

Studying health accessibility issues faced by migrant workers in cities like Bangalore and Delhi

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Abstract

The main purpose of this project was to understand the various health accessibility challenges faced by migrant workers in the use of various available health facilities and social security schemes in major cities like Bangalore and Delhi. Migrant workers belonging to low income categories face multiple cognitive barriers such as lack of information about health facilities, social security schemes and multiple structural barriers such as distance from hospital, language and cost, which reduces their accessibility to health facilities. This gets even worse in major cities where the cost of living is exceptionally high and the language acts as a barrier for the majority of the Hindi speaking migrant community from states like Jharkhand and Bihar to communicate about their health problems.

Thus the study takes into consideration these accessibility issues by addressing three major themes (i) the various structural and cognitive barriers faced by migrant workers that affects their health facilities accessibility (ii) the various challenges faced by migrant workers in utilisation of the government funded social security schemes such as Ayushman Bharat and E Sanjeevani which are technology driven and (iii) the role of intermediaries such as occupational nurses in construction sites or factories in resolving these problems of healthcare access for migrants.

Towards the end the study discusses some of the key gaps in the current health access approach and recommends various strategies with special focus on improving health accessibility using technology.

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Introduction

Interstate migration for work is a major coping strategy adopted by many poor households to stabilise their income. The Economic survey of India 2017 found there are almost 60 million inter-state migrants in India(Government of India 2017a). A large proportion of these migrant workers work as casual labourers, that is they are employed in farm or non-farm enterprises in wages according to their terms of the daily or periodic work contract (Ministry of Housing and Urban Poverty Alleviation, 2017). These workers are often hired without regular contracts and a big part of their earnings goes into providing the cost of living and sending the money back to their homes (Kundu and Sarangi 2007). Thus, migrant workers become financially vulnerable in major cities as these cities have high cost of living and therefore they have to compromise on any extra expenditure including essential healthcare services. The Government realising these problems, started to provide health insurance as a part of its social security schemes. However, multiple challenges such as awareness of the entitlement, ability to utilise these schemes, knowledge about the health facility location and time available for visiting these facilities become some of the key challenges for migrants' health accessibility. Technologies for healthcare having the ability to connect migrants to information, facilities and health workers might certainly help in reducing these barriers.

Social Security for Migrants

Discussions around the precarity in the lives of migrant workers has been around for a long time. The Government of India in response to some of these healthcare challenges provided its first health insurance social security scheme called Employer State Insurance in 1948. This scheme targets the informal sector workers in Factories, Construction sites and any other institute employing more than 10 employees below the salary of 20k to compulsorily provide health insurance for their employees. This scheme was very effective in providing financial aid to migrant worker forces as now a specific proportion of their income and their employees

income went into reducing the cost of health services for them and their families, which becomes essential in situations of sickness, illness and any other contingencies of life. But again, the requirements of a company to provide ESI is that the company should employ 10 or more workers which excludes many other informal migrant workforce such as household workers, ragpickers and hotel workers and because the scheme was designed for providing social protection to workforce not migrants, it lacks any recognition of the temporary working tenures which migrants are employed for leading to many loopholes which allows employers to force migrants to work under unacceptable working conditions (Lall, Selod and Shalizi, 2006). Thus, there was a strong requirement for a more inclusive as well as specific social protection for migrant workers.

India as a response to improve the inclusivity, launched its flagship healthcare programme called Ayushman Bharat Pradhan Mantri Jan Arogya Yojna(AB-PMJAY) in 2018. This program provides health expenses coverage of up to 5 lakh Rs per family per year for accessing secondary and tertiary level care services for low income families or families belonging to vulnerable sections of society.

Therefore the current study tries to understand the various healthcare accessibility challenges faced by migrant workers from Bihar and Jharkhand in major metropolitan cities such as Bangalore and Delhi in utilising more inclusive social security schemes like Ayushman Bharat. It also tries to find any gaps and challenges in health accessibility that can be leveraged for improved migrant health with the help of technology.

Ayushman Bharat

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) was launched in the year 2018, with an aim to improve healthcare accessibility for low income families to get several kinds of health treatment up to Rs 5 lakh Rs per family. The treatments are covered in the government and empanelled private hospitals for secondary and tertiary healthcare needs. Other than the insurance, the Ayushman Bharat scheme also provides national level free tele consultancy service in their Ayushman Bharat health and wellness centre through E Sanjeevani application.

Eligibility. The entitled families covered are as per SECC (Socio-Economic Caste Census) 2011. The various categories eligible have been defined based on rural and urban residence. For rural households there are 6 deprived categories based on gender, caste, income, disability, lack of any adult in household and lack of shelter and for urban their 11 defined unorganised sectors of employment including ragpicking, street vendor, sweeper, electrician and similar others.

Some categories such as PVTG and families in complete destitution are automatically eligible. In states like Jharkhand, an income cap wage of any employee less than 72,000 per year is recognized as eligible for Ayushman Bharat health insurance (Official website of Government of Jharkhand State,2021).

Requirements. The requirements for making an Ayushman Bharat E card includes presence of an Individual Id and Family Id of the beneficiary. Individual Id primarily consists of Aadhar linked to any bank account for providing the insurance benefits. During the treatment also only once can the user take some other government recognized id with them and even then, signature of beneficiary to produce Aadhar for next visit is required. Family Id includes the Ration card, Household Id, Pan Card, PM letter, RSBY URN, and any other state recognized Id. To register for the Ayushman scheme, users can check the eligibility on the official website of Ayushman Bharat Digital Health Mission or visit their nearest centre or participate in the nearest digital drive. Other places for knowing entitlement includes empanelled hospitals, Asha or AWC members, self check-in via mobile application (Kerala Development Society,2020).

Treatments covered under Ayushman Bharat. There are secondary and tertiary hospitalisation care covered through a set of 1393 defined packages, including one (1) unspecified surgical package, across 24 specialties from Non-Communicable diseases (NCDs), Mental health, ENT, Ophthalmology, Oral health, Geriatric. Some services that are covered under this scheme includes, Medical examination, treatment, and consultation, Pre-hospitalization, Medicine and medical consumables, Diagnostic and laboratory investigations. The facility also provides Post-hospitalization follow-up care for up to 15 days and non intensive treatments(Medical facilities provided under Ayushman Bharat Yojana 2020).

In Karnataka, Ayushman Bharat works in collaboration with Arogya Karnataka scheme to provide Universal Health Coverage to all residents of the State. Both Ayushman Bharat and Aarogya karnataka have same goal, scope and therefore were integrated under a co-branded name called "Ayushman Bharat-Arogya Karnataka" from 2018. The integrated scheme covers Simple Secondary, Complex Secondary, Tertiary & Emergency Procedures. Primary treatments and simple secondary procedures are limited to PHIs only whereas Complex Secondary procedures, Tertiary procedures and Emergency procedures will be performed in PHIs and empanelled Private hospitals. The scheme also provides benefits to those who do not come under "Eligible Household"under the NFSA 2013 or are not enrolled RSBY beneficiaries, the sum assured is 30% of the package rate up to Rs.1.5 lakh per family per annum.

