Vol. 1 No.3 June 2013 ISSN : 2319-961X

THE AWARENESS, ENROLMENT AND WILLINGNESS TO PARTICIPATE IN THE HEALTH INSURANCE SCHEMES AMONG THE WOMEN INDUSTRIAL WORKERS

Dr. G. Vanithamani

[G] *Department of Econometrics, Bharathiar University, Coimbatore-46.*

Abstract

The health insurance is a vital method of financing the spiraling costs of medical care. The high cost of health services coupled with the unpredictability of health needs and the inadequacy of personal savings is the primary reason for the growing importance of insurance as a means of financing health services. But, In spite of the growing importance of health insurance schemes, the number of people covered by health insurance is very less in India. In this background, an attempt is made to know the awareness, enrolment and willingness to pay for health insurance among the unorganized women workers in the study area. It has been discussed through analysing the variables such as age, marital status, social status, nature of family, educational qualification, occupation, monthly income, total family income, awareness, enrollment, willingness to participate in the health insurance schemes.

Keywords*: medical care, health insurance, unorganized women workers, personal savings, Mediclaim, Out of Pocket Expenditure*

Introduction

The high cost of health services coupled with the unpredictability of health needs and the inadequacy of personal savings is the primary reason for the growing importance of insurance as a means of financing health services. But, In spite of the growing importance of health insurance schemes, the number of people covered by health insurance is very less in India. It has been found that one of the major reasons for low health insurance coverage in India is the lack of awareness of the health insurance schemes among the people. Currently in India, only 2 million people (0.2 percent) of the total population of 1 billion are covered under Mediclaim, the most popular health insurance scheme in India, whereas in developed nations like U.S. about 75 percent of total population are covered under one or the other insurance schemes (Ramanujam, 2009). Income may limit household's access to health care, whereas insurance may guarantee higher access to health care as reimbursements from insurance company reduces the Out of Pocket Expenditure (OOP). On the other hand, insurance may lead to moral hazard problem and individuals having insurance may not have incentive to take care of their health and invest in the preventive care. At the same time, health insurance might increase economic access to better and expensive health care. This may increase the probability of getting ill and thus expenditure on health will be higher. In this context, an attempt is made to know the awareness,

enrolment and willingness to pay for health insurance among the unorganized women workers in the study area.

Need for the Study

Labour is an important aspect of the industrial system for the future economic growth of the country. Therefore, there is a great need for a clear understanding of the various labour problems. The problems of industrial workers are very much complex and dynamic. Their complexity is a matter of concern for the partners of industry, scholars and academicians, planners and policy makers, labour leaders and social workers. During recent years there has been a growing awareness of the existence, importance and needs of the unorganized workers. The Report of the National Commission for Enterprises in the Unorganised Sector (2007) highlights the existence and qualification of unorganized or informal workers, defined as those who do not have employment security, work security and social security.

Women particularly are confined to unorganized sector employment, with 96 percent of all female workers being in this sector. Given the nature of employment in the unorganized sector, it is to be expected that the returns from their work tend to be low and uncertain. Most workers do not have year round employment, and even when employment is available, the income is low. Social security – such as health care, old age benefits child care and housing that is taken for granted by organized sector workers is not even dreamt of by the unorganized sector. In this connection, it is worth noting that 9.7 percent of India's population is reported to be living under the poverty line, all of them from the unorganized sector (Renana Jhabvala and Subrahmanya, 2000). Within the informal sector, women are generally found in low-income activity that barely guarantees survival. Majority of women workers in informal sector come from those sections of the society which need income at any cost. Nearly 50 percent of these women workers are sole supporters of their families. The present study makes a modest attempt to understand the various aspects related to their status regarding Health Insurance Programmes.

Review of the Literature

The study by **Prabhu (1996)** titled 'Health Security for Indian Workers' was concerned with the analysis of health security of Indian workers in a social security framework and examined the issues pertaining to (a) the extent of coverage under various prevailing schemes, (b) the efficacy of such provision, and (c) the measures required for ensuring an equitable and efficient system of health security in the country. The study finally pointed to the utter inadequacy of the present measures to ensure health security for workers, particularly in the unorganised sector, and the suggestions put forth by the researcher for providing health security need to be considered seriously.

