MEDICAL INSURANCE FOR INFORMAL WORKERS: AN EXPLORATORY STUDY OF WASTE PICKERS IN PUNE MUNICIPALITY, MAHARASHTRA

Dissertation submitted to Jawaharlal Nehru University in partial fulfillment of the requirements for the award of the Degree of

Master of Philosophy

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2011

CENTRE OF SOCIAL MEDICINE AND COMMUNITY HEALTH
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Date: 25.07.2011

CERTIFICATE

This dissertation entitled, **"Medical Insurance for Informal Workers: An Exploratory Study of Waste Pickers In Pune Municipality, Maharashtra"** is submitted in partial fulfillment of the requirements for the award of the degree of Master of Philosophy, of Jawaharlal Nehru University. This dissertation has not been submitted for any other degree of this University or any other University and is my original work

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Dedicated to My Dear

Aai and Pappa

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Acknowledgements

Now, when I think two years back, when I actually started preparing for JNU M. Phil Entrance Exam, I could not stop but cherish some moments which I can never forget. And especially in the virtue of me being a girl, in a place like Delhi which is so unsafe further made my struggle more intense. I appreciate all those time spent in a place like Munirka with an emotion full of fear, insecurities both from financial and safety point of view, those whole night studies, homesickness, health problems but still managing everything alone. But still I value all those struggle and the trouble that I took for my education which made me strong enough to face the difficulties of life. In these conditions, in the course of my preparation, a person named Laxmi Kutty, whom I really would like to thank who not only helped me in my studies but also build my confidence especially when she was busy herself in her dissertation submission. It's her high enthusiasm and support that inspired me a lot.

Then coming to JNU was one of the most wonderful experiences that I have ever had. I adore each and every movement of my stay at JNU.

So far as my writing dissertation is concerned, first and foremost, I would like the convey my heartiest gratitude to my supervisor, Prof. Rama V. Baru, for her constant supervision, guidance and insightful ideas throughout these two years of my M. Phil. I also appreciate her for encouraging me, which helped me to boost my confidence. I am indebted to her, for her support especially during my field work which helped me to cope-up with difficulties that I had to face.

I cannot move ahead without expressing gratitude to all the faculty members of the centre as they have shaped and built a perspective in my thinking and action in these two years that I value. It is important to recognize the great help provided by Ganga Madam and Dinesh Sir in using library and tolerating my mistakes in late submission of books. I am thankful to the staff of the CSMCH, who helped me in number of ways during these two years. Special credit goes to the chairperson of the centre Prof. Rama V. Baru who has granted the permission for using room number 206. Writing dissertation in room number 206 was really a beautiful experience. A lot of memories have been captured in this room that has been shared by lot of people and I can not forget these moments in all my life.

I would like to thank the NGO, Deepgriha Society in Pune and especially Rajendra Aher sir, who helped me during my field work to reach to the community.

I am grateful from the bottom of my heart to all respondent waste pickers and to all the key informants who gave me their valuable time and provided precious information, without which this dissertation could not have been completed. My sincere gratitude to Dr. Baba Adhav who allowed me to access the Mahatma Phule Samata Pratishthan library as well as gave his valuable time for me. I am also thankful to the Nitin Pawar for constantly encouraging me and providing important contacts and information for the fulfillment of my dissertation. I would like to thank Ashwini for helping me out in my field work.

My genuine and honest thanks are to faculty members of Karve Institute of Social Services. Firstly Vishal Karuna, for his fatherly support and for encouraging me in each and every difficulty in my personal and educational life, thanks to you sir. The other faculty member is Nagmani Rao who gave her valuable time for my research work.

I would like to express my sincere gratitude towards all of them who have helped and shaped me in a very positive way throughout my career. I would like to thank the people around me who not only encouraged but also believed in my potentials because of which I enjoyed writing this dissertation and I can see the improvements now unlike earlier. I also owe my gratitude to many friends, firstly to Daksha and Pravin who met me in JNU in CSMCH. Their constant encouragement, support and help each time, not only academically but also at personal level helped me in number of ways.

Kaushik, Sabina, Smita, Ankita, Ashwini, Anjali and Swapnali my special gratitude to all of you, for your great help in editing my drafts and valuable hints in my research work. It is also important to mention that their '*moral support*' was really great which I enjoyed a lot.

During writing this dissertation, I came close to many new people for which I feel very lucky. Directly and indirectly they helped me a lot in writing my dissertation. Arathi, I learned a lot from you, such sensitivity you have not only on social issues but in understanding and caring for the problems that friends face. The discussions we had on the many issues were a big learning experience for me. Aparna, it's a really nice feeling being with you. You are not only a good friend but also a very good human being. Indranil, in few men I have seen such gender sensitivity as you have. The discussions gave me a lot of clarity for my research work. Panchi, Urmi and Sudha, I really had great fun with all you guys. It helped

me to reduce my tension during writing my dissertation. I am really thankful to all of you for being with me and I enjoyed eating together in room no. 206 a lot.

There are no words to express my gratitude and feelings towards my *Aai* and *Pappa.* I dedicate this dissertation to both of you. I really appreciate the strong support for my education and appreciate their courage for sending me alone to Delhi. It must have been a difficult decision given the environment from which they come where girls are hardly sent away alone for education. My *Aai*, although living in a strongly patriarchal household, took many decisions for the betterment of her children even though she had to face huge challenges. I always owe her for standing behind me in each and every decision that I have taken in my life. My *Pappa* always dreamed of higher education for his children. He took many troubles and helped me out when I was facing lot of problems in my field work. Today I have been able to realize his dream and make him proud, and his pride makes me the proud daughter of a proud father. It's only because of the support that Aai and Pappa gave that I am here, and I am highly indebted to them.

I am thankful to my sister, jiju, my brother and Vahini for giving me such lovely nephews. *Tai –Bhauji*, Dadya-Bhagyashree thanks for bringing so much joy in my life through both of your children. Sharvil and Praydnesh looking at your lovely smile make me so happy. It's only because of your entry in my house that so much of our tension was replaced by happiness. Thanks to both of you and love you a lot. My little sister, Shweta really can't express fully my feelings towards you for the way you supported me and the way you stood behind me. I know we can share all our feelings with each other, and what we share is not only as sisters but as close friends. My sincere gratitude goes to my lovely *Lata Maushi* for being with me and supporting me emotionally and physically. Your lovely cooking during my research work made my work a lot easier.

Finally I am extremely thankful to my closest friend Deepak. It is really a wonderful feeling being with you. Without you I would not have been here in JNU. Your critical thinking and insightful comments shaped me a lot in a very positive way.

Abbreviations

AALL	:	American Association for Labour Legislation
ACCORD	:	Action for Community Organization, Rehabilitation and Development
AHA	:	American Health Association
AMS	:	Adivasi Munnetra Sangam
ASHWINI	:	Association for Health Welfare in the Nilgiris
CBMI	:	Community Based Medical Insurance
CCMC	:	Committee on Cost of Medical Care
CGHS	:	Central Government Health Insurance Scheme
ESIS	:	Employee State Insurance Scheme
GIC	:	General Insurance Corporation
HMO	:	Health Maintenance Organization
IRDA	:	Insurance Regulatory and Development Act
NCEUS	:	National Commission for Enterprises in the Unorganized Sector
PMC	:	Pune Municipal Corporation
RSBY	:	Rashtriya Swasthya Bima Yojana Scheme
SEWA	:	Self Employed Women Association
U.K.	:	United Kingdoms
U.S.	:	United States of America

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Introduction

Introduction

In the last few decades there have been increasing inequities in health outcomes as well as access to health care (Baru, *et al* 2010). Today, the major crisis that India's health services face is that of financing health care and uneven distribution of health care resources. The state plays the role of financing and provisioning of health care, it plays a critical role in reducing inequities or perpetuating existing inequities and it also shapes the existing pattern of health services (Gilson, *et al* 2007). The growing inequities in health outcomes due to inequalities in accessibility, availability and affordability of health care at national level, across states and as well as within socio-economic groups is widely observed and studied (GOI, 2002; NSSO, 2006; and IIPS and Macro International, 2007). The National Health Policy, 2002 and the utilization data of NSSO (2006), show that there is greater reliance on private sector. As a result, the cost of care has increased tremendously (GOI, 2002; NSSO, 2006).

The Report of National Health Accounts (2004-05), states that "in India total health expenditure from all the sources was Rs. 1,337,763 million during 2004-05, constituting 4.25 percent of Gross Domestic Product. Of the total health expenditure, the share of private sector was maximum with 78.05 percent public sector at 19.67 percent and the external flows contributed 2.28 percent. Among all the sources, households contributed a significant portion at 71.13 percent of total health expenditure for availing health care services from different health care institutions" (GOI, 2009:V). This clearly shows that the public health expenditure is very minimal thereby the quality of public health care deteriorated to a large extent (Baru, *et al* 2010). The last few decades have witnessed increased commercialization of public health services and tremendous expansion of private health sector (Duggal, 2005). These changes have forced majority of the poor people to access expensive private health care. This has resulted in high out-of-pocket expenditure. Indebtedness due to rising cost of health care has increased and there is also evidence that shows high cost of medical care is an important reason for not seeking treatment especially among the lower income quintile (Krishnan, 1999; Baru, 1999; Dilip, 2005; Ellis et.al., 2000; Duggal, 2005). This results in the poor getting excluded from accessing health care despite them being the most needy (Hart, 2000).

In this context of rising cost of medical care and decreasing access to health care, the workers involved in the informal sector who constitute the majority of the marginalized and vulnerable groups are worst affected.

The National Commission for Enterprises in the Unorganized Sector in India has done extensive examination and analysis of the informal sector over four and half year in terms of its nature, extent, its magnitude, and socio-economic characteristics of informal sector. It has observed that over ninety two percent of workforces are engaged in the informal sector. Over the last few decades there has been a tremendous growth in informal sector[1] as well as in informalisation of labour in the formal sector[2]. It is observed that, even though India has gained massive economic growth, the benefits of it have not penetrated to the people who are part of the informal sector (NCEUS, 2007).

The "Report on Conditions of Work and Promotions of Livelihoods in the Unorganized Sector" (2007), has mentioned that half of male informal workers and eighty seven percent of female informal workers in urban areas get wages that are below the national minimum wages. The average wage of an informal sector worker is lower than the wages in the formal sector (ibid). These are the workers who do not come under any legal protection. They lack social security such as provident fund, pension, maternity and health care benefits and paid leaves for sickness, lack employment and work security, and lack organizing powers like formation of trade unions, which to a large extent reduces their bargaining power in improving or bringing about changes in their working conditions. It is also important to remember that this sector is very wide and diverse in nature, their characteristics' and the activities undertaken by them. Workers in this sector have to face poor working conditions which are accompanied by low wages and lack of security making these workers more vulnerable (Holmstrom, 1985; Breman, 2010).

[1] The 'informal' stand for those forms of firms which does not comes under any legal framework (Moghe, 2007). The First Indian National Commission on Labour (1966-69) defined "as those workers who have not been able to organize themselves in pursuit of their common interest due to certain constraints like casual nature of employment, ignorance and illiteracy, small and scattered size of establishments" (Naik, 2009:2). Organized and unorganized sector also interchangeably use as formal and informal sectors.

[2] The formal sector means the firms or industries that come under the purview of legal framework, the workers who are organized and the wages are relatively high.

The major growth of the informal sector workers has been in the service sector consisting of construction, hotels and restaurants, transport storage, waste pickers, home based workers and street vendors. The social characteristics of workers in the informal sector are that they are largely from the bottom of the economy and also from the lower end of the social hierarchy (Holmstrom, 1985; Breman, 2010; Qadeer and Roy, 1989; NCEUS, 2007). It is imperative to understand that historically, most of the informal workers are excluded socially and economically and therefore they end up as part of the informal sector. Develtere and Durme, it is stated that "the existence of the informal sector is a consequence of the exclusion of many social groups" (Develtere and Van Durme, Dec.1999-Jan.2000:68). The NCEUS (2009) report highlighted that in the end of 2004-05 seventy seven percent (836 million) of the people were living below the official poverty line i.e. twenty rupees per day per capita consumption and around seventy nine percent of the informal workers belonged to this group (NCEUS, 2009).

The workers in the informal sector are affected by lack of adequate access to several facilities including health services. The poor living and working conditions of the informal workers who mostly lives in urban slums exposes them to ill health significantly (Gupta, *et al* 2009). It is also evident that those who are economically and socially marginalized get less access to health services (Krishnan, 1999; Sen, *et al* 2007; Baraik, and Kulkarni, 2006). The cut back of the government's role for providing social policies such as on health combined with rampant commercialization of public provisions, resulted in increasing vulnerability of the poor and also the workers of informal sector (Ellis, *et al* 2000).

The government through the National Health Policy 2002 document and also in the 11th five year plan document has expressed concerns about the inequities in access to health care. It has raised the apprehensions about low public health finance, poor quality of health services, inequity in health outcomes, unregulated private sector, rising cost of health care and its impact on marginalized and vulnerable sections of the society (GOI, 2002; GOI, 2006). The real debate among governmental, Non Governmental Organizations and civil society organizations is on how to reduce these inequities in access to health care. Several strategies have been tried by both government and non-

governmental actors. One of the measures to address this problem of increasing cost and inaccessibility to health services is through the introduction of medical insurance schemes especially for the vulnerable sections of the society. These have been initiated by the government, NGO's in partnership with insurance companies and the private hospitals and also by the trade unions.

Some initiatives have taken place to mobilize the informal sector workers and forming their unions to protect the interests of the workers and improve their living conditions , examples of these are Self Employed Women Association (SEWA) in Gujarat, Mathadi Kamgar Union (Head loader's union), The Hamal Panchayat in Maharashtra, the head load workers union in Kerala. Few trade unions and NGO's have initiated a medical insurance programme in order to protect their workers from going into impoverishment due to indebtedness because of high cost of medical care.

Medical insurance is seen as an important measure to improve access and also reduce the burden of expenditure. The central government has introduced the Rashtriya Swasthya Bima Yojana (RSBY) scheme and a few state governments have initiated similar measures for those below the poverty line. In urban areas some initiatives have been taken by trade unions and NGO's in partnership with insurance companies and private hospitals for medical insurance.

This study examines the medical insurance promoted by a trade union for the informal waste pickers in Pune. This study proposes to understand the process of unionization among informal waste pickers, the evolution of the medical insurance scheme and the experiences of waste pickers with the scheme.

Chapter Plan:

This study is divided into six chapters, the first, 'Informal Sector: An Overview' discusses about the socio-economic characteristics and working and living conditions of the informal sector in India. The second chapter, 'Historical Development of Medical Insurance: An Overview', it tries to look into the different types of medical insurance arrangements for workers in the formal and informal sector in order to contextualize the emergence of Community Based Medical Insurance Schemes. It focuses upon the

historical development of medical insurance in selected countries. The third chapter titled 'Research Methodology' discusses about the methodological approach that has been used in this study. The fourth chapter, 'Role of Union in Promoting Medical Insurance for Waste Pickers in Pune Municipality' discusses in detail about the process of unionization covering the history of union and background of the leaders in order to contextualize the role of the union in promoting medical insurance. It also studies the architecture of the medical insurance scheme which includes the main actors, its coverage, the claim and reimbursement procedure. The fifth Chapter, 'The Medical Insurance Scheme: Experiences of Waste Pickers' explores the experiences of the waste pickers with the medical insurance that includes their socio-economic background, working conditions, health problems and difficulties in access to health care. It captures the experiences of waste pickers with claim and reimbursement procedure under the medical insurance scheme. Chapter six, 'Medical Insurance: Who Benefits' includes the summary and discussion.

Chapter One

Informal Sector: An Overview

Chapter 1

Informal Sector: An Overview

This chapter discusses about the socio-economic characteristics of the informal sector and their poor working and living conditions as well as its magnitude. It has tried to understand the vulnerability of the informal sector workers which is imbedded into their socio-economic status. The poor working and living conditions of informal workers exposes them to many diseases due to which their vulnerability increases to a large extent.

1.1 History of Indian Industrialization:

The Indian Industry is largely shaped the colonial rule of the British. The colonization of India by the British had ruined the Indian economy. The British used to buy raw materials from India at cheaper rates and finished goods were sold at higher than normal price. Importing furnished goods to India had led to the decline of the indigenous economy (Duggal, 1997). The exploitation by the British in terms of using cheap labour and giving low wages has resulted in huge inequality amongst the poor and rich. The process of industrialization mainly took place in the port cities of Bombay, Calcutta and later in Madras for the convenience to export goods to the Britain. This unequal system of trade was reflected in unequal development of rural and urban areas. The major reason for establishing industries in India was that the labour was available at very cheap rates and so the production cost was also lower. Labour was not organized and in the early period of industrialization there was no regulation on work or wages. So the British exploited this situation in terms of long hours of working and extracting work from men as well as from women and children at a very low wages (Bhowmik, 2009). There was a large amount of capital invested for the construction of railways and communications in India by the British. This also led to the expansion of process of industrialization in India (Bansal and Bansal, 1984).

In 1931 The Royal Commission's report noted that cotton, jute and railways remained as big employers along with plantations of tea, coffee and rubber. Later, the manufacturing industries such as steel, paper etc also started to expand. At the time of independence

there was small number of labour available but it was quite significant. The Royal Commission's report on Labour found that the working and living conditions of the worker were very abysmal (Qadeer and Roy, 1989)

1.2 Indian Industry in Post Independence:

After independence there were two paths available in front of India as socialist and capitalist growth based on industrial development. India adopted a mixed economy and was designed by central planning through five year plans (Breman, 2010). There was major role played by the state for development of the rural agrarian sector and also urban industrial sector. The first five year plan was focused on the development of the agrarian sector, whereas second five year plan and in the subsequent plans, the major emphasis was given to the industrial development. The period of 1960's in India is known to be a period of industrial development. This period is called to be a modern period and the term labour has begun to signify work in industry (Breman, 2010). However, over the planned years there was a steady neglect of rural areas and tremendous focus was given on the development of urban areas. The rapid growth of industry mostly has been taken place in cities or towns as this notion was established since colonial period. This pattern of unequal development in rural and urban areas reflected in India even after independence.

In India, the main occupation or main source of living of the people is agriculture in rural areas where the majority of the population lives. It has been assumed that the rapid growth of industry in cities and towns will increase the employment opportunities in urban areas, which did not occur. The natural growth of urban population and rural to urban migration resulted to increase in urban labour force. The urban population rose from 4 to 18 percent in between 1901 to 1961. But the fact is that the rate of industrial growth has not been taken place in a rate of increasing urban labour force which resulted in huge unemployment. "The economic development based on large scale, capital intensive and highly formalized management structure fail to generate adequate and equitable employment and income opportunities in the modern formal sector" (Samal, 1990). The major thing is that the modern big industries are capital intensive rather than the labour intensive. The adoption of modern technology reduced the labour force which also resulted in unemployment. "Only half and sometimes less of the urban population

usually finds employment in factories and other establishments in the so called modern sector" (Breman, 1994). The surplus labour is not able to get job opportunities in modern formal sector and this situation forced people to find jobs on their own and thus they had to work in different economic activities which are not supported by the government or remained unprotected. For a long period of time and now also people are working where ever they get some kind of work for their survival. These large populations who are working on their own way are often neglected by the policymakers (Breman, 2010). They are living their life at a subsistence level. A large segment of poor people migrated to urban areas in search for jobs; most of them are working in informal sector where there is low wages, lack of social and employment security, no legal protection and they are not organized.

1.3 The Formal and Informal Sector in India:

There are two sectors, that have coexisted in the Indian industry namely, organized and unorganized, also interchangeably use as formal and informal sectors. The Employment Market Information (EMI), Programme of the Directorate General of Employment and Training (DGET), Government of India, defines "the organized sector as comprising all establishments in the public sector and those establishments in the private sector which employ ten or more persons on any day of the reference period (usually three months)" (Ratnam, 1999:25).

The formal sector means the firms or industries that come under the purview of legal framework, the workers who are organized and the wages are relatively high. Central Statistical Organization (CSO) defines formal sector as "manufacturing units that employ a minimum of 10 workers and use electrical power in manufacturing or a minimum of 20 workers if the unit does not use electrical power (NCEUS, 2007). Generally in the formal sector the worker's wages are protected by legally.

The 'informal' stand for those forms of firms which does not comes under any legal framework (Moghe, 2007). The average wage of an informal sector worker is lower than the wages in the formal sector (Bhowmik, 2009). "Informal sector activities comprise those which are not (a) organized systematically; (b) made formal through mandatory

registration or license; (c) covered by legislation to protect minimum labour standards in employment; and (d) unionized" (Ratnam, 1999:25). From above definitions it clearly indicates the contrast between the two sectors in terms of size, characteristics, technology etc.

There is a need to understand that though the activities and the characteristics are different in the formal and informal sector, but it should not be seen in a way that these two sectors are totally different and have clear cut distinction. In fact, there is close relationship between these two sectors. A Study conducted by Mark Holmstrom (1985), focused on the unorganized sector mainly low paid workers, who were working on temporary jobs and not protected by any security or by trade unions. He conducted his field work in Bangalore and Bombay with an extensive literature survey. He illustrates his analysis on the basis of his earlier work (1971) which focused on the workers in the organized sector factories. He analyzed that there is constant relationship between formal and informal sector. The formal sector is highly dependent on the informal sector as mostly big industries give production of small parts to the small firms to reduce the labour cost. There is constant mobility between these sectors as the worker who works in the informal sector has always makes an effort to go into the formal sector and it also happens that the worker who works in the formal sector comes into informal sector (Holmstrom, 1985). The Jan Breman also argues that the dichotomy between formal and informal sector is not practical thing where as it is a continuum association between formal and informal sector (Breman, 1994).

1.4 The Main Characteristics of Informal Sector:

Some characteristics of informal sector are explained as below:

- Lack of social security (Maternity and health care benefits, pension etc.
- Lack of employment security (No protection against arbitrary dismissal
- Lack of work security (No protection against accidents and illness at the work place
- Relatively Low wages

- Lack of power of organization so it reflects lack of collective bargaining power (Unionized)
- The nature of work is wide and diverse

"They work as so called self employed or wage workers, sometimes located in their homes but mostly outside. Some are lucky to have some kind of regular work but majority of wage workers are employed on a casual basis. Most get wages that are too low to enable them to come out of their poverty, not to speak of overcoming their vulnerability. Discrimination is the norm when it comes to women, children, bonded or migrant workers. Such positions of disadvantage are often reinforced by one's social identity, rural location and, above all, low or no education" (NCEUS, 2007: i).

Thus it can be see that the nature of informal sector is in a way to marginalize people in terms of accessing resources in all ways so that they will remain most marginalized. It has an implication of their development and not only for their development but also their future generations will face the same situation.

Mark Holmstrom, clearly states that "there are two classes of people very differently placed: a lucky minority working in the protected modern sector, and the majority outside it" (Holmstrom, 1985:1). This shows the distinction between the formal and informal sector workers. 'Within informal sector there is again segmentation of work such as location of work, type of work, status of work and across this differentiation there is again high level of segmentation of social group and gender' (Chen, 2003)

1.5 The Concept of Informal Sector:

The concept of Informal sector has been debated in great detail and has defined and redefined over a period of time. It has been first discussed by Hart in 1971 as described 'the informal sector as that part of the urban labour force which falls outside the organized labour market' (Breman, 1994). This definition does not give a clear picture about the informal sector. It only indicates that the informal sector is part of urban labour force and in urban labour force there are two different labour forces as formal and informal. After the introduction of the concept, the International Labour Organization (ILO) sent missions for the enquiry of the informal sector which is outside the formal

sector. The first enquiry has been done in Kenya in 1972 (Naik, 2009). However, it is interesting to note down as Breman has analyzed that when this concept was introduced internationally, then it became popular and "the attention it subsequently drew from development economists and policymakers in particular, the informal sector became, to a significant extent, associated with the economy of the large cities of Africa and Latin America" (Breman, 2010). There was lot of interest in the informal sector because it was growing day by day and the large number of workforce remained outside the purview of formal, stable, full time and protected employment and this was so important for policy makers, researchers, activists who are working with labour issues. There are also new interests as there are new forms of informality increasing and its relation to the formal sector (Chen, 2003)

Initially the informal sector was described 'as the one that comprises economic activities not officially registered, recognized or taxed' (Subramanian, 2001). The First Indian National Commission on Labour (1966-69) defined informal sector workforce "as those workers who have not been able to organize themselves in pursuit of their common interest due to certain constraints like casual nature of employment, ignorance and illiteracy, small and scattered size of establishments" (Naik, 2009). However there is no universal consensus on the definition of informal sector. Informal sector means having many activities which are complex in nature and it is a fragmented and divergent sector where most of the population, from both rural and urban, is involved to earn their livelihoods. (Breman, 1994)

The Arjun Sen Gupta Committee Report (2007) employs, the same definition of the unorganized sector as the International Labour Organization (ILO) that states that,-"The unorganized sector consists of all unincorporated private enterprises owned by individuals or households engaged in the sale and production of goods and services operated on a proprietary or partnership basis and with less than ten total workers" (NCEUS, 2007:3). This definition shows the size of the workers and the goods and services owned by the private enterprises. From the above definitions, it gets reflected that the informal sector is wide and cannot be understood only in one definition or cannot cover the whole range of activities which are diverse in nature. In order to measure the

informal workforce the NCEUS report, 2007 has introduced a definition of informal workforce which is, "Unorganised workers consist of those working in the unorganized enterprises or households, excluding regular workers with social security benefits, and the workers in the formal sector without any employment/ social security benefits provided by the employers" (NCEUS, 2007:3). In this definition it has introduced the worker who works in a formal set up without having social security and this also includes the workers working outside the formal set up without any social employment and work security.

The term informal sector was introduced in 1970's that time there was dualist school of thought and it was initiated by the ILO. It regarded as informal sector is a separate sector and there is no any connection between formal and informal sector. In the period of 1970's and 1980's there was second school of thought initiated by Caroline Moser and Alejandro Portes. It is structuralist school of thought and it considers that informal sector is not a distinct sector and there is a relation to the formal sector. Hemando De Soto introduces the third school of thought in the period of 1980's and 1990's as legalist school of thought. It believes that the informal sectors the small scale entrepreneurs who are unregister are preferred to function informally for the purpose of avoiding time, money and effort of formal registration. (Chen, 2004 as cited in Mathew, 2010).

