally there is no waiting period for entitlement to benefit under SEWA Mediclaim. Once an IIS member is accepted in the scheme, she can claim immediately in the event of illness. The only exception is that a waiting period may be imposed in the case of chronic diseases, depending on the length of time the claimant has been a member of the IIS.

Hospitalization

General diseases have been covered since the health component was added to the insurance package in 1992. They include diseases such as malaria, respiratory illnesses, infections of the urinary tract, accidents and injuries, heart disease, diarrhoea/vomiting, various fevers, gastro-enteritis, as well as special categories of treatment such as hysterectomies.[44]

Gynaecological and reproductive ailments have been covered since 1995, but excluding hospital deliveries for various reasons discussed in section 1.2.

Occupational health-related diseases and injuries, including those to the skin and eyes, burns, sunstroke, snake bites and fractures were added to the package of cover in 1995. The decision to include occupational health-related issues was linked to SEWA Union's mandate as a trade union representing workers in the informal economy. When cases are identified, they are referred to specialists by SEWA Union in conjunction with SEWA's occupational cooperatives.

44 The complete SEWA Mediclaim disease list is not available for publication.

Maternity benefits

The maternity benefit is a lump sum of Rs.300. It is intended to allow women to stay at home slightly longer after delivery, to rest and recuperate, to continue breast-feeding rather than being forced to wean babies to return to work and to obtain extra nutrition from calorie-rich traditional food during pregnancy and in the post-natal period. It does not cover other aspects of maternity. When it was introduced in 1992, all IIS members were eligible.[45] In 1993, SEWA decided to restrict it to those who paid their premiums by the fixed deposit method, as an additional incentive to use that method.

Special services

Cover for special services, cataract operations, hearing aids and/or dentures up to the ceilings shown in Table 13, was added in 1999, for those paying their premiums through the fixed deposit method.

1.2 Choosing the services to be covered

The decision to cover the mentioned diseases was made in consultation with SEWA's existing health network, chiefly SEWA health cooperatives and health centres. SEWA decided to cover only hospitalization and not outpatient care in the health component of the IIS, because the latter is provided through SEWA's own primary health care network of curative, preventative and educational services. The hospitalization expenses cover should be seen as complementary to the services offered by SEWA's health care network. Another argument was that outpatient cover would involve high administrative costs for the IIS because there would be many more, mostly small claims, as well as greater potential for abuses and fraud.

The decision to cover only hospitalization posed a problem for some rural members. As SEWA discovered, often there was no hospital available within a reasonable distance, which meant high travel costs for people who could little afford it. Moreover, for rural people especially, there were high costs of working time lost in travel to the hospital. Delays in processing claims also left people out of pocket. This could account for the fact that only one-third of claims come from rural areas, although over half of IIS members live in rural areas.

45 When SEWA began providing maternity benefit, members were required to attend pre- and post-natal clinics and undergo three-monthly check-ups to obtain the benefit. This condition proved difficult to enforce, so it was discontinued.

SEWA decided to provide a maternity benefit directly to IIS members because many women working in the informal economy had no access to maternity benefits under state social security schemes or were not aware of them. Moreover, maternity benefits were not included in the package arranged by SEWA with the two insurance companies, UIIC and LIC. SEWA took the view that the work-related benefits to which workers were entitled should include maternity benefits.

1.3 *Diseases covered and the main causes of mortality and morbidity in India*

The two main causes of death in rural India are old age (23.5 per cent in 1992) and respiratory disorders (19.6 per cent in 1992). A third category includes diarrhoeal diseases, acute respiratory infections, malaria, tuberculosis, pneumonia, neonatal and other forms of tetanus, enteric fever, hepatitis and several smaller categories. Within the 25-34 age group, approximately 45 per cent of all deaths occur due to complications in pregnancy and childbirth. Other significant causes of death are meningitis and viral hepatitis.

The major causes of morbidity in the 1993 all-India data are chiefly diarrhoeal diseases and acute respiratory infections followed by malaria (13 per cent), tuberculosis (7 per cent), pneumonia (3 per cent) and neonatal and other forms of tetanus.

All the above diseases, other than tuberculosis and hospital births, including occupational health-related diseases, are covered by the IIS. Tuberculosis is treated free by the SEWA health care network in collaboration with the World Health Organization (WHO). The cost of hospital births is not included for the following reasons:

- higher premiums would be needed to take account of high hospital costs and the number of deliveries, given that mothers have three to four children on average. Even if members could afford the higher premium, which many could not, and even if only part of the cost were covered, the indirect costs would still be too high;
- in rural areas over 60 per cent of women give birth at home and only go to hospital in the case of an emergency;
- many women prefer delivery by midwives for traditional reasons. SEWA's health care network places special emphasis on the training of midwives, and sees their promotion as complementary to the insurance scheme and a cheaper form of prevention.

2. The Integrated Insurance Scheme and health care providers

The following section examines the relationship between the IIS and both SEWA's own health care providers, mainly health cooperatives and health centres, and other health care providers.

2.1 *The Integrated Insurance Scheme and SEWA's health care providers*

The IIS and SEWA's own health care providers have no formal relationship because, as noted above, the IIS covers hospitalization, which is outside the scope of SEWA's own health care providers. Some links, however, have been established between the IIS and SEWA's health workers, who play a crucial role in SEWA's health cooperatives and health centres.[46] These health workers have the following responsibilities under the IIS:

- they publicize the IIS and sign up new members, thus constituting the first point of contact for SEWA members. They also provide information to non-SEWA members who may be interested in joining the IIS;
- they collect claim documents and bring them to Ahmedabad for processing. In rural areas especially, they register claims and keep a record of the diseases and nature of health services sought. They also keep records of members' general data, such as name, occupation, age, address, number of family members, level of education;
- based on their local knowledge, they are able to provide a more informed opinion on the validity of the claim and the appropriate amount of reimbursement than the SEWA doctor in Ahmedabad or the insurance company;
- finally, they collect claims payments from SEWA Bank and deliver them to members, who live in rural villages.