Kwadwo Asenso *et.al*. (1997) made a study on 'Willingness to pay for health insurance in a developing economy of Ghana using contingent valuation method'. In the midst of high cost of health care both at the macro and micro levels, health insurance becomes a viable alternative for financing health care in Ghana. It was also a way of mobilising private funds for improving health care delivery at the macro level. This study used a contingent valuation method to assess the willingness of households in the informal sector of Ghana to join and pay premiums for a proposed National Health Insurance scheme. Focus group discussions, in-depth and structured interviews were used to collect data for the study. There was a high degree of acceptance of health insurance in all the communities surveyed. Over 90 percent of the respondents agreed to participate in the scheme and upto 63.6 percent of the respondents were willing to pay a premium of $5000 or $3.03 a month for a household of five persons. Using an ordered probit model, the level of premiums, households were willing to pay, were found to be influenced by dependency ratio, income or whether a household has difficulty in paying for health care or not, sex, health care expenditures and education. As income increases, or the proportion of unemployed household members drop, people were willing to pay higher premiums for health insurance.

Anil Gumber *et.al*. (2000) conducted a pilot study on 'Health Insurance for Informal Sector in Gujarat' and explored the availability of health insurance coverage for the poor and especially women, their needs and expectations of a health insurance system, and the likely constraints in extending current health insurance benefits to workers in the informal sector. The study found that Employee State Insurance Scheme has substantial scope for improvement of its services. The survey showed that the poor prefer public sector management for health care facilities.

The study by **Anil Gumber (2001)** presented the health expenditure, morbidity pattern, demand for insurance and health seeking behaviour of low income households covered under ESIS, mediclaim and SEWA health insurance scheme. The survey reveals that share of direct medical costs was about two-thirds of the total costs in all groups and rural households invariably paid higher costs as compared to their urban counterparts. The per capita expenditure on treatment was much lower for ESIS households as compared to SEWA and non-insured households, both in rural and urban areas. A majority of households indicated strong inclusions for any kind of health insurance scheme and demand for SEWA scheme was the highest among the non-insured. Both rural and urban households were willing to pay an annual per capita premium of Rs.80 and Rs.95 respectively, for the coverage of services of hospitalisation, chronic ailment, specialist consultation and the like. The researcher strongly felt a need for health insurance among low-income households due to heavy burden of out-of-pocket expenses while seeking health care.

Inke Mathauer *et.al*. (2008) analyzed the demand for health insurance of informal sector workers in Kenya by assessing their perceptions and knowledge of and concerns regarding health insurance and the Kenyan National Hospital Insurance Fund (NHIF). It

serves to explore how informal sector workers could be integrated into NHIF. It was found that the most critical barrier to NHIF enrolment is the lack of knowledge of informal sector workers about NHIF, its enrolment option and procedures for informal sector workers. Inability to pay is a critical factor for some, but people were, in principle, interested in health insurance and thus willing to pay for it. In sum, the mix of demand-side determinants for enrolling in the NHIF is not as complex as expected, the study found.

Data Sources and Methodology

For the purpose of present study specified area selected on the assumption that specific area based studies expected to give more meaningful and significant information. Accordingly the present study was done in Coimbatore. Coimbatore City is the second largest city of the Tamil Nadu. Coimbatore is one of the most industrialized cities in Tamil Nadu and is known as the textile capital of South India or the Manchester of the South. Among all the districts of Tamil Nadu, Coimbatore district is one of the most prosperous and industrially advanced districts of the State. It has more than 40,000 small, medium and large-scale industries, which serve the engineering needs of the major parts of the country.