1.6 The Magnitude of Informal Sector in India:

The National Commission on Enterprises in the Unorganized Sector (NCEUS), 2007 has estimated that in 2004-2005 the total employment in India was 458 million and among that 395 million workers are working in unorganized sector. This estimation shows that the informal sector accounts 86 percent and the informal workers who does not have any job or social security constitutes 92 percent. Among these 395 million workers, 253 (64 percent) and remaining 142 (34 percent) million workers comes under agriculture and non agriculture employment respectively. In the total agricultural sector, almost all are informal workers around 98 percent and they are mainly self-employed workers (NCEUS, 2007).

Table: 1.1 Interfaces between Formal/Informal Sector and Formal/Informal Worker in Non-agricultural Sector in India, 2004/05

Employment in Millions

	Informal sector	Formal Sector	Total
Informal worker	141	25.5	166.5
Formal worker	1	31	32
Total	142	56.5	198.5

Source: NCEUS, 2007

Above table shows that 142 million (by using informal sector definition) informal workers are in the non agriculture, which constitutes around 71.6 percent of the total non agricultural workforce in 2004-05. By using the second definition of informal workforce[3] it shows that 166.5 million workers are in the non agriculture, which constitutes around 83.9 percent of the total non agricultural workforce. This shows the huge difference if we include the informalisation of labour in formal sector and also the difference between the formal and informal employment. The report shows that, between 1999-2000 to 2004-2005, the percentage of non agricultural worker in the informal sector has increased from 32 percent to 36 percent and mostly they are self employed workers, constitutes 63 percent, followed by casual (20 percent) and regular workers (17 percent) (NCEUS, 2007).

The report of the 55th Round of the National Sample Survey (1999-2000) shows that the total employment was 397 million persons, this figure increases to 458 million in the 61st Round (2004-2005). But by dividing into formal and informal it shows that the employment in the formal sector has remained static at about 35 million during the same period. Therefore it clearly indicates that, there is increase in the employment in the

[3] The NCEUS report, 2007 has introduced a definition of informal workforce to measure the informal workforce, "*Unorganised workers consist of those working in the unorganized enterprises or households, excluding regular workers with social security benefits, and the workers in the formal sector without any employment/ social security benefits provided by the employers*" (NCEUS, 2007). The underestimates of informal sector has been captured by this definition considering the informalisation of labour in the formal sector.

informal sector 61 million (17 percent). The informal sector constitutes 93 percent of the total workforce and remaining only 7 percent constitutes for formal sector. In the year of 1999-2000, only 0.4 percent of the informal sector workers were receiving social security benefits and this proportion had not changed since this period (NCEUS, 2007)

This clearly indicates that the nature of the employment is increasing in the form of informalization without any job or social security.

1.7 Categories of Informal Sector: There are four categories of informal sectors as explained in Arjun Sengupta Committee Report, 2007:

- ***Wage Workers in the Informal Sector***:

In this category the worker who have been employed by employer, by agencies or by contractors. These are the workers works on a temporary or casual basis. It also includes migrant workers and those who are working at household level means domestic workers as well.

- ***Self-Employed in the Informal Sector***:

The worker who works on their own account or works individually or with the partners also includes household workers or unpaid household members. It can be small enterprises who are not registrar and engaged in trade, owned by individual or by the partners.

- ***Regular Informal Workers:***

The workers who are getting money on regular basis and who works for others, on behalf of their work they get salary or wages on regular basis are called regular informal workers.

- ***Unprotected Wage Workers in the Formal Sector:***

It means the worker who works at formal set up but remains unprotected due to non compliance of existing laws. It can be casual, regular or contract workers (NCEUS, 2007:5)

The informal sector is heterogeneous, under which many activities come and many players as well. Almost it includes every sector. The head load workers, rickshaw workers, waste pickers, small shops includes vegetable sellers, fish, meat, snack foods,

barbers, cobblers, etc. the workers who repairs locks, keys, etc. are all informal workers. In all this huge heterogeneous sector the most invisible workers are the women workers, who works at their homes by producing or selling goods and services such as garment makers, embroiderers, incense stick rollers, cigarette rollers, Bidi rollers, paper bag makers, kite makers, hair band makers, food processors, and others (Chen, 2003).
There is a growing section of self-employed-waste pickers (waste recyclers), home-based workers, and street vendors etc. These self employed workers are outside the purview of social security and welfare as they remained an invisible section of the urban labour force (Bhowmik, 2009).

It is important to note down that there is no any clear cut boundary in which this segmentation of informal work has been brought out. The complexity of this informal sector is much larger and cannot be brought out only by doing categorization of this informal sector. "In the real world, no clear-cut borders exist between the above segments and there is constant mobility of workers between different employment categories and even occupations, depending on the time of year, the economic situation and the demands of their survival strategies" (ILO, 1999). So, most important thing is that there is hierarchy within informal economy and the level of income differs by the type of work you do. The worker, who works waste picking, is more vulnerable than the worker who sells small goods and services. The workers vulnerability depends upon the type of work, the status of work, the location of work and mostly the social background of the worker.

1.8 Social Structure and Industrial Inequality:

It is well known that the Indian social structure is mainly based on the caste system and the division of labour is caste based. The hierarchy in the caste system is exploitative in nature and the persons who belong to the lower strata of hierarchy are more vulnerable than the upper one. This vulnerability becomes more critical when it comes to the lower class and to the gender. So it is necessary to understand the social origins of the labour force because "the social origins frequently determine the type of work carried out" (Breman, 2010:180). Informal workers are mainly belonging to the lower caste and lower class. A study done by Qadeer in 1984 in the district of Shahdol in Madhya Pradesh indicated that the skilled and semiskilled workers are largely from the upper and middle

caste families and those who works as casual or wage labour largely belongs to the Dalit or tribal communities (Qadeer, 1984 cited in Qadeer and Roy, 1989:56). Jan Breman also pointed out that "workers who perform the most humble and miserable forms of informal work are mostly recruited from the lowest social ranks and are often from tribal and Dalit communities" (Breman, 2010:180). A study conducted in Coimbatore in India by Harriss *et al* (1990), found that the urban labour market segmentation is formed along the lines of social stratification which influences ones mobility into the labour market. It is found that the lower castes are disproportionately to be found in unprotected regular and irregular jobs whereas the upper castes are concentrated in protected and unprotected but in regular long term jobs (Harriss, *et al* 1990).

In the report of NCEUS, 2007 stated that "substantial proportion of wage workers in agriculture (77 percent) and all workers in non agriculture (76 percent) are either landless or land poor and landlessness is higher among schedule caste and among Muslims" (NCEUS, 2007). Thus this indicates that it has direct implications on seeking any type of job which is available in market and thus forces to work any miserable conditions for survival. Securing job or maintaining the particular job becomes primary responsibility of worker, even if it does not provide any kind of security. The persistent socio economic inequality primarily based on caste system gets reflected in the labour market as well. In paper by Thorat and Sabharwal (2010), states that, in economic spheres exclusion take place through the denial of equal opportunities in the labour market and this exclusion may be practiced through the denial of jobs. It has been also stated that "a group (particularly the 'untouchables') may face exclusion and discrimination from participation in certain categories of jobs (the sweeper being excluded from jobs inside the house), because of the notions of purity and pollution of occupations, and engagement in so-called unclean occupations" (Thorat and Sabharwal, 2010: 10-11).

In urban areas, informal sector workers are mostly rural migrants and landless laborers who are being pushed from the rural agrarian sector where unemployment is high. A study conducted by Harris, *et al* (1999) in the city of Coimbatore, found that a higher proportion of migrants who come from urban areas outside Coimbatore, as opposed to

rural areas, are found among the relatively privileged self-employed with capital and in protected, regular wage work (Harris, *et al* 1999:19).

In a study conducted by Madheswaran and Attewell (2007), based on National Sample Survey examined the wage gap between higher caste and lower caste in the regular salaried urban labour market. This study have found and states that "(a) discrimination causes 15 percent lower wages for SC/STs as compared to equally qualified others; (b) SC/ST workers are discriminated against both in the public and private sectors, but the discrimination effect is much larger in the private sector; (c) discrimination accounts for a large part of the gross earnings difference between the two social groups in the regular salaried urban labour market, with occupational discrimination, unequal access to jobs, being considerably more important than wage discrimination, unequal pay in the same job; and (d) the endowment difference is larger than the discrimination component" (Madheswaran and Attewell, 2007: 4146).

The level of education determines the type of work you get. The level of education among the big industries and in formal sector workers is quite higher than in the informal workers. Because it is again a question of who has access to education? Who has access to land? It is well documented who belongs to the upper caste such as Brahmin, Maratha has access to education, land etc, so this inequality is perpetuated into the industrial inequality. Historically the lower caste landless people mainly Dalits are servant of the upper caste landlord people now in industrial society the similar structure has been replicated in terms of working class exploited by the ruling class. Harris, *et al* (1999), states that more educated people with better endowed, migrated from outside the city were placed into protected regular work. On the other hand, after migration to city, the poor and more poorly educated rural people were found into more marginal occupations (Harris, *et al* 1999:19).

The NCEUS, 2007 report shows that in the unorganized sector average years of education is 6.6 years and in the organized sector it is 10.1 years in 2004-05, it means the gap is 3.5 years, which again shows the inequalities at educational level. Among this, women are the most vulnerable as they are less educated than men in all segments of workforce. If it is seen in socio-religious background then the vulnerability of the worker becomes

clearer, "that ST's have lowest years of schooling followed by Muslim, SC and OBC in that order". Casual workers are at bottom level in education and women are the least one. It has seen that the 38 percent upper caste men and 37 percent upper caste women are most likely to get jobs in organized sector whereas 12 percent Muslim, OBC men and 13 percent women were least likely to do so (NCEUS, 2007). In India caste system restricts access to different types of occupation and education as well, for lower castes people there is little access to education and in present situation education decides the entry of the job. It is well known that, even to get unprotected job in the organized set up, there is a need for some level of education. Education is seen as important asset for getting job; it decides the level of position, the type of work, the sector and ultimately the income. Thus it shows how the system made to suffer only for lower socio-economic groups. A study conducted by Nambissan, in the village of *Tila and Village* of Jaipur district in Rajasthan, has explored the process of exclusion and discriminatory practices in the school towards Dalit Children. The study reveals that tasks considered to be menial and 'polluting' (such as sweeping) are more likely to be assigned to Dalit as compared to general caste children while those concerned with serving of water and food to teachers (with its caste based implications) are assigned mainly to those belonging to general castes. It also revealed that, teachers labeled Dalit children as 'weak' and fails to give confidence to participate in the classroom (Nambissan, 2009:26). This clearly indicates the way in which discrimination and exclusion take place in schools towards lower caste background children, which denies the access to have education and thus ultimately denies the developmental opportunities which could have been achieved through education.

One more aspect is important, the role of kinship or social network. Holmstrom states 'that people from a particular caste or area or religion are often found in large numbers in one industry or firms or skill, for historical reasons'. People entered into the one type of work because of some kind of skill, then their relatives or friends also come into the same line as employers also supported to the people from same origins. Because of lack experience, skills and contacts, people from the poorest groups were forced by sheer need to take such kind of work which no one can do (Holmstrom, 1985: 38). Similar findings have been explored in a study conducted by Harris, *et al* that, most of the groups were effectively excluded from access to better job due to lack of contacts, caste and

community networks (Harris, *et al* 1999). It is being noted that the work of manual scavenging and work of waste picking is historically done by Dalits as this is caste based occupation and even in contemporary modern industrial society this work is done by these communities only (Thorat and Sabharwal, 2010).

Chapter Two

Historical Development of Medical Insurance: An Overview

Chapter-2

Historical Development of Medical Insurance - An Overview

The main objective of this chapter is to understand different types of medical insurance arrangements for workers in the formal and informal sector in order to contextualize the emergence of Community Based Medical Insurance Schemes. It focuses upon the historical development of medical insurance in selected countries. It also tries to locate the role of the state in the provision health care in various phases.

The provision of health services varies across countries and its evolution is shaped by socio-political forces. Global context is significant because it has influence on the evolution of health services and determines the health policies of other countries as well. In this section we take the example of Europe and U.S. to show how their socio-political context shaped the kind of medical insurance schemes they have. In the United States medical insurance model is basically individualistic and prominently privatized model where health is seen as individual entity. Medical insurance is seen as individual choice depending upon the ability to pay for it. While in the European countries medical insurance model is based on solidarity and collective investment. However in today's highly commercialized era, health care is increasingly being looked at as consumption good, where the patient becomes a consumer. In recent times, medical insurance is becoming an important mechanism creating demand for health care services.

2.1 The Difference between Health Insurance and Medical Insurance:

Conceptually, there is a difference between health insurance and medical insurance. Health insurance is seen as financial support to individuals against illness or other misfortunes through financial cross subsidizing. It covers promotive, preventive and curative care. On the other hand, medical insurance is a narrower term focusing largely on secondary and tertiary level care. In medical insurance individual buys the services depending upon his/her ability to pay for it. The term medical insurance and health insurance are often used interchangeably. However, for the purpose of this study the term medical insurance is used.

"Medical insurance can be defined in a very narrow sense where an individual or group purchases in advance health coverage by paying a fee called "premium". But it can be also defined broadly by including all financing arrangements where consumers can avoid or reduce their expenditures at the time of use of services" (Mavalankar and Bhat, 2000).

2.3 History of Development of Medical Insurance for Formal and Informal Workers:

- **Europe:**

In Western Europe the development of medical insurance has a long history during the medieval times through the guild system (Saltman, 2004).

- *Mutual Aid Societies and Friendly Societies*:

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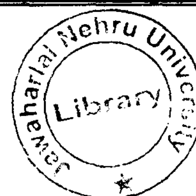
The guild system was basically a small group of workers who, working in same occupation came together and shared the financial risks in order to provide protection from future sickness. These guilds established their medical insurance funds for their members under the auspices of their craft guild. This was also known as Mutual Aid Societies. This form of medical insurance was completely on voluntary basis and was restricted only for the members of the guilds. The other members were dependent upon the charitable and religious organizations for care. This occupation based medical insurance model became the core of the social health insurance (Saltman, 2004) and continued in Germany, Austria, partially Switzerland and Sweden (Abel-Smith, 1988). Similar kinds of voluntary medical insurance evolved in France and Britain where groups of people mutually contributed and funds were organized by friendly societies or mutual aid societies (Porter, 1999). In industrialization period mutuality among workers increased as working in the common area and needs of the worker being shared. Friendly societies were a form of this kind of mutuality. Gosden's (1961) study concluded that the history of mutuality among workers is determined by "the needs of the growing number of the industrial workers" (Gosden, 1961 as cited in Gorsky, 1998). Industrial workers adopted the same principle set up by the guild system as occupational self help and regulation (Porter, 1999; European Observatory on Health Care Systems, 2000).



In the United Kingdom, the friendly societies were the single, largest category of medical insurance, in which workers helped each other mutually to each other in situations like sickness, unemployment, death or other misfortune. These friendly societies grew throughout the eighteenth century (Rosen, 1958). These friendly societies were highly influential and one of the most stabilizing society. But these societies could not reach to those people who were not able to contribute funds and hence these poor people remained outside the Friendly societies. "These poor people when disabled by sickness became a charge upon public relief funds or private charity or both. Such persons would not come within the scope of medical insurance without some form of compulsion, and years ago advocates of compulsory insurance began to be heard in England and Germany" (McCleary, 1934:5).

The mutual aid societies established by the guild system became powerful and to break this power, the State started to abolish the guild system (Abel-Smith, 1988). The guild systems were first abolished in 1789 in France, in 1798 by Netherlands, 1861 by Denmark and later other European countries also abolished the guild systems. Parallel to this process in the late eighteenth century and early nineteenth century, the state's role became prominent in providing health services to the people. In Sweden the government started providing services for the poor and this was the major step taken by the government as the district physicians were started to provide medical care on free of cost basis to the poor people and this was followed by Norway and Finland (Saltman, 2004). During the late eighteenth century and early nineteenth century the industrial revolution took place in European countries and the principle of guild systems mutual aid societies was transferred to industrial workers, as workers of the industry came together and started to set-up self-help and regulation on voluntary basis (European Observatory on Health Care Systems, 2000). These kinds of voluntary medical insurance evolved in other European countries and also the abolition of guild system led to the establishment of private medical insurance for profit and for non profit (Saltman, 2004).

- ***The Role of the State and Rise Of Compulsory Medical Insurance:***

The compulsory medical insurance was first started for miners in Prussia in 1849 and it regulated compulsory financial contributions from the employees and their employers.

On the one hand worsening miserable living conditions of the urban working class due to the multiple economic crises during the period of rapid industrialization period was led the workers to protest through trade unions. "The government responded to increasing worker's protests by prohibiting socialist and communist organizations in 1878 including trade unions, but increasingly it perceived political repression as an insufficient measure of maintaining the existing social order". With this socio-political background, the compulsory medical insurance system under the state regulation was pioneered in Germany by Chancellor Bismarck in 1883 (European Observatory on Health Care Systems, 2000:8). The Bismarck put the same idea of occupation based sickness funds by replacing their functions under state support (Saltman, 2004). The compulsory medical insurance is a system where every worker has to contribute for themselves and their families on the basis of their income and the employer also contributed on behalf of the worker. So in this system the higher income persons subsidize the less income persons and the young or single subsidize the elderly. The unemployed, chronically sick persons were enrolled in the basic medical insurance scheme and their contributions were paid for by the state (Smith, 1991). These types of medical insurance models became highly influential in industrialized European Countries. This resulted in formation of legislation not only in Germany but also in much of the Western European countries, such as in Austria (1887-88), Belgium (1894), Switzerland, (1899) and so on. This process was continued till the end of the First World War (Saltman, 2004).

However, late nineteenth century onwards, provisions of health care became a prime responsibility of the state. There were major shifts into the role of the state in financing health care. The initial medical insurance model was based on contribution but later this process was transferred into tax based medical insurance model. After the Second World War, most of the Western European countries have shifted from contributory medical insurance to a tax based medical insurance system (Saltman, 2004). The concept of welfare state became influential and was strengthened after the socio-economic devastation of the Second World War. Provision of welfare services and social security to the people became an important means for reconstruction of the society. In 1942 William Beveridge Committee was appointed to analyze the welfare needs of British society and a planned system to meet these needs. This report suggested a National Health Service

System which was based on taxation and free care at the point of service delivery for every individual (Porter, 1999). The first sign of it came in 1948 to 1973 in countries like United Kingdom, Denmark, and Finland and from 1978 to 1986 Southern European Countries such as Italy, Portugal, Spain and Greece (Saltman, 2004). Even though, these countries have maintained national health services which are principally based on universality and state funding through taxation, the private players also play a major role in provision of health services. These countries have adopted some form of co-payment system (Tritter, *et al* 2010). This reflects the shift from the mutuality among local groups of people, which were based on the principle of solidarity and collective responsibility to a rights based approach that has to be fulfilled by the state.

However, over the last few decades there has been a change in the role of the state, as the focus has now shifted to looking at health care as individual responsibility rather than as state responsibility. This shift has been discussed briefly in the following paragraphs.

- ***The Changing Role of the State During Post 1970s:***

There was a marked shift during the late 1970s when there was a gradual withdrawal and restructuring of the role of the state in health services. The three decades following this period were witness to a range of reforms in the health sector. The role of the state has changed after the Health Sector Reforms in the period of late 1970's and it diminished the role of the state in financing and provision of health services. Under reforms the market principles for service delivery were applied in health care provisioning. The study conducted in Finland, Sweden and England by Tritter, *et al* (2010) based on extensive literature survey and interviews of key stakeholders with the different categories as health professionals, civil servants, policy makers, etc. shows two phases of commercialization of health services. In the first phase, the emphasis was given to the use of managed competition and planned market mechanisms within the public health sector. It created a 'level playing filed' for privatization. The purchaser-provider split which enabled for further commercialization in health care. The second phase of commercialization took place outside the public health sector in way that health services have been contracting out to the private health sector. In the second phase health sector was considered as a commercial service hence patient is increasingly viewed as a consumer. The focus was

given to provide multiple choices and 'granting rights to choose their service providers' (Tritter, *et al* 2010:34-37).

The process of commercialization is evident in the National Health Service System in UK where 'choice and book services' are implemented since 2003. In this, patients referred by the general practitioners for secondary level treatment has to 'choose' the service provider. In this, private providers are also included. This clearly reflects the way in which the process of commercialization is being incorporated within publicly funded health service system through contracting in and contracting out of services. It is stated that "the practical outcome of choice agenda is a slower process with less opportunity for patients to maximize relevant information at the appropriate point in their decision" (Tritter, *et al* 2010:43-44).

- **United States:**

In the United States (U.S.) medical services have been always expensive and have been a matter of individual choice. Medical insurance is a twentieth century phenomenon in the U. S. Before this some form of sickness insurance was given to the workers. These sickness insurance was mainly to sustain family from economic burden, as these were given to the breadwinner of a family in times of illness or when unable to work. It was also called Industrial sickness funds and this created association between workplace and insurance (Roberts, 2009). It was found that the cost of medical care was less than the loss of wages due to sickness. "A 1919 State of Illinois study reported that, lost wages due to sickness were four times larger than the medical expenditures associated with treating the illness" (State of Illinois, 1919 as cited in Thomasson, 2003). These sickness funds were operated under the company support for their employees or by labour unions for their members. However, these sickness funds did not gain much popularity in United States whereas in Europe it became popular and became as agenda in national policy. It has been argued that United States having greatest hold on liberalism, whereby priority is given to maintaining private interests. As a result of this sickness funds or any other insurance never became an agenda in national policy in U.S. (Roberts, 2009).

The progressive era, after the turn of 1900, workers compensation law was being operated in U.S. However in this law, as well, the employers tried to defense themselves against the loss of cost related to injury and tried to put whole responsibility on to the employee but the court cases were increasing due to frequent occurrence of injuries. "Fishback and Kantor (2000) argued that state workers' compensation laws arose because workers' rights advocates saw such reforms as a means of shifting the costs of workplace injury to the employer. Employers saw reforms as a way to reduce the legal costs associated with negligence claims and to increase the payments to injured workers while at the same time reducing overall costs" (Fishback and Kantor, 2000 as cited in Morrisey, 2007:4). Under this insurance scheme injured worker was used to take treatment from their family doctor and these doctors were being paid by the workers' compensation funds. However, employers started to employ a physician or establishment of clinic for providing medical services to the employee. This led to the reduction in the demand for services for the local doctors. On the basis of this model there were some state initiatives for compulsory medical insurance by contribution from employer, employee and state (Morrisey, 2007). There were oppositions to this initiative in putting forward this insurance scheme as the scheme interfered with the doctor patient relationship (Morrisey, 2007). The other reason for the strong oppositions from the physician, pharmacist and commercial insurance companies was the fear that government intervention will determine their business and profits (Thomasson, 2003). The positive success of Blue Cross and Blue Shield Plans showed that the problem of adverse selection can be solved by focusing only on the employed workers. This led to the commercial medical insurance companies to entered into the market and offering different packages to the people who were working in the industries. These private medical insurance companies started targeting healthier group of people, i.e. the employed workers (Roberts, 2009; Gorman, 2006). In the Second World War period the government itself restricted limited wage increases but employers were allowed to adopt and offer medical insurance plans for their employees as a pre tax fringe benefit (Gorman, 2006). During the 1940s the labour unions also collectively bargained for the right of health benefit plans. The government also ruled out that the employer have to contribute to the health plans on behalf of their employees and they did not have to pay payroll tax (Roborts, 2009). This led to the

demand for medical insurance which furthered strengthened the employment based medical insurance plan.
In the U.S. whole medical insurance was restricted to people who were working in industry and who had ability to pay. The people who were aged and unemployed remained out of any coverage. In 1960 under the Lyndon Johnson administration, the Medicare programme was enacted for the elderly (over 65 years) under the Social Security. Similarly, Medicaid programme was introduced for the poor person which is a joint federal state programme based on means tested (Gorman, 2006; Morrisey, 2007).

However, the rising cost of medical care remains a major concern in the U. S. The dominance of private medical insurance and private service providers left out a sizeable population from accessing health care as these corporations deems this population as commercially unviable. The rising cost of health care and the implications of reforms have led to increasing inequality among the different socio-economic strata. The UN Human Development Report mentioned (2005) that, "More than in any other major industrial country the cost of treatment is a major barrier to access in the United States. Over 40 percent of the uninsured do not have a regular place to receive medical treatment when they are sick, and more than a third say that they or someone in their family went without needed medical care, including recommended treatments or prescription drugs, in the last year because of cost" (Human Development Report, 2005:27).

In summary, the U.S. health system has always depended on individual responsibility and emphasized buying insurance either employer driven or private. The private insurance predominates with targeted public insurance schemes.

Thus, the history shows that the development of medical insurance scheme in different periods and in different countries principally evolved for the skill based industrial workers. But the other workforce who are working informally and does not come under any social security remained uncovered.

2.4 Status of Medical Insurance in Low and Middle Income Countries

It is always a big challenge to include informal sector workers under medical insurance for universal healthcare coverage in low income and lower middle income countries

where large sections of workers in the society are working in the informal sector. More than 1.3 billion of the people in low and lower middle income countries are in the informal sector and are from rural poor. So it is a great challenge in the world and specifically in low and middle income countries to provide and finance health care cost to these poor people who constitute more than 1.3 billion (Preker, *et al* 2002). It is also a concern and difficult to have a nationwide consensus on accepting social health insurance principle, that is taking responsibility by the working population for the other sections of the society, mainly in low and lower middle income countries where inequalities in income and resources are high. Moreover the lack of government managerial organization, lack of infrastructure and lack of public finance in health care are the major factors which leads to find out other financial arrangements (Carrin, *et al* 2005; Bennett, *et al* 1998). As Preker, et al (2002) observed that "most community financing schemes have evolved in the context of severe economic constraints, political instability, and lack of good governance" (Preker, *et al* 2002:143). The state as well as market is ineffective in providing medical insurance to poor and informal sector worker (Jütting, 2003).

The review of the history and status of medical insurance in developed and developing countries shows a rise in plurality of arrangements during the last four decades. Increasingly individual responsibility has become centre stage where the state plays a role of a partner or an arbitrator. The next section captures the different types of arrangements for medical insurance in developing countries for informal workers with special focus on Community Based Medical Insurance schemes in India.

