2006 | ASIAN DECENT
2015 | WORK DECADE

International Labour Organization

SERIES:

SOCIAL SECURITY EXTENSION INITIATIVES IN SOUTH ASIA

INDIA:
SELF-EMPLOYED WOMEN'S ASSOCIATION INSURANCE SCHEME
(GUJARAT)

"OFFERING A COMPREHENSIVE BENEFIT PACKAGE"

ILO Subregional Office for South Asia

INTRODUCTION

The fourteenth Asian Regional meeting of the ILO recently organized in Busan, Republic of South Korea (August 29th – September 1st) endorsed an Asian Decent Work Decade (2006-2015), during which concentrated and sustained efforts will be developed in order to progressively realize decent work for all in all countries. During the proceedings, social protection was explicitly mentioned as a vital component of Decent Work by a number of speakers including the employers and workers representatives. The need to roll out social security to workers and their families in the informal economy, to migrant workers and to non regular workers in the formal economy was also perceived as a major national social policy objective. The need to enter into a more intensive dialogue with respect to the design and financing of national social security systems to equip them to cope with the new requirements and challenges of a global economy also emerged as a major outcome of the meeting.

The challenge of providing social security benefits to each and every citizen has already been taken up in India. In 2004, the United Progressive Alliance (UPA) Government pledged in its National Common Minimum Programme (NCMP) to ensure, through social security, health insurance and other schemes the welfare and well-being of all workers, and most particularly those operating in the informal economy who now account for 94 per cent of the workforce. In line with this commitment, several new initiatives were taken both at the Central and at the state level, focusing mainly on the promotion of new health insurance mechanisms, considered as the pressing need of the day. At the same time, and given the huge social protection gap and the pressing demand from all excluded groups, health micro-insurance schemes driven by a wide diversity of actors have proliferated across all India. While a wide diversity of insurance products has already been made available to the poor, health insurance is still found lagging behind in terms of overall coverage and scope of benefits, resulting in the fact that access to quality health care remains a distant dream for many.

Given this context, the ILO's strategy was to develop an active advocacy role aiming at facilitating the design and implementation of the most appropriate health protection extension strategies and programmes. Since any efficient advocacy role has to rely on practical evidence, the ILO first engaged a wide knowledge development process, aiming at identifying and documenting the most innovative approaches that could contribute to the progressive extension of health protection to all. One such innovative and promising approach is the comprehensive social security cover, including health care benefits, provided by the Self-Employed Women's Association (SEWA) to its members.

BACKGROUND

The Self-Employed Women's Association (SEWA), established since 1972 and since 2006 registered as a trade union, is currently representing the interests of some 1,000,000 poor women working in the informal economy, mainly: home-based workers, street vendors, manual labourers, service providers and small producers.

SEWA pursues two main goals: first is to organize women workers to attain full employment security (job security, income security, food security and social security), second is to make them individually and collectively self-reliant, economically independent and capable of making their own decisions.

In order to achieve these goals, SEWA has been actively engaged in various activities, such as the creation of its own bank, providing some 200,000 women member with tailor-made savings and credit services. Since 1985, SEWA has also operated an innovative insurance scheme designed to protect

poor women against the major risks they face on a day-to-day basis that could drive them deeper into poverty.

SEWA was the very first organization to adopt a social perspective and to set forth a clear social security agenda while preparing its insurance initiative aimed at covering the various life cycle needs of its members. The insurance scheme called VimoSEWA proposes a composite package, simultaneously covering: life, assets and health care while also providing maternity benefits. The scheme was designed to evolve into a new insurance model in which the members would be the users and at the same time the owners and managers of all services provided.

In the early nineties, VimoSEWA innovated in linking insurance with savings. The premium for insurance came from the interest that the members got on their own deposits, while the savings remained intact. This fixed deposit methodology helped VimoSEWA to reach a critical mass of members, allowing it to play an active role in negotiating the best conditions with insurance companies.