In the study area, the sample unprotected women workers in the unorganised sector are mainly in the categories of regular, casual and contract workers who remain unprotected because of non-compliance of the provisions of the existing laws. As working women in informal sector of Coimbatore city constitute a heterogeneous group, stratified disproportionate sampling has been undertaken while collecting the sample workers. In engineering industry 49 units and 55 units of textile industrial units were selected for the study. In these units, there were 4320 and 3696 workers of which 30 percent each constitute the sample. Thus, the number of workers who constitute the sample frame was 1296 in engineering industrial units (778 male workers and 518 female workers) and 1109 workers in textile industrial units (425 male workers and 684 female workers). However, as the study intends to cover only women workers, all those women workers were covered from these selected units as the sample respondents (518 + 684 = 1202). Data was collected through personal interviews with the help of a questionnaire. The surveyed data were manually edited, coded and then, entered into Statistical Package for the Social Sciences (SPSS) spread sheets. In order to find out the principal determinants of respondents' Willingness to Pay Health Insurance logistic analysis is used. This technique is more apt for such analyses because the dependent variables were dichotomous in nature i.e., whether respondents are having willingness to pay for health insurance or not. A score of '1' if yes and '0' if not, respectively are assigned for the categories of the variables.

Empirical Results

Table 1 shows the personal profile of the sample respondents

	Age in Years	Workers	Percentage
Age in Years	15-30	486	40.4
	31-45	549	45.7
	46-60	157	13.1
	61-75	10	0.8
Marital Status	Unmarried	176	14.6
	Married	874	72.7
	Widowed	114	9.5
	Divorced	38	3.2
Social Status	Forward Community	56	4.6
	Backward Community	609	50.7
	Most Backward Community	243	20.2
	Schedule Caste/Schedule Tribes	294	24.5
Nature of Family	Nuclear Family	998	83.0
	Joint Family	139	11.6
	Individual	65	5.4
Educational Qualification	Illiterate	313	26.0
	Primary	275	22.9
	Middle	302	25.1
	Secondary	214	17.8
	Higher Secondary	91	7.6
	Graduate / Diploma	7	0.6
Occupation	Engineering	518	43.1
	Textile	684	56.9
Monthly Income (in Rs)	Upto 2500	467	38.9
	2501-5000	678	56.4
	5001-7500	48	4.0
	Above 7500	9	0.7
Total Family Income (in Rs)	Upto 2500	80	6.7
	2501-5000	298	24.8
	5001-7500	458	38.1
	7501-10000	200	16.6
	Above 10000	166	13.8
Awareness	Aware	504	41.9
	Not Aware	698	58.1
Enrolment	Enroled	274	22.8
	Not Enroled	928	77.2
Willingness to Participate	Willing	757	63.0
	Not Willing	445	37.0
Total		**1202**	**100.0**

The above analysis reveals the fact that a significant proportion of the sample was female members. Majority of the respondents belonged to the age groups of 31-45 years and 73 percent were married and living in nuclear families. Maximum respondents were illiterate. Nearly 57 percent of the workers were working in textile industry. Only 41.9 percent of the workers were aware of the term health insurance and the remaining 58.1 percent of the workers were not having any knowledge about the existing private health insurance schemes. It is found that a majority of the workers were not having much knowledge about the availability of existing private health insurance schemes except Government health insurance scheme.

Logistic Regression Results of Respondents' Willingness to Pay Health Insurance

For identifying the factors that determine the respondents' willingness to pay health insurance, the logistic regression analysis is carried out and the results are presented in table 2

Table 2 Logistic Regression Results of Respondents' Willingness to Pay Health Insurance