Objectives

- To understand the awareness of Ayushman Bharat PM-JAY among the migrant workers of Jharkhand and Bihar living in major cities like Bengaluru and Delhi.
- To identify the various healthcare challenges these workers face and whether they are able to utilise any of the benefits of their entitled social security.
- To identify any possible challenges in enrollment or utilisation of these social security schemes and discuss opportunities for technology to be leverage for improved healthcare accessibility.

Research Questions

- What are the different challenges they face in utilisation of the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana?
- What can be done to strengthen health insurance and health entitlements for interstate migrant workers?
- What are the areas that can be used by technology to provide assistance while implementing a social security programme for interstate migrant workers?

Prior Literature

Accessibility of Social Security Schemes

Migrant workers in India continue to have poor access to social security schemes due to various structural and cognitive barriers. A study by Kerala Development Society (2020) on migrant workers from states like Jharkhand, Bihar coming to Kerala shows poor access to a number of central and state level healthcare schemes due to the lack of awareness among beneficiaries about their various entitlements. Migrants were found to usually work in high occupational risk situations and the low health accessibility for them is very concerning and requires improved understanding about these challenges these interstate migrants face for assessing social security schemes.

A study by Public Health Foundation of India (2014) found, In Nasik city of Maharashtra, Construction migrants faced two major barriers to health access. First, lack of awareness of health facilities and their entitlements and second lack of confidence in utilising these facilities. The lack of confidence among migrants stems from their fear of a new system, local language, cultural bias, and distance from the hospitals. Understanding the small periods of employment i.e. seasonal migration and fitting them in a health accessibility conversation is itself a challenge.

Another study by Santalahti(2020) on the construction workers in the Manipal region in Karnataka found structural barriers to healthcare access including the distances from the hospital, inability to afford treatment and some cognitive barriers such as lack of adequate information to access basic facilities and distrust in public health services for any treatments. The distrust was largely due to difficulties of migrants to speak the local language.

Further, recent studies have also highlighted an invisibility of women's work as migrants even when they are having a higher rate of migration than men(Census, 2011). Mishra(2020) did a study on women's accessibility to maternal health facilities in slums of bangalore and found that private healthcare centres have more presence and acceptance for the poor migrant communities due to they are greater in number. However the high cost of maternal facilities led to the utilisation of prenatal and postnatal healthcare services being unsatisfactory.

Discussions around Social protection have also been raised where some of the recent work from Sewa, an Indian based women NGO indicates a lack of social security protection and healthcare access for women during Covid-19. Prof Deepa sinha working with Sewa says "For instance, when a woman is married out of her village, but goes back to her natal village to deliver for five or six months, often for those months, which are the most important, she doesn't get these services because her residence seems to be somewhere else; all of our schemes are still linked to the place of residence. This keeps women out particularly from anganwadi services and PDS"(Express News Service, 2022). Another NGO called Sampark which helps migrant workers in Karnataka to apply for 19 different types of social protection schemes found very few women entitled to the social security schemes and many of those who were aware, were not able to utilise it due to various existing gender bias and barriers within the family(Sampark, 2020).

When considering the case of social protection with specific focus on Ayushman bharat, Muraleedharan(2019) conducted a quantitative study in three states of India including Haryana, Tamil Nadu and Bihar with the help of National Health Authority as supporting organisation. The results of this study indicate the role of the state in promoting the social security schemes, where the poor and late campaigning strategies resulted in lack of awareness among people about Ayushman cards in the state of Haryana and Bihar. The lack of awareness was observed even in proper utilisation of Ayushman Bharat as no information was provided for knowing the empanelled hospital, diagnostics and procedures and thus most of the beneficiaries remained non users, unaware of any grievances and support.

Research Gap

The literature gaps explored here include a lack of any qualitative research to understand the effects of Ayushman bharat and its challenges. The studies mentioned above provide a very myopic view of migrants living conditions and not much exploration on the various intermediaries that assist in healthcare accessibility. Therefore, the current study would try to understand who helps in healthcare accessibility and what can be done with technology to improve the current process. Also, no research has been done to identify the role gender plays in health related communication for migrants and whether women are able to express their problems to community health workers.

Methodology

Study Design

The current study is an explorative, cross sectional, qualitative study, aiming to explore the various health accessibility challenges for migrants and find the intermediaries associated with the process for the migrant workers from Bihar and Jharkhand living in major cities like Bangalore and Delhi. The use of semi structured qualitative interviews is done in order to understand migrants' perception of problems and some structured questions are provided to confirm some of the concrete information useful in further analysis. Questions were structured around Ayushman Bharat, its awareness and the accessibility of the various health facilities nearby. Participants were allowed to discuss their own challenges of using different social security schemes such as ESI or any other scheme and describe reasons whether they were able to utilise its benefits.

Sampling

The study used purposive sampling. PHIA foundation, a partner organisation provided numbers to conduct telephonic interviews with low income migrant workers of Jharkhand. For identifying the target population, occupational categories were used which belonged to low income informal sectors eligible for the Ayushman Bharat health insurance. Other than the telephonic interviews, purposive sampling was also followed in Electronic city, where specific shops or regions belonging to low income workers were chosen for the interviews.

The study was conducted between January, 2022 to April, 2022 and the interviews were taken across the time span of two months that is between March to April, 2022. The results included interviews of 25 individuals, 20 of which were migrant workers from Jharkhand and Bihar while the other 5 interviews were of the employers who were identified as a major stakeholders when studying healthcare accessibility for migrants. The questionnaire prepared was translated into Hindi and administered alone.

Participant recruitment

Participants were contacted with the help of cold calling methods for telephonic interview and visits were also made in electronic city phase 1 of bangalore for in person interviews. After calling over 40 numbers of migrants from Jharkhand, only 18 responded out of which only 11 telephonic interviews were taken into consideration due to the time and details they provided. These workers on telephone were not only from Jharkhand but some of them were also from Bihar working in two major occupational categories i.e. seven as the factory workers, 5 in an automobile factory and two in cloth factory. while three as household monthly wage workers in Delhi and one electrician. Other than this, I also visited 9 migrant workers living in Electronic city phase 1, Bangalore in which five were Construction workers, two were working in restaurants and two as security guards. I also visited their working places to understand how far they stay from hospitals and whether they are aware of any nearby health facilities. The interviews lasted an average of 12 minutes for telephone and around 15 minutes in person.

An additional five interviews of the stakeholders were also considered, one from the Ayushman healthcare and wellness centre in Bihar, one from a manager in an automobile factory in Delhi and others from an occupational nurse in a construction site in Bangalore and the two restaurant managers having Jharkhand migrants working under them. These interviews helped in understanding the role of intermediary in making the health accessibility better.

Data analysis

The data collected in the form of an interview was coded using open coding and later, I used affinity mapping to find the qualitative patterns existing. I used grounded theory for this study and some of the quantitative data were also analysed using excel to build relationships among variables. The responses collected were in hindi and were translated into english for the final report submission.

Ethical Consideration

The study did not require any personal identifiable information and therefore columns such as mobile numbers, names were not made and used for any form of analysis. Both telephonic and in person interviews were conducted from 10th to 25th april. Ethical clearance for the study was obtained from the IRB committee at IIIT Bangalore.