In October 2002, VimoSEWA took a major initiative in establishing its insurance business plan which relied on an efficient information management system. This new instrument, providing detailed information on all aspects of the insurance activities was expected to facilitate the scheme's evolution into a sustainable insurance model that could gradually scale up across all India.

TARGET POPULATION

Poverty and vulnerability still have a women's face in today's India. Informal economy women workers operate in the labour market under less favorable conditions than men. Their work is by essence intermittent, casual and insecure. Moreover, it often yields too little to cover the full costs of social security, considering that in many cases they are not directly linked to employers who could provide a matching contribution.

For women workers in the informal economy, the economic and social aspects of their lives are closely connected. They need economic security – continuous employment so that they can earn enough in cash or in kind to meet their needs.

They also need social security to prevent and combat the chronic risks faced by them and their families. Social security therefore is a means of increasing and maintaining the productivity and income of the worker, thereby increasing her overall economic security. Due to these facts together with women's productive and reproductive role, women's situation as regards social protection, especially health insurance, is a critical concern

ORGANIZATION

SEWA Insurance or VimoSEWA is a separate unit within the trade union. It is running as a de facto cooperative, and hopes to be registered as a full-fledged insurance company soon. Targeting first the SEWA Bank members in 1992, VimoSEWA is now insuring women workers, their spouses and children in eight states of India. About 80 per cent of VimoSEWA's insured members are in Gujarat state. A sizeable membership exists in Bihar and Tamil Nadu. Work in Rajasthan has recently begun with 3,000 insured. VimoSEWA works with its sister organizations in other states as well. It also partners with other NGOs, as is the case in Bihar, Tamil Nadu and Rajasthan.

THE INSURANCE PLAN

Eligibility

The insurance plan is open to all women operating in the informal economy and their families without any age limit.

Exclusions

The insurance plan does not have particular exclusion clauses except for HIV/AIDS cases

Plan Benefits

The insurance package provides the following benefits:

	Scheme 1			Scheme 2		
	Wom	Men	Childr	Wom	Men	Childr
Health	2000	2000	2500	6000	6000	2500
Asset	10000			20000		
Life	7500	7500		20000	20000	
Acc. D. (M)	40000			65000		
Acc. D. (H)	15000	25000		15000	50000	

Premium Rate

Premium increased in 2007, from Rs 100 to Rs 125 for women member in Scheme 1, and from Rs 225 to Rs 275 for women member in Scheme 2. Present premium structure is as follows:

	Scheme 1			Scheme 2		
	Wom	Men	Childr	Wom	Men	Childr
Premium	125	100	100	275	225	100
Fam. Discount			25			50

Plan Distribution

The marketing of VimoSEWA's products is done by its Aagewans. This is a dedicated team of women who are central to the programme. In VimoSEWA's experience, one of the most effective ways of member education and maketing insurance remains face-to-face and door-to-door. However, this is also the most expensive marketing method, pushing up transactional costs considerably.

Experimenting with other methods, the scheme used the linkage with Self-Help Groups and other organized communities to further spread the distribution effort. It also developed an effective convergence with other SEWA teams dealing with programmes such as: cooperative development, health promotion and micro-finance activities.

General Overview

Starting date	1992
Ownership profile	Trade union
Target group	Poor self-employed women
Outreach	Gujarat and three other states
Intervention area	Rural & urban
Risks covered	Risk package: health, life accidental death, assets, maternity
Premium Ins./Year	Rs 125(women)
Co-contribution	-
Total premium	Rs 125
No of insured	194.000
Percentage of women	60%

Operational Mechanisms

Type of scheme	Partner-agent
Insurance company	1 public -1 private
Insurance year	Fixed (Jan. to Dec)
Insured unit	Individual
Type of enrolment	Voluntary
One-time enrolm. fee	None
Premium payment	Yearly – upfront
Easy payment mechanisms	Interests yielded by fixed deposit acc.