Explanatory Variables	Beta	Exp (B)	Level of Sig.
Age *(Ref: 15-30 Years)*	--	1.000	--
31 – 45 *Years*	- 0.104	0.901	0.499
46 + *Years*	- 0.369	0.691	0.119
Social Status *(Ref: SC/ST)*	--	1.000	--
MBC	1.214	3.367	**0.001**
BC	- 0.149	0.862	0.375
FC	0.854	2.349	**0.05**
Type of Family *(Ref: Joint Family)*	--	1.000	--
Nuclear Family	0.253	1.288	0.237
Educational Status *(Ref: Illiterate)*	--	1.000	--
Primary School	- 0.033	0.968	0.871
Middle	0.197	1.218	0.330
Secondary School	0.456	1.578	**0.05**
Higher Secondary School & above	0.398	1.489	0.189
Occupation *(Ref: Textile)*	--	1.000	**--**
Foundry	1.889	6.611	**0.001**
Respondent's Monthly Income (in Rs.) *(Ref: 2500 or less)*	--	1.000	**--**
2501 – 5000	0.478	1.613	**0.001**
5001 +	- 0.078	0.925	0.833
Monthly Family Income (in Rs.) *(Ref: 2500 or less)*	--	1.000	**--**
2501 – 5000	0.681	1.975	**0.05**
5001 – 7500	0.344	1.411	0.255
7501 – 10,000	1.731	5.646	**0.001**
10,001 +	1.688	5.408	**0.001**
Respondent's Health Status *(Ref: No)*	--	1.000	**--**
Yes	- 0.093	0.911	0.541
- 2 Log likelihood		**1318.811**	
Chi-square (df)		**265.595**	
Significance Level		**0.000**	
N		**1202**	
Cox & Snell R Square		**19.8**	
Nagelkerke R Square		**27.1**	

Determinants of Willingness to Pay for Health Insurance by Women Workers

Previously, the gross differentials in respondents' willingness to pay for health insurance have been analysed across their selected background characteristics. However, such gross differentials are less conclusive, and generalizations drawn from such analysis have their own limitations. Therefore, in the present section, an attempt is made to find out the principal factors that are likely to affect the respondents' willingness to pay for of health insurance. For this purpose, the respondents' willingness to pay for health insurance has been considered as dependent variable and as dichotomous viz., whether the woman worker is willing to pay for health insurance (by assigning a score of '1') or not (score of '0') and all the independent variables as categories. In such a condition, adopting the logistic regression analysis is more appropriate and therefore, such an analysis is carried out. The results are presented.

Among the sample respondents, it is striking to note that controlling for all the variables used in the model, the odds of willingness to pay for health insurance by the women workers are more than 5.6 and 5.4 times higher (and statistically highly significant, $p<0.001$ in each case) among those whose monthly family incomes is Rs. 7501–10,000 and Rs. 10,001 and above, respectively as compared to those whose monthly family income is Rs. 2500 or less. Such pattern is also noticed in the case of those respondents whose monthly family income is Rs. 2500– 5000, but this result turns out statistically significant only at a moderate level ($p<0.05$). These findings clearly support the fact that women workers are willing to pay for health insurance when their monthly family income is higher. Next to monthly family income, type of occupation engaged in by the respondents seemed to be major deciding factor in assessing whether they are willing to pay for health insurance or not. For instance, compared to those who are working in different occupations related to textile industry, women participating in jobs related to foundry industry have shown greater tendency to pay for a health insurance policy. This result also turned out to be as highly significant ($p<0.001$). Comparatively better income on regular basis in the latter type of job as compared to the earlier one (textile industry) could be the reason for such a finding. However, women workers' personal income has exhibited mixed results on their willingness to pay for health insurance. For example, while respondents who earn moderate personal income per month (Rs. 2500–5000) has demonstrated higher likelihood of willingness to pay for health insurance as compared to those whose monthly personal income is Rs. 2500 or less. Such pattern is surprisingly negative and of course, insignificant in the case of those who earn comparatively better income per month.

The net effect of social status background on the women workers' willingness to pay for health insurance is also worth noting. The odds of willingness to pay for health insurance are found to be higher by 3.4 times and 2.3 times among the most backward and forward castes, respectively, than those belonging to SC/ST communities. However, the t-test results turned out to be significant at 1 percent in the case of the former one, whereas

it was 5 percent level in the case of latter one. Finally, though the women workers who are educated comparatively to a higher level have more likelihood of willingness to pay for health insurance then their illiterate counterparts. The results turned out to be moderately significant ($p<0.05$) only in the case of women who are educated upto secondary school level. Among the other variables included in the model, while current age and respondents' better health status have shown negative independent effect on their willingness to pay for health insurance, residing in nuclear family has shown net positive effect; but all these results are statistically insignificant.