SEWA dispensaries have an indirect impact on the IIS because they sell the medicines that members need for their hospital treatment at reduced prices, but they do not directly subsidize the IIS. SEWA health centres are the main channel for the payment of maternity benefits.

46 These workers operate in SEWA's health cooperatives and health centres, as described in Chapter 1.

2.2 *The Integrated Insurance Scheme and external health care providers*

IIS members are free to choose the public or private hospital where they wish to receive treatment. Usually they base their choice on the hospital location, personal knowledge, word-of-mouth recommendations and, of course, cost.

The IIS has no formal agreement of any sort with private or public health care providers or charitable organizations offering hospitalization. It does, nevertheless, develop relationships with certain trustworthy and quality health care providers which it can informally recommend to its members. It also blacklists fraudulent or untrustworthy medical practitioners. SEWA also provides its members with information on the charges of different health care providers.

Private health care providers can, in principle, charge whatever they like for their services. In most cases, especially in rural areas, private treatment is much more expensive than the public health service. However, it is often preferred because it is perceived to offer better quality.

Public health care providers normally have fixed charges throughout the state, and many services are available free or for only a small fee. Family planning services are also provided at modest cost. However, additional charges are payable for many services, including some basic care. Moreover, the quality of care is considered to be uncertain and only sporadically available.

SEWA does not offer any special incentives to health care providers. However, its considerable bargaining power does make it a force to be reckoned with. Some health care providers have offered lower rates on their own initiative to SEWA to attract a larger clientele among its membership.

For the benefit of extremely poor members who cannot pay for their medical treatment, SEWA has links with various charitable organizations which provide free hospital treatment.

3. Health claims and characteristics of claimants

3.1 *The most common claims*

According to the Ranson study, the most common claims were for accidents and injuries, followed by malaria, diarrhoeal diseases and respiratory illnesses. Table 14 shows the full breakdown:

Table 14. Frequency of claims by type of disease

Illness type	No. of claims	% of total
Accidents and injuries	277	14.5
Malaria	200	10.4
Acute gastro-enteritis	198	10.3
Hysterectomies	167	8.7
Digestive system	123	6.4
Circulatory system	116	6.1
Respiratory system	115	6.0
Genito-urinary system	104	5.4
Other symptoms and signs	100	5.2
Typhoid and enteric fever	98	5.1
Nervous and sensory	91	4.8
Other infectious/parasitic	78	4.1
Fever of unknown origin	60	3.1
Neoplasms	42	2.2
Skin	37	1.9
Disease of blood	36	1.9
Complications in pregnancy	26	1.4
Musculoskeletal	19	1.0
Endocrine and nutritional	15	0.8
Mental disorders	12	0.6
Total	**1 914**	**100**

Source: Ranson, 2000.

3.2 Number of claims

In the period from 1992 to 1998, a total of 2,426 claims were received, of which 2,027 were allowed and paid out. Between 1995 and 1998, the number of claims remained quite steady, while the number of members of the IIS increased. The trend was reversed from 1998 when the number of claims rose, while the number of members declined slightly. Table 15 shows the annual breakdown for claims received and allowed, split between rural and urban areas.

Table 15. Number of claims received and paid out

Year	IIS member-ship	Claims[47] received	Rural	Urban	Claims paid out	Rural	Urban
1992-93	38 136	150	66	84	70	10	60
1993-94	7 000	93	31	62	58	23	35
1994-95	10 000	209	60	149	162	48	114
1995-96	12 784	315	150	165	288	135	153
1996-97	15 846	353	130	223	329	124	205
1997-98	19 515	310	128	182	288	121	167
1998-99	26 000	487	149	338	420	127	293
1999-2000	23 214	509	159	350	412	117	295
TOTAL		**2 426**			**2 027**		

Source: SEWA, 1999 and internal documents of the Integrated Insurance Scheme.

Approximately two-thirds of the claims under the health component of the IIS between 1992 and 2000 came from urban areas, and only one-third from rural areas. Until 1998 the ratio of urban to rural members of the IIS was also two-thirds to one-third. Since 1998, rural IIS members have increased their share to 50 per cent, although they still account for only one-third of claims.

From 1992 to 1994, when the health component was managed primarily by the insurance company UIIC, the number of claims disallowed was quite high. One of the reasons why the UIIC often rejected claims was that medicines, which make up a large proportion of the total cost of hospitalization, did not figure on the UIIC's

47 As the majority of claimants claim only once a year, SEWA equates one claimant to one claim.

list of approved medicines, even though they were prescribed by a registered medical practitioner. In some cases, doctors' credentials were questioned and if they were not registered, the claim was disallowed. In other cases, additional documents were demanded. Table 16 shows the rate of disallowed claims.

Table 16. Rate of disallowed claims

Year	Claims received	Claims paid out	Claims settled (%)	Claims disallowed (%)
1992-93	150	70	46.7	53.3
1993-94	93	58	62.4	37.6
1994-95	209	162	77.5	22.5
1995-96	315	288	91.4	8.6
1996-97	353	329	93.2	6.8
1997-98	310	288	92.9	7.1
1998-99	487	420	86.2	13.8
1999-2000	509	412	80.9	19.1
TOTAL	**2 426**	**2 027**	**83.6**	**16.4**

Source: SEWA, 1999 and internal documents of the Integrated Insurance Scheme.

The high proportion of members' claims disallowed was one of the main reasons why SEWA Mediclaim was formed to take over the management of the health component in 1994. Since then the local insurance committees and the Insurance Committee of the IIS decide claims on the advice of a medical doctor. Almost half of the average of over 15 per cent of claims now disallowed, according to the Ranson study, concern chronic or pre-existing diseases, which are only exceptionally covered. In 15 per cent of claims, documents were incomplete, 10 per cent were fraudulent and in 7 per cent the patient had not been admitted to hospital.