Scope of Health Benefits

Tertiary health care	No
Hospitalization	
Deliveries	
Access to medicines	No
Primary health care	No

Level of Health Benefits

Hospitalization	Up to Rs 2,000
Maternity benefit	Rs 300 per child

Service Delivery

Health prevent./educ. programmes	No
Prior health check-up	No
Tie-up with H.P.	No
Type of health prov.	Private
Type of agreement	No agreement
No of associated HP	-
TPA intervention	No
Access to health care services	Free access
Co-payment:	No
HC payment modality	Reimbursement

Service Delivery

The scheme has not tied up with specific health providers. The insured are free to choose any health provider, pay for the service received and then submit their claim for reimbursement.

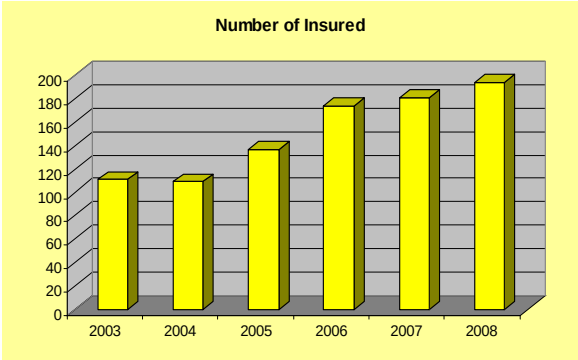
Administration

The scheme is fully administered by the VimoSEWA staff.

MAIN ACHIEVEMENTS

Coverage

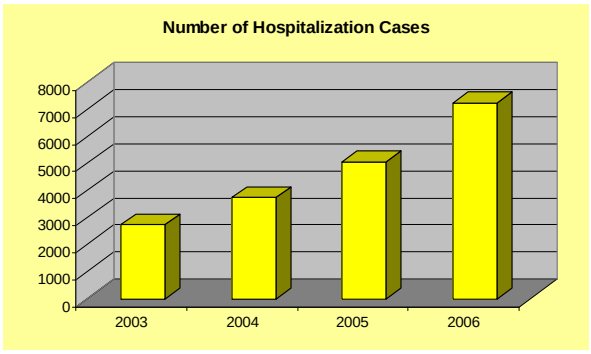
Total number of insured steadily increased over the last four years, reaching 194,000 this year. In 2006, the scheme caught up for the first time with the targets that were set. Women's share of total insured decreased over time as a result of efforts to enroll more husbands (25%) and children (increasing from 2% to 15% in 2008).



	2004	2005	2006	2007	2008
			X 1000		
N°Insured	109	137	174	181	194

Services Provided

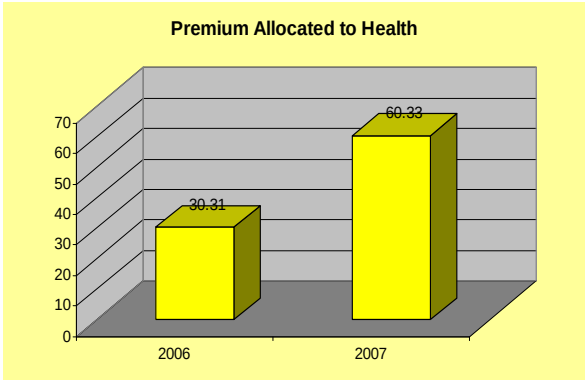
The scheme reimbursed a total of 18,700 claims over the last four years. Health claim incidence showed however a strong upwards trend over time, reaching the high peak of 4.1% in 2006.



	2003	2004	2005	2006
Health care	2,726	3,728	5,038	7,213
Maternity	682	511	451	NA
Life	382	382	395	603
Accid. death	23	31	23	20
Assets	2,299	621	3,711	6,367

Premium Allocated to Health

In order to reduce its health claims ratio which remained excessive over the last years, the scheme had to renegotiate its premium structure with the insurance company in 2007. As a result, the amount allocated to its health component sharply increased from Rs 30.31 to Rs 60.33.