From the foregoing analysis, it may be concluded that economic background of the women workers, namely, personal income and family monthly income closely followed by type of industry they work turned out as the chief determinants of their willingness to pay for health insurance. Added to these, their social status and educational status background also to some extent show a tendency to motivate the women workers to pay for health insurance.

Conclusion

Majority of the sample women workers were going to the Government hospitals for treating illness. They select the hospital because of the free services and medicines and low expenses. More than half of the workers are aware of health insurance schemes and there is almost an equal number of workers who are unaware of health insurance schemes. Lack of publicity of various health insurance schemes happens to be an important factor resulting in this situation. It is suggested that the Government should review the Life Insurance Corporation and Mediclaim policies, improve them and give a wider publicity so that some kind of insurance is available to the general population. About the reasons for not having an insurance coverage, nearly half of the workers feel that claim settlement procedure is very complicated. Some workers feel that sufficient money is not available for securing an insurance coverage. These may be the workers who belong to the low income group who have very little savings. Some workers feel that insurance coverage is not so useful because they are not satisfied with the benefits given by the insurance companies. Even though the Government provided free health insurance scheme it is not properly reached to all the people in the society. It is suggested that the government should encourage the private health insurance companies to play a more active role and take measures to create a comprehensive health insurance market in India.

References

1. **Anil Gumber, Veena Kulkarni (2000),** "Health Insurance for Informal Sector Case Study of Gujarat", Economic and Political Weekly, Vol. 35, No. 40 (Sep.30-Oct. 6), pp. 3607-3613.
2. Hengjin Dong, Bocar Kouyate, Rachel Snow, Frederick Mugisha and Rainer Sauerborn (2003), "Willingness to Pay for Community-Based Insurance in Burkina Faso", Health Economics, vol. 12, pp. 849-862.

3. **Inke Mathauer and Jean-Olivier Schmidt and Maurice Wenyaa (2008),** "Extending Social Health Insurance to the Informal Sector in Kenya. An Assessment of Factors Affecting Demand", International Journal of Health Planning and Management International Journal of Health Plan Management, 23: 51-68.+6
4. **Kwadwo Asenso-Okyere, Isaac Osei-Akoto, Adote Anum and Ernest N Appiah (1997),** "Willingness to pay for health insurance in a developing economy. A pilot study of the informal sector of Ghana using contingent valuation", Health Policy, Volume 42, Issue 3, December, Pages 223-237.
5. **Prabhu. K. S. (1996),** "Health Security for India Workers", in The Indian Journal of Labour Economics, 39 (4), pp. 937-958.
6. **Santerre (2006),** "Examining the Marginal Access to Private Health Insurance", Risk Management and Insurance Review. Vol. 9, No 1, pp. 53-62.

BOOKS

1. **Anita Dash (2009)** "Women Industrial Workers", Regal Publications, 2009.
2. **Dharmaraj.S (2007),** 'Informal Sector in India', Abhijeet Publications, Delhi.
3. **Renana Jhabvala and Subramanya R.K.A (2000), (eds)** "The unorganized sector; work security and social protection", Sage Publications, New Delhi.
4. **Jiwitesh Kumar Singh (1998),** "Labour Economics: Principles, Problems and Practices of Trade Unionism, Industrialisation, Wages, Social Security and I.L.O", Deep and D Publications, New Delhi.
5. **Meenakshi Gupta (2007),** "Labour Welfare and Social Security in Unorganised Sector", Deep and Deep Publications, Rajouri Garden.
6. **Ramanujam.P.G. (2009),** "Marketing of Healthcare Services", Excel Books, New Delhi.
7. **Renana Jhabvala(2000),** "The unorganised sector work security and social protection", Edited by Renana Jhabvala and R.K.A. Subramanya, New Delhi, Sage Publication.
8. **Saba Anjum (2011),** "Women Workers in Informal Sectors", the Women Press, Delhi.
9. **Saran.A.B and Sandhwar. A.N (1990),** "Problems of Women Workers in Unorganized Sectors", Northern Book Centre, New Delhi.
10. **Tripathy. S.N (1996)** "Plight of Unorganized Women Workers", Discovery Publishing House, New Delhi.