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Assessing Health Care Scenario and Willingness to Pay for Health Insurance in Slums of Mumbai and Its Periphery

Basudeb Chaudhuri, Namrata Gulati, Imdadul Halder, Apara Banerjee, Ahana Roy, Safayet Karim

CNRS (India)

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Abstract:

Limited access to health care finances in developing countries results in increased “out-of-pocket” expenditures on health services. This pushes a significant percentage of the population towards impoverishment. This calls for intervention, that can lead to economic prosperity and reduce existing inequity. Can health insurance serve as a tool to finance health care to eradicate poverty? The objective of this paper is to detail the existing health insurance market for the economically weaker section in the state of Maharashtra. It attempts to find out the health status, health insurance coverage and willingness to pay for prepaid schemes in Mumbai slums and its periphery, based on a household survey done in the slums of Mumbai in 2013. The expenditure behaviour on health care reveals that out of the households that have spent a large amount on a major illness, about 32.7 per cent have had to incur out-of-pocket expenses. The penetration of health insurance is very low with only 15 per cent of the surveyed households being insured. Fifty-two per cent of the insured households show a tendency to prefer private medical institutions for treatment. Out of 85 per cent of the uninsured households, 22 per cent were willing to pay for health insurance. Results show low penetration of health insurance due to un-affordability and lack of awareness implying that there is lot of potential to develop this market.

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Introduction:

The health status of a country’s population is considered a critical factor in the economic development of a country today. The soaring cost of health care is a matter of concern the world over. The financial burden of health care is particularly onerous in the case of low income countries. According to Wagstaff (2002), the causality between poverty and ill-health runs in both directions. The poor are often caught in a vicious circle with poverty leading to ill-health. A World Bank report (2002) highlights how ill-health can lead to out-of-pocket payments leading to further impoverishment and indebtedness. Ahuja and De (2004) advocate health security to be a probable solution to come out of poverty trap, suggesting health insurance is an integral part of any poverty reduction strategy.

As per Bhat (1999), the health financing system in India is dependent on government budgetary allocations and private financing. The role of the latter has increased significantly in recent years. Most of it is ‘out-of-pocket’ private expenditure, which has grown at the rate of 12.5 per cent from 1995-96 to 2004; for each 1 per cent increase in per capita income, privately financed health care expenditure has increased by about 1.44 per cent. Peters et al., (2002) came up with the startling observation that more than 40 per cent of individuals who are hospitalised in India in a year borrow money or sell assets to cover the cost of health care. Bhat and Babu (2004) reveal how lack of effective regulation of private health services makes the cost of health care facilities unaffordable for the poor. As per the World Bank report (2002) one episode of hospitalisation accounts for 58 per cent of per capita annual expenditure, pushing 2.2 per cent of the populations below the poverty line. These studies thus imply that the poor and deprived households spend a much larger proportion of their meagre income on health care compared with socio-economically better off households.

Therefore, it is necessary to find alternative health financing mechanisms and one such alternative is health insurance (Bhat and Babu, (2004)). Zeller and Sharma (1998) have shown that even the poor can make small, periodic contributions that can help pay for their health care needs. Using the experience gathered in the slums of Mumbai and its periphery, this paper attempts to understand the existing health scenario, the extent of health insurance coverage and willingness to pay for it among the economically weaker section. A survey was conducted in
Mumbai and peripheral villages to elicit the willingness of the poor to pay for health insurance. Major findings have pointed out that the existing penetration of health insurance is still very low both because of it being too expensive and also because of lack of awareness.

The rest of the paper is organised as follows. Section I talks about the existing health insurance schemes for the poor both at National and for the state of Maharashtra. Section II elaborates the methodology adopted for the study. Section III reports the major results from the survey. Section IV discusses the health problems and expenditure along with the willingness of Mumbai slum dwellers to pay for health insurance schemes and factors inhibiting health insurance affiliation. Section V concludes by focusing on possible solutions.

**Section I: Existing Health Insurance schemes**

Initially, it was assumed that health insurance was never an option for the poor. They were assumed to be too poor to save and pay a premium. The government used to provide free health care facilities but this did not work well because of the inferior quality of services, as pointed out by Ahuja (2004). Soon it was realised that health insurance is an efficient way out.

The health insurance programme in India dates back to the early 1950s. This was when the Central Government Health Scheme for civil servants and Employees’ State Insurance Scheme for workers in the formal sector were provided as reported in PHFI, 2011. The next major milestone came in 1991 with the new economic policy and the liberalisation process followed, which paved the way for the privatisation of the insurance sector in the country. Dror et al. (2006) reported that policy makers in India turned their attention to proposals of health insurance for poor. As a result, community-based health insurance was developed in 2007 by subsidising premium for the poor and employees in the informal sector (PHFI, 2011).

At the central government level, the National Rural Health Mission and Rashtriya Swasthya Bima Yojana (RSBY) were started in 2007 while states specific initiatives consisted of Rajiv Aarogyasri (Andhra Pradesh), Kalaignar’s Insurance Scheme for Life Saving Treatment (Tamil Nadu), Vajpayee Arogyasri and Yeshasvini programmes in Karnataka, etc.(PHFI, 2011).
The Rashtriya Swasthya Bima Yojana (RSBY) has been one of the most important schemes at the national level. It was started for BPL families in the unorganised sector. The scheme started soliciting subscriptions on April 1, 2008, and has been implemented in 25 Indian states. It provides for cashless insurance for hospitalisation in public as well as private hospitals. By March 31, 2011, RSBY succeeded in covering about 27.8 per cent of the number of BPL households, categorised as such by the Tendulkar Committee. The scheme issued smart cards to BPL families on paying a registration fee of only Rs.30. In return, the BPL family was entitled to more than 700 in-patient medical procedures with a cost of up to Rs.3000 per annum in any of the empanelled hospitals. Coverage extends to the head of the households, spouse and up to three dependents; there was no age limit. It also covers pre-existing medical conditions (rsby.in). Although RSBY grew rapidly, only a minority of BPL households in India have been covered so far, and the scheme is yet to be implemented in all districts of all states to cover all BPL households in India, as has been mandated by the Government of India.