CHALLENGES

The insurance plan has still to address the following key challenges:

- Increase health benefits which presently remain at a very low level;
- Shift from individual to family enrolment;
- Generalize the cashless system introduced in Ahmedabad City to all members in semi-urban and rural areas;
- Develop efficient tie-ups with health providers in order to obtain service advantages and quality health care;
- Address the adverse selection phenomenon;
- Reduce the drop-out ratio and rely on a stable membership;
- Reduce administrative costs;
- Further develop the management information system in order to track all activity and performance indicators;
- Reach full operational sustainability in the years to come;
- Evolve into a comprehensive social security model that can be easily replicated in other states.

THE LINKAGE EXPERIENCE

Developing efficient partnership arrangements is already seen as a key element for the successful implementation of any health insurance scheme targeting the disadvantaged groups. Evidence also suggests that building efficient linkages between community-based initiatives and government programmes in order to exploit their respective strengths is another major requirement. This necessary synergy may be developed at various levels.

Scope of Linkages	
Financing:	☺
Operations:	No
Service Delivery:	☺
Governance:	No
Policy Planning:	☺
Legal Framework:	☺

VimoSEWA's unique approach is that social security needs are a basic right or entitlement, as opposed to the view that it is a "safety net", or welfare and charity-oriented intervention. In its broad advocacy efforts, VimoSEWA highlighted the need for an integrated insurance scheme which is part of the overall financial services needed by poor women and is linked with other financial and social protection services like savings and credit. The scheme should be designed in such a manner that it covers all the risks the poor face on a daily basis.

1. Financing

The scheme doesn't benefit from any co-contribution mechanism. However, various external donors contributed to the functioning of the scheme through subsidies and an endowment fund whose earnings could cover the promotional and administration expenses of the scheme, until the membership could reach a critical mass.

2. Operations

The scheme has tied up with two insurance companies (one public and one private) to offer a bundled product to its members. The scheme currently operates without any other partnership arrangement with the exception of a short-time technical support aiming at preparing the yearly income statement and analysis provided by an external actuarial and management expert under external funding.

3. Service Delivery

For years, the scheme operated in an independent way, without any direct relationship with health providers. It recently introduced a new innovative service payment mechanism whereby the scheme is informed as soon as a member is hospitalized, allowing it to pay the covered amount before discharge of the patient.

4. Governance

The representative governing body of the scheme takes all decisions pertaining to its operational activities and development plans. The Scheme has engaged into a negotiation with the Insurance Regulation and Development Authority (IRDA) aiming at reducing the capital requirement for insurance companies which would enable it to establish and run its own co-operative company.

5. Policy Planning

VimoSEWA was invited to give its suggestions and share its experience with the National Commission for Enterprises in the Unorganized Sector (NCEUS), set up in 2004. Based on VimoSEWA's experience, the Commission has set up a task force to recommend and develop an insurance programme for the unorganized sector for the entire country. VimoSEWA is a member of the sub-committee on social security of the task force. Before this, it was a member of the study group on social security, set up by the National Commission on Labour in 2000. In 2007, VimoSEWA also introduced a proposal aimed at being part of the new health insurance scheme designed by a new Health Security Task Force set up by the Ministry of Labour and Employment.

6. Legal Framework

The scheme falls under the partner-agent model as described by the Micro-insurance Regulations issued in November 2005 by the Insurance Regulatory and Development Authority (IRDA) of India. It is therefore under regulation of the IRDA and would be considered as fulfilling VimoSEWA insurance partners' obligations to the social and rural sectors.

CONCLUSION

VimoSEWA has demonstrated the poor women willingness to take insurance in increasing numbers, setting aside their meager earnings well in advance to pay for the annual premium. There has been no demand or expectation of "free" insurance. However, women certainly expect, and demand, timely and high-quality need-based insurance services. VimoSEWA also showed that the key, apart from service efficiency, is faith and trust in the institution which organizes these services. This should preferably be through their own membership-based organization, where they are the share-holders, leasers and managers.

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