For the interviews, Oral consent was obtained from the participants and all concerns and questions were answered before the questionnaire was administered. There were no recordings made of the interviews conducted and only pen and paper were used for participants' observations. Anonymity and confidentiality of the beneficiaries was assured, and maintained.

Findings and Analysis

Demographics

The data using excel for analysis is given below. The participants belonged to different age groups from minimum 21 to maximum 47. The mean age of the participants was 26 years. Gender ratio between male and female was 4:1 where there were 16 men and 4 women. Out of the 20 migrants, Fig 1.0 shows that there were 13 migrants interviewed belonging to Jharkhand while the rest 7 belonging to Bihar.

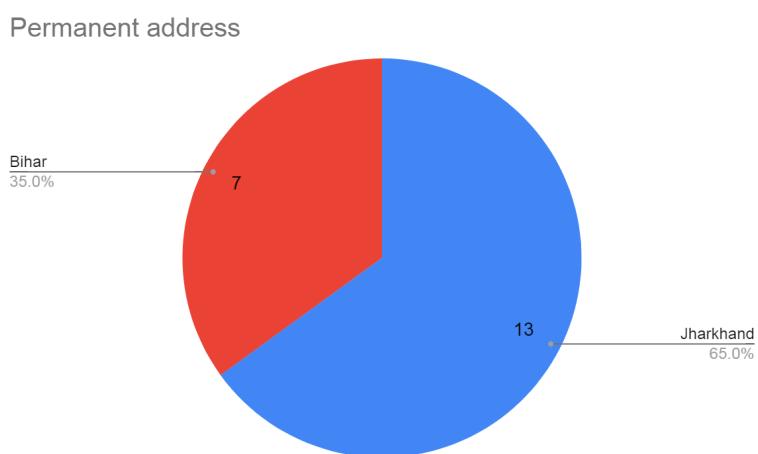


Fig 1. State wise Permanent Address- 13 from Jharkhand and 7 from Bihar

The interviews were taken in Bangalore(13) and Delhi(7) as shown in Figure 2.0.

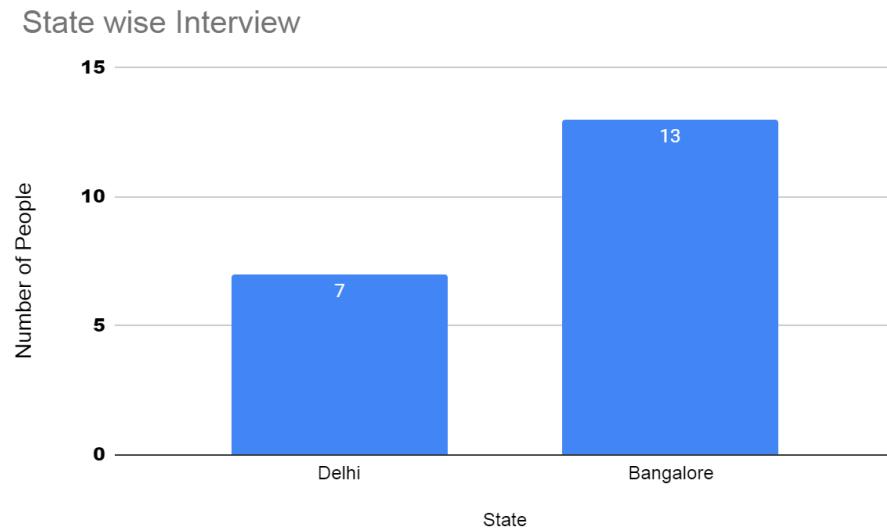


Fig 2.0 -State Wise Data Collection - 13 from Bangalore and 7 from New Delhi

As shown in figure 4.0, migrants interviewed were less than 2 years of migrants, 5 were less than 4 while the rest 4 were less than 6 and 4 were more than 6 years of migration.

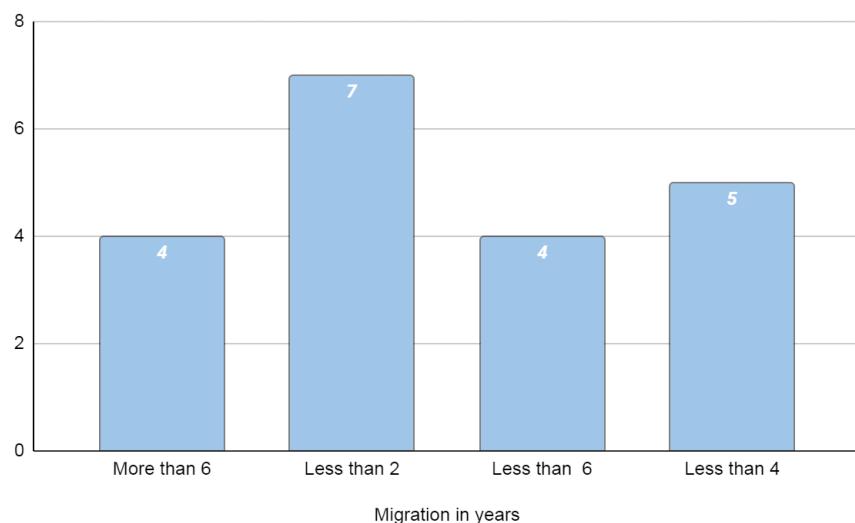


Figure 3.0 Migration in year

The Fig 5.0 shows the distribution by occupation where the two most prominent occupations included in the study were the factory and construction workers which together make for 12 interviews. Three Household worker interviews were also considered along with two hotel workers, an electrician and two guards.

Occupation

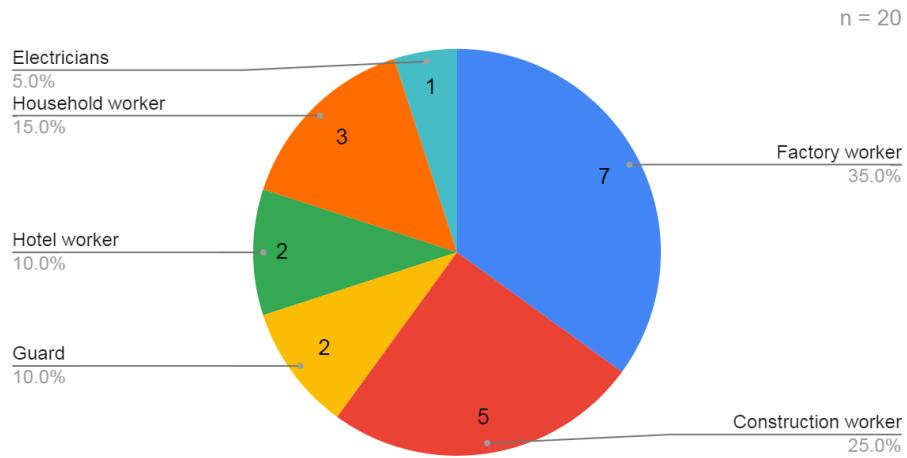


Fig 5.0 Occupation wise distribution

Fig 6.0 shows Out of these 20 workers, 14 owned a smartphone in which all of them were using Whats app, facebook was the second most prominent website with 11 users confirming its use.