- ***The Emergence of Community Based Medical Insurance (CBMI):***

The first initiative for Community Based Medical Insurance (CBMI) scheme was undertaken by Bamako Initiative in 1987 in Africa. The main objective of these initiative was to "(i) to revitalize public health systems; (ii) to decentralize decision-making; (iii) to mobilize resources to cover local operating costs; (iv) to encourage community participation through management of services and locally generated funds; and (v) to define the minimum package of essential health services" (UNICEF 1987 cited in Rao, 2005:285). Even though this experiment was failed, it got recognition mainly in developing countries where public health facilities are poor and large sections of the

society have a low payment capacity (Rao, 2005). As an appropriate strategy to reduce health care burden on the poor, the CBMI received increasing attention from policy makers from 1990's period (Carrin, *et al* 2005). It evolved in the context where health sector reforms had started in most of the countries. Reduction in public health expenditure resulted in worsening of the quality of public health services where majority of the poor and informal sector workers are dependent on it. Moreover introduction of user fees at various levels of public health services becomes one of the important barriers for accessing health care (Wiesmann and Jütting, 2000). The other barrier turns out to be contracting out with private sector for clinical services and public private partnerships were major steps exercised by the government to improve the efficiency and quality of care (Baru, *et al* 2010). However, the outcome of these exercised measures resulted in increasing the out of pocket expenditure on health care. This is becoming a major burden and one of the major reason for indebtedness for the poor (Gumber and Kulkarni, 2000). In response to this entire situation, CBMI schemes evolved in developing countries specifically emerging in African and Asian countries where it was seen as a more viable option for financing health care through community participation (Wiesmann and Jütting, 2000).

CBMI schemes are voluntary (Carrin, *et al* 2005) and involve community participation in decision making regarding contribution level and collecting mechanism (Ranson, 2002). "Musau, (1999) explains CBMI as, "It cover any non profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of an ethic of mutual aid and the collective pooling of health risks and in which the members participate in its management" (Musau, 1999, as cited in Jakab and Krishnan, 2001:10). This definition explains the characteristics of CBMI scheme as being not for profit, risk sharing and community involvement and principally meant for poor people who are working in the informal sector. Risk sharing and pooling of resources protects people from the unexpected health expenditure and facilitate accessing medical care. "By pooling resources, health insurance schemes can improve equity of and access to health care and can offer financial protection" (Ranson, 2002: 614).

A study on effectiveness of community health financing based on literature survey conducted, by Preker, *et al* (2002) have shown that the community health financing improves the access of health care by poor and informal sector workers and provides some financial protection against health care cost (Preker, *et al* 2002). Ranson, (2002) also indicates similar experiences as these CBMI schemes can protect poor households against the uncertain risk of medical expenses (Ranson, 2002). Evidence from rural Senegal showed that there are higher probabilities of using hospitalization services among members who have taken medical insurance than the nonmembers. It is also reported that members when they need care, substantially pay less (Jütting, 2003).

2.5 The Case of India

Development of Medical Insurance for Formal Sector in India:

In India medical insurance is very recent phenomenon the exceptions being the Central Government Health Scheme (CGHS) and Employees' State Insurance Scheme which is available only for the central and state government workers mostly organized or formal workers. Private medical insurance schemes offer different packages but these schemes are mainly for those people who have ability to pay for it (GOI, 2006 cited in Baru, *et al* 2010).The coverage of medical insurance in India is very limited covering only ten percent of the total population (Mavalankar and Bhat, 2000). In all these insurance schemes the worker in the informal sector gets excluded. Due to poor quality of public health services, lack of resources, reduced public health expenditure and increasing privatization of health care the poor informal sector workers have to bear a high burden of out-of-pocket expenditure on health (Baru, 2003). In this context increasing inequality in access to health care becomes a major concern. In India also CBMI is emerged in the context of reducing health care cost and increase accessibility of health care by poor and thus reducing inequality (Devadasan, *et al* 2004). In India, commercial medical insurance excludes the poor as high premiums and low awareness about insurance have kept the poor out of the pool (Public Health Foundation of India, 2011).

- ***Central Government Medical Insurance Scheme (CGHS)***

The central government medical insurance scheme started in 1954 for the central government employees and for their families. It is a mandatory medical insurance scheme which provides comprehensive medical care as it covers Allopathic, Homeopathic and AYUSH treatments. Funding is mainly from the central government but there is also contribution taken by the employees and this contribution depends upon the payment of the employee as it differs from 50 rupees to 500 rupees (Scott, 2010). There are some separate dispensaries in place for the use of the central government employees covered by the scheme. In addition to this there are clinics for dental care, hospitalization, polyclinics, laboratories, specialist consultation have been covered under this scheme (Ellis, *et al* 2000). Under the CGHS there are 248 allopathic clinics, 19 polyclinics, 78 AYUSH clinics, 3 yoga centers, 65 laboratories and 17 dental units spread across 22 cities in India (Garg, 1999 cited in Scott, 2010) All these services provided by public health facilities as well as private facilities if referral is being made by the public facility. Department of Health spent 18 percent of health budget on 44 lakh beneficiaries or 0.5 percent of the country's population in 2004-05 under the Central Government Health Scheme (CGHS) (Rao, 2005).

However the possibility of using health services likely to be above average as the large central bureaucracy in India definitely belongs to the middle-income and high-income categories. The CGHS is criticized in its accessibility and quality of care (Ellis, *et al* 2000) because the delivery of services is spread out inequitably and there are no systems of checks on moral hazard (Rao, 2005).

- ***Employees' State Insurance Scheme (ESIS)***

ESIS was enacted in 1948 and was the first legislation for social security in India. It was envisaged for formal sector workers as compulsory social security benefit. The scheme is to be allowed only for the factories that are using power and employing ten or more workers as well as the firms that are not using power and employing twenty or more workers. It is eligible only for those workers whose income is less than seven thousand five hundred rupees per month. It is managed completely by government owned

enterprise. The coverage is about eighty four lakhs employees and three hundred fifty three lakhs beneficiaries across twenty two States and Union Territories in 1998. The benefit is given to medical care as well as cash benefit and it includes, sickness, maternity care, permanent disability of self and dependents additionally funeral expenses and rehabilitation allowance. It covers hospitalization; specialist treatments as well as other Indian systems of medicine provided through a network of ESIS facilities and public care centers, non-governmental organizations (NGOs) and empanelled private practitioners. The scheme is contributory in nature on the basis of payroll tax and contributions by employers, employee and state government with 4.75 percent, 1.75 percent and 12.5 percent respectively (Ellis, *et al* 2000; Rao, 2005).

However it has been criticized from the user point of view and by the internal review committee. Subrahmanya (1995) "A committee for review of the scheme noted that "the criticism has been persistent and scathing" and that "the medical benefits provided have not kept up with the standard of facilities provided by the private clinics and diagnostic centers" (Subrahmanya, 1995 as cited in Ellis, *et al* 2000: 210). In Gujarat, a report based on detailed patient surveys (Shariff, 1994) revealed that unsatisfactory nature of services is provided under ESIS, as it includes low quality of drugs and long waiting period. It also revealed "impudent behaviour of ESIS personnel, lack of interest on the part of employers and low awareness of ESI procedures" (Shariff, 1994 as cited in Ellis, *et al* 2000: 211).

These two medical insurance schemes are primarily meant for the organized sector workers who have security of wages, employment and health. The other population is dependent upon the public health services provided by three tire structure of Sub Centre, Primary Health Centre and Community hospital and District hospital and on the private health sector.

General Insurance Corporation (GIC) was set up in 1973 to provide range of insurance services to the population. One hundred and seven private medical insurance companies were brought under the umbrella of GIC (Rao, 2005) and these GIC companies were merged into four subsidiaries i.e. the National Insurance Corporation (Calcutta), New India Assurance Company (Bombay), Oriental Insurance Company (New Delhi) and

United Insurance Company (Madras). All these insurance companies operate nationally which offers a range of different types of insurance benefit packages (Ellis, *et al* 2000). In 1999 Insurance Regulatory and Development Act (IRDA) was passed for the entry of private and foreign companies to provide a range of health benefit packages to people (Rao, 2005). Thus the emergence of private companies was started and these private companies are only for the people who have ability to pay for it thus excluding the poor.

2.6 Medical Insurance for Informal Sector:

In India large section (93 percent) of society have to earn their livelihood from the informal sector where there is lack of social security and have to work in poor conditions. As working in informal sector they do not get any health care benefits, maternity benefits, insurance, paid leaves for sickness etc. The poor people are dependent upon the public health services but due to the poor quality of services and user charges for various services they are compelled to avail private health care services which are more costly. The burden of expenditure on health care is high in those households who are engaged in informal sector as compared to organized sector (Gumber and Kulkarni, 2000) because of the low levels of income among the informal sector workers. This not only widens the disparities in income but it also restricts access to minimal needs of the informal sector workers (Unni and Rani, 2002).

- **The Role of the State:**

Extremely low public health investment over the years have resulted in poor quality of public health services thereby forcing people to avail private health services which are expensive (Ellis, et al2000). National Health Accounts 2004-05 Report presents that "in India total health expenditure from all the sources was Rs. 1,337,763 million during 2004-05 constituting 4.25 percent of Gross Domestic Product. Of the total health expenditure, the share of private sector was maximum with 78.05 percent, public sector at 19.67 percent and the external flows contributed 2.28 percent. Among all the sources, households contributed a significant portion at 71.13 percent of total health expenditure for availing health care services from different health care institutions" (GOI, 2009:V). This clearly reflects that the contribution of households on health expenditure is

enormous and this is mostly private sector out of pocket expenditure, hence putting huge financial burden on to the individual and families. Even within public health facility, individual has to pay from their pocket and this expenditure largely goes on to medicines, laboratory tests, dressings, linen and/or food or direct payments to providers (Ellis, *et al* 2000). It is being stated that "most of the out-of-pocket expenses are borne by households engaged in low income informal economic activities" (Ellis, *et al* 2000:216).

According to the 60th round of NSSO (2004-06), the average direct health expenditure on outpatient care per treated person in rural areas was nearly twenty percent of total household consumption expenditure, whereas the corresponding percentage for urban areas is lower, at about thirteen percent (Baru, *et al* 2010:52). The burden of expenditure increases when it includes the indirect cost such as income loss in times of illness. Baru, *et al* (2010), states that "the poorer sections carry a higher burden as compared with the better-off; this burden is quite heavy for even the remaining consumption classes" (Baru, *et al* 2010:53). It has been shown in NSSO data that these expenditures are mainly financed by households own resources and borrowings. "The reliance on borrowing is significantly higher for the poorer sections of the population as compared to the better-off with sharp differentials, especially in urban areas (NSSO 2006 cited in Baru, *et al* 2010:53).

- **Overview of Some Community Based Medical Insurance Scheme in India**

Community Based Medical Insurance (CBMI) in India has plurality of approaches as Non Governmental Organizations (NGO), Trade Unions, Co-Operatives, Self Help Groups, etc. taking a part into the initiation of CBHI with the involvement of community, insurance companies and providers. There are twenty CBMI schemes being operated in India. "It is estimated that about five million people are covered under various NGO insurance schemes" (Mavalankar and Bhat, 2000).

Devdasan, *et al* (2004) has introduced three types of CBMI.

- Type one: The hospital plays the dual role of provisioning of health care and running the insurance scheme.

- Type two: NGO or voluntary organizations becomes the insurer, while purchasing care from independent providers
- Type three: The voluntary organization plays the role of an agent, purchasing care from providers and insurance from insurance companies (plays an intermediary role)

He explains that these CBMI is a result of high cost of health care and failure of the government to provide quality care. The main objective of CBMI was to provide low cost of health care and protecting poor people from financial burden due to high cost of hospitalization. Some CBMI is also seen as method of encouraging community participation and some CBMI who are drawn from the activist are seen as medium to increase solidarity among the member (Devdasan, *et al* 2004:3180).

- ***Self Employed Women Association (SEWA):***

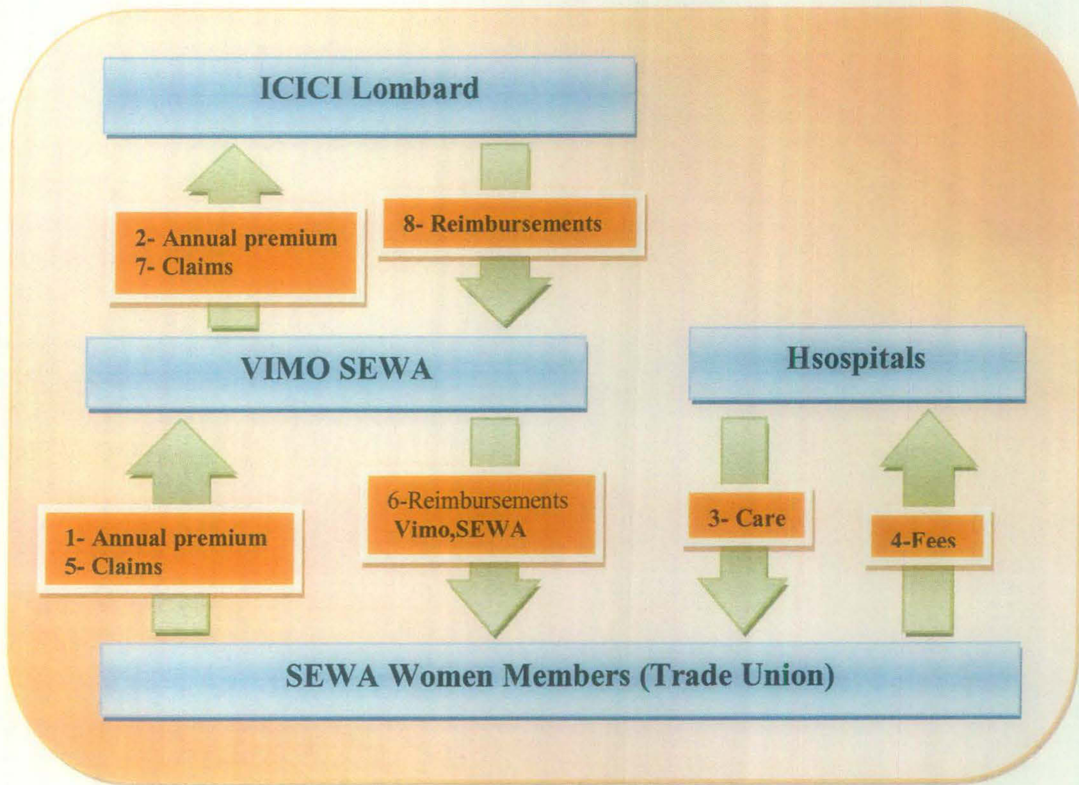
SEWA is a trade union of women workers who are working in the informal sector based in Ahmadabad, Gujarat. It was established in 1972 and having membership of 6, 00,000 women workers in union. The medical insurance scheme of SEWA started in 1992 to provide health care services at reasonable rate to the members of the union. It has three types of insurance scheme, medical insurance, life insurance and asset insurance. It is also called as Vimo SEWA and this scheme started with the support of the public sector insurance company called National Insurance Company (NIC). The membership of the Vimo SEWA was around 5000 in 1992-93 and increased almost 90,000 in 2001-02 (Acharya and Ranson, 2005). According to Devadasan, *et al* Vimo SEWA medical insurance scheme comes in third type of model as a linked model (Devadasan, *et al* 2004).

Eligibility:

This scheme covers only the members of the union i.e. women, their children and their spouses as well. To join the scheme women member should be between eighteen to fifty eight years old.

The Design of SEWA Medical Insurance Scheme:

(The numbers represent the sequence in the chain of events, with 1 being the first step and 8 being the last step in the chain)



Source: (Vimo SEWA Team and Devadasan, 2006:70)

Inclusion and Exclusion:

The members of the scheme can avail services at any hospital Public, Private or Trust. It is a reimbursement scheme as women have to pay at the time hospitalization from out of pocket and can apply to the Vimo SEWA. The members have to submit doctor certificate, discharge card, prescription and medicine bills, and diagnostic test bills within three months after the discharge. The exclusion criteria under this scheme is preexisting illness such as chronic tuberculosis, certain cancers, diabetes, hypertension, piles and the diseases caused by addiction (Ranson, 2002).

Coverage:

The most accepted scheme under the Vimo SEWA is, who pay the annual premium of 85 rupees in which 37.5 rupees is assigned to medical insurance coverage. Under this coverage women are covered for maximum of two thousand rupees for hospitalization for at least 24 hours per year. There is also a facility of SEWA bank where women can put a fixed deposit of 1000 rupees and interest of it used as a annual premium and this deposit is returned to the members after the age of sixty (Acharya and Ranson, 2005).

SEWA plays an intermediate role, as enrollment of members, their collection of premiums and claiming procedure and approving claims is done by SEWA. Study done by Acharya and Ranson, 2005, shows that utilization rate is low as only the eighteen claims per thousand per year have been claimed. No particular reasons have found out, but it may be the difficulties by the members in compiling the claims, lack of awareness about how and when to submit the claims among the members (Acharya and Ranson, 2005). Ranson have done analysis of six years of Vimo SEWA and it found that around eleven percent claims have been rejected within six years. It stated that "Out of 1930 claims 1712 claims were reimbursed as 805 (47 percent) fully and 907 (53 percent) at a mean reimbursement rate of 55.6 percent" (Ranson, 2002:613). It showed that the Vimo SEWA scheme protected against the catastrophic health expenditure among the members. Paying at the time of service utilization and then to file a return is major barrier as many times families borrow the money to pay and have to repay to the money lender with the interest rate (Ranson, *et al* 2006).

- ***Action for Community Organisation, Rehabilitation and Development (ACCORD), Association for Health Welfare in the Nilgiris (ASHWINI), Adivasi Munnetra Sangam (AMS) Community Based Medical Insurance Scheme:***

This medical insurance scheme is started in 1992 and jointly managed by three organizations. This scheme also known as AAA scheme. ACCORD is non-governmental organization started in 1986 in Gudalur sub-district of Tamil Nadu. It works for development and empowerment of the tribal people. ACCORD provides health, education, agricultural support and housing and for the provision of these services,

ACCORD collaborates with AMS which is union of tribal people and ASHWINI which is a sister NGO of ACCORD. ASWINI started in 1990 to provide health services for tribal people (Devadasan, *et al* 2011; Devadasan, *et al* 2006).

Insurer:

The tie up of this AAA medical insurance scheme was with New India Assurance Company (NIAC) from 1992 to 2003. In 1992, AAA negotiated with NIAC to insure All the AMS members for a period of five years. The scheme was renewed in 1997 for another five-year period. However, after five years the NIAC increased the premium so it was then decided to have a tie up with Royal Sundaram Alliance Private Limited. Since 2003 it is provided by Royal Sundaram Alliance Private Limited with coverage of one thousand rupees for a premium of twenty rupees for per person per year (Devadasan, *et al* 2006).

Eligibility:

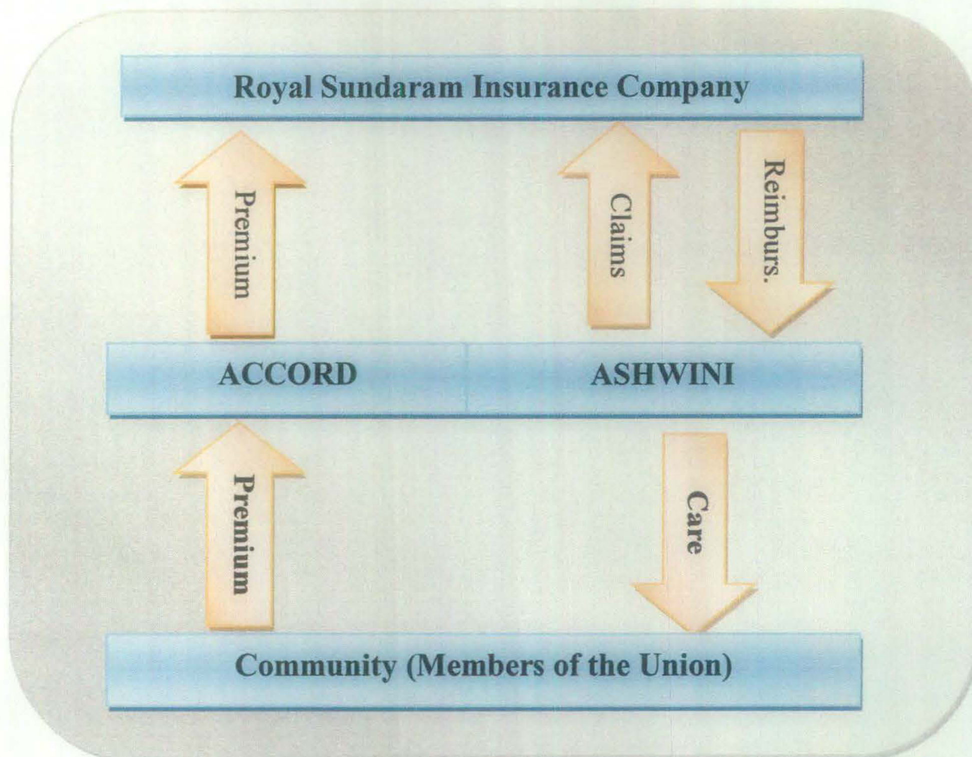
The members of the AMS and their family members between age group of six months to sixty years and who residing in Gudalur sub-district are eligible for this medical insurance scheme (Devadasan, *et al* 2011)

Coverage and Benefit Package:

The premium for former medical insurance (NIAC) was thirteen rupees per year for five members. It was covered for six thousand members in first round (1992-1997) and then move up to nine thousand members for next round (1997-2003). It included hospitalization with coverage up to one thousand five hundred rupees per year per person. It excluded pre existing illnesses, diseases due to substance abuse and self inflicted diseases. Maternity care was also excluded however later it was included with two deliveries and family planning operation. The Royal Sundaram Alliance Private Limited provides benefit up to one thousand rupees and first two deliveries for five hundred rupees with no exclusions. In 2004, twenty five rupees premium was collected for per person per year. This was collected by the ACCORD and ASHWINI field staff members and AMS leaders (Devadasan, *et al* 2011). According to Devadasan, *et al* (2004), AAA

medical insurance scheme come under type one model as provider model (Devadasan, *et al* 2004).

The Design of AAA Medical Insurance Scheme:



Source: (Devadasan, *et al* 2006:14)

Provider:

The benefit package from The Royal Sundaram Alliance Private Limited gets to ACCORD-ASHWINI. ASWINI is the main provider of health care which include promotive, preventive and curative health services with having a three tire structure of community health workers, health centre and twenty bed hospital. ASHWINI gives more comprehensive health care with no upper limits and no any exclusion. For the insured patient, both Out Patient care and hospitalization is provided for a small co-payment of ten rupees per visit. The provision of primary care services is accessible for all AMS members irrespective of their insurance status. If hospitalized in ASHWINI hospital then the maximum benefit they get is up to one thousand rupees. If the insured person is hospitalized in any other hospital then they does not get the benefit. If uninsured person

gets admitted in ASHWINI hospital then they have pay for the services used (Devadasan, *et al* 2011; Devadasan, *et al* 2006).

The main features of this scheme are that it is a cashless insurance scheme, no exclusions, free outpatient care at hospital and no upper limits. The ASHWINI hospital is financed by the community and some donors. So that is why there are two levels in this scheme which needs to be understood, as insurance company provides benefit package at the level of ACCORD-ASHWINI and then ASHWINI provides more comprehensive benefit package to the tribal people who are members of AMS (Devadasan, 2006).

The studies conducted by Devadasan, *et al* (2006) and Devadasan, *et al* (2011) has showed that among insured utilization of health services have increased and mostly those who are residing in middle distance are accessing these health services more. However it is important to understand that forty to fifty percent AMS members have enrolled in this medical insurance scheme at any point of time and over the years this enrollment is decreasing. The reasons in regard to this have mentioned the worsening local economy which resulted in retreating of enrollment (Devadasan, *et al* 2006; Devadasan, *et al* 2011).

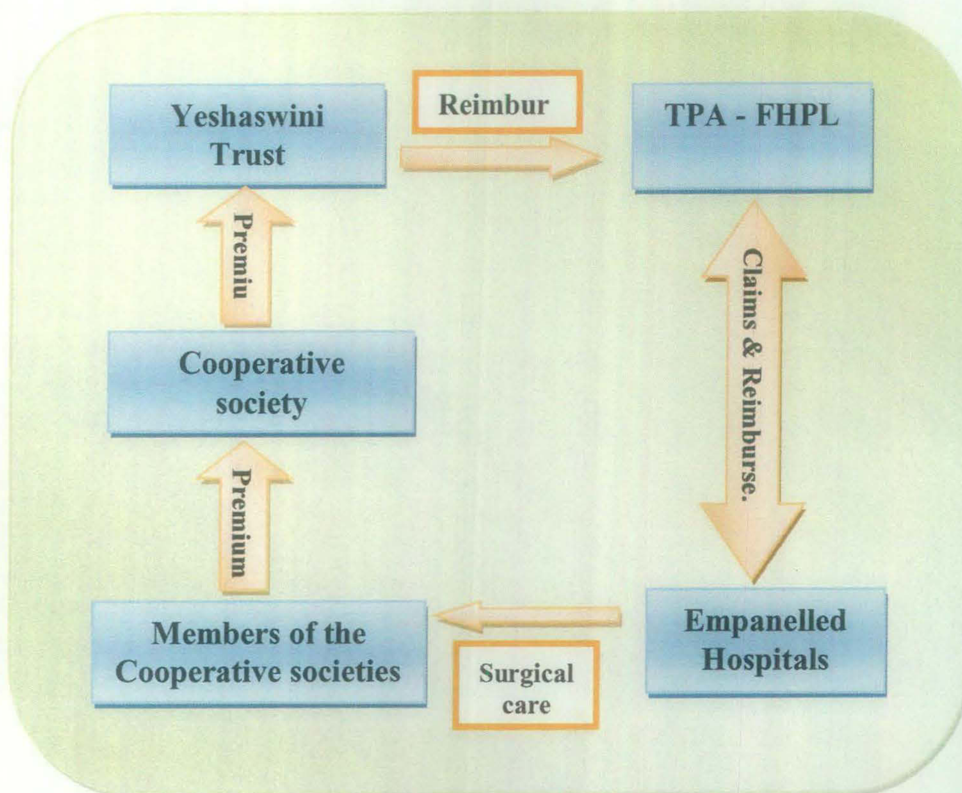
- ***Yeshaswini Medical Insurance Scheme:***

Yeshaswini medical insurance scheme is introduced in 2002 in Karnataka state and implemented in 2003. The surveys conducted by different public and private hospitals in Karnataka have found that bed occupancy rates remained low everywhere as thirty five percent and the major reason for this low bed occupancy as large numbers of people were not able to afford the medical cost. In this regard, to provide affordable health care for poor the Yeshaswini medical insurance scheme was designed with the collaboration between department of co-operatives, government of Karnataka and the Yeshaswini trust. The scheme is targeted to poor farmers who have organized into co-operatives and more than twelve million people have organized through the co-operatives. It was designed that, the collection of premium and distribution of insurance plan co-operative staffs can play an important role. The members of the co-operatives and their dependents are eligible for this scheme and it is a voluntary scheme. The age of eligibility is newborn to

seventy five years old. The annual premium for per person was increased from sixty rupees to one hundred and thirty rupees. In addition, the Government of Karnataka provided each year a subsidy directly allocated to the premium. The benefit package mainly covers high cost of catastrophic surgeries. It approves one thousand six hundred surgeries in any empanelled hospital (around hundred and fifty private hospitals aligned to this scheme) as well as out-patient care is also provided free of cost. The tariffs are fixed for each surgery. It is cashless model of medical insurance. The upper limit of the coverage is one lakh rupees for per procedure and two lakhs rupees annually for per insured person. However, this medical insurance scheme is able to cover only about 2.2 million (in 2005) people out of 20 million people who have registered in Co-operatives. This medical insurance scheme is administered by Third Party Administer (TPA) named Family Health Plan Limited (FHPL). The TPA plays an intermediate role as approving and processing of claims, managing relations with the aligned hospitals and checking the eligibility of health facility is with TPA (Radermacher, *et al* 2005; Devadasan, 2006; ILO, 2006). According to Devadasan, *et al* (2004), Yeshaswini medical insurance scheme come in second type of model, as an insurer model (Devadasan, *et al* 2004).