3.3 *Characteristics of the claimants*

The characteristics of the claimants according to the STEP-Srinivas study are summarized in Table 17. They are compared with those of the target group, i.e. the total SEWA membership in Gujarat State, since the data for the member of the IIS only are not available.

Table 17. Characteristics of claimants

Characteristics	SEWA membership[48]	Claimants
Location	Mostly rural Urban: 34% Rural[49]: 66%	Mostly urban Urban: 68% Rural: 32%
Age	Mainly members aged from 30 to 45 years[50]	Average 40 years (41 years in Kheda and Anand District)
Income	Not available separately	Annual average all claimants: Rs.18 396 Annual average urban: Rs.20 844 Annual average rural: Rs.13 236[51]
Area of Occupation	Services and labour: 60% Home-based workers[52]: 34% Hawkers, vendors and traders: 6%	Services and labour: 49% Home-based workers[53]: 43% Hawkers, vendors and traders: 8%
Religion/ caste	Predominantly Hindu, the largest population group, the majority lower caste; Muslims and other minority groups.	Hindu, predominantly lower caste: 85% Muslim: 10% Other (Jains, Christians etc.): 5%
Literacy	Female illiteracy in Gujarat State 51.4%[54]	83.3% illiterate
Housing	Kutcha: urban: 4% rural: 19% Pucca: urban: 80% rural: 37% Semi-Pucca: urban: 16% rural: 44%	Kutcha[55]: 30% Pucca: 36% Semi-Pucca: 34%

Source: Various, see footnotes below.

48 Where separate data are not available for the target group, they are taken from the 1991 census of the whole of India and Gujarat State in 1991 (Government of Gujarat State, 2000), which refers to the whole population of Gujarat State.

49 SEWA, 1997, 1998, 1999.

50 Various SEWA sources. Although technically, only women between 20-58 are allowed in the scheme, some women aged as low as 18 and up to 65 are registered. These may be discretionary cases or simply reflect failure to enforce the age rule. This can also be seen in the survey of Kheda district.

51 In 1998 Rs.; for 1999/2000, the Ranson study reports an average income of Rs.26,072.

52 SEWA includes both home-based and household workers in the home-based worker category (SEWA, 1998).

53 Made up of 26 per cent home-based workers and 17 per cent household workers.

54 Government of Gujarat State, 2000.

55 Urban and rural claimants combined.

4. Cost of services and reimbursement

4.1 *Cost of services*

The cost[56] of treatment for each disease covered is shown in Table 18. Table 19 shows the total cost of hospitalization for 1,712 claims allowed and paid. The average cost for all hospital admissions was Rs.2,044. Based on the 1,031 claims for which the breakdown was available, total cost includes the following direct costs: medicines (57 per cent), bed fees (17 per cent), doctors' fees (12 per cent), laboratory and x-ray fees (10 per cent) and other fees (5 per cent). Indirect costs, such as the cost of transportation and food, are not included.

Table 18. Breakdown of costs by type of disease

Disease	No of claims (N = 1 914)	Average cost in Rs. (N = 1 914)	Claims × cost in Rs.	% of total
Accidents and injuries	277	1 772	490 844	12.49
Malaria	200	1 485	297 000	7.56
Acute gastro-enteritis	198	1 496	296 208	7.54
Hysterectomies	167	4 421	738 307	18.79
Digestive system	123	2 744	337 512	8.59
Circulatory system	116	2 197	254 852	6.48
Respiratory system	115	1 533	176 295	4.49
Genito-urinary system	104	2 239	232 856	5.92
Other symptoms and signs	100	1 930	193 000	4.91
Typhoid and enteric fever	98	1 717	168 266	4.28
Nervous and sensory	91	1 844	167 804	4.27
Other infectious/parasitic	78	1 658	129 324	3.29
Fever of unknown origin	60	1 082	64 920	1.65

56 The costs in this section are expressed in 1999/2000 Rs., i. e. values for earlier years have been inflated to make them comparable.

Disease	No of claims (N = 1 914)	Average cost in Rs. (N = 1 914)	Claims × cost in Rs.	% of total
Neoplasms	42	2 799	117 558	2.99
Skin	37	1 987	73 519	1.87
Disease of blood	36	1 473	53 028	1.35
Complications in pregnancy	26	2 211	57 486	1.46
Musculoskeletal	19	1 750	33 250	0.85
Endocrine and nutritional	15	1 730	25 950	0.66
Mental disorders	12	1 841	22 092	0.56
Total	**1 914**	**-**	**3 930 071**	**100**

Source: Adapted from Ranson study (Ranson, 2000).

Table 19. Average cost of hospitalization and amounts reimbursed, by year

Year	No. of claims[57]	Average total	Average reimbursed	Average of percentage rate reimbursed
1994-95	167	2 166	1 185	79.9
1995-96	127	1 556	1 051	84.8
1996-97	240	2 236	1 039	74.2
1997-98	349	2 004	966	74.3
1998-99	467	2 115	1 050	76.4
1999-2000	362	1 977	933	76.1
Total	**1 712**	**2 044**	**1 019**	**76.5**

Source: Adapted from Ranson study (Ranson, 2000).

57 Note: Ranson grouped the claims by date of admission to hospital, while SEWA IIS grouped them by date of payment of the claim. The number of claims by year thus sometimes differs from the figure shown in Table 15. In some cases, too, only incomplete information on claims was available.

Costs of private and public hospitals

Members are free to choose between public or private hospitals, the majority of them choosing the latter. The STEP-Srinivas study found that 66 per cent of claimants preferred private hospitals. According to the Ranson study, which distinguishes between private for profit, private-non-profit (charitable) and public hospitals, 64 per cent of all claimants choose private-for-profit hospitals, 29 per cent public hospitals and 7 per cent private-non-profit (charitable). Often there is no public hospital available within reasonable travelling distance. Moreover, when a choice is available, private hospitals are generally considered to provide better quality treatment than public hospitals.