Smart phone availability

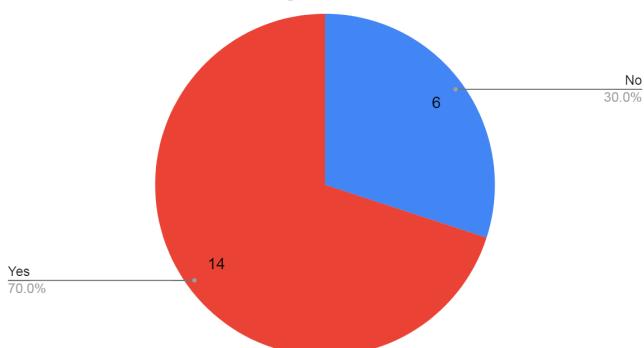


Fig 6.0 Availability of Smartphones

Social Protection data

Figure 7.0 shows that Out of the 20 migrant workers, 14 workers said they have been covered by some or other form of health insurance- Ayushman and ESI.

Do you have any health insurance scheme covered?

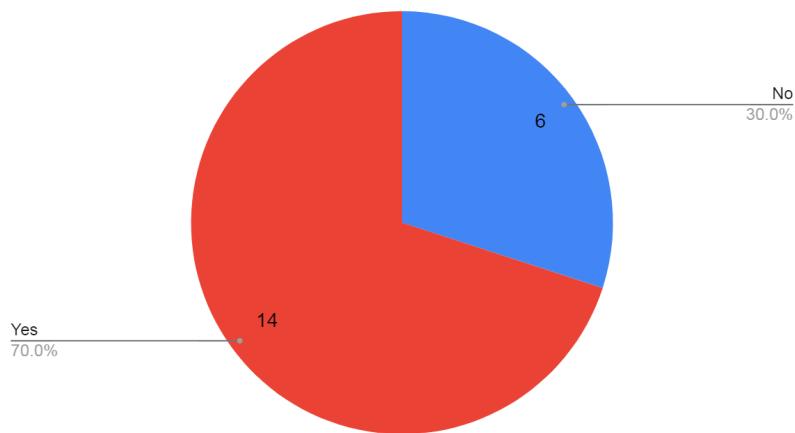


Fig 7.0 Health Insurance Covered

When asked about the presence of Ayushman Bharat Card, 11 people responded with a yes to having an Ayushman Bharat card, while 6 people who responded did not try or had failed to make one and 3 people responded with never heard as shown in Fig 8.0.

Ayushman Bharat Present

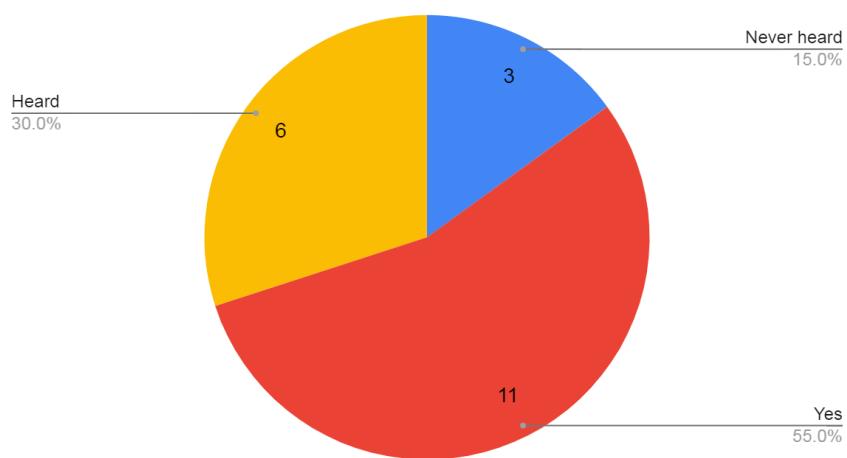


Figure 8.0 Presence of Ayushman Bharat

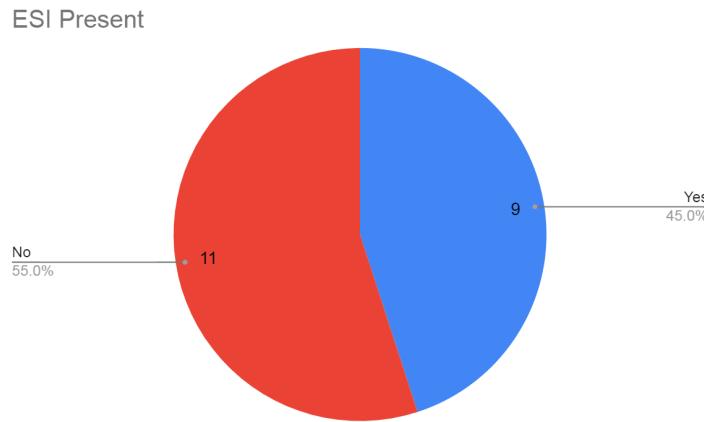


Figure 9.0 Presence of ESI

Fig 9.0 shows Migrant workers who admitted to be covered by ESI included 9 workers, out of which 7 were from the factory and the rest 2 were security members.

Healthcare Accessibility

In the current study, I found many structural and cognitive barriers to access to healthcare. Structural barriers were universal, such as distance from health and cost of private health facilities while cognitive barriers include fear to visit the hospital or unawareness of the health facilities nearby. One problem which migrants talked about was their inability to understand the local language which led to problems in communicating with the health facility or having confidence issues in visiting the health facility in some cases.

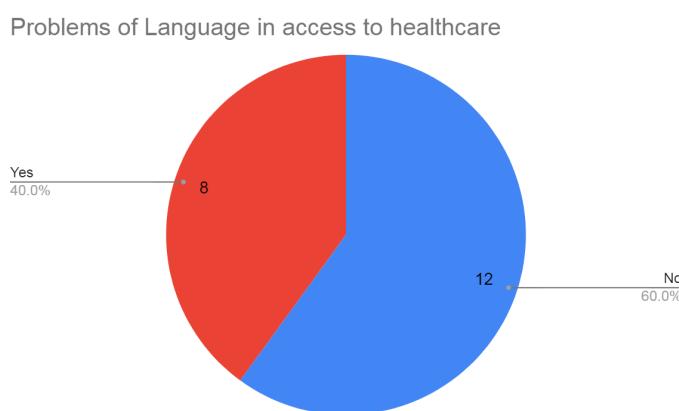


Figure 10.0 Problems with communicating

Migrants of Jharkhand and Bihar were comfortable in speaking Hindi. They explained how language was a major barrier to access healthcare. Among the 7 migrants

interviewed in Delhi only two complained about their inability to explain the problems to the doctors in private hospitals and they were able to find some of the alternatives. But in Bangalore, among the 13 migrant workers interviewed 6 complained of not being able to access healthcare due to language problems. Out of these 6 workers only 3 had utilised any health facility, while the other 3 interviewed had never gone to any hospital but were hesitant that they would not be able to speak.

Birju the barber says,

"I haven't faced any health problems till now here but I wouldn't go to any of the doctors. The only way to survive in Karnataka is to learn Kannada and after two years I can barely take a bus, hospitals are a long way".