Yeshaswini trust is the insurer of this scheme and the unit of enrollment is the individual. The following design depicts the process of medical insurance scheme in Yeshaswini plan.

The Design of Yeshaswini Medical Insurance Scheme:



Source: (Devadasan, 2006:51).

It has been noted in a paper by Radermacher, *et al* (2005), that "In a household survey conducted by the project "Strengthening Micro Health Insurance Units for the Poor in India", fifty five percent of the interviewed insured households (N=364) did not even have a rough idea of what insurance is or how it functions (uninsured (N=354): 71 percent). Hence, dissatisfaction often arises when clients need treatment that is not covered, but which they expected to be" (Radermacher, *et al* 2005:18).

Apart from these three CBMI models there are other CBMI schemes which provide various services and benefit.

2.7 CBMI: Some Key Issues

The CBMI scheme principally evolves targeting the poor to provide financial security to them in an event of medical emergency. To make the schemes more equitable and financially viable, the CBMI generally seeks subsidies from government or from donor

agencies (Ranson, 2002). All the above three models of CBMI scheme throws a picture that these schemes are essentially evolved at targeting poor people. The CBMI schemes are diverse in terms of their design, management benefit and service provisions. Many a times it is difficult to compare these schemes as because of their diversity in nature and each scheme has their own uniqueness. Many of the CBMI schemes are implemented as a part of wider community development goal (Acharya and Ranson, 2005) such as SEWA, AAA, Kagad Kach Patra Kashtakari Panchayat etc. Some studies have shown that CBMI schemes increase utilization and access to health care (Ranson, 2002; Jakab and Krishnan, 2001; Jütting, 2003; Devadasan, *et al* 2006).

However in the context of universal health care there is a need to understand that it mostly covers only curative care that too selective hospitalization and in-patient services. In most of the CBMI scheme out-patient care is excluded. However it is a well known fact that poor people are not even able to afford the cost occurring in out-patient care which actually leads to delays in health care seeking. Moreover it does not consider indirect cost which is also one of the barriers in accessing health care for poor people. Thus, it shows that CBMI schemes are in fact not able to cover the needs of the poor people.

The governments across the world started looking at alternative health financing methods to protect the interests of the poor and ensure health service accessibility to a certain level (Saikia, 2010). This is clear indication that welfare state failed in providing public health services and to cope up with this situation government started to look alternative mechanisms and thereby subsidizing these medical insurance schemes.

The financing mechanism of the CBMI generally put the burden on the poor as poor are subsidizing for poor. Where as in the other medical insurance schemes which evolved for formal sector workers all contribute to the medical insurance scheme in order to reduce the financial risk, protection and reducing financial barrier due to high medical expenditure. In an analysis done by the Public Health Foundation of India it states that "It is a classic case of poor subsidizing the poorest and is not necessarily the most equitable. A better contributory mechanism would be if high wage earners were also included in the scheme so that cross subsidy through pooling can be carried out more effectively" (Public

Health Foundation of India, 2011: 30). It is also imperative to understand that even though the CBMI targets the poor but still the poorest of the poor remain excluded from this scheme as they are not able to afford the premium rate (Jütting, 2003).

The reimbursement scheme hardly protect poor people from indebtedness as at the point of service utilization, insured person have to pay from their pockets and its difficult to pay in the situations of high cost of hospitalization. In this regard equity becomes a major concern. Reimbursement schemes do not seem to be meant to bringing equity.

There is also a need to understand that even if any CBMI scheme gets success in terms of increasing accessibility or improving equity it does not mean that it will succeed at broader level or in a broader systemic framework (Bennett, 2004).

Summary:

The chapter discusses the historical development of medical insurance scheme and links and locates the genesis of the CBMI from the European Guild System and Friendly Societies or Mutual Aid Societies. Here it is crucial to understand that the role of the state in the financing and provisioning of the health services in different period. The history indicates that, before the entry of the state there were informal arrangements created by the people specifically by workers in financing of health care. The mutual aid societies, friendly societies, sickness funds are the examples of informal arrangements created by the workers based on the principle of solidarity. In these informal arrangements the health needs of the workers were hardly being recognized as these were mainly focused on the curative care. In these arrangements the poorest of the poor who were unable to work or unable to pay the contribution remained uncovered. However, after the Second World War the role of the state became prominent primarily into financing and provisioning of health care. The development of National Health Service System on the basis of universality and free care for all at the point of services was an important shift which was adopted by other European countries as well. However, the emergence of neoliberal policies in the 1980's has diminished the role of the state in financing and provisioning of health care all over the world. In the period of weakening public health, there is again informal type of arrangements through introduction of CBMI is being created or rather is

being forced to create for these kinds of alternative mechanisms by the poor informal workers.

Chapter Three

Research Methodology

Chapter 3

Research Methodology

This chapter discusses the methodological approach that has been adopted in this study. The topic of the current study is **'Medical Insurance for Informal Workers: An Exploratory Study of Waste Pickers in Pune Municipality'**.

3.1 Conceptualization of the problem:

Since last two decades there is increasing commercialization and weakening of public health provisioning. As a result, the cost of medical care has risen and lack of financial resources has become an important reason for not seeking care. Clearly it is those who are socially and economically marginalized who are most affected. In the industrial sector it is those who are employed in the informal sector who are getting excluded the most, since they lack work and social security.

This study is informed by Mark Holmstrom[4] and Jan Breman's[5] frame work. These two frameworks have conceptualized the relationship between social and work hierarchy. They analyzed the relationship between inequality and work hierarchy and observed that the workers in the informal sector are the one who are right at the bottom of this hierarchy. Informal sector itself is heterogeneous and can be broken down into various layers. In Mark Halmstrom work it has been shows that, people from different social-economic origins have different level of opportunities in the market place in terms of getting jobs. It has been analyzed that, the two sectors, formal and informal, interact with each other and have a constant relationship with each other. They are not totally segmented from each other rather have mutual dependence and have constant mobility among them. Jan Breman's (2010) work also shows that, informal workers are vulnerable and largely excluded from getting better work and working conditions, dignity of life and stability in social and economic life. It has observed that, the process of globalization has

[4] Holmstrom, M. (1985), *Industry And Inequality: The Social Anthropology Of Indian Labour*, Cambridge University Press, Cambridge
[5] Breman, J. (2010), *Outcaste Labour In Asia: Circulation And Informalization Of Workforce The Bottom Of The Economy*, New Delhi, Oxford University Press.

worsened the situations of these informal workers which to a large extent restrict their overall development.

It is evident that the existing social hierarchy is also reflected in the industry and in the production process. It is exploitative in nature and denies access to those at the bottom of the work pyramid to the major resources. This has a differential impact on to the health of the workers in the informal sector.

Given the fact that, informal sector workers belong to the social and economically marginalized community they do not have job security, legal and social security. In the context of rampant commercialization of medical care, the burden of expenditure due to medical care is disproportionately high among these informal sector workers. High burden of expenditure due to medical care leads first to indebtedness, second it leads to cutting back on some other essential expenditure in order to pay for medical care such as food clothing etc. The third aspect is that it leads to rationing of medical care within family. It means within family reducing medical care for some people and in this situation women are the ones who cut back on their medical needs. Several NGO's, trade unions and other organizations have initiated medical insurance schemes to address this problem or to overcome the barriers for accessing health care.

There are pluralities in insurance arrangements for providing medical care to the informal workers. This study focuses on the actors, agencies and coverage for informal waste pickers[6] in Pune Municipality. It explores the specific historical and socio-political context in which the scheme was conceived and operationalised. It examines the coverage and experiences of informal waste pickers with the scheme.

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[6] This study is on waste pickers, as one category of informal sector. The waste pickers are mostly those who belong to the Dalit and Other Backward Class who are mainly from economically poorer sections. This type of work comes under the self employed category and there is no any legal protection or no any employer-employee relationship. Waste-pickers work in appalling conditions in garbage bins on the streets and at landfill sites where garbage is dumped. They earn their livelihood by collecting scrap at dumping bins, door to door collection of garbage, segregation of scrap and selling it to the scrap traders. Traditionally this type of work has been given to the untouchable communities such as Dalits who are also socially and economically marginalized (Jayaraman, 2008).

3.2 Study Area:

This study makes an attempt to understand and explore case of waste pickers in Pune Municipality in Maharashtra and the insurance mechanism that it has adopted. In this case there is a union of these waste pickers in Pune, called Kagad Kach Patra Kashtakari Panchayat registered in 1993. The union had struggled to provide basic health services to the waste pickers who had registered with the union. The union made efforts and negotiated with the Pune Municipal Corporation (PMC) to provide medical insurance to the waste pickers, paying annual premium, since these workers are reducing the cost of PMC by cleaning up the city. In 2003, PMC started to provide medical insurance to the waste pickers by having a tie-up with the New India Assurance Company. This scheme is open to all waste pickers who have registered in the union. This study proposes to understand the process of unionization among informal waste pickers, the evolution of the medical insurance scheme and the experiences of waste pickers with the scheme in Pune Municipality.

3.3 Objectives of the Study:

Overall Objective:

- To study the role of union in promoting medical insurance scheme among informal workers, specifically among waste pickers in Pune Municipality of Maharashtra.

Specific Objective:

- To study the history of unionization among waste pickers in Pune.
- To study the evolution and working of the medical insurance scheme among the union members of the waste picker
- To study the experiences of the workers with medical insurance scheme.

3.4 Design of the Study:

Given the nature of the study, it was felt appropriate to use a qualitative research design which would capture the process of unionization, the role of the union in promoting medical insurance scheme and experiences of the waste pickers in regard to this scheme. The study has accessed both primary and secondary sources of data. The study is an

exploratory in nature. In order to achieve these objectives researcher had undertaken the in-depth interviews with the various key informants and accessed secondary data.

Specific Objectives	Primary source of data collection	Secondary source of data collection
To study the history of unionization among waste pickers	In-depth interviews of Key-informants • President of the waste pickers union, • Presidnet of the Hamal Panchyat • Faculty member of the Karve Institute of Social Services • Secretary of Mahatma Phule Samata Pratishthan	Published Reports, Micro level studies Published studies and articles
To study the evolution and working of the medical insurance scheme among the union members of the waste picker	• President of the waste pickers union, • Presidnet of the Hamal Panchyat • Faculty member of the Karve Institute of Social Services • Assistant of Solid Waste Management Department of the PMC • Administrative officer at New India Assurance Company Ltd • Community leader of waste pickers	Published Reports, Micro level studies Published studies and articles
To study the experiences of the workers with medical insurance scheme	• The members of the union (waste pickers) • one community leader of waste pickers	

Secondary sources also included reports, micro level studies, and published articles of the organization (Union of Waste Pickers Kagad Kach Patra Kashtakari Panachayat) which have been referred to and analyzed extensively during the study period. It also included

studies, published articles and reports on waste pickers, informal sector and medical insurance.

3.5 Sampling:

In this study purposive and snowball sampling methods have been used. Purposive sampling as it is the only union of informal waste pickers in Pune that has taken certain important steps for providing medical insurance for the members of the waste pickers union.

It had used snow ball sampling for conducting in-depth interviews with the waste pickers who have taken a benefit of medical insurance scheme. In this study the focus was on to understand the experiences of the waste pickers regarding medical insurance scheme, the level of care which was used by the beneficiaries such as inpatient, outpatient, the type of illness, the claim procedure and the experiences with the reimbursement. In order to understand this, the study has confined only to the waste pickers who have taken the benefit of the medical insurance scheme. Snow ball sampling method was used because, firstly, it was difficult to locate the waste pickers who have taken the benefit of medical insurance scheme in the community. It was also the fact that, very few waste pickers have taken the benefit of the scheme. Secondly, there was no any list of members available who have taken the benefit of the scheme. There was lack of support from the union to the present study, so to get the list of members who have taken the benefit of the scheme became difficult task for researcher. This is reimbursement scheme, so there was no any possibility of getting list of members from the provider. Thirdly, the residents of the community were from different background and were working in different occupations. So in this context finding out the waste pickers and that too the waste pickers who had taken the benefit of medical insurance scheme were difficult task for the researcher. Therefore researcher had decided to enter into community and find out the waste pickers who have taken the benefit of the scheme with the help of snow ball sampling method.

The researcher had collected data from two communities i.e. Patil Estate and Ramtakedi in Pune. These two communities had been selected purposively according to researcher's convenience. The researcher had decided to collect data from ten individual waste pickers

(who were taken the benefit of the medical insurance scheme), from one community (six individuals from Patil Estate community); but due to inconvenience in getting the required number of respondents from one community, the researcher had to collect data from four individuals in (Ramtakedi) community also. The number of respondents was confined to ten keeping in consideration the availability of time.

3.6 Methods and Tools of Data Collection:

In this study, ten in-depth interviews were conducted with the help of **in-depth interview guideline.** These in-depth interviews were conducted primarily to understand the experiences of waste pickers regarding medical insurance. It included their socio-economic background, their working conditions, their health problems and institutional treatment seeking behaviour, their experiences of hospitalization for which they have taken the benefit of the medical insurance scheme, the experiences of claim procedure and reimbursement of medical insurance scheme. It also tried to understand their experiences with the trade union.

The other interviews were conducted with the key informants as it has stated in the above table. All these key informants had initiated or participated directly or indirectly in the formation of the union of waste pickers in Pune. To understand the process of unionization and the role of the union in promoting medical insurance scheme, it was necessary to conduct the interviews with these key informants.

3.7Approaching the Community:

Initially the researcher faced a lot of problems while collecting data. The major problem was acceptance by the waste pickers. Second was the fear, they felt that, I am not from the union and that I came from government and would take away their work.

In approaching Patil Estate community, in initial period, researcher took the help of one colleague who had worked with the waste pickers. Later on researcher collected data through the help of one community leader of the waste picker. For data collection in Ramtakedi community the researcher took the help of the "Deepgriha Society" [7] (Non

[7] 'Deepgriha Society' is a Non Government Organisation working the Ramtakedi community in Pune.

Governmental Organization). It was difficult to collect data in the Ramtakedi community because the acceptance from the respondents was a major barrier that was faced by the researcher. Moreover this community is known to be unsafe for women to work in. Therefore, the researcher took the help of the field work staff of the Deepgriha Society to initiate contact with the community.

3.8 Data Analysis:

In this study, all in-depth interviews were recorded with the consent of the respondents. The in-depth interviews were transcribed and translated from Marathi to English language. Based on these translations, narrative analysis has been done.

3.9 Limitations:

The study was conducted with ten waste pickers that too, it was only confined to waste pickers who had taken the benefit of the medical insurance scheme. More aspects could have been explored if the researcher could have included the waste pickers who had rejected the benefit of the scheme. Their experiences regarding this particular medical insurance scheme could have been different. Finding out the waste pickers in the community who had rejected the benefit of the scheme itself was such a difficult task, as well as time period was very short. Therefore the study could not include the waste pickers who had rejected the benefit of the scheme.

It is also difficult to generalize the findings to overall experiences of the waste pickers with this particular medical insurance scheme because it was only confined to ten waste pickers who had taken the benefit of the scheme.

The researcher also felt that this study could have included more detailed interaction with social activists of this trade union who had taken the chief initiative for organizing the informal waste pickers in Pune. It would have been helped to understand the process of unionization and the role of the union in promoting medical insurance scheme more thoroughly.

Chapter Four

Role of Union in Promoting Medical Insurance for Waste Pickers in Pune Municipality

Chapter-4

Role of Union in Promoting Medical Insurance for Waste Pickers in Pune Municipality

This chapter deals with the medical insurance scheme for waste pickers that was started by their union. It takes into consideration the history of union and background of the leaders in order to contextualize the role of the union in promoting medical insurance. It further explores the role that the union played in negotiating and making state accountable through the Pune Municipal Corporation for providing basic facility of medical insurance to the waste pickers. The chapter discusses the main actors involved in the promotion of medical insurance scheme and also gives a detailed outline of different components of the medical insurance scheme.

4.1 Waste Picker as a Category of Informal Sector:

Across cities and more so in developing countries millions of people are dependent on the collection and sale of waste for their survival and livelihood. Waste pickers belong to the bottom of hierarchy of waste collection and even rank lowest in the urban informal economy (GOI, 2002). The push factor poverty forces waste picker to engage in this type of work and they are invisible from the mainstream society and economy (Medina, 2005). Their work is considered as "dirty" and thereby looked down upon. Waste pickers' experience shows that they are exploited and discriminated by the society and by the authorities such as police, guards. Samson (2009) observed that "they are frequently ignored within public policy processes and harassed and persecuted by authorities" (Samson, 2009). According to Medina, "the World Bank estimates that one percent of the world's population, or fifteen million people, earn their livelihood from these activities" (Medina, 2007 as cited in Samson, 2009).

In India, more than fifteen lakhs people work as scrap or waste collectors. They earn their livelihood from the collection and sale of plastic, waste paper, metal, glass scrap etc. to the recycling industries (Alliance of Indian Waste Pickers, 2010).

A description of the various tasks undertaken by them has been summarized by Kuria and Muasya who observed that "Waste pickers collect and dispose of waste by collecting, using and selling reusable or recyclable materials, and disposing of what they cannot sell in a variety of ways. Waste is collected from houses, restaurants, hotels, markets and streets. Waste pickers are paid directly by their clients and also make money from sales of recyclables and other items. Waste pickers can be street dwellers (homeless), youths or families. They may work as individuals, or be organized as self-help groups (SHGs), community-based organizations (CBOs), Non Governmental Organizations (NGOs), networks, associations or cooperatives" (Kuria and Muasya, 2010:3).

Most of the studies have observed that waste pickers belong to the marginalized and vulnerable sections of the society mostly as poor people, women, children, and migrants. They live in precarious conditions of urban slums. The literacy level is very low among these waste pickers. For example in India they belong to the untouchable castes as Dalit and among the Dalit this task has been done by the "*Mang*" and "*Mahar*" Communities. Along with hostile social status the living and extremely hazardous working conditions exposes them to multiple and constant health risks to waste pickers (Wilson, *et al* 2006, Cointreau, 2006, Sarkar, 2003, Chikarmane and Narayan, 2005, Hayami, *et al* 2003, Hunt, 1996).

Organizing waste pickers at country level and as well as international level can strengthen their voices being heard and strengthen their bargaining power with the government and with the industry. It is also being realized that it can increase the economic stability and remove the illegalities associated with this work (Medina, 2008). In India, SEWA (Gujarat) was formed as a union of women working in the informal economy in 1972. It has taken great efforts in organizing and mobilizing women around issues that are concern them. SEWA organized different numbers of workers working in different informal sector such as street vendors, midwives, weavers, handicrafts etc. and it also includes organizing waste pickers. This is the foremost initiative taken by the SEWA in India since 1970 started organizing these workers into union. The SEWA have more than million members and among these waste picker members are approximately 2.5 percent of the entire strength of SEWA (Samson, 2009). The similar efforts of

organizing waste pickers into union have taken in Pune in 1993. SEWA have included all other informal workers however the union in Pune have only confined to waste pickers because there were already efforts being made to unionize the head load workers (Hamal Panchyat), auto drivers, domestic workers etc. led by Dr. Baba Adhav (Veteran union leader of informal workers in Pune) (Chikarmane and Narayan, 2005) The efforts in Pune might have taken the inspiration from the SEWA as it was the leading initiative of formulating union of informal sector workers in India.

4.2 The History of Unionization among Waste Pickers in Pune:

It is well known that the activity of organizing workers into union specifically belongs to the formal sector workers. On the other hand, it is a challenge to organize informal sector workers because of the scattered nature of work and absence of employer employee relationship. However there have been initiatives to organize the informal sector workers into unions. The case of waste pickers' union in Pune is a successful example of organizing informal workers. The important feature of this union is to make the state accountable for providing basic services to the informal workers. The waste pickers' union has struggled to improve the working conditions of the waste picker. Firstly the initiative was taken to recognize the waste pickers as workers and in regard to this, union negotiated with the Pune Municipal Corporation to provide authorized identity cards to the members of the waste pickers union. The other initiative was taken to reduce the work burden of the waste pickers through source segregation of waste. It also made efforts for door to door collection of segregated waste which enhanced the value of scrap and increased the economic security of workers. Campaigning for education among the waste pickers for their children was one of the main agenda in the union. Certainly the main concern was waste pickers children should not do the same task as their parents do. In all these initiatives one of the initiative was to provide medical insurance for the members of waste pickers union. After several efforts the union succeeded in negotiating with the Pune Municipal Corporation to provide medical insurance for its members. All these initiatives and efforts have been discussed in detail in this chapter. However it is important to understand the initiatives undertaken for the formation of union and the role played by the various actors in promoting and enhancement of the waste pickers'

livelihoods and their overall situation. It believes that only organized workers can bring changes in their conditions through collective actions so, it is necessary specifically, for informal workers to organize (Chikarmane and Narayan, 2005).

4.3 Initiatives for Formation of Union:

There have been efforts to organize the waste pickers during the 1990s. The initiatives to organize these workers into union have been taken by people from three varied streams of the society. These people were major actors in the formation of union consisting of historical conjecture and belonging to different ideological perspectives came together for the formation of waste pickers union in the period of 1990.

- **Poornima Chikarmane and Lakshmi Narayan**
- **Mr. Mohan Nanavare**
- **Dr. Baba Adhavs**

Poornima Chikarmane and Lakshmi Narayan were employees of the SNDT Women's University in Pune. They had taken certain initiatives for the formation of union of waste pickers under the project called "Empowerment of Waste Pickers" which was started by the SNDT Women University. These two social activists were trained in social work from Nirmala Niketan and Tata Institute of Social Science in Mumbai respectively[8]. Poornima Chikarmane has also specialized in Gender and Development Studies at the Institute of Development Studies in Sussex[9]. She is actively involved in the women's movement in Maharashtra and associated with the "Stree Mukti Andolan Sampark Samiti" which is a network of women's organizations for the protection of women against domestic violence and abuse. She is also an active supporter of women's political parties, like Janwadi Mahila Sanghatana which is a wing of All India Democratic Women's Association (AIDWA)[10]

[8] Rao, N. (2011), Faculty of The Karve Institute Of Social Service, Pune, Interview conducted on 9 th April, 2011
[9] This.is participants information given at 4th Annual Global Development Conference, as available on http://depot.gdnet.org/gdnshare/pdf/GDNConferenceParticipants.pdf as accessed on 14th May 2011
[10] Rao, N. (2011), ibid

Mr. Mohan Nanavare is the son of a waste picker and has been educated till 8th standard. He was one of the leaders of the Dalit Swayamsevak Sangh[11] and has played an important role in organizing the informal workers (waste pickers) into union. He has closely worked with sociologist ideologist of Dr. Baba Adhav and Bhai Vaidya and participated in the various social movement led by Dr. Baba Adhav such as "Devdasi Pratha Nirmulan" "Ek Goa Ek Panthvatha". Presently, Mr. Nanavare has completely devoted his life to the waste pickers union and taking upfront the issues of waste pickers[12].

The role of Dr. Baba Adhav in supporting the formation of waste pickers union is also important to understand because he has made a significant contribution in organizing most of the informal workers into a union in Pune. Dr. Baba Adhav is one of the veteran socialist leaders of Maharashtra and actively participated in social movements. In early periods of 1955 to 1971 he worked with the Socialist Party of India. He quit active politics in 1971 due to some differences in the decision making process in the party regarding electoral alliances with other parties (Deshpande, 1989:12). In 1955 he formed the union of head load workers called Hamal Panchyat[13] in Pune. He also organized other informal workers into union such as auto drivers, domestic workers, construction workers, vegetable and fruit vendors ('Pathari' Panchyat), mine workers (Deshpande, 1999, Malekar, 2008, Kalbere, 2009, Vaidya, 2009)[14].

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[11] Dalit Swayamsevak Sangh is an organization that is working on Dalit issues in Pune, since 1977.

[12] Nanavare, M.(2011), President of Kagad Kach Patra Kashtakari Panchayat, Interview conducted on 4th April 2011

[13] Hamal Panchyat is union of load carriers/coolie's in Pune started in 1955 under the leadership of Dr. Baba Adhav. The most of the Hamal's were migrated from the Western Maharashtra specifically from Marathwada region which is a known to be a drought area. Most of the Hamal's belongs to the Maratha community. The Migrated Hamal's started working on contract on daily basis and the contract was between trader and hamal. The hamal's had to work in extreme physical labour and heavy work load along with carrying a variety of tasks and without any social security. Dr. Baba Adhav has implemented the welfare schemes into Mathadi Act of Hamal's in Pune.