Both a SEWA internal study and the Ranson study show variations in the cost of private hospitals because they vary their prices for medicines and treatment from one district to another. According to SEWA, private hospitals cost on average three times more than public hospitals (see Table 20).

Table 20. The cost of private and public hospitals

Average cost	Private hospitals (Rs.)	Public hospitals (Rs.)
Hospital fees	1 301	367
Medicines	450	473
Laboratory tests/X-rays	203	135

Source: SEWA internal documents.

Ranson calculates the average overall cost of hospitalization in a private-for-profit hospital to be Rs.2,530, in a private-non-profit hospital Rs.1,613 and in a public hospital Rs.1,108 (see Table 21).

Table 21. Costs by type of hospital

Hospital type	Cost on average (Rs.)
Private-for-profit	2 530
Public	1 108
Private-non-profit (charitable)	1 613

Source: Ranson, 2000.

4.2 *Reimbursement*

Ranson found that of 1,712 claims allowed (see Table 19) the average reimbursement was Rs.1,019. The average rate of reimbursement for all claims taken together was 76.5 per cent. Some 47 per cent (898 claims) were reimbursed in full, and in 22 per cent of cases, less than one half of the total cost was reimbursed. Of the 10 per cent of claimants who received the lowest reimbursement for the cost of hospitalization, the proportion borne by the member ranged from 42 per cent to 5 per cent of self-reported annual income. Members also bear any indirect costs, such as transportation and food, as well as income lost while unable to work.

5. Health premiums in relation to Integrated Insurance Scheme members' income

The annual premium for the health component alone is Rs.30, although, of course, the member has to pay the whole package of Rs.60. That is 0.22 per cent of the income of households with the lowest income and 0.14 per cent of those with the highest annual income, in urban areas.

Table 22. Annual premium as a percentage of average annual income

	Average annual income (Rs.)	Annual health premium, Rs.30, as a percentage of annual income
Average annual income of claimants in STEP-Srinivas survey (1992-98):	18 396	0.16
• urban claimants	20 844	0.14
• rural claimants	13 236	0.23
Average annual income of claimants in Ranson survey in 1999-2000	26 072	0.12

Sources: Srinivas, 1999 and Ranson, 2000.

Even if the premium seems to be affordable, it should be borne in mind that even if claims are met in full, claimants still have to bear the indirect costs. Where claims are not met in full, in over 50 per cent of cases, claimants also have to pay part of the direct costs. Moreover, members have to pay the whole cost of hospitalization immediately on admission, while the reimbursement may take up to three months.

6. Time taken to process health claims

According to SEWA the average time taken to process claims, from submission to reimbursement, has been reduced since SEWA Mediclaim took over the management of the health component from the UIIC. In the past, it often took up to two months to process a claim and it might be up to eight months before reimbursement.

The Ranson survey examined the days from discharge to the reimbursement of the claim in the period 1994-2000 (see Table 23). On average it took 151 days from discharge from the hospital to the payment of the claim. This roughly breaks down into 73 days from discharge to submission of the claim to the Insurance Committee, 36 days from submission of the claim to the date of the Insurance Committee decision and 42 days between the decision to the reimbursement. This is below the time taken for processing claims by the UIIC. Nevertheless in the years 1996 to 1998 the processing time is still very high. There is a considerable improvement in the last two years (1998-99 and 1999-2000).

Table 23. Days from discharge to submission of claim (a), submission of claim to insurance committee's decision (b), decision to reimbursement (c)

Year	a	b	c	Total
1994-95	67	32	27	126
1995-96	108	26	24	158
1996-97	45	81	71	197
1997-98	106	23	94	223
1998-99	55	29	16	100
1999-2000	57	23	21	101
Average	73	36	42	151

Source: Ranson, 2000.

Urban members generally receive health care faster than their rural counterparts and from a wider variety of health care providers. They can also submit claims direct to SEWA Bank, thus shortening the processing time. In rural areas the processing time is still longer. One indirect reason is the shortage of SEWA village leaders trained in insurance claims procedures, which are more complex than banking, for example. Often, too, doctors' certificates are written in English, which means that village leaders, local insurance committee or spearhead team members need to know English in order to check the documents. All these factors make claims processing much slower, especially when the claimants are illiterate. SEWA IIS is undertaking a great effort to decentralize the scheme to rural areas.

Chapter 4

FINANCIAL ASPECTS OF THE INTEGRATED INSURANCE SCHEME

This chapter deals with the financial aspects of the SEWA Integrated Insurance Scheme from its inception in 1992 up to 2000. As well as drawing on information provided by SEWA officials themselves, this analysis is based on information extracted or constructed from the accounting records. It is pertinent, therefore, to include some comments on the accounts themselves and the accounting systems used by SEWA in managing the insurance scheme.

1. Accounting treatment

The accounts of the Integrated Insurance Scheme have been maintained up to now in the form of manual ledgers kept at SEWA Bank. These are now in the process of being transferred to a computerized ledger system. Such a process can sometimes create difficulties in keeping track of past changes to the scheme through the accounts. Against this background, a number of specific aspects of the accounting records of the Integrated Insurance Scheme deserve attention.

1.1 *Major issues*

Apart from some limited sharing of administrative support functions, the Integrated Insurance Scheme operates as a self-contained entity. Formerly, it had maintained separately an accounting system for the insurance premiums and claims and an accounting system for the fund provided by GTZ, effectively an "endowment", in 1993. The latter was subject to independent external audit, to ensure transparency and accountability to the donor. According to SEWA, the two accounting systems have recently been merged.