Similar fears of concerns were shared by participants who believed that going to any health facility will be a problem. Three of the participants who went to a health facility and faced problems because of language and explained that they were unable to utilise their social security schemes because they found it difficult to explain their problem.

Shravan A guard says 5 says,

"I have both ayushman card and ESI. I had to go for an emergency operation for my wife and doctors said it cost Rs 1 lakh 20 thousand, when I went there I asked them about ayushman to which they denied and it is impossible to use ESI without knowing Kannada here. So I ended up paying the complete cost"

In the same electronic city, migrants who were assisted by community nurses to take them to hospital indicated that they were able to communicate in Hindi with the doctors and staff which indicates that hesitancy towards language might stem from lack of support.

Awareness about the nearest health facilities

Table 1 shows some of the health facilities participants talked about. Most of the participants went to the nearest shops to buy medicines for any problems. When asked about healthcare they only named a few private hospitals, that too only two workers were able to.

Health Centre	Nature	Participant talked about
Narayana	Private	Yes
Kauveri	Private	Yes
Hebbagodi Govt Hospital	PHC	No

Table 1 - Health facilities participants talked about

Awareness about nearest health facility

Figure 11.0 shows the number of migrants who had some idea about the nearest health facility. Construction and Factory workers reported a high dependence on their health supervisor for treatments and most of their knowledge about health facility came only through these supervisors.

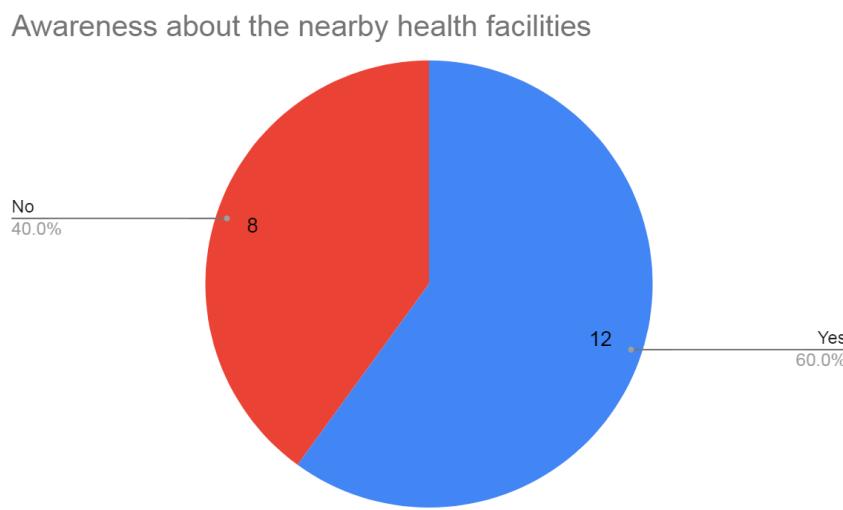


Figure 11.0 Awareness about the nearest health facility

Dheeraj a construction worker responds,

"I do not have a choice to go to any hospitals here. Sir takes me to any government hospital as he wishes, we just sit in the van and go"

Those who were unaware about the health facility included the occupations such as household workers, hotel workers and some factory workers in Bangalore which did not have a proper health supervisor. Even when asked about health facilities known to them, most of them would point out that private hospitals in electronic cities to which they referred lack affordable treatment.

\Keshav a hotel worker says,

" I only have heard of a government hospital which is around 40 km away from here, this is too far and so I do not go there."

Three participants also talked about how Ayushman is not being accepted in the nearest private hospital and thus distance becomes an important variable when considering health accessibility and use of social security schemes.

Awareness about the Ayushman Bharat Scheme

Figure 12.0 shows that Ayushman Bharat was fairly well known among the participants. Only 3 participants responded that they did not have heard of the scheme. However, it was noted that people recognize ayushman bharat as pradhan mantri yojana and only 8 identified themselves as beneficiaries. The rest would ask me about the benefits and the process of making the card which shows that awareness about the procedure has not been very good. Some participants also demonstrated a lack of interest in health insurance due to their rental concerns and high cost of living. They also talked about nearest health facility being enough, while others remained confused about the right documents

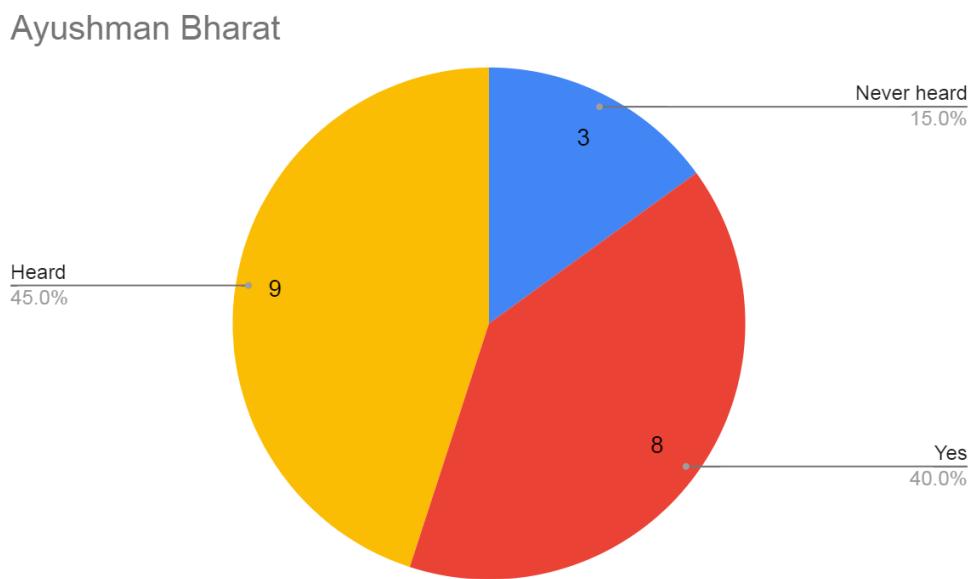


Figure 12. Awareness about the Ayushman Scheme

Concerns for Ayushman Bharat

Access to attend drives. Ayushman Cards for all the participants were made during digital drives in their own native states. If one member of the family went to the drive, others were naturally enrolled with an exception of those who live in different states. Some migrants living in Delhi talked about no need for health insurance as most of their needs are covered by government hospitals and medicine shops. Government hospitals provide minor treatment at very minimal cost and even free in some instances and therefore access to government hospitals remains crucial.

Pappu, a household worker says,

"I do not have ayushman card, I get my treatment done free in the government hospital and get medicine in the corner shop. It was only in 2018 that I had to pay 47 thousand for appendix surgery in a private hospital but now things are fine, mother is telling me to make ayushman card and I will make it when I go back to my home. "

Lack of Document Availability. The second problem was document availability for the Ayushman Card. Ayushman card requires some documents such as Aadhar, ration card or any family card and many of the participants complained that their ration card was at home. While other household ids could also be used, participants were only aware of the ration card which they failed to produce even before going to the digital centre. One participant complained about his failure to link aadhaar with the bank account and thus was not making his ayushman card,

Iqbal who works as a barber in Bangalore says,

"After coming for work, I wanted a bank account linked to aadhar to get government benefits. When I went to the bank they needed my residency certificate for making the account. Unable to understand, I am still using my wallet for transactions."