[14] Nanavare, M.(2011), ibid

All these social activists who were influenced by different shades of leftist ideology came together and complimented each other for the formation of waste pickers union in Pune in 1993. The waste pickers union was named "Kagad Kach Patra Kashtakari Panchayat"[15]

- ***History of the Union:***

In 1990, before the formation of the official union of waste pickers efforts were made by Poornima Chikarmane and Lakshmi Narayan. Both of them worked in Adult Education Programme in SNDT Women's University, Pune. They came into close contact with waste pickers through the implementation of National Adult Educational Programme. It was a project called "Empowerment of Waste Picker" under which small honorariums were given to those who were working on the project (Tamara, 2010). Working with the waste pickers' children the social activists identified that the waste picker's situation is more vulnerable as they have to work for a long period of time and in extremely miserable working conditions. Many waste pickers were taking their children for waste collection to support the family income. Waste pickers were subjected to many forms of discrimination as part of their work. Considering the prevailing situation, campaigning for education was seen as an important way for improving the conditions of waste pickers' situations and their families. This led them to realize that the segregation of waste at source will be helpful for waste pickers as well as their children. This would help to reduce their working hours and allow their children to take advantage of education. This led to the issuing of identity cards by the SNDT Women's University to about thirty waste pickers for source segregation in elite neighborhood societies. This was the first initiative taken by the activists under the project. This initiative was described as successful as noted in a case study done by the social activists Chikarmane and Narayan that "the earnings improved dramatically because source segregated scrap fetched better rates, reduced their hours of work and improved the actual physical conditions of their work" (Chikarmane and Narayan, 2005:1). This intervention enabled the activists to elucidate the importance of source segregation for improving the working conditions of the waste pickers. It also helped to increase their economic security. Further, it was a more hygienic way compared to collecting waste from the garbage bins

[15]ibid

and moving from road to road in search of waste. The other important thing is that the participation of communities into the process of waste segregation increased the value of work done by the waste pickers. This led to the thinking of mobilization of waste pickers to form a union (Tamara, 2010).

The other important incident that led the activist towards mobilization and formation of union was the entry of private entrepreneurs into the field of source segregation. After six months of implementation of source segregation activity, one private entrepreneur started to provide service of door step collection of waste from the households by charging fees. The people utilized the service because they were unhappy with the municipality's work of waste collection. This had a direct effect on the livelihoods of the waste pickers. The activists with the waste pickers struggled and protested against this activity to the private entrepreneur as well as to the citizens. The 'Bin Chipko Andolan' held in this regard had a great impact as the private entrepreneurs withdrew from this activity. This experience was a lesson for the waste pickers as they became conscious that such situations can recur in future. It was also realized that the small groups could not fight for risks in future. Organizing waste pickers on a large scale thus came up as an important agenda in struggle for their rights in a collective manner (Chikarmane and Narayan, 2005). This became the basis for organizing the waste pickers into unions. These initiatives taken by the activists strengthened the trust among the waste pickers to come together in order to fight for their own interests and rights.

At the same time, initiative was taken by Mr. Nanvare, who was a leader of the Dalit Swayamsevak Sangh also started a similar initiative. Mr. Nanavare had himself worked as a waste picker collecting waste along with his mother as a child. It was the close contact with veteran union leader of the Hamal Panchyat Dr. Baba Adhav that led him to take active participation in the social issues. The social exploitation and humiliation of waste pickers by the police, by the citizens and by the scrap traders led Mr. Nanavare to think about organizing the waste pickers into a union. He had experienced how it was to be cheated by the scrap traders. Often scrap traders underpaid and cheated the waste pickers. Mr. Nanavare was aware that most of the waste pickers are women and belong to the Dalit communities. So these women were the most marginalized among the

marginalized sections. After long discussions with Dr. Baba Adhav, he put forward the idea of organizing waste pickers into a union. Dr. Baba Adhav had always been supportive for the formation of unions of informal workers as he himself recognized the importance of unions in changing life of the informal workers[16].

The social activists of SNDT Women's University also approached Dr. Baba Adhav to put forward the idea of formation of union of waste pickers[17]. Thus, the social activists of SNDT Women's University and Mr. Nanavare came together for organizing waste pickers on a mass scale. In order to materialize the idea of organizing waste pickers, the members of the Dalit Swayamsevak Sangh and Mr. Nanavare moved around the slums in Pune mobilizing the waste pickers[18]. The process of mobilizing waste pickers was also done by the activists and the thirty women simultaneously who had an experience of collective action. This forced the private entrepreneurs to withdraw from this domain of work. The waste pickers were already experiencing difficulties of harassment by the authorities such as police, humiliation and discrimination by society, health and safety problems. All this led them to think about the organization. The realization was that their working conditions can be changed by collective actions. They realized that the benefit of improving the value of their work and more specifically its recognition as 'work' boosted the process. The whole process was premised on the belief that 'scrap collection was socially relevant, economically productive and environmentally beneficial "work"(Chikarmane and Narayan, 2005:3). The hope that waste pickers themselves can make changes in their working life through collective action can make the state accountable became an inspiring thought for the mobilization of waste pickers on a mass scale.

- ***Formation of Union of Waste Pickers:***

Finally a Convention of Waste Pickers took place in May 1993 under the guidance and leadership of Dr. Baba Adhav. The process of mobilization became fruitful as around 800

[16] ibid
[17] Dr. Baba Adhav, (2011), President of Hamal Panchyat Union, Pune, Interview conducted on 12th April 2011
[18] ibid

waste pickers attended the convention. The membership of the union has now increased to around 6000 waste pickers. The basic principles and its organizational structure were decided at this convention. The major objectives and principles have been described by Chikarmane and Narayan (2005:4) as follow.

- "The Kagad Kach Patra Kashtakari Panchayat (KKPKP) (organization of scrap collectors) would be set up as a registered trade union to represent the collective identity and interests of scrap collectors.
- Members would pay an annual fee to support the running of the organization.
- Men and women working as scrap collectors would be eligible to become members irrespective of caste, region and religious affiliation.
- The organization would not only address the immediate/sectoral needs of members but also be a part of the larger struggle against injustice and exploitation, for a socially just, equitable and humane society.
- The organization would adopt non violent methods of resistance and "satyagraha" to challenge systemic injustice" (Chikarmane and Narayan, 2005:4).

- ***Organizational Structure:***

As already mentioned, the organizational structure was decided in the convention itself. Mr. Nanavare the son of the waste picker and Lakshmi Narayan were chosen the president and general secretary of the KKPKP respectively. Surekha Gade and Rajiv Dade who were waste pickers were chosen as Joint Secretary and Treasurer respectively. The governing body had eleven members and all were waste pickers [19]. After the formation of the union, representatives from waste pickers across city were elected for the process of decision making, for planning and to discuss the issues important for waste pickers' working conditions. These members were elected informally by members of the waste pickers union (Chikarmane and Narayan, 2005).

[19] Nanavare, M.(2011), ibid

4.4 Union's Achievements:

- *Issuing Authorized Identity Cards:*

For the recognition of waste pickers as "workers" and waste picking as "work" by the municipality, the union struggled for the demand of authorized identity cards to waste pickers. Through the process of series of protest demonstrations, public rallies, posters and pamphlets, union demanded for the authorized identity cards in 1993. This process resulted in issuing of identity cards by the municipality in the year 1996 after three years of constant struggle with the Pune Municipality. In this struggle, thousands of waste pickers participated for the issue of their own identity. As Mr. Nanavare in his interview said that *"our first struggle was to demand for identity cards. The Pune Municipal Corporation had to give the identity card because it was clear that waste pickers reduce the work burden of the municipality by collecting waste across city. The collection of waste and its disposal is supposed to be done by the municipality however most of the informal waste pickers in urban areas are doing this work and surviving on this type of work thus reducing the work burden of the municipality"*[20].

"The Pune Municipal and Pimpri Chinchwad Municipal Corporations conceded to the demand in 1995-1996 and became the first municipalities in the country to officially register (through the KKPKP) and endorse the identity cards of waste-pickers in recognition of their contribution to the management of urban solid waste" (Chikarmane and Narayan, 2005:14).

The terms of the issuing ID cards are that, this is only for the purpose of identification of waste picker as a worker. The ID cards endorsed by the PMC has no legal basis and these ID cards were prohibited for the children below the age of 18 years (SNDT and Chintan, 2008).

This initiative indeed changed the situations of work and increased the security, as waste pickers themselves said[21],

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[20] ibid

[21] Interviews conducted with the waste pickers in the month of December and January 2010- 2011, Pune

"………that time[22] we were facing problems like when we were going out to collect scrap, auto walas, Police, and other people were going to harassed us" (Kamal, 45 year old Waste Picker, Ramtakedi, Pune, 2011).

"……previously the people's attitude towards us was very bad. They used to call us "ye Kachara wala", ye Kachara wali bai" etc. (hey you waste picker man, hey you waste picker women). They were giving us very low status and low standard, while talking with us. So now there is a difference after we got the identity card. Now if anybody would ask us or see us suspiciously then we can show them our ID card. Now, even Police also do not harass us or is no more threat to us. Now people are afraid to talk to us badly because they know that we are united and we have union. So they became aware that they also have some responsibility so now they talk to us in proper manner" (Sitaram, 35 year old Waste Picker, Patil Estate, 2010).

This innovation helped to change the image of waste picker among themselves as well as in the society. They were able to use their ID cards for a number of reasons such as to rescue from the police if they were arrested on grounds of suspicion, sometimes for space to segregate the collected waste and so on (Chikarmane and Narayan, 2005:14). This was the first step to build relationship with the PMC and to make state accountable through the issuing of authorized ID cards[23] .

- ***Waste Segregation at Source and Doorstep Collection of Waste:***

The important initiative taken by the union was segregation of waste at source and door to door collection of waste. It was seen as the way forward for improving livelihoods of waste pickers (SNDT and Chintan, 2008). It has been noticed that door to door collection is a provision of service to the citizens. "It enhances the value of scrap, reduces the time required for collection and the health hazards involved in handling garbage" (Chikarmane and Narayan, 2000:3641). Campaign took place for the segregation of waste and door to door collection with the support of the PMC. To interact and to establish link between citizens, the administration, and the councilors, the ward co-coordinators were appointed.

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[22] Before issuing the authorized identity cards
[23] Nanavare, M. (2011), ibid

PMC agreed for the provision of infrastructural support to the waste pickers. This programme was started as integration of waste pickers into the urban solid waste management in PMC (SNDT and Chintan, 2008). In the system of doorstep collection, waste pickers collect the segregated scrap which is in the form of organic and recyclable waste. Organic scrap is deposited in public garbage bins or in vermiculture pit. The trolley is being provided by the PMC for this activity. Each household is supposed to pay 10 Rs. per month to the waste picker for the provision of this service. Around 300 waste pickers are benefiting from this type of work by covering 25, 000 households across city (Chikarmane and Narayan, 2000). It is important to note that only because of strong union of waste pickers, PMC could not do away the contract based system of urban solid waste to the private sector which in turn would have been affected the livelihoods of waste pickers.

- ***Promotion of Education Among The Children of The Waste Picker:***

Educational promotion among the waste pickers' children has always been a core agenda of the union. Initially the efforts were for non formal education of the children who are not attending school, but later the efforts reinforced the enrollment of the children in schools. One respondent have said that, *"there were problems in the school enrollment of the children such as lack of birth certificate. Many times children were not interested in going to school because teacher used to call them 'dirty' boy" (Ganabai, 40 year old Waste Picker, Patil Estate, Pune, 2010).* The union helped out in times of these problems by negotiating with the government departments and sensitizing the schools to abolish these kinds of discrimination. The union struggled for claiming for Pre-Matric scholarships for the waste pickers' children to the state. Media also played a powerful role in pushing this demand further in order to get acceptance by the state. Earlier this scholarship was only for children of night soil careers. "In 2001, the Maharashtra government conceded to demand that the municipal endorsed Id card constituted proof of "unclean occupation" and extended the benefits of the Scheme to the children of waste-pickers" (Chikarmane and Narayan, 2005:15). Many waste pickers are now taking the benefit of this scheme. Tuition fee support and loans without any interest for the higher education is given by the union for the children of waste pickers. Some respondents have

said that their children get notebook and books by the union. Also one respondent said that "her girl child got 5000 rupees after she passed her matric exam" (Waste Picker, 2010, Patil Estate in Pune). This is the way in which the union is actually promoting education among the waste pickers' children for the major concern that their children should not do waste picking work as their parents do. It is a fact that this occupation has low status and concentrated among specific caste communities and this cycle needs to be abolished. Promoting education is therefore the progressive steps taken by the union[24].

Eliminating child labour and early child marriages among waste pickers community was also one of the imminent strategy of the union. The studies have revealed (Chikarmane, Narayan and Phadnis, 1995 and Chikarmane, Deshpande and Narayan, 2001) that there has been a significant reduction (76 percent) in the number of child waste-pickers (Cited in Chikarmane and Narayan, 2005). In an interview with Nagmani (2011), (Faculty of Karve Institute of Social Service in Pune), she also supported the argument that there was a reduction in the child waste picker. This was supported by an investigation on child waste picker done by two students, who found that the practice had reduced among children. In this definitely union consorted efforts have impacted in a positive manner[25].

- ***Medical Insurance***

The extremely hazardous working condition of waste pickers exposes them to many health related problems and this vulnerability increases due to poverty and lack of access to resources. Many a times, waste pickers cannot afford the cost of the treatment. To deal this problem, the union argued with the PMC that it is the prime responsibility of the PMC to protect the marginalized sections of society and waste pickers are among the most marginalized sections of society. The other argument put forward by the union is that the Municipality is benefited financially from the waste pickers work as they are collecting recyclable material from the garbage thereby reducing the transport and disposal cost. Based on these arguments the union demanded from the PMC for the provision of medical insurance to all registered waste pickers. After a series of fights in 2002-03 PMC agreed to provide the medical insurance to the waste picker (Nanavare,

[24]ibid
[25] Rao, N. (2011), ibid

2011[26], Samson, 2009). (This scheme is explained in detail in this chapter in the next sections)

The union has taken up many initiatives for the up gradation and enhancement of livelihoods of the waste pickers. For instance, creating savings and credit cooperative for members in 1997 are a few initiatives taken up by the union. Members of the union also created their own scrap shop co-operative for getting better prices for their scrap (Chikarmane and Narayan, 2000).

The Union actively took part at national and international levels of organizations as "it recognizes that social reality and change involve a complex interplay of social, economic, political and cultural factors" (Chikarmane and Narayan, 2005:39). It has alliances with the, "Alliance of Indian Waste Pickers" (AIW) which is a national network of 35 organizations focusing on the issues of informal sector and waste picker for peer support, policy advocacy and cross learning. The other is "Committee for Asian Women" (CAW), a network of women groups in 14 Asian countries working on the issue of empowerment of women workers to protect, advocate, and advance their rights. The union is also involved with an international network of Women in Informal Employment: Globalizing and Organizing (WIEGO) which is a global policy research network working with poor women workers in the informal economy. Thus broadening the network across countries seemed to be important for understanding different approaches used across countries for the upliftment of the waste pickers and to improve the recyclable strategy.

4.5 Background of the Union Leaders:

- ***Veteran Union Leader Dr. Baba Adhav:***

Dr. Baba Adhav is now eighty years old. He was born and brought up in the heart of the market place of Pune while watching the daily sweat of the Hamal (Load Carriers). His father died when he was just one and a half years old. His father was a businessman but due to economic depression in 1929 his business collapsed and after his death Dr. Baba Adhav and his family were living at his grandmother's place in Pune. Dr. Baba Adhav's

[26] Nanavare, M. (2011), ibid

grandfather actively participated in "Saytya-Shodhak Movement" led by Mahatma Joytiba Phule. Dr. Baba Adhav never became a businessman like his father but was influenced by the Saytya-Shodhak Movement and the roots of his Saytya-Shodhak thought can be traced back to his childhood. He was brought up under the guidance of his grandfather

Dr. Baba Adhav completed his B.Sc. in chemical science and at the same time he completed his D.A.S.F medical degree at the Ayurvedic College. Bhai Vaidya was his classmate at the time of high school. After completing his medical degree he practiced as a doctor for some years. Dr. Baba Adhav developed his thinking process in the "Rashtra Sewa Dal" as he was a regular member of the Rashtra Sewa Dal for several years. The close contact with socialist ideologies of S. M. Joshi, Bhai Vaidya, N.G. Gore, Dr. Ram Monahar Lohiya etc. had a great impact on Dr. Baba Adhav. During 1955 to 1971, he actively participated in different social movements, participated and led many Andolans and struggled for the marginalized sections of the society. Under the influence of S. M. Joshi and Bhai Vaidya, he joined the Socialist Party of India. He was a councilor of Pune Municipal Corporation for 10 years (Kalbere, 2009, Vaidya, 2009). However, due to some reasons such as decision making process in the party, different levels of negotiations with other parties at the time of elections, the party workers were not so keen towards the issues of vulnerable and marginalized sections of the society. Due to all these reasons he quit the politics in 1971 (Deshpande, 1989:12).

The centre of the movement of Dr. Baba Adhav is establishment of the trade union of Hamal Panchyat in 1955. Dr. Baba Adhav recognized that the working conditions of Hamal were extremely bad and exploitative in nature. 'On November 19, 1956, the Hamal Panchayat in Pune struck work for the first time over the issue of denial of wage hikes by jaggery merchants to hamals. The four-day strike was a success, and the porters realized the power of the trade union. In 1962, the Hamal Panchayat sought a law to protect the rights of the unorganized porters. It was a long struggle till the Maharashtra Mathadi, Hamal and other Manual Workers (Regulation of Employment and Welfare) Act was passed in 1969' (Malekar, 2008). Baba have not only focused on organizing Hamals but also struggled to organize the Rikshwa (auto) drivers union, domestic

workers union, waste pickers union, construction workers union, the 'Tampo' Panchyat (the auto drivers which carries the heavy loads of material) 'Pathari' Panchyat (workers who sell vegetables and fruits) Mine workers union etc. Apart from this work he has also taken great efforts for the rehabilitation of slum dwellers, rehabilitation of the residents who have affected in dam projects. He actively participated for the acts to be passed against this injustice. Baba put all his efforts for the annihilation of 'Devdasi' Pratha as well as the movement of 'Ek Goa Ek Panvatha' which is a fight for the access of drinking water for the lower caste communities (Deshpande, 1989).

A detailed case study of Hamal Panchayat done by Deshpande states that, "Apart from his efforts at mobilizing the unorganized workers, Adhav has been leading a number of social movements targeting caste, class and gender inequalities. He has contributed a great deal in developing Phule's anti-caste discourse". 'All efforts of mobilization initiated by Adhav simultaneously focused on the caste-class gender injustice' (Deshpande, 1999: L-25).

Dr. Baba Adhav said in his interview that *"I am a socialist person and highly influenced by the thoughts of Mahatma Phule and Dr. Babasaheb Ambedkar. I believe that union is the most influential way and has great strength to fight for the rights of the workers specifically for those workers who are working in the informal sector because these are the most neglected and marginalized workers and victims of the recent globalization process"*[27].

- ***Social Activist Poornima Chikarmane:***

Poornima Chikarmane belongs to Mumbai and completed her educational career in Mumbai. She has a Masters in Social Work from Nirmala Niketan, Mumbai. During educational career she became more inclusive and sensitive towards women's issues[28]. After completing her academic career, she associated herself with various women's and worker groups[29].

[27] Baba Adhav, (2011), ibid
[28] Rao, N. (2011), ibid
[29] ibid

In Pune, she is working with the Department of Adult and Continuing Education, SNDT Women's University. She started working with the women issues at grass-root level in Pune slums for the upliftment of the women. The initiatives were mainly to raise the socio-economic status of disadvantaged women. The main agenda of this association was to organize women and to assert for economic rights through income generation activity. Later on they realized that along with economic rights there are other issues which determine the conditions of women, such as child labour, illiteracy. There was a commitment that, the extension education should benefit community so few years they were trying to focus on the educational campaigning and empowerment of the women.

However while working on women's issues, she realized the limitations of the income generation activity implementation at the NGO level. She also realized that market competition and various small activities were not going to sustain or change the women workers situation and it was realized that in way it is adding to the chain of exploitation of the workers. Larger questions about weather their activities were making a difference to society at large and if at all, what was its nature. This questioning started in the period of 1989 and 1990. By this time, she started working with campaign against child labour and got involved in the network of Child Rights Actions. In this situation, she started looking critically at her own interventions in the community and realized that there is a huge section in the slums working in informal sector. Also, within informal sector, there is large chunk of waste pickers who are most marginalized and vulnerable and belong to unorganized sector. The other large section of the informal worker was domestic workers. However they had their own union. It was this process of introspection and critique of her past work which led her to think about the organization of waste pickers and simultaneously took up project for the Empowerment of Women Waste-Pickers. This project also promoted and nurtured the formation of the union of these waste pickers. Later, she approached Dr Baba Adhav as he was the union leader of the informal workers in Pune. Her sensitivity towards Dalits developed after working with the Waste Pickers and the Dalit perspective came through the experience of working with waste pickers[30]. She was central in the formation of union as there was genuine concern about the women

[30] ibid

workers and this concern was built through her own work experience. Right now she is Assistant Director of the Department of Adult and Continuing Education, SNDT Women's University. Her current work focuses on gender issues, informal labor, child labor, and marginalized groups. She is a member of the International Advisory Board for the Indian Journal of Social Work[31].

- ***Social Activists Lakshumi Narayan***

Lakshmi Narayn was born in Kerela[32]. She grew up in Pune as her parents settled down in Pune. Her educational career was shaped in Pune and Mumbai. She completed her bachelor's degree from Ferguson College in Pune and then shifted to Mumbai for completion of Masters Degree in Social Work from Tata Institute of Social Science (TISS). After passing out from TISS in 1989, she joined the Department of Adult and Continuing Education, SNDT Women's University in Pune. Right from the beginning, she has been involved in the project of Empowerment of Women Waste-Pickers. Working with Poornima she was also genuinely involved in the process of organizing the waste pickers and became general secretary of the union.[33]

4.6 Promotion of Medical Insurance Scheme by the Union:

Waste pickers are from the poor socio-economic background and hence are subjected to many forms of health hazards. Most of the times waste picker's compromise to their dignity and health because of precarious working conditions. "The harsh conditions of work are offset by the fact they often have more freedom in comparison with wage employment and a greater degree of control over their earnings. Waste pickers are economically marginalized and sometimes belong to the most socially excluded groups in their respective countries such as the Dalits in India" (Chikarmane and Narayan 2009).

A literature review done by Cointreau, (2006) of studies conducted in USA, Denmark, Switzerland, Italy, India, Romania with a viable appropriate control group on the

[31] This is participants information given at 4th Annual Global Development Conference, as available on http://depot.gdnet.org/gdnshare/pdf/GDNConferenceParticipants.pdf as accessed on 14th May 2011
[32] Nanavare, M. (2011), ibid
[33] Rao, N. (2011), ibid

occupational health risks in solid waste management shows that people engaged in waste collection and management report that

- "Back and joint injuries from lifting heavy waste-filled containers and driving heavy landfill and loading equipment.
- Respiratory illness from ingesting particulates, bio-aerosols, and volatile organics during waste collection, and from working in smoky and dusty conditions at open dumps.
- Infections from direct contact with contaminated material, dog and rodent bites, or eating of waste-fed animals.
- Puncture wounds leading to tetanus, hepatitis, and HIV infection.
- Injuries at dumps due to surface subsidence, underground fires, and slides.
- Headaches and nausea from anoxic conditions where disposal sites have high methane carbon dioxide, and carbon monoxide concentrations.
- Lead poisoning from burning of materials with lead-containing batteries, paints, and solders" (Cointreau, 2006:10).

In another study in Mexico City it was observed that 'Mexico City dumpsite waste pickers have a life expectancy of thirty nine years, while the general population's is sixty seven years' (Castillo, *et al* 1990 cited in Medina, 2005:9).

A 10 week small scale study done in Vietnam by Nguyen, *et al* has observed that nearly all waste pickers suffered from cuts in hands, feet and limbs. Other major health problem reported by waste pickers are back pain due to constant bending motion required to search for waste, the prevalence of accidents and injuries at work place. It ranged from minor scrapes to dislocated shoulders from a collision with a moving truck. Nguyen, *et al* further states that, 'the risk is greatest in developing countries where the contact between the solid waste worker and waste is greatest and the level of protection is least (Nguyen, *et al* as accessed on 3rd March, 2011).

This is corroborated by a number of small scale studies done by researchers and Non Governmental Organizations in India.

Waste picking creates health risks among the waste pickers as a result these workers become more vulnerable to a number of occupational related illnesses. In a study of waste pickers in Bangalore, Hunt observes that 'waste pickers were still two and a half times more likely to be ill than non waste pickers' (Hunt, 1996:114).

It has been noticed that the health risks among waste pickers in developing countries are high because of manual handling of waste which has direct contact with waste and moreover lack of safety equipments results in high exposure to health hazards (Cointreau, 2006). Anemia, tuberculosis, under nutrition, etc. are common health problems among the waste picker as a result they are more susceptible to occupational health hazards. Cuts in hands due to glass, metal sharps and broken bottles are very common injuries among the waste pickers. Almost all respondents have faced these injuries. One respondent said that *'even if there is injury due to broken bottle or glass then we just put "Chunna"[34] on that wound'* some have responded that they just keep the wound open[35]. This kind of approach has also been seen among the waste picker's children as noted in Hunt's (1996) study in Bangalore (Hunt, 1996). In a study done in Delhi, it has been noted that 28 percent waste pickers have experiencing such injuries often and 61 percent got injured once in a while. It has been also noted that injuries due to medical waste are more dangerous 'because the waste pickers maybe unknowingly get infected by Hepatitis B and C or HIV or other bacterial infections through contaminated sharps and needles' (Sarkar, 2003:8). Back pain is one of the major problems faced by the waste pickers.