The fact that SEWA's financial year does not correspond to the premium payment period specified for the original insurance policies leads to lack of clarity. According to the Indian Trade Union Act, which SEWA follows, the financial year

ends on 31 December of each year. Meanwhile, to avail of the special subsidy offered by LIC, SEWA has to tailor its "insurance year" to that of LIC. Meaningful comparisons, therefore, between life insurance premiums and claims for a specific calendar year or "insurance year" are difficult. This is particularly so for the half-year periods involved at the inception of the insurance schemes with LIC and GIC or, indeed, for the half-year of insurance cover completed at the calendar year-end when each year's annual report and financial statements are prepared. The IIS management is aware of this problem, and a suitable management accounting system is now being designed.

1.2 *Subsidiary issues*

During the first two years of the scheme, the accounts made no allowance for depreciation of equipment such as computers, which meant that the costs were not properly apportioned over the whole time when the equipment was in use. Parallel to that, no dedicated reserve was created for the replacement of such equipment as it became worn-out or obsolete. This has since been remedied.

2. Financial history of the scheme

The history of the scheme, which is fully described in Chapter 2, is one of constant evolution and experimentation, developing mechanisms and products suited to the needs of the women, mostly poor, who make up its membership. It has not always been easy to reflect this development in accounting terms.

The arrangements under which various sections of the scheme have been secured with state insurance companies have changed from time to time, for reasons which are documented in the first section of Chapter 2. These insurers included the United India Insurance Company, a subsidiary of the General Insurance Corporation of India (GIC).

The funds available to the scheme, which include the grant from GTZ, initially over Rs.10 million, together with the accumulated surplus premium income retained by SEWA, in respect of health and asset insurance, have been invested in various instruments, mainly fixed deposits.

The members of the SEWA Integrated Insurance Scheme have also benefited throughout its history from the Government subsidy to the LIC designed to broaden social security coverage, albeit on a limited basis, amongst the less well-off groups. The subsidy enables LIC to reduce by a proportion of one half the premiums chargeable for life insurance cover.

3. Financial development of the scheme

Up to and including the insurance year 1992-93, the insurance operations of the Integrated Insurance Scheme were conducted entirely through LIC or GIC, with SEWA acting, in effect, solely as an agency for the collection of premiums and effecting of benefit payments. The details shown in the accompanying tables and analysis focus, accordingly, on the period since SEWA assumed responsibility for part of the insured liability, i.e. the insurance years from 1994-95 onwards.

The figures shown in the following sections represent the financial operations of the Integrated Insurance Scheme over six years of operation. However, because the figures are drawn from a number of different sources, notably the manual ledgers, and are stated for different periods of time, it has not been possible to ensure full consistency between all the figures. The figures set out in this commentary are therefore in the nature of estimates, although they do substantially correspond with those set out in SEWA's Annual Report, *SEWA in 1999*. Two items were not fully clarified.

The first uncertainty relates to premiums paid to GIC in the year 1994, as variously stated in documents either as Rs.300,000 or Rs.30,000, possibly a typing error, whereas an estimate based on membership numbers gives around Rs.150,000. Premium income for 1998 is stated as Rs.405,860, compared with an estimate of Rs.180,000 based on membership numbers, assuming that the insurance for the assets component was transferred to the scheme itself in that year.

Second, the members of the scheme have an option (in principle exercised once at the beginning of their membership) to pay the premiums annually when they fall due or, alternatively, by an automatic annual transfer of interest on the fixed deposit held by SEWA Bank. Those paying annually also pay an annual administration fee or service charge of Rs.5. In the case of the deposit mechanism, the service charge is a one-off up-front payment. However, these service charges are not identified separately in the accounts or in the supporting analysis.

Table 24 shows the actual cash income and expenditure of the insurance scheme. Table 25 shows the same figures, adjusted to "real value" based on purchasing power in 1994. The adjustment from Table 24 was made using annual values, averaged over 12 months, from the Consumer Price Index. The figures therefore show changes in different elements of the accounts from year to year in terms of comparable values.

Table 24. SEWA Integrated Insurance Scheme – Income and expenditure, 1994-99, in thousands of Rs.

Year	1994	1995	1996	1997	1998	1999
Income						
Members' contributions	480	800	975	1 275	1 650	1 495
Other contribution-related items	0	0	56	10	0	0
Interest and other income on investments	1 633	1 842	1 917	1 532	1 447	1 834
Total cash income	2 113	2 642	2 948	2 817	3 097	3 329
Government subsidy (LIC scheme)[58]	180	225	300	375	480	450
Total	**2 293**	**2 867**	**3 248**	**3 192**	**3 577**	**3 779**
Expenditure						
Premiums to LIC (incl. subsidy) and GIC	660	650	834	1 062	1 366	1 078
Claim payments paid by SEWA	126	124	259	266	396	397
Maternity and other non-claim benefits	99	77	148	198	151	157
Administration costs charged to scheme	283	292	511	832	651	409
Operating balance	1 125	1 724	1 496	834	1 013	1 738
Total	**2 293**	**2 867**	**3 248**	**3 192**	**3 577**	**3 779**

58 The Government subsidy is included here to ensure that the premiums and claims, for this section of the insurance scheme, are stated on bases which are properly comparable. In fact, the subsidy is paid directly to the LIC and does not represent any cash sum which passes through SEWA's scheme.

Table 25. SEWA Integrated Insurance Scheme – Income and expenditure, 1994-99, in thousands of 1994 Rs.