Lack of Acceptance in Hospitals. Many participants complained about the expenditure they had to pay for their treatment, three of which were Ayushman holders but were unable to use it.

Fig 13.0 shows only 4 people said they have used the Ayushman Card or have helped their family in using the card. Most of them talked about using it efficiently for health services in their own states and only 2 answers living in Delhi said they were able to use it.

Those who have ayushman card and have used

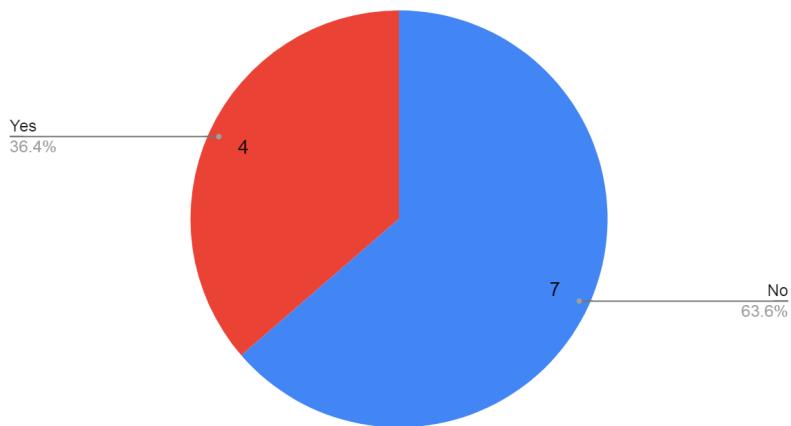


Fig 13. Ayushman Bharat and its use

Seema says about her inability to go for an expensive treatment,

"All of us in our family had ayushman card, my husband broke his foot and was fitted with a rod, he had to leave his job and we went for an operation. The operation was paid by us only but we want now to remove his rod. The doctors in Delhi denied our ayushman and we had to come to patna, It has been 6 months we are trying to get a date in Government hospital".

Brajesh a guard from Bangalore provides similar insights,

"I visited the hospital yesterday for my wife's eye operation. "I went to the nearest hospital with my Ayushman card but got rejected on the counter. I had to use my ESI instead for getting the treatment done. For using ESI we need to have some proficiency in kannada and if it was Jharkhand I would be able to use Ayushman benefits easily".

Nayan, his friend also says,

"I have been living in karnataka for the last 5 years, I know the hospitals nearby don't accept ayushman. ESI they do, and you have to explain to them in some little kannada about the scheme."

While both these schemes offer some forms of health insurance and almost equal numbers of participants had Ayushman and ESI, most participants without even knowing the benefits of Ayushman preferred using ESI as shown in Fig. The first reason provided by migrant workers in Karnataka was the complete denial of the ayushman scheme by nearby hospitals. Another reason provided by the factory workers in Delhi and Bangalore was lack of assistance in the Ayushman Bharat scheme by the employer whereas the ESI showed some form of assistance by the employer.

Major health issues Payment method

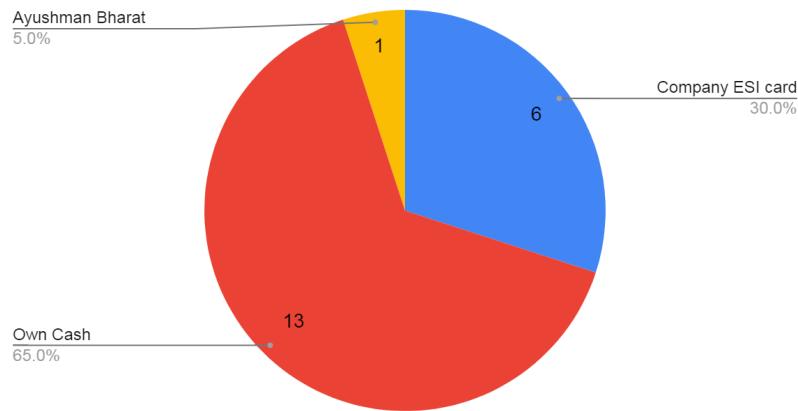


Figure 14: Payment method for migrant workers

Birju working in a Factory says

"If I have any health problem I go to the health facility that sir has told us to go to. It does not reject my ESI and I can also contact sir in any need". Another participant of the same factory said"

Iqbal also working factory says,

"I find difficulties in using ESI elsewhere, sometimes they say no, but here they don't say no as sir talks to them".

This indicates an importance of the relationship formed between the employer, worker and the hospital. For construction workers the community nurse says,

"I always get them free treatment in any government hospitals no matter if they bring ayushman, ESI or any other scheme, I would talk to the hospital and get their treatment done".

Role of Intermediary

Intermediary played a very crucial role towards healthcare accessibility. Construction and Factory workers, two of the major demographics of this study, relied completely on their intermediary for health needs. The reliance was so much that none of them shared any incidence of visiting a hospital without informing their employer.

Pappu a construction worker responds,

"For simple things like medicine I go to the nearest shop by asking our munshi(construction nurse), but for any major illness which I haven't faced, they take us in a van to the hospital to get his treatment done".

This community nurse was the occupational health nurse in civil construction and his duty was to look after around 400 construction workers on site. Even for factory workers, an absolute dependence on their employer for any small health needs was seen. Moreover, Intermediaries were also counted as the home owners in which household workers were working.

Guddi a household worker says,

"My daughter was very ill and I had no place to go, I asked madame to help me and they took her to the nearest hospital, they paid the cost which I could not have afforded"

However, Mantu, another household worker, did not receive any help from his employer for his appendix treatment. Intermediary also provided confidence. Two of the restaurant workers I went to, I encountered 2 migrant workers from Jharkhand who said they completely believed their employer for their treatment.

Intermediary Concerns

One of the hotel employer whose said,

" Ask the nearest hospital, do they accept ayushman!? I only know of one government hospital 40 km away, even there these people won't get their number done on time, so what can I do ?"

Another hotel employer responded,

"I drive 50 km away on some days, I am new to this place and do not know many hospitals here, if they would require me to go anywhere I can google the hospitals and help them."

One construction nurse who handles around 400 workers said,

“ I provide them all the small medication here in my office but when they require me to go to hospital, I find it difficult to book appointments and it takes time and rest. I do all the processes Ayushman or ESI use for their free treatment.”

None of the participants or employers had heard or used the E sanjeevani telemedicine application of Ayushman Bharat.

Discussion

The findings were mostly aligned with the previous work. One of the major problems that exist in the way of Ayushman Bharat was the lack of awareness about the process to make an e card in a different state. Many migrants who had heard of the Ayushman Bharat insurance confirmed that their families have made the Ayushman card in their native places and they are not able to register due to an inability to find time as well as having no knowledge about the centre and the process in the new state. An even more severe concern for migrants included the lack of awareness of hospitals which would accept their insurance scheme. While ayushman makes it clear that eligibility includes all government hospitals and empanelled private hospitals, in areas like electronic city where there are no big names in government hospitals and only private hospitals, distance to health facility becomes a barrier to health accessibility. This is similar to Santalahti(2020) where structural barriers including the distances from the Government hospital and the inability to afford private treatment become significant barriers to access of healthcare for migrant construction workers.