The study carried out by Chintan[36] (2003) on health conditions of waste pickers in New Delhi have revealed that the poor basic facilities such as unavailability of proper sanitation, clean water and housing is directly linked with the underprivileged social and economic status of the waste pickers. They are aware about the importance of health and hygiene but because of the lack the basic facilities they are susceptible to disease. The continuation of work by pregnant waste pickers also exposes their unborn children to various environmental hazards. It also revealed that '7 percent of the children were tested positive for round worms and 17 percent were found to suffer from chronic gastro

[34] Chunna is white paste of calcium generally used with chewing tobacco
[35] Interviews conducted with the waste pickers in the month of December and January 2010- 2011, Pune.
[36] Chintan is a Non Governmental Organization working with the waste pickers in New Delhi.

intestinal track (GIT) diseases. Amongst women, 24 were tested positive for round worms and three percent for hook worms, while another twelve percent of them suffered from chronic gastro intestinal problems. These could not only be linked to the poor quality of sanitation and water available to them, but their contact with waste including faecal matter'. It found that 84 percent children were anemic and it could be linked to their exposure to toxic chemicals which may have prevented the absorption of iron (Chintan, 2003cited in Chikarmane and Narayan 2009).

4.6.1 Why did the Union promoted Medical Insurance Scheme among the Waste Pickers in Pune?

A study conducted in 2000 on behalf of the International Labour Organisation (ILO) by a team of researcher of SNDT Women University gave an opportunity to quantify the contribution of different actors at different levels in informal waste sector. It revealed that,

- "Collectively, scrap collectors salvage 144 tonnes of recyclable scrap prior to its transportation, thereby saving the Pune and Pimpri Chinchwad Municipal Corporations the sum of 15822750 rupees (16 million rupees) per annum in transportation costs alone. By implication each waste-picker contributed 246 rupees worth of unpaid labour per month to the municipality.
- Each waste-picker and itinerant buyer has average earnings of 60 rupees and 75 rupees per day, respectively. At conservative estimates this amounts to 375000 rupees per day, in the primary transaction that takes place between the scrap collector and the local retail scrap store. Further value addition takes place as the scrap is sorted, graded and traded.
- The annual contribution of the scrap trade to the total income generated in Pune is 184824000 rupees (185 million rupees).
- The environmental benefits that are derived from the work done by waste-pickers would be difficult to quantify in economic terms" (Chikarmane and Narayan, 2005:14).

On the basis of the above findings the KKPKP argued that the Municipality is gaining financially from waste pickers. This is because they collect the waste and save the transportation costs of the municipality and also the health costs because waste-pickers are labouring under abominable conditions of work leading to higher levels of morbidity. The argument was substantiated by the findings of small sample study of waste pickers in Pune that observes some patterns of illness and that reported by the waste pickers. The major reported illnesses were severe musculo-skeletal problems, injuries due to falling from or into garbage bins, respiratory tract infections and gastrointestinal ailments, occupational related accidents, tuberculosis and eye infections. It has been observed that waste pickers, particularly women, tended to ignore minor illnesses till they assumed dangerous proportions and became chronic 'conditions' (Chikarmane, Deshpande, and Narayan, 2001cited in SNDT and Chintan, 2008:49). In respect of the both studies findings it recommended that waste pickers should be considered as 'unprotected workers' and Municipality should provide some welfare benefits as life and medical insurance to the waste picker.

This evidence led the union to demand for medical insurance from the municipality and after two years of constant struggle the collective voice of the waste pickers was being heard and ended in successfully. In 2003, Pune Municipal Corporation agreed to provide medical insurance to the all registered waste pickers thus became the first municipality in the country to provide medical insurance scheme for the waste pickers on payment of an annual premium (Chikarmane and Narayan, 2005) Social activist Lakshmi Narayan said that "the mass support of our members have helped in making the scheme see the day of the light and also convincing the municipal corporation to acknowledge the contribution made by them to the society" (cited in Ahmed, 2007).

4.6.2 The Medical Insurance Scheme:

In the beginning a range of quotations were asked from the different General Insurance Companies to act as an insurer. On the basis of the interest which best served to the waste pickers quotations, were called for. The New India Assurance Company was selected as the official insurer for the waste pickers union and a scheme was started under the social insurance scheme of the company called as Jan Arogya Bima Policy. The insurance

scheme started in 2003 with an enrollment of 3707 members which rose to 5411 members in 2007 (Ahmed, 2007) and 6555 in 2010[37].s In this insurance scheme trade union act as a channel and bridge between the Pune Municipal Corporation, Insurance Company and the beneficiary. Entire annual premium of all registered waste pickers is being paid by the PMC. The members who have joined the union and have taken the membership card are automatically covered under medical insurance scheme. This is reimbursement scheme and at the time of hospitalization patient or beneficiary must have to pay from their pocket and then later they can claim for reimbursement (Scott, 2010).

- ***The Eligibility and Inclusion Criteria in the Scheme*:**

Only the members of the union of waste pickers (KKPKP, Pune) can avail the benefits of the scheme. The union members are 6555 currently[38] and ninety percent of them are women. The age of eligibility is between eighteen to seventy years old[39].

The criteria for selection of hospitals are that, it should be a registered hospital and have the required facilities for indoor treatment[40]. However, the union negotiated with the insurer to waive the minimum bed requirement to 15 beds as waste pickers are too poor and generally prefer to go to the nearest hospitals which are small and may not fulfill required bed criteria. Many waste pickers take treatment on credit because of good relationship with the local doctor (Ahmed, 2007).

The conditions for claims are that the notification should be given within seven days of the date of hospitalization to the insurance company with the particulars and claims must be filed up within thirty days from the date of discharge from the hospital[41].

[37] Pujari, (2010), The information collected from the assistant of the Solid Waste Management Department of Pune Municipal Corporation, 17th December 2010
[38] Pujari, (2010), ibid
[39] Deshpande, S. (2010), Administrative Officer at New India Assurance Company Ltd., Information collected on phone, 29th December 2010
[40] Prospectus of Jan Arogya Bima Policy, New India Assurance Company Ltd
[41] ibid

- *The Coverage:*

The reimbursement amount is five thousand rupees for a period of one year. It covers hospitalization if it is more than or at least for 24 hours.

- *Administrative Cost:*

The beneficiary is to pay twenty rupees as an administrative fee at the time of filling up the insurance claim. This fee goes to the KKPKP union. This amount is used for administrative work like extensive record keeping and paper work (Scott, 2010).

- *Exclusion Criteria:*

This scheme is only provided to the individual worker and does not include family members. It does not cover out patient care and only hospitalization is covered by this scheme. Any pre-existing illness is not covered under this scheme. It has been stated in the prospectus that 'the pre-existing condition means any disease, or symptoms of any illness and injury which existed prior to the effective date of this insurance' is excluded from this scheme. It also stated that any expenditure on hospitalization which occurred during the 30 days of commencement date of insurance will be excluded except in case of injury arising due to accident. Dental treatments or surgery of any kind unless requires hospitalization, convalescence, general disability, "run down" condition or rest cure, venereal diseases, congenital external diseases, sterility, HIV/AIDS are such disease is being excluded from the coverage. Expenses on vitamins and tonics, treatments arising from or traceable to pregnancy/child birth inclusion of caesarian section are also excluded. During the first year of operation of insurance cover, the expenses on treatment of diseases such as cataract, benign prostatic hypertrophy, hysterectomy for menorrhagia or fibromyoma, hernia, hydrocele, congenital internal diseases, fistula in anus, piles, sinusitis and related disorders are not payable[42] As of 2007 the premium for the insurance scheme stands at[43]

[42] Prospectus of Jan Arogya Bima Policy, New India Assurance Company Ltd
[43] Deshpande, S. (2010), ibid

Table: 2.1 Premium Rate and Total Members according to Age Group

No.	Age group	Premiums (Rs.)	Members in 2007 (Ahmed, 2007)
1	18-45	70	4656
2	46-55	100	564
3	56-70	120	191
			Total – 5411

4.6.3 Main Actors and Architecture of the Medical Insurance Scheme:

In this particular medical insurance scheme the main actors playing role in implementing this scheme are:

- The Trade union (KKPKP)
- Pune Municipal Corporation
- New India Assurance Company
- The waste pickers as beneficiary

- ***The Trade Union:***

Union acts as an intermediary between insured workers, insurance company and Pune Municipal Corporation and acts as a third party arrangement for the scheme. The main function of the trade union is to ensure enrollment of new registered workers in the insurance scheme, to scrutinize the claims and forward it to the insurance company. The union also distributes reimbursement money which came from the insurance company to the claimants. The trade union maintains all the data-base related to the scheme such as details of the workers pertaining to the name, age, address etc., the number of claims made by the workers in a year, registering new workers under the scheme, and other administrative work relating to the smooth functioning of the scheme (Ahmed, 2007).

- ***Pune Municipal Corporation:***

In this scheme, Pune Municipal Corporation act as the premium payer and pays the annual premium of the all registered waste picker's calculated on the basis of number and age differentiate.

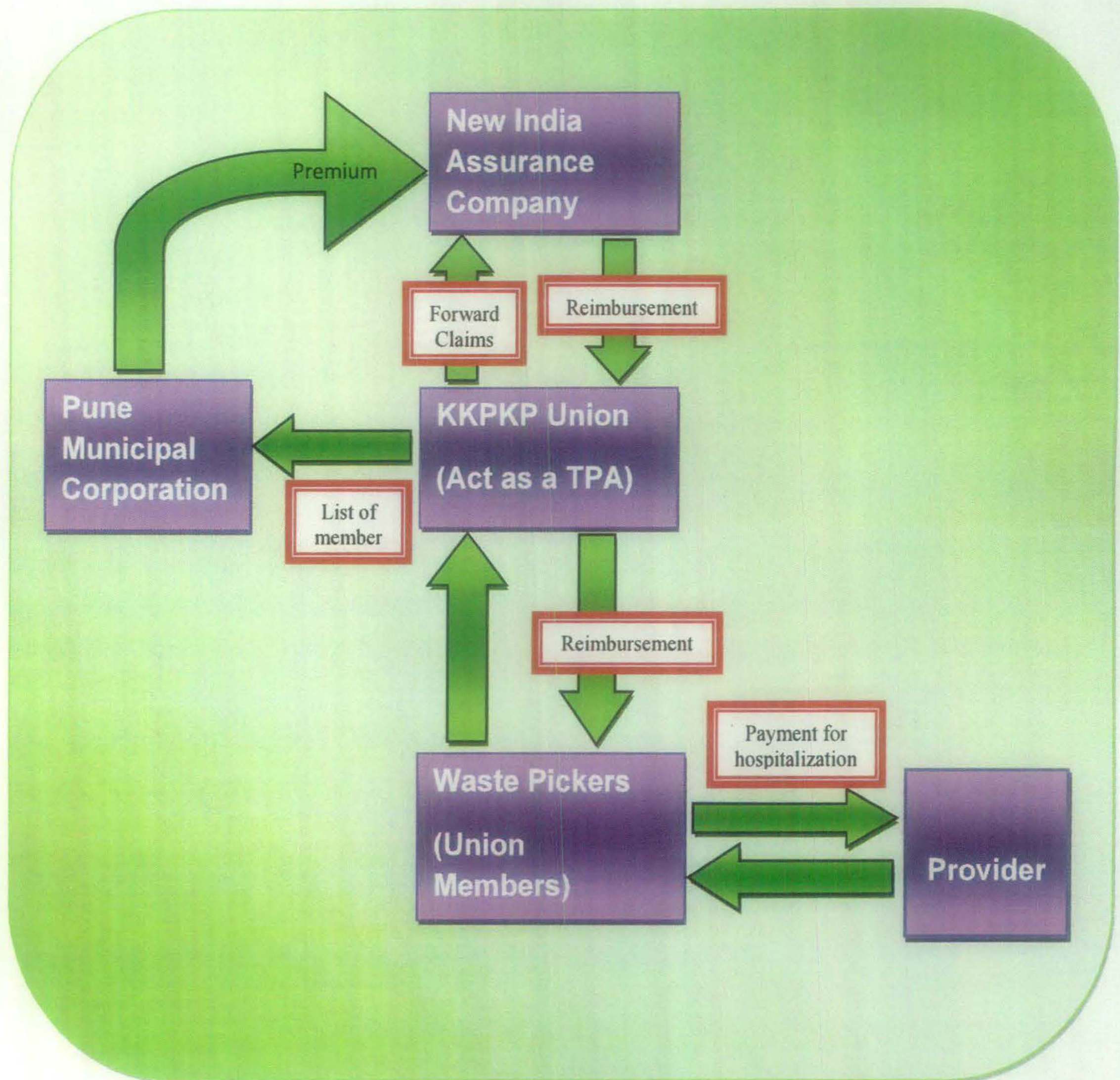
- ***The New India Assurance Company:***

The company acts as the insurer for the schemes. It scrutinizes the claims on the basis criteria which are set out by the company and then it gives reimbursement money to the union.

- ***The Waste Picker as Beneficiary:***

The role of the insured worker is to claim the money which occurred at the time of hospitalization. Worker has to fill up the claim form with all documents such as medicines bills, diagnostic test bills, discharge card etc. and then have to submit to the union.

4.6.4 Design of the Medical Insurance Scheme:



- ***Operationalisation of the Scheme:***

At the time of illness patient has to inform the union about any hospitalization. Then the union conveys this message to the insurance company. At the time of illness patient has to pay from their pocket and within 30 days patients is suppose to claim with all the documents for the reimbursement. The claim procedure, securitizing it and keeping all the records and then forward it to the insurance company all this procedure is being done at the level of union. Then the Insurance Company scrutinizes the claims and then gives the reimbursement money to the Union. And the union distributes the reimbursement money to the claimants.

4.6.5 The Claim Analysis:

This section analyzes the number of claims that have been claimed, the trends in premium to payout and time taken to get claims reimbursed. This data is substantiated by study conducted by Ahmed (2007), Centre for Insurance and Risk Management (Institute for Financial Management and Research).

Table: 2.2 Number of Claims according to Year[44]:

Year	2003	2004	2005	2006	2007	2008	2009
No. of claims	44	103	102	95	136	125	105

The data has been provided by Deshpande, (Administrative officer at New India Assurance Company Ltd.). It shows the trend in the number of claims that have been claimed over the years. Table 2.2 shows that the number of claims has declined from year 2007. The other important thing is that in 2007 the total number of waste pickers were 5411 that means the percentage of claim was 2.5 percent which was slightly less that the claim percentage in 2006 at 2.6% (Table 2.3). It has come down to 105 claims out of 6555 members in 2009 which is only 1.6%. This data can be substantiated by the study conducted by Ahmed, 2007 as follows:

Table: 2.3 Current Claims Incident:

Year	2003	2004	2005	2006
No. of Members	3708	3352	4208	4735
No. of Claims	39	93	101	125
Percentage	1.05 %	2.7%	2.4%	2.6%

Source: Ahmed, 2007:37

[44] Deshpande, S. (2010), ibid

The above data shows some inconsistency[45] but it shows the percentage of claims was maintained similar around 2.5 percent over the years. The same study (Ahmed, 2007) mentioned that in 2003 the claim rate was lower because of low awareness about the insurance scheme among the members (Ahmed, 2007: 37). However this study shows that the claim rate has remained low and has declined over the years.

Table: 2.4 Premium to Payout Trend:

Year	2003	2004	2005	2006	Total (Grand)
Premium paid	2,92,140	2,54,210	3,30,680	3,63,720	12,40,750
Claim amount Disbursed (Payout)	89,953	2,71,995	3,09,365	2,65,862	9,37,175

Source: Ahmed, 2007:43

The above table clearly shows that in all years except 2004 the payout is lower than the premium paid. That means the total premium paid by the PMC is higher compared to claim amount disbursed. In a period of four years (2003-06), the insurance company has benefited financially at the tune of around Rupees 3, 03, 575. This indicates that the insurance company is financially gaining as the claim rates are low.

According to Ahmed (2007),"the maximum sum insured is not sufficient to meet the basic hospitalization expense of the members" (Ahmed, 2007:44).

[45] The data is inconsistent may be because of information that is collected in this study was on phone.

Table: 2.5 Time Lag in Claim Settlement:

Process	Time Lag (Delay)	
	Minimum	Maximum
From discharge of patient to submitting claim paper to KKPKP	1 month	3 months
From submission of claims to KKPKP to the submission by KKPKP to the insurer	1 week	3 weeks
From submission of claim to NIA to the client getting reimbursed	2 months	6 months

Source: Ahmed, 2007:52

The above table shows that, getting reimbursement from the insurance company to the union and then to the member, takes a maximum of six months. Thus it shows the process of getting reimbursements to the members is very prolonged.

It is possible that the low claim percentage is due long time taken for reimbursement. Additionally the reimbursement amount is very small and members may not have all the required documentation for completing the claim process.

In my study, all respondents have said that the hospitalization amount was more than 5,000 rupees and most of them received an amount only up to 4000 to 5000 rupees. Even though the scheme clearly stated upper limit of reimbursement 5000 rupees, this sum does not cover the full cost of treatment and hence is not able to meet the needs of the members. Almost all respondents have mentioned that they got their reimbursement amount only after four to five months.

4.6.6 Key Issues in the Scheme:

A study done by Centre for Insurance and Risk Management (Institute for Financial Management and Research) on behalf of ILO has discussed major issues which are of major concerns and that, first there is no formal agreement or MOU being undertaken by the insurance company from the providers. Second, similarly there is no formal

agreement or MOU from the insurance company to the union. Many times this leads to issues of standardization of treatment as many times doctors take different charges for similar diseases conditions among other issues. Third, it has been noticed that most of the claims for hospitalization are for communicable diseases. The causes for this are due to the poor living and working conditions of waste pickers. Fourth, in its present situation community feedback is not taken into consideration for the schematic or modifications of the programme (Ahmed, 2007:6-7).

Another issue was the rejection rate of insurance claims. This problem rose because of a technical problem. One of the rules stated that the claimant must inform about hospitalization within eight days. The insurance company had been flexible about this rule but after staff change in the insurance company a number of claims were rejected on this ground by the new staff. Many of the beneficiaries had not been properly informed and were not aware of this rule. They were aware about another rule stating that one had to claim within a month after they got discharge from the hospital. Rejection of claims at this point led to the mistrust among the members of the union who thought that the administration was getting the reimbursement money from the insurance company but were not distributing it to the members. Thus union took up this issue with the New India Assurance Company and argued that the rule was not enforced by the insurer earlier and thus rejecting claims on this criterion was unjust. After several demonstrations they discussed this issue with the chairman and a consensus was reached. They agreed to give reimbursement money to the claimants who had been rejected by the insurer on the above mentioned grounds (Scott, 2010:27-28).

It is essential to understand that in this medical insurance scheme the patient gets the freedom to choose provider, however, there are no any mechanisms to check the quality of care that the patient is getting. It is observed in a paper that, most of the schemes the freedom of choice for provider is often limited because of the quality of care however some have succeeded in including providers closer to the beneficiaries, but this is at the expense of the quality of care (Michielsen, *et al* accessed on 23rd May, 2011).

Summary:

This chapter discusses about the evolution of the waste pickers union and the background of the social activists who played an important role in the overall development of the waste pickers working and living conditions. The rising cost of health care and high level of indebtedness due to cost of care among the waste picker lead the union to implement a medical insurance scheme. In this context it is need to be understood that the KKPKP have promoted this medical insurance as part of overall development of the waste picker.

It is clear from this scheme that, the claim rate is very low and the small amount of benefit package is not enough for the needs of the members. The other major finding is that, the PMC is actually benefiting more than the waste pickers from this kind of medical insurance. While the total premium cost of all members that PMC is paying is very limited at around five lakh. On the other hand the waste pickers are saving the cost of PMC at around 16 million rupees annually. Thus the PMC's is grant appears as mere tokenism to the waste pickers. The PMC is availing the labour of these waste pickers through doorstep collection of waste but not providing them with any security. It can also be seen that the insurance company is financially gaining as it benefited 3, 03, 575 rupees from the four years (2003-2006).

Chapter Five

The Medical Insurance Scheme: Experiences of Waste Pickers

Chapter-5

The Medical Insurance Scheme: Experiences of Waste Pickers

This chapter intends to capture the experiences of waste pickers with the medical insurance scheme. It presents the analysis drawn primarily from primary data gathered from in depth interviews with the waste pickers. It locates and supplements these interviews with secondary literature that has focused on the forms of social exclusion, poor working conditions, health problems and difficulties in accessing health services faced by these workers. It then analyses the experience of the workers with procedure for claim and its reimbursement under the medical insurance scheme.

5. Background of the Waste Pickers:

5.1 Social Status of Waste Pickers through the lens of Social Exclusion

Certain social groups have suffered from discrimination and have been left out from the process of participation in multiple spheres over time. Exclusion and inclusion with unfair treatment accelerates a high level of deprivation (denial of equal opportunity) and poverty which results in an increasing inability of a person to participate in mainstream society. Thorat and Sabharwal (2010) have defined the term social exclusion as "as a social process which involves denial of fair and equal opportunities to certain social groups in multiple spheres in society, resulting in the inability of individuals from excluded groups to participate in the basic political, economic and social functioning of the society" (Thorat and Sabharwal, 2010: 3).

It has mentioned the main characteristics of social exclusion as denial of equal opportunity in multiple spheres and that social exclusion is embedded in the social inter-relations (Thorat and Sabharwal, 2010: 3). In this chapter we employ this definition and analyze the domains and forms of social exclusion experienced by waste pickers. A review of existing studies on waste pickers clearly points to caste as being an important determinant for social exclusion.

- *Caste:*

The central point of social exclusion revolves around social inter-relations which exclude people on the bases of their group identity. In the Indian case, exclusion most often takes place on the bases of their caste group identity and also includes others forms such as religion, ethnicity and others (Thorat and Sabharwal, 2010). As one goes down the caste hierarchy, the form of social status and access to various recourses become narrower (ibid). This has been elaborated in first chapter, under the section 'Social Structure and Industrial Inequality' as "*social origins frequently determine the type of work carried out*" (Breman, 2010:180). It can be seen that the waste pickers are ranked lowest in the caste hierarchy in Indian society.

In this study the respondents from Pune region belong to communities which are "*Mang/ Matang*" and "*Mahar*" community which categorized as Schedule Castes (SC). *Mang and Mahar*[46] community are the downtrodden lower castes in social hierarchy (division of people in social groups) therefore have lower social status. In Maharashtra *Mahar* and *Mang* communities constitute the largest number among the SC population (Wankhede, 2001). In a case study done by the Chikarmane and Narayan they observed that waste pickers in Pune, exclusively belong to the *Mahar* and *Mang* community (Chikarmane and Narayan, 2005).

- *Caste and Occupation:*

In India, the social status of an individual is associated with his/her occupation. Schedule Castes in India have been historically associated with work which is ritually considered as impure such as removal of dead animals, waste, leather work and removal of human faeces (Thorat *et al* 2009). Traditionally *Mahar's* occupation was to work as village messengers, village guards, sweeping streets, and removal of carcasses and *Mang's* occupation was making ropes and beating drums (Wankhede, 2001). Both these are

[46] 'There were 1,092 scheduled castes in India and 59 in Maharashtra as declared in 1991 in the census' (cited in Wankhede, 2001:1553). Out of 59 SCs, Mahar, Mang, Bhambi and Bhangi together constitute 92 percent of the SC population of the state. Mahar are numerically the largest in SC's, constituting 57.5 percent followed by Mang (20.3 percent), Bhambi (12.5 percent) and Bhangi (1.9 percent) of the SC population of the state (Census Report, 2001).

considered as lowest level of work in the occupational hierarchy and hold lower social status. In the caste hierarchy where an individual's occupation is determined by birth and from one generation to the next, restricts occupational mobility. Waste pickers have said they are inducted into waste picking at a young age when accompanying their parents to work to help to supplement the family income. A 30 year old woman waste picker narrated that,

"We migrated to the city when I was very small, around 10 years old. We were living in Barshi, Solapur district. We were working on daily 'majuri' (daily wages) on others land. At that period of time it was difficult to get work on daily basis. Due to the lack of work in village we were not getting enough money and managing a square meal became difficult. So my whole family migrated to the city and started working as waste pickers in the city. I also joined them to supplement the family income. I was around 12 years when I started this work. I got married in this city itself and my husband was also doing the same work" (Seeta[47], waste picker, Ramtakedi, Pune, 2011)[48]

- ***Migration:***

It was observed in this study that most of the waste pickers belonged to early migrant groups. A case study also noted that waste pickers migrated to Pune city in large numbers during the drought in 1972 (Chikarmane and Narayan 2005). Largely they belonged to the Marathwada region and surrounding areas of Pune city. In this study most of the waste Pickers had migrated from Usmanabad, Beed and Solapur district which are known to be drought prone districts of Maharashtra. Most of them migrated in the period of 1970. Prior to migration, they were working as mostly agricultural labourer's in their villages. Due to conditions of drought, they faced severe difficulties for their day to day survival. This was the push factor which led them to migrate to cities in search of work over the distance, only in order to survive. A 55 year old woman waste picker responded that,

[47] The name of the all respondents (Waste Pickers) have been changed who were interviewed and participated in the informal discussions in the study in order to protect their identity and privacy.
[48] In this study all narrations are being translated from Marathi to English

"... we were living in a village of Usmanabad district. In our village there was nothing to eat. We were daily wage earners. We did not have any land; we used to go for 'majuri' (daily wage) on others land but that time earnings were so meager. Many times we were also deprived of daily wage labour and did not have enough food to eat. There were poor agricultural conditions during at those times. "Shetata Dhanaych Pikat navat tar mag amhi tari kay karnar, korada dushkal padala hota, jagana kathin zala hota" (If there is no production of grains in farms then what we could do, it was drought, survival also became difficult)" we decided to come to the city as my brother was already in Pune. My brother was doing the waste picking work and found it marginally beneficial as compared to the daily wage labour back in the villages. So when we came here, my husband and I started doing waste picking (Rukhmini, waste picker, Patil Estate, Pune, 2010)

Seasonal variations in rainfall and period of drought became major cause of disruptions which threatened basic survival due to loss of livelihood. Migration remained the only option in order to escape the problem of drought in the villages, however, finding jobs in the city being equally difficult; they had to resort to earning their livelihood through waste picking.

Waste picking as an occupation was chosen by many as their kin or people they knew were already involved in it. As many waste pickers have said that they entered this work because of their relatives and their neighbor. Some have responded that there were nobody they knew in the city when they migrated to the city, initially they survived by begging.