Year	1994	1995	1996	1997	1998	1999
Income						
Members' contributions	480	726	812	990	1 132	980
Other contribution-related items	0	0	46	8	0	0
Interest and other income on investments	1 633	1 671	1 595	1 190	993	1 202
Total cash income	2 113	2 397	2 453	2 188	2 125	2 182
Government subsidy (LIC scheme)	180	204	250	291	329	295
Total	**2 293**	**2 601**	**2 703**	**2 479**	**2 454**	**2 477**
Expenditure						
Premiums to LIC (incl. subsidy) and GIC	660	589	695	825	937	706
Claim payments paid by SEWA	126	113	215	207	272	260
Maternity and other non-claim benefits	99	69	123	153	103	103
Administration costs charged to scheme	283	265	425	647	447	268
Operating balance	1 125	1 565	1 245	647	695	1 140
Total	**2 293**	**2 601**	**2 703**	**2 479**	**2 454**	**2 477**

The operating balance shown in the tables is the surplus for the year. The accumulated surpluses constitute the scheme's reserve. It is good insurance practice to allocate such reserves to various "technical" or insurance reserves which are earmarked to cover contingent liabilities under the scheme. SEWA's Integrated Insurance Scheme does not yet do this, and it is no doubt an area that the management will seek to address in the near future.

The Fund, largely created from the GTZ grant provided to SEWA for the purposes of the scheme in 1993, has been invested in deposits and

fixed-interest-bearing securities in a range of Indian institutions. Of these, the investment in the ailing Hindustan Machine Tools company has proved to be non-performing, although a significant proportion of the capital invested has, in fact, been recovered. Nevertheless, the real value of the investment is uncertain. In the following analysis, the value of the assets has been taken as that stated in the audited accounts. In such situations, management and auditors take a prudent view, based on frequent monitoring, of the real value of such an investment and adjust the value stated in the accounts accordingly. This issue is fully discussed in a 1999 report by Markus Sailer.[59]

Table 26 shows the consolidated funds of the Integrated Insurance Scheme, and so includes not only the "GTZ Fund", from which administrative expenses are drawn, but also the reserves which have been built up through the accumulation of premiums, less expenses and claims, in the health and assets components of the scheme.

Table 26. SEWA Integrated Insurance Scheme – consolidated funds statement, 1994-99, in thousands of Rs.

Year	1994	1995	1996	1997	1998	1999
Fund – Opening Balance	10 787	12 063	13 795	15 671	16 517	17 694
Add:						
Net operating income	-357	-110	-411	-686	-270	-106
Income from investments	1 633	1 842	1 917	1 532	1 447	1 834
Additional grant	0	0	370	0	0	0
Fund – Closing Balance	12 063	13 795	15 671	16 517	17 694	19 422
Representing:						
Balance on "GTZ Fund"	12 039	13 511	15 196	15 708	16 293	17 535
Health branch reserves	24	284	475	809	1 196	1 506
Assets branch reserves	0	0	0	0	205	381
Total	12 063	13 795	15 671	16 517	17 694	19 422
Fund closing balance at mid-1994 Rs. values	11 540	12 070	12 460	12 250	11 570	12 450
of which the Grant Fund was	11 520	11 460	12 080	11 650	10 870	11 240

59 Sailer, 1999.

These reserves are not at present separately identified in the IIS accounts. The last two lines of the table show the total fund balances at each year end, converted into 1994 Rs. equivalent values. This shows that there has been steady, if not spectacular growth, in real terms of the IIS as a whole, which reflects the build-up of the in-house health and assets components. The value of the Grant Fund has been broadly been maintained in real terms, after recovering from a dip in 1997-98.

Table 27 shows the nominal rate of return on investment of the funds, calculated as the interest and other investment income as a percentage of the opening balance shown in Table 26. The net, or real, rate of return on investment, is estimated as the return calculated after allowing for inflation as measured by the Consumer Price Index.[60]

It can be seen that the returns, although maintained at a high level in the early years of the scheme, declined steadily in both nominal and real terms until 1998, in which year the real rate of return, i.e. net of inflation, was in fact negative. In 1999, the rate recovered, aided by a fairly low level of inflation. Overall, the average real return over the six years was positive at 3.4 per cent.

Table 27. SEWA Integrated Insurance Scheme – Rates of return on investment, 1994-99

Year	1994	1995	1996	1997	1998	1999	Av. 6 yrs
Nominal return on investment %	15.4	15.3	13.9	10.0	8.8	10.4	12.3
Estimated inflation rate %	9.8	9.4	10.0	7.2	13.4	2.0	
Real return on investment %	5.1	5.4	3.5	2.6	-4.0	8.2	3.4

Another question, given the need to avoid unfair competition following the liberalization of the insurance market in India, is whether the state subsidy will continue to be paid to the LIC. Withdrawal of the subsidy would have serious implications for the stability and growth of the overall scheme funds, and alternative sources of income would be needed to maintain positive growth and ensure its long-term viability.

60 It should be noted that the basis of calculation is not directly comparable with the analysis of funds in Markus Sailer's report.

Table 28 sets out estimated figures for the claims ratio experienced year by year by each component of the Integrated Insurance Scheme. The six-year average figures are weighted according to the relative real values of the rupee in each year.

The last two lines of Table 28 show movements in two particularly important ratios. The ratio of claims to premiums paid, which include the subsidy for LIC life insurance premiums, is a measure of the effectiveness of the insurance scheme from the viewpoint of its members.

Table 28 shows that, over these six years, the scheme has been very effective indeed for the members, although this largely reflects the very big claims paid out by LIC and GIC in the early years. The overall claim ratios for the most recent years are more in line with typical stable insurance patterns, despite wide variations between the different components.

The analysis of the life insurance component is complicated to some extent by the division of cover between "natural" and "accidental" death, and between LIC and GIC (which provides only accidental death cover). From the members' point of view, the most useful analysis is of the overall total coverage, and it can be seen from Table 28 that claims paid out have considerably exceeded premiums paid to the insurance companies, the six-year weighted average claim ratio being over 160 per cent. This is clearly an unsustainable situation. It is therefore hardly surprising that LIC have announced that the premiums for 2000 will be considerably increased. A serious problem, however, in establishing a "scientific" basis for the premium is that the age profile of members seeking insurance (the major actuarial determinant of the relevant risk) is not known.