Also, the study finds language becomes a major barrier towards accessing healthcare facilities especially in affecting confidence in utilisation of social security schemes in Karnataka. This also aligns with Public Health Foundation of India (2014) study in Nasik city in Maharashtra where construction migrants lacked confidence because of the fear of a new system and local language. A new finding from our study indicates that language can actually lead to denial of social security schemes and protection which needs to be dealt with tighter regulations.

Nearby Facility

One of the major study focuses is to address migrant workers' health accessibility with special focus on secondary and tertiary healthcare due to the scope of ayushman being applied there. However, participants that were interviewed also shared their everyday health experience where the nearest medical store was coming out to be the most accessible healthcare solution.

In my opinion, hospitals seem to be a major healthcare barrier, and where PHC can reduce these barriers its awareness is close to nil. Therefore, the government should either focus on the visibility of PHC or ensure that PHC access can be through multiple small outlets such as medical stores helping participants take consultancy or reach the nearest PHC instead of hospitals.

Digital Literacy

In the discussion of migrants, digital literacy is an important variable to be considered. Migrants, because of working in major cities have adapted to smartphones and the 70% smartphone adoption rate from this study is a good indicator for this. Buying a smartphone is also an indicator of the ability to manipulate it, as our study shows all the smartphone users were connected on whats app with their families. While they might not be aware of the nearby health facility, they certainly could take help from digital applications for healthcare. But, keeping multiple applications such as E sanjeevani has found zero awareness. Therefore, new applications for telemedicine firstly require awareness programs, then usability testing, then adoption aids and finally some expertise training among migrants to operate cameras, voice and many more features. This is where platforms such as tik tok, facebook, whatsapp will prevail as their ability to connect to a much larger set of audience with entertainment and easy to use interface could help in improving healthcare accessibility by spreading information and generating awareness.

Intermediaries

The role of Intermediary is the most significant finding of this report. The high dependency of factory and construction workers on their employers helped them to have improved healthcare access. Intermediaries also provided information, thereby reducing the cognitive barrier and at times would also pay the cost and travel fees and help utilise their social security thereby reducing the structural barrier.

In Karnataka, where there was a constant fear of inability to speak the local language in hospitals, the workers associated with intermediaries such as construction workers demonstrated no such fears. Conversations with the employees also revealed that the barriers of language, distance and the inability to use social security were effectively tackled at their employer's end. Even in some instances, employers assisted workers till the hospital and ensured proper treatment takes place.

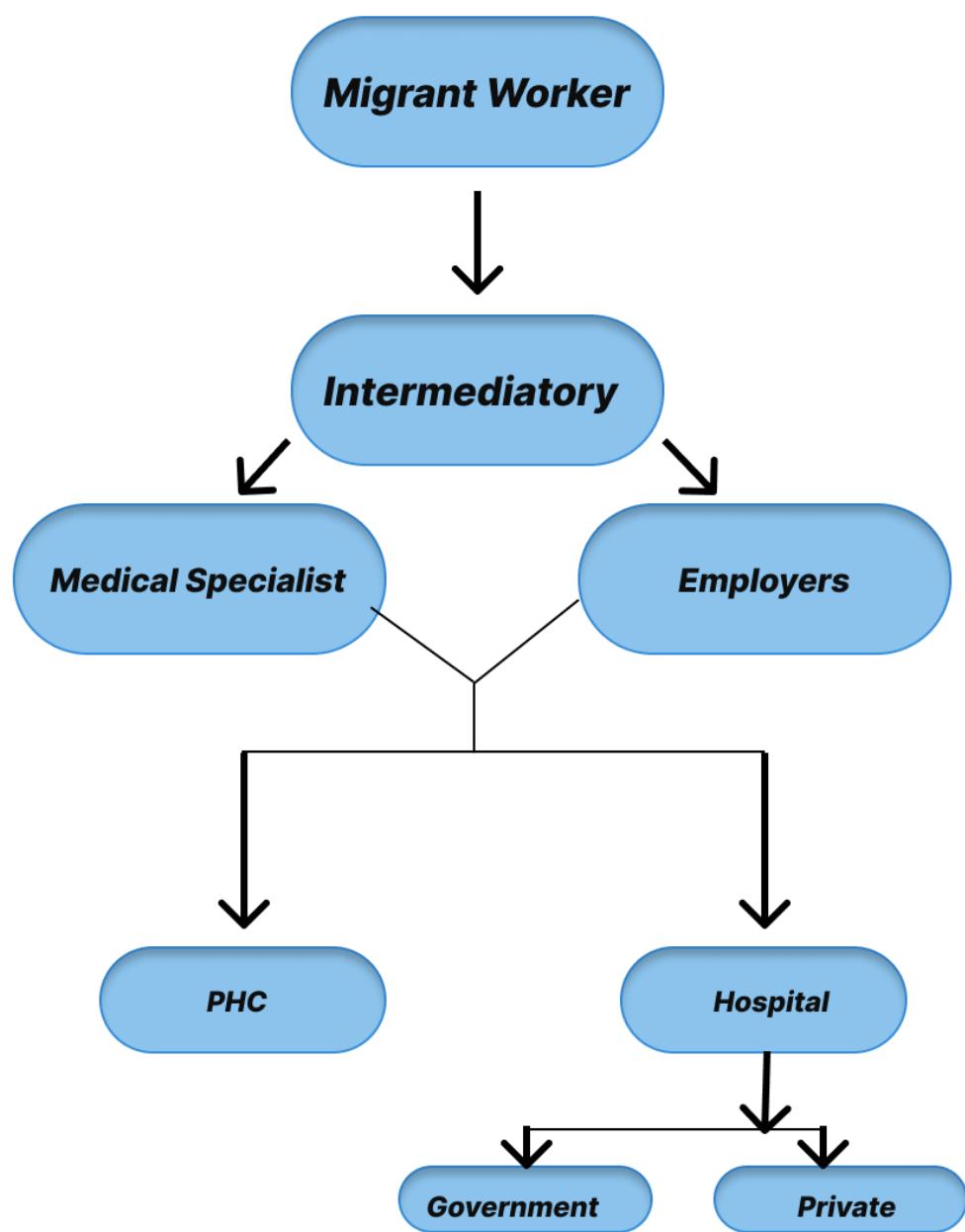


Figure 15 - Authors Own Working of an intermediary

Fig 15 shows the different classification of intermediaries by the author into two types. First, the employers who would take their staff to the health facilities. These include the construction and factory site owners, hotel as well as household worker employers.

The second type of intermediary is a medical specialist which could be a formal(by the legislation) or informal medical specialist. Formal medical specialists are the community nurse that takes workers to the government hospitals when necessary. They also ensure that social security schemes are getting utilised and are given incentive by the government for their work. Informal medical specialists include the nearest medical store that provides them with medicine when in some problems. These stores also guide them to hospitals and medical facilities nearby.

An essential finding of this study is improving healthcare awareness and accessibility of intermediaries about the nearest health facilities such as PHC will help them to guide their employees to the places that are affordable and accept their medical insurance. While, not much can be said about utilising informal medical specialists for healthcare access through technology, making healthcare applications compulsory for the formal health intermediaries can be very helpful. This will also solve their challenges of prescribing medicine, booking appointments and enrolling workers in social security schemes.