"......... when we came to city we had no relatives here or anybody we knew. It was very difficult to get any kind of work in city. We started our living in Pune by begging for food. I used to go marriage ceremonies for begging only in order to feed my children. There was no other alternative before us. My neighbors were involved in waste picking work and I found it comparatively beneficial to begging. I started going with my neighbor for waste picking and that's how I entered this work" (Bhama, 45 years old waste picker, Ramtakedi, Pune, 2011).

The experience of the waste pickers in Pune reflects the social hierarchy. Some scholars have argued that the caste identities and occupations are disappearing in the urban setup (Kapur et. el., 2010). However in case of menial jobs like waste picking it does not seem to be true. These jobs are primarily confined to only schedule castes. With the development of the city various caste groups started migrating towards Pune. These included Marathas', and caste groups categorized in OBC category along with schedule castes. Traditionally all caste groups were engaged in agriculture and intense physical labour including the poor among the Maratha's but when they migrated to cities the Maratha's (upper caste) preferred to work as *Hamal's* (load carries) rather than do waste picking. These *Hamals* did not enter into the waste picking work as it was deemed of lower social status and traditionally assigned to the *Mahar* and *Mangs* (the schedule castes) in Maharashtra. Within caste hierarchy, *Hamals* enjoy high social status (Deshpande, 1999). It is been argued that in modern economy caste based occupational boundaries are getting blurred and urban structure provides opportunity to accept any other occupation there by narrowing inequalities (Gupta, 2000 cited in Desai and Dubey, 2011, Kapur, *et al* 2010). But it is clear from this study that in an urban setting like Pune occupational stratification and preference of labour is still based on caste status when it comes to accepting jobs like waste picking and other menial work. This argument can draw support from the paper by Thorat, *et al* (2009), which states that, "Dalits worked in stigmatized occupations that handled 'impure' materials such as human faces, dead animals, hides etc. Tanning, scavenging, sweeping, and cleaning jobs remain distinctively Dalit's occupations in modern India" (Thorat, *et al* 2009: 4). These dehumanizing jobs have remained 'lower caste jobs' from generation to generation limiting their scope and development

- ***Literacy Level:***

It was observed in the study that literacy levels were low in these workers families and most of the waste pickers were illiterate. The analysis of educational inequalities among the Schedule Castes in Maharashtra shows that within the Schedule Castes *Mang's* are the most educationally and economically backward and *Mahar's* are relatively better in education because they have a long history of social and religious movements. Dr.

Babasaheb Ambedkar's Movement, their conversion to Buddhism, migration to cities and group solidarity were the main reasons for this relative better educational condition. He concludes that despite having a long tradition of social reforms led by reformers Joytiba Phule and Dr. Babasaheb Ambedkar the Schedule Castes still lag behind as compared to others and still have a long way to go (Wankhede, 2001). Illiteracy is stated as a major obstacle for getting any skill job. When the researcher asked about 'why they came into this kind of work', one waste picker answered,

"We are so poor and illiterate, who will give us jobs. If you are literate only then you will get job, if we don't have any kind of skill then who will give us job. This work doesn't need any skill, still nobody wants to do this kind of work as it is deemed low status but due to our poor conditions we have to do this kind of work. My elder brother was rikshaw (auto) driver, we had our own auto but due to hospitalization expenditure we sold the auto and now he is doing a waste picking work. What else we can do? Ultimately Waste becomes the only survival for us" (Ashok, 20 year old waste picker, Patil Estate, Pune, 2010).

Waste pickers have also said that if they would have been literate they would have not been cheated by the Scrap dealers or they could have got better jobs which would have enhanced their social and economic status. Thus, deprived groups often face difficulties in getting employment and have greater likelihood of losing it (Kabeer 2008).

- ***Poor Economic Conditions:***

Multiple facets of deprivation increased vulnerability of the waste pickers and they continued to be trapped in the vicious cycle of poverty. During the interviews it was found that the waste picker's social exclusion is primarily based on his/ her caste and most often it is accompanied by poor economic conditions. It is being found that the wages for this type of work is very minuscule. The workers are earning only around eighty rupees to ninety rupees daily which is very small amount considering the rise in cost of living. Almost twenty rupees is spent on travel out of this meager amount as a result they are left with little money for household expenditure. Within this amount they have to provide a square meal for the whole family. Some times they are forced to work

extra in order to buy food supplies for the day. During fieldwork the researcher has observed that food will be cooked in house only after the waste picker comes back from selling the collected waste. In the case of one waste picker it was observed (which could be generalized to a great extent) every day she bought only one onion, one tomato and a little oil from a shop near her house, then the food was cooked for nine members of the family. When I asked about the contribution of her husband and her son to the running of the household she replied:

"..they are also waste pickers but never give money for household expenditure, they just spend their earnings into drinking and gambling. Many times they take money from me as well when they need it for drinking and gambling. I have to manage the whole household on my own" (Ganabai, 40 year old waste picker, Patil Estate, Pune, 2010).

This narrative indicates that along with poor economic conditions gender inequalities are persistent. Most of the women waste picker also faced domestic violence in their homes which is corroborated by a study conducted by Chikarmane and Narayan, (2005).

These socio-economic and gender inequalities become more pronounced when it comes to treatment for ill health. A waste picker preferred to go for treatment only when they were ill, up-to a level where he/she was unable to go for work. Meager wages became a major hindrance for accessing the resources. In one particular case, the worker responded that,

".....the health care is so costly that we cannot afford it, so instead of going to clinic in times of minor illness we take one medicine from the medical store" (Ashok, waste Picker, Patil Estate, Pune, 2010).

Fraser had argued that economic forms of injustice deals with the appropriation of the fruits of one's labour, exclusion from the means of livelihood or confinement to poorly paid, undesirable forms of work and being denied an adequate standard of living (Fraser's 1997 as cited in Kabeer 2008). All these forms of exploitation, marginalization and deprivation are quite noticeable among this segment of the population who are working as waste pickers.

- ***Poor Working Conditions:***

Waste pickers work in abysmal and inhuman conditions as they have to collect scrap on streets, dumping bins, door to door collection of garbage, and segregation of collected scrap and selling it to the scrap traders. The working hours of their work are long; they have to start their work early in the morning and work till late evening, putting in around twelve hours of work. Waste pickers duties involved door to door collection which meant that they leave their house at around eight in the morning and return by six or seven in the evening.

Workers engaged in scrap collection from streets have to leave their house before dawn at around five or six in the morning as they were likely to get more scrap thrown by people over the day and in the night. These waste pickers traveled around nine to ten kilometers distance for waste collection. In Pune most of the waste pickers are women who are overburdened with additional household responsibilities. Women waste pickers said that they got up early in the morning and cooked for members of the family and then left for work. After a strenuous day at work they have to resume their responsibility of cooking and other household work. One women waste picker said that:

"..I wake up early in the morning; I do not cook food in morning because if I start to cook food then it becomes too late for work. So, I cook some extra food at night itself so that family members can eat that food in the next day. Moreover my daughter is there to take care of household work. I carry the left over in my tiffin so that I can eat that food at my work place in the afternoon" (Ganabai, 40 year old waste picker, Patil Estate, Pune, 2010).

The above narrative indicates that the quantity and quality of food which may be of poor nutritional value on a regular basis is bound to have adverse effects on the health of the waste picker and their families. Moreover, the unhygienic work conditions are worsened by the lack of safe drinking water facilities, sanitary facilities and an appropriate place to eat their food, these conditions are specifically worse for the workers who work on the streets. These poor conditions put the health of the waste picker at constant risk.

Many times waste pickers have to put in extra work to earn a little amount for daily survival. This is visible from a response by a worker,

"…..many times we work extra. In the door to door collection people in the society do not give money on time. Different people give money at different time, according to their convenience. Therefore there is no regular income, thus in order to meet daily expenses we have to work extra. It becomes difficult to survive if we don't earn on daily basis. So after doing door to door collection we both, my wife and I, often go for scrap collection on streets" (Sitaram, 35 year old waste Picker, Patil Estate, Pune, 2010).

Waste pickers have to carry heavy load of collected scrap on their back. They walk long distances carrying heavy loads on their back to the scarp dealer. They do this to save a few rupees on transport. Some waste pickers use transport service provided by the scrap dealers on a condition that the scrap should only be sold to them forcing the waste pickers to sell the collected waste to the particular scrap dealer itself. This similar observation was found in a study conducted by Chikarmane, Deshpande and Narayan (2001), which stated that 'waste pickers carry loads of over seventy five kg on their heads and make repeated trips to the trade establishment in order to save transport costs' (cited in Chikarmane and Narayan, 2009:33).

The waste pickers have no social security like the formal sector workers. The waste pickers are aware the privileges that the municipality workers get. One of the waste pickers said that

"Municipality workers get everything like holidays, pension, monthly payment, bonus etc. every security they will get, but we are deprived from it. Moreover we are the only who are actually saving the cost of municipality by cleaning up the city. They are getting clean city by free of cost and they will take the whole credit for it on the expense of us" (Sitaram, 35 year old waste Picker, Patil Estate, Pune, 2010).

This illustrates that the waste pickers are well aware of their deprived condition as compared to municipality workers who are better off in terms of social security. The future of these workers remains marred in insecurities because they are not provided any facilities.

Another major problem is that the workers do not get regular remuneration for the service they provide. The workers engaged in door to door collection face lot of problems at their work place as the people have a derogatory attitude towards because of the 'dirty' nature of their work. Humiliating and inhumanly treatment is a prominent feature at work place for the waste pickers. There is no dignity in their work as police and other people in the society harass them. In this regards, worker responded that,

"In the society if we tell people to keep wet garbage and dry garbage separate then some people talks to us harshly, "that is your job and do your job, this is not our job" (Kamal, 45 year old waste picker, Ramtekadi, Pune, 2011).

This reveals that the notions of work are still embedded within the caste system. The social exclusion of the waste pickers are often based on their caste and the nature of their work are clearly indicated here.

The door to door collection waste pickers have to arrange for a replacement to work if he/she feels ill or cannot go for work due to other reasons. As getting a replacement is a difficult task the waste pickers can hardly ever take holidays. When asked about the use of safety measurements such as mask, hand gloves, shoes etc. they replied that they are not provided with safety measures and there is no point asking for them also. The workers who work in door to door collection integrated into the urban solid waste management by the municipality also not provided with safety materials. Some waste pickers said that there have been times when the union has provided these safety measures but the thought of travelling cost and the loss of wages incurred prevents them from going to the place of distribution as stated by one waste picker

"...who will go to collect this stuff. The place was so far and we will go to collect the safety material or we will go for work, because if we go for collect the safety material then we will loss our wages and besides that the transport cost will be an additional burden for us"(Sundara, 35 year old waste picker, Ramtakedi, Pune, 2011).

Thus it shows that apathy of the municipality in providing these safety materials to these waste pickers inspite of them financially gaining from these waste pickers.

It can be concluded that poor and unhygienic working conditions and lack of access to basic services and derogatory attitude that they face results in poor health conditions of the waste pickers.

- ***Indignities in Social Relations :***

The exercise of power and control in a caste based hierarchical society gets reflected in the social relations. This can be seen in the day to day language and treatment used by the upper caste people when referring to lower caste people. Using humiliating language is one form of violence and lower caste people are forced to bear this on regular bases. This prevents them from attaining their full potential and participating in social life as equals.

A women waste picker around fifty years old said that,

"....when I work for whole day traveling around the streets of the cities and gathering garbage on the streets, dumping bins, sometimes I go to the railway stations just in a hope that I get enough garbage at least for that day and my family can eat for another day. Working in the garbage my cloths become dirty and my body smells dirty but what can be done. This has become our life. Sometimes, after finishing my whole days work I come back by bus. I have very bad experience in the bus; the passengers do not sit besides me even though there is place to sit. Some times bus conductor behave very badly with us passing comments like "hi ghanerdi bai ka bus madhe ali ahe, kiti ghan vas yetoy hicha angahcha" (why this dirty women sitting in the bus, her body smells very dirty). This gives me very humiliating feeling, it feels like I am not a human being" (Bhama, 45 year old waste picker, Patil Estate, Pune, 2010).

It gives an inherent behavior of the society who is privileged to systematically exclude the underprivileged from the participation in social life. Another waste picker around forty years old said that,

"We face a lot of discrimination from the society. Before the union was formed we were labeled as criminals. People suspect us as if we are thieves and still there are waste pickers who face similar discrimination. If anything gets stolen then the first persons to get targeted were the waste pickers. Police also suspects us as thief. They used to talk to

us very harshly. Many a times police demanded to check our bags (in which waste has been collected) and in this whole process they treated us in very inhuman way. Certainly women face a lot of harassment by the police, by the people in the bus, autos etc. it is only because we are very poor and the work that we do has a low status" (*Sitaram, 35 year old waste picker, Patil Estate, Pune, 2010).*

"……people's treatment towards us was very inhuman when there was swine flue spread out in Pune. That time people were not talking to us, they were not touching to us, they were keeping distance from us they treat us like we are the only one who are spreading out the swine flu, because they know that we are doing bad dirty work and comes from poor background" (Kamal, waste picker, 45 year old waste picker, Ramtakedi, Pune 2011).

In the light of above whole discussion it shows that how waste pickers are excluded in social, economic spheres on the bases of their caste, type of work and their poor economic conditions, gender and their poor appearance. Historically the waste pickers lacked access to land, property, education which resulted in their inability to participate in mainstream social life. However, even if they migrated to the city the new forms of discriminations get reflected at the level of market and in social life. Thorat and Sabharwal (2010) argue that "in the market economy framework, restrictions would operate through denial of access to various markets such as land, labour, credit and services necessary for any economic activity. Exclusion may be operated in the market economy through the denial of jobs" (Thorat and Sabharwal, 2010:8)" This is evident in this study that when waste pickers migrated to the city they were denied jobs because they lacked skills and education. This is the result of the thinking embedded in the caste based feudal society which has denied the basic rights of the persons ranked in lower caste. This is evident that waste pickers are from lower caste, lack in capital in terms of land or any other property, poverty, illiteracy which are multiple facets increasing their vulnerability. It shows that this section of the society has lacked from various basic needs, livelihood resources, knowledge, information, and technology over generations which are embedded in the caste structure of the Indian society.

5.2 Health Problems and Treatment Seeking Behaviour:

In this section, recent ailments for which waste pickers have claimed the benefit of medical insurance are studied. This section tries to get a comprehensive view about the experiences of people in availing the medical insurance facility. This was done through asking questions their ailments, their institutional treatment seeking behavior, access to health care and experiences about insurance claim and reimbursement procedure. It also includes their expectations from this insurance scheme.

- ***Health Problems and Institutional Treatment Seeking Behavior:***

Socio-economic, cultural and political determinants are factors influencing the health outcomes of individuals (Marmot, 2005). Amongst all, waste pickers are subjected to adverse socio-economic, cultural and political odds which go against healthy living. The previous section has lucidly demonstrated how social exclusion is a determinant of access to work, food security and living conditions. This is further compounded by poor conditions in the work place and a set of occupational hazards faced by the waste pickers.

The work environment of the waste pickers is characterized by unfavorable working conditions. Many times while collecting waste on roads or garbage bins or segregating it, they come into daily contact with several kinds of biological waste material including dead rat, cat or other animal, human faces, hides etc. which exposes them severe health risks such as severe infections. Almost all among the waste pickers interviewed were subjected to some or the other kind of injuries, cuts in hands and legs. This is generally because of the broken glass or metal pieces in the garbage these wounds makes them vulnerable to infections like tetanus and ulcers. Exposure to medical waste and accidents is another big hazard exposing them to verities of health risks. Due to long hours of work and carrying heavy luggage they face backache, body pain, stomach pain and cramps in stomach (Cointreau, 2006, Medina, 2005, Hunt, 1996, Sarkar, 2003, SNDT and Chintan, 2008).

One waste picker narrated that

"...it is very common thing that we face injuries from broken glass or metal etc.This is a daily experience and we cannot do anything for it, we have to face such problems and we are used to it" (Ashok, 20 old waste picker, Patil Estate, Pune, 2010).

The other experiences of the waste pickers mentioned back pain and pain in joints as major problems for them as result of carrying heavy load of collected waste for a long distance. These problems are high among those workers who are working on the streets, walking long distances in search for waste. The worker engaged in door to door collection have lesser workload but face similar problems as they were working on streets before they began door to door collection. As one waste picker said that,

"I am facing enormous pain in my back, this problem is persistent when I was working on Urali Depo[49] *(dumping site of waste) where I used to carry heavy load of waste"(Seeta, 30 year old waste picker, Ramtakedi, 2011).*

Another fifty five years old woman waste picker also mentioned that she is facing back pain since she started this work thirty five years ago. She said that

"I am having lot back and body pain it might be because I have been working since long and also due to my age. Daily when I come back from work I take one painkiller then only I feel little bit better" (Rukhmini, 55 year old waste picker, Patil Estate, Pune, 2010).

Injuries due to accidents are also one of the major problems faced by waste pickers. The waste picker *(Rukhmini)* reported that she had an accident when she was working on the streets and collecting waste. Since then she has not been able to work properly and can not work for long hours. One waste picker mentioned about a relative death due to accident at work place. The health problems cited by the waste picker pose serious concerns about the occupational health hazards faced by these waste pickers.

[49] Urali Depo is place where the whole waste of Pune city is being dumped. The waste picker are used to go this dumping place for waste collection however this place is now prohibited for waste collection because municipality has given this place to the private company for waste segregation and recycling it.

Although they suffer from many ailments their economic conditions does not permit them to seek medical help. That is why they do not prefer to go to the doctor for such daily pains and sufferings. First response to any physical suffering is to avoid it. They do not give importance to minor illness as they believe that it part and parcel of life of any waste picker. The rational of such behavior lay in the cost of accessing medical care which they cannot afford as explained by one waste picker,

"...how can we go to clinic if we are earning eighty to ninety rupees daily and one visit to the doctor means loss of hundred to hundred and fifty rupees. We go to medical store and just take one medicine, if we spent hundred rupees for clinic then what we will eat and moreover if the illness is going to be managed by taking just one medicine then why we will go to clinic to spend amount of money which becomes burden for us" (Sitaram, 35 year old waste picker, Patil Estate, 2010).

The above statement clearly brings out that affordability and rising cost of medical care worker makes it difficult to access health services. They prefer to buy medicines over the counter and if there are wounds or injuries due to broken glass then they just put "*Chunna*"[50] on that wound or they keep that wound open and continue to work. In the life of a waste picker only serious illness perceived as direct threat to loss of wages and life are worthy of attention and medical care.

"If anybody falls ill severely then we go to the clinic, we have to take treatment otherwise how we will work. Even if we don't have money we have to arrange it somehow or borrow from relatives or from moneylender. If we are healthy then only we will be able to work and earn enough to even cook food in our house. There is no alternative for us" (Sitaram, waste picker, Patil Estate, 2010).

This indicates that waste pickers generally do not pay attention to routine problems such as minor injuries which is regarded as part of their lives. The income and the high medical cost stand as obstacles in dealing with majority of health problems. It is not the case that they are not willing to treat these health problems but the fact is that medical care is not within their reach.

[50] Chunna is white paste of calcium generally used with chewing tobacco.

The researcher also asked about the choice of provider i.e. where they take treatment when they fall ill. The waste pickers replied that they prefer to go to the private clinic. The most common reason for choosing private clinic was the proximity. Most of the waste pickers said that it is easily accessible because it is closer to their house and they do not have to lose their daily wages. Easy access, availability of doctor at convenient time and proximity makes these clinics an easy choice. Ultimate aim is to save wages. Other reason to choose these clinics is the relationship with the provider. Trust on the private doctor because these doctors also provide services on credit. The waste pickers do not prefer government hospitals because it takes almost same amount of cost including the loss of wages, lack of free treatment at government set ups and the transport charges are high bringing it as much as the fees of the private doctors moreover they believe that quality of care is poor in government hospital. The similar observation have found in study conducted by Ahmed, (2007), that most of the members accessed private hospitals because of proximity and faith in the doctor, flexibility in payment mechanism and quality of care (Ahmed, 2007: 48). The waste pickers mentioned number of other reasons than just cost for not choosing government hospitals such as the long waiting line for the doctors, unfair treatment by doctors and other medical staff and non availability of medicine.

A waste picker who was admitted in the government hospital (Sassoon Hospital district hospital of Pune) told,

"…… they treat us as if we are animals. Doctor just come and will check us, that's it. They don't even tell us what has happened to us, what health problems are we suffering from. We are illiterate people, how we will understand what happened to us until and unless doctor says. However, they will behave well for those to whom they know. I still don't know what was exactly happened to me and even if we ask to doctor then they will not explain. Ward boy, sister, Aaya, all staff don't even listen us. Even if there is medicine available they will tell us to buy from outside. All staff takes the medicines home and don't give it to the patients. This is the situation at government hospital that we have to face" (Sitaram, waste picker, Patil Estate, Pune, 2010

The narrative clearly indicates the level of discrimination at health care institute which is an indication of increasing inaccessibility of health care. The levels of discrimination at health care institute is well studied by Acharya (2010) and it is noted that "if the interaction with the provider is restricted due to use of derogatory words and refrain from touch (or offending touch) during diagnosis, counseling, pathological test or while seeking referral, there is a likelihood that the required health care will not reach the use" (Acharya, 2010: 35).

Given the rising cost of medical care and the variable quality of care that they receive, the idea of a medical insurance scheme was seen as an important input by the union. The following section presents the workers' experience with the insurance scheme.

5.3 Experiences of Hospitalization:

The researcher tried to document the health seeking behaviour and experiences of hospitalization in the public and private sector by waste pickers.

Case 1:

Ashok is 20 year old man working as a waste picker since his childhood. His family migrated from the Akluj block in Usmanadbad district in 1972. His mother and father worked as daily wage labourers on others land in their native place. However the concurrent drought in their area devastated their livelihoods and forced them to migrate. His mother and father are also working as waste pickers since their migration to Pune. In his family of nine, four members work as waste pickers.

Ashok had dengue around a year back. Initially Ashok suffered from body pain, shivering, cold and joint pains. He visited a private clinic near his house where he was examined and given some medicines. The doctor did not suggest for any clinical investigations. However those medicines did not change the condition of Ashok and he continued to suffer from body pain and joint pain. Ashok again visited the same doctor as his condition became worse. The doctor suggested that he get admitted in his own small

hospital[51]. Even after getting admitted in the hospital his condition continued to deteriorate to a state that made him unable to walk due to severe pain in joints. The doctor was not able to diagnose the condition / disease. At this stage the doctor referred Ashok to "Surya Hospital"[52] which is fifteen kilometers away from his house. In Surya Hospital the doctors diagnosed his illness as dengue after a wide range of clinical investigations. He was admitted for fifteen days in Surya Hospital.

According to the respondent, the quality of care in Surya Hospital was good compared to the earlier hospital where he was admitted, because in "Surya Hospital" there were all facilities available and quick treatment saved his life. The respondent used the term "quality care" to mean prompt treatment, availability of medical and diagnostics facilities and continuous nursing care. However the cost of treatment was so high that it made their household economic and financial situation worse.

The bed charges per day in Surya hospital was around three hundred to four hundred rupees as Ashok stated. Apart from that they had to buy all the medicines prescribed by the doctors as well as injections, syringes, saline bottles, the cost of laboratory test etc. The total cost incurred for the entire treatment process was around sixty to seventy thousand rupees. The cost of earlier treatment was around four thousand rupees. This amount calculated was only for medical costs and did not account for the loss of wages due to hospitalization and also the loss of wages of his mother who used to accompany him to the hospital, cost of transport, and cost of buying food in the hospital. Because of the high cost of treatment the family had to sell their assets. Ashok said that to manage his treatment cost his elder brother had to sell his *auto rikshaw* and had to take a loan on an interest rate of ten percent. They are still paying this debt. According to Ashok's words,

"We were not aware what was happening to me, the condition became such that my family thought that I am going to die. Still we believed on the doctor because we thought he knew everything. We are poor people and illiterate, hence subjected to experiments in

[51] According to the respondent hospital is having around 4 to 5 bed capacity and very limited facilities. No any lab facilities available.

[52] Surya hospital is multispecialty hospital in Pune.

our bodies. If the earlier doctor had investigated me properly then I would have not suffered a lot and would have been saved from incurring such a huge treatment cost. This illness took my brothers livelihood and this situation forced him to work as a waste picker as there was no other alternatives in front of us"

Case 2:

Sitaram is 40 years old working as a waste picker since last twenty five years. He was admitted in government hospital two and half years prior to this field work. He explained that one day when he came from the work at around five in the evening he was eating his food, suddenly he felt restless and fainted. He does not know what exactly happened to him. His wife and relatives took him to "Sassoon hospital" (District Hospital of Pune) and he was admitted immediately.

His experience in the hospital was pathetic. Doctor neither gave him any information about his illness nor told him about what he was suffering from. The derogatory attitude of the nurses and other staffs augmented to the suffering not only to the patient but also his family. Negligence of the staffs towards patient care was major problem they faced. It was experienced and expressed and these were the words by Sitaram.

"When I was admitted the hospital, my saline was going to get over and my wife called a nurse to put another one. However she did not turn up to put the next saline. She shouted on my wife that we know our job and in fact she asked my wife to change the saline. How can she do a nurse's job? Isn't there risk involved in it? If we tell them that we have BPL card then they tell us to go to some other office, then in that office no body cared about it, then they will again send us to another office and in the entire complex procedure people (who accompany the patient) become tired. In such situations when will the attendant (wife) care for patient, when they have to do other administrative procedures? In government hospitals people become mad, especially illiterate people and if there is the ward boy then the sister is not available, if there is sister then there is no doctor and waiting for them is a major problem. Patients definitely will die, waiting for them for such a long period of time. There is no cleanliness at all in this hospital. The internship

doctor asks too many questions repetitively. Giving all the information to them, people themselves become patients"

Non availability of staff and doctor on time is one of the major problems experienced by the patient and highlighted by this narration. The complex documentation procedure to avail the facilities for BPL and derogatory attitude towards the BPL card holders is another major setback for the waste pickers to avail health in government facilities by increasing their susceptibility rather than curing the illness.

In this case, the cost of treatment in the government hospital went around nineteen thousand rupees. It includes bed charge, diagnostic tests, and medicines. The transport cost of accompanied person and loss of wages of his and his wife was a major economic burden as they were the only earners in the family. He reported hospital took money for every services used by them. Even they took bed charge as five rupees for per day. The cost is managed by taking money on loan and the interest rate was eleven percent and they are still paying this debt.

The above case studies put forward the main problems in accessing the health care and their experiences at government hospital set up.