The six-year weighted average claim ratio under the health component is only just over 50 per cent. This is low, and suggests that the scheme is not very effective in providing cover for the members. The reasons for this are not immediately apparent, but could include:

- premiums set at too high a level;
- members unable to obtain medical treatment of the kind for which cover is provided;
- members' failure to claim when entitled;
- members' failure to establish (and document) claims in such a way that they can be accepted;
- lack of integration of this coverage with the broader health facilities provided by SEWA.

Table 28. SEWA Integrated Insurance Scheme – Ratio of claims to premiums, 1994-99

Year Claims ratio (%)		1994	1995	1996	1997	1998	1999	Av. 6 yrs
Life and Accidental Death (LIC portfolio)	Claims	1 161	849	1 183	1 297	1 553	1 112	
	Premiums	360	450	600	750	960	900	
	Claims/ premiums ratio %	322.5	188.7	197.2	172.9	161.8	123.6	184.5
Accidental Death (GIC portfolio)	Claims	10	70	61	30	80	35	
	Premiums	70	89	103	140	182	162	
	Claims/ premiums ratio %	14.3	78.7	59.2	21.4	44.0	21.6	39.1
Combined Life & Accidental Death	Ratio %	272.3	170.5	177.0	149.1	143.0	108.0	161.7
Health Component (SEWA portfolio)	Claims	125	124	259	266	393	387	
	Premiums	150	384	450	600	780	696	
	Claims/ premiums ratio %	83.3	32.3	57.6	44.3	50.4	55.6	50.8
Assets Component (GIC portfolio to 1997, SEWA portfolio from 1998)	Claims	345	7	117	0	3	10	
	Premiums	80	102	120	160	208	186	
	Claims/ premiums ratio %	431.3	6.9	97.5	0	1.4	5.4	69.2
Combined Insurance Operations	Claims/ premiums ratio %	248.6	102.4	127.3	96.5	95.3	79.4	113.8
	Admin. costs %	12.3	10.2	15.7	26.0	18.2	10.8	15.5

Whatever the reason for the situation, the figures do highlight the need for deeper investigation of this component of the Integrated Insurance Scheme.

The year-on-year experience under the assets component of the Integrated Insurance Scheme has been highly variable. The overall claims ratio has been low, at just over 55 per cent, an apparent reflection of the very low levels of claims paid since the IIS itself took over management of the scheme from GIC. As in the case of the health component, it is not a very satisfactory situation from the viewpoint of the members, and perhaps the reasons are similar. However, this type of cover is inherently subject to considerable fluctuations from year to year, in part due to natural climatic variations, such as drought and floods. Such peaks and troughs make it important to maintain substantial reserves, ring-fenced for the purpose, and shown separately in the accounts. It is also true that the IIS itself has only been managing the scheme for a short time, and that the picture may stabilize as its experience grows.

The ratio of administrative costs to overall income measures the efficiency of the scheme's administration in financial terms, and this appears to have been generally satisfactory. Ratios of over 20 per cent or more are high, here reflecting the cost of special workshops, which perhaps should not be charged to the IIS.

CONCLUSION

The world today is changing on a scale that has never been known before. The technological revolution, the astounding development of communications, the unbridled growth in capital flows and trade in goods are just some of the events that have shaken our planet. "Globalization", the term often used to characterize these epoch-making changes, is full of opportunities. In particular, the global expansion of markets has led to productivity gains, better allocation of resources and a general growth in business. The benefits of globalization, however, have remained highly concentrated, both as to the number of countries and the people that benefit from it.

For many people, the ability to survive and attain a better life does not spring from global movements. They owe that to their ingenuity and tolerance of hardship. In the effort to provide for life tomorrow, organizing to pool forces and interests is a powerful weapon. SEWA is a praiseworthy example of an organization created by the poor for a better life. Anyone looking at the Integrated Insurance Scheme should keep that in mind. SEWA is not an insurance company, but a vast social movement which, down a long and hard road, has managed to meet the essential and varied needs of its members. Indeed, it has become more than that. SEWA has become a model and an international ambassador for millions of women throughout the world.

The social objectives pursued by SEWA in no way detract from the need for viability and efficiency in its activities. Creating a social protection scheme for poor women working in the informal economy is a highly complex task, for which there is no model. SEWA succeeded in its task through a process of continuous adjustment sustained by great creativity and tenacity. The fact that the scheme was built partly on empirical lines should in no way be regarded as a weakness. On the contrary, it demonstrates an ability to take account of the real world, especially the world in which its members live, to adapt to institutional change and increase its expertise on the basis of practical experience.

Today the scheme has achieved a degree of financial stability. This stability relies in part on resources provided by the Indian Government and by an external partner. Such financing should not come as a surprise. Given that the scheme is aimed at the very poor, it is entirely legitimate, on grounds of solidarity and equity, that it

should be subsidized. Generally speaking, actions by the poor to solve their own problems should not be a reason for reducing national solidarity whereby the rich contribute to the well-being of the poor. In this area, too, by linking the efforts of the poor with those of the nation as a whole, channelled by the State, the SEWA's Integrated Insurance Scheme has played a trail-blazing role.

The scheme has now become so large that further measures are needed to consolidate its management and financial position. On the management front, SEWA is focusing its efforts on improving the accounting system and, more generally, the management information system. Ensuring financial stability will involve both strengthening management controls and protecting the scheme against specific crises such as natural disasters or epidemics. The latter can probably best be achieved by increasing reserves and re-insurance. The scheme's long-term viability will in all probability depend on its ability to make these improvements.

How the scheme develops in the future will also be determined by the legal and institutional framework in India. Under the continuing liberalization of the Indian insurance market, which affects corporate insurance operations, SEWA is contemplating converting part of the Integrated Insurance Scheme into a cooperative. A financial feasibility study is currently being undertaken, because a move in that direction would require a substantial initial capital investment and a large increase in membership. SEWA is also considering possible future links with foreign and/or private insurance companies which, under the new legal framework, are required to write insurance for a certain percentage of clients from poor rural areas.