Thus, the study urges us to look further into the dynamics between intermediary and the beneficiary and see whether digital application can be provided to these formal intermediaries to impact a larger scale of employees . However, the same can not be said for other informal workers such as household workers and hotel workers, who do not have a formal intermediary incentivised by the Government of India.

Conclusions and recommendations

The study provides an insight into the migrant workers health accessibility challenges. The migrants continue to face various cognitive and structural barriers in Bangalore city such as low confidence level, unawareness about the location of hospitals and financial constraints. Social security schemes such as Ayushman which are aimed at improving healthcare access have also not been very useful due to denial at the nearest hospital or inability of migrants to express their rights as seen in case of ESI. Therefore, the study is able to show multiple gaps in health accessibility of migrant workers in major cities and technological solutions such as E sanjeevani demonstrates a strong use case in addressing these gaps. Some of the study recommendations are given below:

Targeting Technological Solutions:

Visibility of PHC

The study reveals that the current approach towards migrant workers' health accessibility is not suitable. This was established because migrants lack awareness and interest in using digital applications such as e sanjeevani for healthcare purposes. The Health and Wellness centre and nearest PHC both remained out of reach for migrants due to lack of available time and awareness about their existence and so most health problems were tackled at nearest medical store or visible hospitals(Government/ Private).

Therefore in order to improve overall health accessibility, visibility of PHC and nearest health and wellness centres are essential. This can be done through offline campaigns or use of facebook and whats app to target the migrants about their nearest health facility. I see OTT platforms as a valuable source of spreading awareness because the 9 migrant workers that did not have ayushman and lacked information were very interested in knowing about the health scheme and making them aware of its requirements and existence would definitely help. However, it requires a lot of effort to make sure that these OTT platforms guide the migrants to the health facilities instead of becoming a nuisance in their life.

Intermediaries

Another recommendation that comes forward through this study is pinpointing some of the constant intermediaries as channels for better healthcare access. Community nurses and factory health staff should be made compulsory to use telemedicine facilities to engage with medical specialists.

This was because E sanjeevani for migrants remained unused, as there was no awareness about the facility and also the centre that provided this facility. Even considering digital literacy to not be a problem, for migrant workers new applications require awareness, understanding of its features and the specific requirements such as good quality camera and audio in smartphones which might be a challenge that can be better tackled at the level of intermediaries. Even digital literacy seems to fall as we move towards more vulnerable sections of migrants.

Therefore the study recommends telemedicine or health accessibility related digital applications for formal intermediaries who themselves have a use case to receive guidance and assistance from medical staff for tasks such as booking appointments or prescribing the right medicines. Also, formal intermediaries can be made to assist in making the social security entitlement available to all migrant

workers working under them by requesting on the application for a digital drive nearby or taking its employees to the PHC location.

States

The strength of Ayushman enrollment is more in the native state than the migrant state. Most of the participants who had heard of ayushman bharat said that their families were able to make ayushman cards during the digital drive, but they were unable to. Their local ayushman centres and digital drives can use video conferencing to assist these family members staying away to be enrolled in the ayushman scheme as well. The document verification can be assisted by providing information about the nearest PHC. This process will ensure no one gets left out.

States could also assist in connecting these migrants to the nearby ashा workers. Often Asha workers and health workers act as strong health support systems that ensure social protection for their population. However, for migrants, there is a lack of access to this facility as indicated by Mishra(2000) which can only be helped by maintaining a strong database on migrants.

Challenges and Limitations

The outcomes of the study should not be considered without the various limitations that might have affected the findings and conclusion given above.

1. Limited access to data

The study has faced issues with limited access to data. The limited access can be divided into two categories. First, lack of representation and second lack of data from Geographies.

Lack of Representation

One of the major research gaps explored in the literature section included how women interact with health facilities and what kinds of effects gender play in access to social security schemes. Only 4 women agreed to answer the questions in health accessibility. Other women had either changed their number or their husbands were picking up the call creating suspicion for me as a researcher. This sampling bias can be filled by future research. The same goes for the construction workers where at two of the sites I was denied the access to talk to workers by their supervisor. Permission was denied and I had to move my study into different areas.

Lack of Geographical Representation

The study was conducted only in Electronic city phase 1. As I was unaware of other areas and was restricted due to time constraints, I only visited the construction site in electronic city Bangalore. Therefore, the study cannot be generalised for the whole of Bangalore as the availability of occupational nurses, government hospitals and private hospitals accepting ayushman card can differ.

The study provides its most important finding in the terms of the role of intermediaries in improving health accessibility. While the intermediary in construction and factory sites had improved the healthcare accessibility of migrant workers, not much could be said about their presence in every site and their nature towards healthcare. More in depth interviews are required for the beneficiaries of the health services received by occupational nurses and only then can we substantiate to provide technological solutions for intermediaries.

2. Time Constraint

Because the study was conducted in the middle of an academic semester, the author suffers from lack of effective time devotion to the current study. Therefore, the study would be continued.

Future Work

The study recommends more work to be done on understanding of interactions between community health workers and the migrants, with more representation across geography, gender and occupation. A promising outcome of the study on the role of intermediaries can be utilised for building upon the improvement in migrant work health accessibility and social protection. Empowering these intermediaries with technology and health application would certainly be a landmark step towards improving migrants health accessibility.

Annexure

Images



Image 1 Construction Site 1 - Electronic City



Image 2 Occupational Safety office in a construction site in Electronic city

Interview Guide

Demographics and General Information

1. Age
2. Gender
3. Occupation
4. Current Address
5. Permanent Address (DISTRICT)
6. Literate(Ability to read and Write)
7. Marital status
8. No of family members living together
9. Availability of smart phone
10. Ability to use any social media application such as Facebook and Whatsapp

Migration

11. When did you migrate to Bengaluru?
12. How many months/years have you been living in Bengaluru?
13. Who facilitated this migration?
14. Did you migrate alone or with your family?
15. Did you migrate as a group/unit?
16. What are some of the key health problems you face/faced during your stay in Bengaluru?
17. What did you do to solve these problems?

Health Accessibility

18. Did you also face any difficulties in reaching your nearest health facilities?
19. Were you able to tell your problems clearly to the medical staff?
20. Were you able to get the treatment done? If yes, describe your experience and any challenges you faced.
21. Did your employer provide any healthcare insurance for the cost coverage?
22. Did you also use any schemes to cover the cost of the treatment? Name the scheme.
23. If yes, were all other costs such as medication, tests and reports covered under this scheme?
24. Were you also provided any information about healthcare schemes and benefits given by any government or non-government agencies when you were migrating from Jharkhand?
25. Did you avail any of the government healthcare schemes in your native place?
Which and for what purpose did you use it?
26. Were you able to avail their benefits outside Jharkhand as well?

Ayushman Bharat

27. Have you heard of Ayushman Bharat?
28. Did you make your E card?
29. Have you ever used an E card?
30. Where and for what purpose did you use it for?

31. Did this cover all your health costs? Did you also have to pay any extra for medications or reports on your own?

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