- Low level of income and high cost of medical care forces poor people into medical poverty debt.
- User charges for various services and poor quality of care in government hospitals forced people to access private health care which is unaffordable due to high cost of treatment.
- Derogatory remarks and treatment of staff in government hospitals towards patients is inhuman in nature, as in this case, worker said that "*they treat us as if we are animal*"
- Even if there is availability of medicines staff does not give medicines to the patients
- Long waiting period to see the doctor,
- The long and lengthy procedure for availing treatment for the BPL families

The above points explain the increasing economic and social vulnerability of poor people due to hospitalization. Low level of income forces them to sell assets and take money on

loan in order to manage the cost of medical care. In this study it is found that worker has to do extra work to have additional income to pay the debt creating a vicious cycle of ill health and poverty. In this study highlights the affect of poverty, poor quality of care and discrimination at government health care institute in relation to delay in treatment seeking and health seeking behavior of the waste pickers.

5.4 Experience of Medical Insurance Scheme:

The unhealthy working condition of waste pickers enhances risks of health hazards and ultimately increases the economic burden on the waste pickers. Union did struggle for getting medical insurance scheme from the municipality for the waste pickers. It argued that waste pickers reduce the cost of municipality by collecting and segregating the city's waste which is the responsibility of Municipality. This aspect has been proved by the union through the studies mentioned previously demanded for provision of medical insurance for the waste pickers from municipality. Since 2003 this medical insurance scheme is operated among the waste pickers.

The workers experiences speaks out that union had taken great efforts in reducing the economic burden due to health expenditures however it does not fulfill their needs of health care and does not ease out the economic burden completely. The medical insurance scheme is a reimbursement scheme and the insurance benefit offered is very minimal in the context of rising cost of health care. In this study it is found that the workers are well aware about the claim procedure as all respondent claimed reimbursement in some point. The experience of workers shows that arranging money for payment to the health facility is a huge problem and a difficult task.

In this study almost all waste pickers said that the benefit amount is inadequate and therefore it does not provide any financial security in case of a health incident. The main reason they talk that ultimately at the time of illness they have to pay the amount for treatment. There is no escape from it and to pay that hospitalization expenditure they have to take money on loan or sell their assets. One twenty year old waste picker said that

"…….when illness occurs we have to pay for the treatment. The "health bima" (medical insurance benefit) we get later after the discharge from the hospital and that comes after

three or four months. Till that time we cannot wait and nobody will wait for that money because there is no scope. We know that nowadays hospitalization means the amount spend is more than ten to twenty thousand rupees. In our case (hospitalization due to Dengue as discussed above) the hospitalization expenditure went sixty to seventy thousand rupees. My brother sold his auto and took some money on loan in order to pay for my treatment. The interest rate is ten percent *and still we are paying that debt. We got five thousand rupees of our 'bima' (medical insurance) but what is the point of it after we take the loan or sell our livelihoods assets. Moreover they just give five thousand rupees which is very negligible amount in comparison to this huge hospital expenditure. The amount is not even enough to pay interest rate. So you think does it really help us?..." (Ashok, 20 year old waste picker, Patil Estate, Pune, 2010).*

"...even if we get five thousand rupees from the 'aroygya bima policy' (health policy) but we have to pay double. This money goes only in paying the interest rate. They are not paying the amount at the time of illness. So the amount we get is actually not benefitting us" (Kamal, forty five year old waste picker, Patil Estate, Pune, 2010).

"...union did this struggle only for us. This health bima is like better than nothing. However at times of illness we only have to pay the hospital expenditure by taking loan that becomes huge burden for us." (Seeta, 30 year old waste picker, Ram takadi, Pune, 2011)

These narratives raise many issues regarding the medical insurance scheme and also express the feelings of the waste picker about this scheme. Firstly, the sum assured is very less and does not reduce the economic burden. Secondly, it is a reimbursement model and not a cashless model, where the waste picker gets the refund only after three to four month which is quite a long period in the context the poor economic conditions of the waste pickers.

When researcher asked waste pickers about the illness which are not covered under this scheme they said that maternity benefits, HIV AIDS and Cancer are not included in the scheme. They also stated that they were aware only of these diseases being excluded and

have no idea about others that may not be covered. They feel that these condition to be included in the scheme although they have not experience HIV AIDS and Cancer.

The waste pickers from whom information gathered were aware about the claim procedure they have to follow to get the benefit from medical insurance scheme. The first thing they knew was that they have to inform to the union about any hospitalization directly or over the phone. They also knew the detail documentation they are required to submit while claiming the benefit. According to the waste pickers they have to claim it within seven days after discharge from the hospital. One waste picker speak about it

"We have to submit all bills to the union. We have to fill up the claim form and have to submit the bills. Such as diagnostic tests bills, medical bills, laboratory bills, and discharge card. If these bills are there then only they give the benefits otherwise they do not process the claim till they give the bills" (Rukhmini, 55 year old Waste picker, Patil Estate, Pune 2011).

This narrative speaks about the procedure and the documents they have to submit however some waste pickers found it difficult task as the procedure is lengthy. The waste pickers think that the procedure to claim the benefit is cumbersome. Sometimes arranging documents becomes difficult. Many times pharmacists (medical store) do not give bills if the bill amount is small. It also happens that in the whole procedure of illness at hospital they tend to lose the bills because of stress due to the situations that they are going through. Later it becomes a major hindrance for arranging documents for medical insurance claim. As one waste picker also said that

"....it is really difficult to arrange the bills because when we go the medical store and asks for bill then they refused to give bill for small amount, we are taking the medicines according to doctors prescription, and doctor also do not give whole medicines at one time. I know that they cannot give and according to the patients illness they have to keep changing medicines. So we also cannot demand for that" (Rukhmini, waste picker, Patil Estate, 2010).

It is also that after the discharge they have to follow the post care procedure due to which claiming the benefit within seven days becomes difficult.

Waste pickers think the insurance scheme should follow the cashless model instead of the reimbursement model by paying directly to the hospital for the services used. They also feel that the sum assured should be increased and at least should pay the half of the amount incurred in hospital expenditure, which will reduce their economic burden considerably.

In this study it is found that this insurance scheme for waste pickers does not cover the cost fully. Secondly, there is out of pocket expenditure even after medical insurance scheme is very high as the insured amount is very small (Rs. 5000/- only). The third thing is that, long time for getting reimbursements increases their economic burden and in the emergency period it is not useful. It is also important that it does not cover the maternity care where as most of the waste pickers are women.

Summary:

Various domains and forms of social exclusion of waste pickers in their daily life have resulted in multiple level of deprivation. The lower access to public health services compels poor waste pickers to avail services from private health care which are highly expensive leading to increasing indebtedness. This is ultimately affecting the income levels of the waste pickers. In this context, union has taken efforts to reduce economic burden arising due to ill health to a certain level by promoting medical insurance scheme. However, according to workers experience it gets reflected that this reimbursement scheme is certainly not reducing the economic burden of waste pickers. It is also needs to be understand that this is a problem of medical insurance scheme not a union.

It may be also reflected that inclusion of waste pickers into medical insurance scheme is at on the different terms and conditions such as entitlements only to certain services and certain cost. It is reflection to the concept of "Unfair Inclusion" which is explained in paper by Thorat and Sabharwal (2010), "Unfair inclusion will involve access (or inclusion) to the rights and entitlements but with unequal terms and conditions or differential treatment in accessing the rights and entitlements" (Thorat and Sabharwal, 2010:12).

Chapter Six

Medical Insurance: Who Benefits

Summary and Discussion

Chapter - 6

Medical Insurance: Who Benefits?

Discussion and Summary

The available studies on informal workers have shown that, given the poor working and living conditions the extent of ill health among the informal workers is significant. The wages are very low that makes it unable for them to access basic resources including health. Due to the low wages, financial barrier has become a major constraint for accessing health care. Majority of them are unable to pay for medical care because of its rising costs, as a result they tend to forgo medical care. One of the ways in which to address the problem of financial barrier for accessing health care has been through the evolution of the Community Based Medical Insurance Scheme (CBMI). There have been plurality of these schemes and they are shaped by different socio-political context. In the plurality of models, the particular study is looking at the initiative of a union in providing medical insurance to the informal waste pickers in Pune.

6.1 Vulnerability of Informal Sector:

It is well known that the informal sector and informalization of labour is increasing day by day. The NCEUS report on unorganized sector (2009), mentions that, more than 92 percent of workforce is in the unorganized sector. It mentions that there is tremendous decline in the rate of wages and the average earnings of the workers over the years. The low wages accompanied by lack of employment, work and social security increases their vulnerability to a large extent. The wide and scattered nature of work reduces their collective power and makes difficult formation of union which can bring changes in their working and living conditions.

The working and living conditions of the informal workers are extremely appalling. As regard to this, studies have shown that they live in slums in urban areas where they lack in basic services such as proper housing, safe drinking water and sanitation facilities. They have to work in poor and inhuman working conditions for long hours in order to meet their daily expenses which add to their vulnerability. Even at work place they lack

basic facilities such as safe drinking water, sanitation.etc. As a result they are exposed to occupational health hazards and communicable diseases.

Majority of workers in informal sector are from the lower caste mostly belonging to Dalit and Tribal communities. In this context, informal sector workers are marginalized in their access to resources in multiple ways and suffer from continued insecurities in social and economic spheres. Even within the informal sector, it is observed that there exists hierarchy in work and workers who perform lowest and miserable conditions of work belong to lowest social ranks. Lack of access to basic facilities such as food, shelter, health, education etc. due to low socio-economic status accelerates their vulnerability and deprivation.

It is in this context that the present study attempts to examine how the workers in the informal sector face barriers in accessing and utilizing health services.

6.2 Financial Barrier in Access to Medical Care:

Studies have shown that the inability to pay for health care restricts or acts as a barrier in accessing health services. This is largely due to increasing commercialization of public health services and increasing privatization which led to increasing health care cost for the poor informal workers who are not avail medical care easily. Evidence shows that indebtedness due to rising cost of care has increased and high cost of medical care is one of the leading causes for not seeking treatment especially among the lower income quintile. Studies have also shown that in urban areas the informal workers who are the poorest get least access to health care. Under commercialized health care, health is increasingly seen as a commodity and thereby as consumption good. It has also resulted in the transformation of patient into a "consumer" (Tritter, *et al* 2010).

Weak public provisioning and inefficiency in the provision of health care is another reason why poor informal workers are pushed to access commercial private health services which are heterogeneous in nature. Therefore, accessing different levels of care in private health care increases their financial burden and hence becomes major barrier.

In the context of rising cost of medical care, the introduction of medical insurance schemes for vulnerable and marginalized sections of the society is seen as an alternative approach to increase accessibility and reduce burden of health care expenditure. The government is primarily promoting the introduction of number of schemes of medical insurance and has therefore subsidized several of these insurance schemes. In addition, across the country a number of community based medical insurance schemes is being implemented by NGO's, trade unions, co-operatives and governments.

6.3 Changing Role of the State in Financing and Provisioning Health Care: (Medical Insurance Scheme):

It is important to understand that, in Europe and U.S. historically medical insurance schemes were started only for the workers working in the formal sector and who had the ability to pay for it. So workers who are poor, working in the informal sector, unemployed, women, children, aged, and sick persons always got excluded from accessing these medical insurance schemes. In European countries medical insurance have transformed in multiple ways from contributory medical insurance to a compulsory medical insurance and then to a tax based medical insurance. It shows the changing role of the state in financing and provisioning of the health care.

Historically the role of the state has been minimal. The private arrangements had existed, for protection against risk arising out of ill health. The example of this comes largely from the 18th and 19th century in Europe, where informal arrangements as friendly societies and mutual aid societies were existed. These informal arrangements were mutually created by the worker to provide protection from future sickness. The early part of the 20th century, witnessed greater state involvement. In this period, state intervention increased primarily through the medical insurance schemes. As the state intervention increased the role of informal arrangements such as friendly societies and mutual aid societies reduced. The state involvement moved from not just medical insurance but also in provisioning, which restructured the role of insurance dramatically. However, post 1970's across the world when there was cut back on resources of the state, once again those who were marginalized were being increasingly covered through a plurality of insurance arrangements. After the health sector reforms in the 1980's the withdrawal of

the state intervention in health sector has again created a situation where people have to take care of their health on their own. Health is increasingly seen as individual responsibility. During this period of weakening public health, once again there has been creation of various informal types of arrangements. One such alternative mechanism is the CBMI which has been created or rather been forced to create for the benefit of the poor informal workers.

6.4 Plurality of Approaches in CBMI:

In low and middle income countries the plurality of informal arrangements is evident where poor workers have covered through the different models of CBMI. In low and middle income countries a large proportions of workforce works in the informal sector and hence it is a big challenge to include informal workers into medical insurance. It is also the fact that in these countries inequalities in income and resources are high, therefore financing health care becomes a major issue. Therefore alternative strategy for financing health care the CBMI was introduced in the low-middle income countries to cover the poor people. In these forms of CBMI, community participation for financing health care through cross subsidizing became a chief point.

It can also be analyzed that, historically the development of medical insurance was started with the European Guild systems, Sickness Funds and Friendly societies or Mutual Aid Societies with an idea of collective responsibility and social solidarity for protecting each other in times of ill health through financial cross subsidizing. The current form of CBMI is linked and can be located within this history. The current form of CBMI is also seen as community responsibility and there needs to be community participation in the formation of CBMI.

In these CBMI one can find plurality of approaches. Since various actors like the Non Governmental Organizations, Trade unions, co-operatives and the state are actively playing part as insurer or as provider.

In this study, the particular case of CBMI is actively initiated and run by trade union of waste pickers in Pune.

6.5 Role of Trade Union for Informal Waste Picker:

It is well known that the trade unions primarily evolved for the protection of rights of the workers. However, these trade unions were often confined to workers who were working in the formal sector, thus leaving out the large number of informal workers that needed the support of unions the most. There are some initiatives to organize informal workers into union as in the case of waste pickers in Pune. The trade union of waste pickers in Pune had evolved in a different socio-political context and has taken number of initiatives to organize the informal waste pickers into union. This trade union has made efforts to make the state accountable for the protection of informal waste pickers both socially and economically. Introducing medical insurance scheme for informal waste pickers through making state accountable is also an important initiative taken by the union.

The initiatives to organize these waste pickers into union have been taken by three different activists. The background of these social activists shows that they believe in the left ideology and thus the idea of building union of informal waste pickers may lie into this ideology. After the formation of the union it first started to negotiate with the Pune Municipality for recognition of the waste pickers as worker and demanded authorized identity cards for waste pickers. Another initiative was taken to reduce the work burden of the waste pickers through source segregation of waste. It made efforts for door to door collection of segregated waste with the support of the Pune Municipality. The doorstep segregated waste collection was seen as reducing the work burden and enhancing the value of scrap and thereby increasing the economic security of workers. Campaigning for education among the waste pickers for their children was one of the main agenda of the union. Medical insurance was also one of the agenda in the union for protecting their workers from falling into impoverishment and poverty.

Within the informal sector, waste pickers rank lowest socially and economically. They are unprotected and deprived of basic facilities such as safe drinking water, sanitation, housing etc. The multiple facets of deprivation on the basis of caste along with poor economic conditions and low literacy level increase their vulnerability. Therefore they experience social exclusion in terms of inability to participate in social and economic spheres. The extremely poor living and working conditions exposes them to

communicable diseases and also they are highly exposed to health hazards due to direct contact and manual handling of waste. In this study, the union has viewed the most hazardous working conditions of the waste pickers leading to many infectious diseases and injuries thereby increasing their vulnerability.

The other important thing was that the union showed that Pune Municipality is gaining financially on account of informal waste pickers because they are collecting waste and segregating it thereby reducing transportation costs of the municipality. In this context, union had massive struggle for demanding medical insurance for the waste pickers from the Pune Municipality. The collective voice of the informal waste pickers was finally heard by the Pune Municipality and it agreed to pay the annual premium of medical insurance scheme for all members of the union.

The trade union of waste pickers in Pune has promoted medical insurance scheme in the context of overall development of the waste pickers, specifically, in improving the working conditions of the waste pickers. As it was observed the working conditions of waste pickers are most hazardous to health so promoting medical insurance was seen as an important initiative taken up by the Union.

6.6 The Major Issues in Medical Insurance Scheme:

Coverage:

A total of 6555 workers are covered under this medical insurance scheme. Around ninety percent of the waste pickers in Pune Municipality are covered and age eligibility is between eighteen to seventy years old.

The extent of benefit package being covered under this scheme is only five thousand rupees. It is a reimbursement scheme and covers only hospitalization. It excludes outpatient care and pre existing illness. The unit of enrollment is the individual waste pickers. It does not include the family members. In this medical insurance scheme the contribution is made by the government i.e. Pune Municipality. The annual premium of all member waste pickers is being paid by the Pune Municipality.

The Waste Pickers Experience of Medical Insurance Scheme:

The workers experiences' shows that the union had made great efforts to reduce the economic burden due to health expenditures. However it does not fulfill their needs of health care and does not ease out the economic burden completely. The medical insurance scheme is a reimbursement scheme and the insurance benefit offered is very minimal especially in the context of rising cost of health care. In this study, it was found that the workers are well aware about the claim procedure as all respondents had claimed reimbursement at some point. The experience of workers shows that arranging money for payment to the health facility is a huge problem and a difficult task because claim reimbursement takes place long time.

In this study almost all waste pickers said that the benefit amount is inadequate and therefore it does not provide any financial security in case of ill- health. The main reason they talk that ultimately at the time of illness they have to pay the amount for treatment. There is no escape from it and to pay that hospitalization expenditure they have to take money on loan or sell their assets. Workers experiences are also shows that sometimes claim procedures become lengthy and there by become difficult to claim.

Issue of Comprehensiveness:

This particular medical insurance scheme clearly shows that it has implications for comprehensive health care. It focuses only on curative care and that too for selected medical care, as in this scheme pre existing illnesses are excluded. It is also important to note that it does not cover maternity care even though most of the waste pickers are women. In this scheme out-patient care is also excluded where it is known that cost of outpatient care is also becomes an important barrier for accessing care. Thus, in a way it is going towards breaking the comprehensiveness of health care.

Issue of Partial Coverage:

This medical insurance scheme for waste pickers does not cover the cost of medical care fully. Even after there is a medical insurance scheme, out of pocket expenditure is very high as the insured amount is very small (Rs. 5000/- only). The waste pickers'

experiences show that even though they are covered under medical insurance scheme, they have to take money on loan for hospitalization. Long waiting time for getting reimbursements increases their economic burden and during emergencies it is not useful. Thus it gives a mixed kind of picture about the benefit of the scheme where poor people are accessing health care but are not covered fully and therefore it does not necessarily reduce the indebtedness.

Studies have shown that though CBMI is targeting poor people, the poorest of the poor get excluded due lack of ability to pay for premium. Thus it can be said, it is leading to reinforce social divisions by targeting only on poor and segmentation of services by covering only curative care.

6.7 Major Findings:

- Informal workers and especially waste pickers are an extremely marginalised group because of their socio economic status. This vulnerability is compounded when there is an episode of ill health. Due their poor socio-economic status and high cost of medical care, health care becomes inaccessible and poor health further increases their vulnerability.
- Integration of informal waste pickers into solid waste management by the municipality has not meant movement of these workers into the formal sector. Currently the waste pickers help in door step collection of waste which benefit the PMC, but the PMC does not acknowledge this benefit and has made no provisions for these workers in terms of wages or other benefits. It reveals how the state is reducing its responsibility by keeping workers in the informal sector, by not providing employment, regular work and social security. It shows the withdrawal of state i.e PMC, in providing formal work opportunity and cost savings by the municipality. It is withdrawing from its responsibilities and reducing costs at the expense of these informal workers.
- The entire shift of in-formalizing the waste collection in the city has actually benefited to the municipality in terms of cost saving as it shown in the study, done by the trade union, that, "*Collectively, scrap collectors salvage 144 tonnes of recyclable scrap prior to its transportation, thereby saving the Pune and Pimpri Chinchwad*

Municipal Corporations the sum of Rs.15822750 (Rs.16 million) per annum in transportation costs alone. By implication each waste-picker contributes Rs.246 worth of unpaid labour per month to the municipality" (Chikarmane, Deshpande, Narayan, 2001 cited in Chikarmane and Narayan, 2005). On the basis of this finding the Pune Municipal Corporation has agreed to provide medical insurance to the worker but it appears that even this scheme of medical insurance is a mere tokenism to the worker as only five to six lakh rupees is paid as a annual premium by the PMC and of the total workers only around 2.5 percent workers claim medical insurance which is also inherent with the number of problems. This clearly shows in this entire process only the state i.e. municipality is benefitting on the expense of the informal workers work

- In the absence of strong public health services that can provide affordable and quality care, even the poor are forced to access expensive medical care from private hospitals. It is evident from the findings that lower access to public health services compels poor waste pickers to avail services from private health care which is expensive leading to increasing indebtedness. They are forced to access private health care by selling their assets or taking loan. This is ultimately affecting the income levels of the waste pickers. Those who have insurance prefer to go to the private sector. It can therefore be said that medical insurance scheme is actually a process of legitimizing the private sector.
- In the case of this particular insurance scheme, it was found that the workers are getting very minimal benefit which is actually not enough to cover medical cost fully. Very often it is not able to cover the entire cost of hospitalisation. This has meant that even though workers have insurance they still get indebted due to medical expenses. The insurance scheme's exclusion criteria include outpatient care and also chronic illnesses like cancer. Thus all the medical needs of the workers are not met. It therefore highlights the critical issue of comprehensive health care.
- The claim percentage is low and has been declining. It is possible that this is due to the long time taken for reimbursement. Additionally the reimbursement amount is very small and members may not have all the required documentation for completing the claim process.

- The workers expressed that it should be a cashless model instead of a reimbursement scheme and the sum assured should be increased. They also suggested that at least half of the amount incurred in hospital expenditure should be paid. These measures can reduce their economic burden considerably.

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Annexure

Annexure

Medical Insurance for Informal Workers- An Exploratory Study of Waste Pickers in Pune Municipality, Maharashtra

M. Phil Dissertation Research Project

In-depth Interview Guideline

A: Personal Information of the Respondent:

- Name, age, religion, caste, education
- Details of family such as no. of family members, their education, occupation
- Total earning members, dependent members in the family.

B: Migration Related Information:

- Native place of the respondent
- Years passed for migration, first place of migration, etc.
- Reason of migration
- Nature of occupation the family involved in
- Role of the relatives and friends in terms of migration

C: Work Background:

- Number of years working as waste picker
- The reason of choosing this work
- The role of friends, family, kinship networks in the process of finding
- The working conditions and wages, daily routine of work (the process of work), no of working hours etc.

- Work hierarchy- the levels of work hierarchy, experience of chances of getting into high level, the level of mobility etc.
- Work area- do they work in specific area, who decided this work, the distance of this area from the house, the transport and related cost
- Segregation of waste-where do they segregate collected waste, is there any specific area
- The place of sellers: where do they sell their waste, how do they know about this place, is there any co-operative, the rate of the segregated waste
- Daily earnings
- Safety measure-do they get any safety equipments such as hand-gloves, shoes etc.
- The problems faced due to this work, the mechanisms for tackling these problems, experiences of such situations

D: Health Seeking Related Information:

- Experiences of minor and major illness- what type of illness they suffer from, minor and major illness.
- Treatment seeking behavior for minor illness-where do they go for treatment (government or private) why do they choose particular institution, the cost of medical care, how do they manage the cost of medical care
- Treatment seeking for major illness- experience of any family member or themselves have major illness, where do they go for treatment (government or private) why do they choose particular institution, the cost of medical care, how

do they manage cost, the experience of institution, whether they satisfied or not, if not why?

- The health problems particularly arise due to the work – what are they, do they take treatment for illness

E: Medical Insurance Related Information:

- The experience of medical insurance scheme: when they have taken the benefit of medical insurance scheme, what is the process of insurance scheme
- The details of illness, the name of the institution, the distance of the institution from house, experience about hospital staff's treatment towards them
- The cost of treatment, the details of cost of treatment (consultancy fee, diagnostic test cost, medication cost, etc.), details of indirect cost, how did they manage the cost of treatment
- The criteria for medical insurance scheme-do they get treatment cost for minor illness or only for hospitalized admissions, do they get treatment cost at the time of illness or after the illness covered (reimbursement scheme). Is they are aware about what are the illness covered under this insurance scheme
- Details about premium payment such as who pay the premium, how much is the premium
- The type of scheme (individual or group or family members)
- Experience about the whole insurance scheme – this insurance scheme useful or not, what they feel about it. Is there any suggestion about this scheme

F: Unionization Related Information:

- Years of membership in trade union
- Experience of the workers making union-what difference they found by making union, what are the initiatives taken by this union, do these are useful initiative
- Photo identity card, experience of the workers of this card, the use of this card.
- Membership fee of the union

Interview Guideline for Key Informants

A: The History and Politics of Unionization of Waste Pickers in Pune

- How did the trade union of waste pickers evolved?
- When does this trade union started?
- Who are the leaders and main actors of the trade union?
- What is social and political background of the trade union leaders?
- What is motivation behind this trade union?
- What are the initiatives that have been taken place by this trade union for the waste pickers?

B: Pune Municipal Corporation and Trade Union

- Why trade union has felt to have tied up with the PMC?
- How did trade union negotiated with PMC for the I-Cards, Medical Insurance scheme for these workers?
- How and why PMC has agreed for paying the premium of medical insurance scheme for these workers?

C: The Socio-Economic Background and Working Conditions of the Waste Pickers

- Who are these waste pickers? (Caste, class, family Background)
- How did they came to the city or do they basically from the city?
- How do they enter into this work?
- What is work process of these waste pickers?

- Do they get safety Kits (Hand gloves, mask etc.), if not what do they for their safety?

D: The Eligibility, Provisions and Implementation of the Medical Insurance Scheme:

- Who are included in this medical insurance scheme? (Exclusion and inclusion criteria, main actors in this schemes)
- What are the provisions given under this scheme? (Which illness covered?) Who pay the premium? How much is the premium?
- What is type of the scheme (direct payment or reimbursement)?
- Who are the providers of this scheme?
- From where these workers can avail treatment? Which hospitals or clinics as provider come under this insurance scheme?
- Who take the responsibility of the administrative work?
- What is process of the implementation of the medical insurance scheme?