Every environment has its own specific characteristics, every player his strengths and weaknesses. To try and replicate the Integrated Insurance Scheme would be to fly in the face of reality. Far more than just a "technical product", the scheme is above all the result of dealing almost daily with need, capacities and opportunities. It is the story of that process, and how the scheme developed, that holds the greatest lessons for others interested in setting up a micro-insurance scheme.

Some may find that SEWA enjoyed particularly favourable opportunities. In reality, it should always be remembered that it was through its bargaining power and credibility that SEWA was able to obtain certain advantages at the political and institutional level. Similarly, it was able to draw on the infrastructure, networks and management systems that it had created to conduct its other activities. While the scheme nowadays needs a certain degree of independence, it would probably

never have seen the light of day if it had not originally been an integral part of the other activities.

In drawing this study to a close, it is fitting to pay tribute to the members of SEWA. It is for them and because of them that the Integrated Insurance Scheme exists. For all those committed to the fight against poverty and social exclusion, they are a source of admiration, inspiration and hope.

ANNEX

Documents required for reimbursement

When making a claim, members are required to present the original insurance certificate, issued when the premium is paid, together with the relevant documents as listed below.

Claim for hospitalization (SEWA Mediclaim)

- Doctor's report (including information on reason for admission, date of admission and discharge date).
- Medical reports, e.g. blood or stools tests
- Doctor's prescriptions of drugs
- Receipts for drug purchases
- Receipt for hospital expenses with serial number of hospital bill.

Claim for natural death (LIC)

- Death certificate
- Bills for any funeral expenses

Claim for accidental death (UIIC or LIC)

- Original death certificate
- Autopsy report
- Police report

Claim for loss of asset in case of floods, fires, and riots (SEWA Emergency)

- An immediate report of the incident to SEWA
- If an immediate report is not possible, photographs documenting the disaster are required.

Claim for maternity benefit (SEWA)

- Confirmation that the member uses the fixed deposit scheme (fixed deposit certificate)
- Child's birth certificate.

BIBLIOGRAPHY

ACHAN (Asian Community Health Action Network). 2000. *Asian Health Report 2000* (Chennai, India).

American International Group (AIG)/Winterthur Alliance. 1999. *Social security survey* (Winterthur).

Chatterjee, M.; Jayshree, V. 1997. *Organising insurance for women workers: The SEWA experience* (Ahmedabad, SEWA).

EIU (Economist Intelligence Unit). 2000. *Country Profile, India 1999-2000* (London). On website: http://www.eiu.com/schedule.

Ginneken, W. van (ed.). 1999. *Social Security for all Indians* (New Delhi, Oxford University Press).

—. 1998 *Social Security for the excluded majority: Case studies of developing countries* (Geneva, ILO).

Government of Gujarat State. 2000. *Socio-Economic Review of Gujarat State 1999-2000* (Gandhinagar, Gujarat State, Directorate of Economics and Statistics).

Gupta, R.C. 1994. NGO *Experiences in social security* (New Delhi, Friedrich Ebert Foundation).

Hauck, K. 1998. *The social security programme of the Self-employed Women's Association (SEWA)* (Geneva, ILO-STEP/WHO).

ILO. 2000. *World Labour Report 2000. Income security and social protection in a changing world* (Geneva).

ILO-STEP. 2000. *Methodological guide for undertaking case studies on micro-health insurance schemes* (Geneva, STEP).

ILO-STEP, PAHO (Pan American Health Organization). 1999a. *Synthesis of case studies of micro-insurance and other forms of extending social protection in health in Latin America and the Caribbean* (Geneva, STEP).

Jain, S. 1999. "Basic social security in India", in W. van Ginneken (ed.): *Social Security for the excluded majority: Case studies of developing countries* (Geneva, ILO).

Kelles-Viitanen, A. 1998. "Social security for unorganized women workers", in W. van Ginneken (ed.): *Social Security for all Indians* (New Delhi, Oxford University Press).

Lund, F.; Srinivas, S. 2000. *Learning from experience: A gendered approach to social protection for workers in the informal economy* (Geneva, ILO-STEP/WIEGO).

Ranson, K. 2000. *Impact of a community-based health insurance scheme in Gujarat State, India. Evidence from 1,930 insurance claims*, Preliminary Report, Health Policy Unit, London School of Hygiene and Tropical Medicine (London) (unpublished research).

Sailer, M. 1999. *Insurance schemes for poor groups of the population based on self-help assessment of the pilot schemes and prospects for expansion, extension and spread*, Mission report (Berlin, German Technical Development Agency).

SEWA. 1997. *SEWA in 1997*, Annual Report 1997 (Ahmedabad, SEWA).

—. 1998. *SEWA in 1998*, Annual Report 1998 (Ahmedabad, SEWA).

—. 1999. *SEWA in 1999*, Annual Report 1999 (Ahmedabad, SEWA).

Srinivas, S. 1999. "The future of social security coverage for informal sector workers: An Analysis of the SEWA Integrated Social Security Scheme" (Geneva, ILO-STEP) (unpublished).

Subrahmanya, R.K.A. 1998. "Extension for social insurance in the formal sector", in W. van Ginneken (ed.): *Social Security for all Indians* (New Delhi, Oxford University Press).

UNDP (United Nations Development Programme). 2000. *Human Development Report 2000* (New York and Oxford, Oxford University Press).

Unit Trust of India, Life Insurance Corporation of India, General Insurance Corporation of India: June 2000 http://www.utibank.com/promo.htm.

Visaria, P. 1996. "Structure of the Indian Workforce, 1961 – 1994", in *The Indian Journal of Labour Economics* (New Delhi).

WHO (World Health Organization). 2000. *The World Health Report 2000. Health systems: Improving performance* (Geneva).