In case of private sector, the lowest premium available for coverage of Rs.1 lakh per annum is Rs. 1700. This is under Apollo Munich and is only applicable for the insured individual.

Health Insurance Schemes for Maharashtra

Although there is already a low-cost health insurance scheme by the government for the BPL population like RSBY, the Maharashtra government has not implemented the RSBY since 2007 in some districts. So there exists a potential market for health insurance in this poorer section of Mumbai. The latest media reports of ILO indicate that the Government of Maharashtra has withdrawn from the RSBY and launched the Rajiv Gandhi Jeevandayee Arogya Yojana (RGJAY) as highlighted by Gothoskar in his paper in 2014.

Other pre-payment mechanisms to finance curative health services for the poor specific to the state of Maharashtra are User Fees and Jeevandai Arogya Yojana (JAY). Both these systems were launched in the 1990s. The User Fees failed to gain coverage as it required the poor to produce evidence of their poverty and in most cases, the deprived were unable to produce such evidences. Jeevandai Arogya Yojana was modified to RGJAY in 2011. The financial limit of the scheme extended from Rs. 50,000 to Rs. 150,000 in 2006 and cancer was added to the list of illnesses that were brought under the scheme. RGJAY was introduced in eight of the state’s 35 districts on a pilot
basis. Currently, the RGJAY offers insurance coverage to 49 lakh eligible beneficiary families in eight districts: Gadchiroli, Amravati, Nanded, Sholapur, Dhule, Raigad, Mumbai and its suburbs. It aims to eventually reach eighty million people. The premium of Rs. 333 per family per year is borne by the state government, (Thakur and Ghosh, 2013). The problem with this scheme, however, is that it excludes general illness and covers procedures like neurosurgery, cardiac surgery, etc., that affect only a small proportion of the population (Gothoskar, 2014).

The above schemes clearly point towards the need to take new initiatives on the road of health insurance. The direction of these initiatives should be evaluated only against the backdrop of the present health care scenario and the level of expenditure made on health. The basic idea is to see to what extent government should intervene given its fiscal status. In order to determine this, we designed a questionnaire to extract information on current health expenditure and establish the willingness to pay for these services. The next section outlays the way the survey was conducted and reports the major findings.

Section II: Methodology

To investigate the extent of health insurance coverage among the urban and rural poor and to find out factors influencing a household’s decision to invest in a health insurance scheme, primary data was collected by conducting a household survey in July 2013 through site visits in different areas of Mumbai and nearby villages. The reason for selecting Mumbai is obvious. The main target population for the survey conducted for the paper was the economically weaker sections of society and hence slum dwellers were focused upon. Census 2001 reveals that among the 4 metros of India, Mumbai has the largest slum population; therefore, Mumbai and adjoining areas were selected for the study. This method of collecting data through household surveys has been frequently used to study the purchasing decision on health insurance as pointed out by Strunk, et al., (1999).

Households were selected on the basis of the random sampling method. According to Kelley et al, (2003) it is one of the most stringent techniques where each individual within a chosen population is selected by chance and each has the same chance of being selected as anyone else. Following this technique, 165 households were surveyed from different slums located in Mumbai and its suburban districts and a few villages of Raigad and Thane districts of
Maharashtra. Seventy per cent of the 165 households surveyed in this study belonged to urban areas while the rest were from rural areas.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Category</th>
<th>% of HH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Income</td>
<td>&lt;5000</td>
<td>21.8</td>
</tr>
<tr>
<td></td>
<td>5000-10000</td>
<td>41.8</td>
</tr>
<tr>
<td></td>
<td>1000-20000</td>
<td>26.7</td>
</tr>
<tr>
<td></td>
<td>20000-40000</td>
<td>7.9</td>
</tr>
<tr>
<td></td>
<td>&gt;40000</td>
<td>1.8</td>
</tr>
</tbody>
</table>

| Education | Highly Educated | 44.2 |
|           | Moderately educated | 41.2 |
|           | Low Educated | 14.5 |
Survey questions were designed to understand why the majority were not insured and what were the cost consequences of remaining uninsured. The other important objective was to obtain information on how much they were willing to pay. Willingness to pay is widely seen as an invaluable research tool to investigate public preferences for goods that do not have a free market price (for instance see Bacon-Shone and McGhee (2007)).

In order to evaluate the willingness to pay for health insurance schemes, consumers were given a choice between two schemes, which varied with respect to coverage and the premium associated with it. Different premiums with related coverage help consumers choose the bundle that gives him highest utility.

In order to keep things simple, we presented them with only two choices. The surveyed population had to choose between two schemes: i) Rs.1500 premium for Rs. 50,000 coverage and ii) Rs.2500 premium for a coverage of Rs. 100,000. This coverage was for the entire family, i.e., parents and their children. These choices were given after studying existing private schemes in the market; e.g., there is a scheme of Apollo Munich with a premium of around Rs.1800 offering a coverage of Rs. 100,000. This scheme was valid only for people having an annual income of Rs. 300,000 or more. However, the income level of about 90 per cent of the surveyed households was much lower, implying that such schemes were of no use to them. In order to cater to the needs of the surveyed population and considering their low-income level, choices with relatively low premium and a low coverage were proposed. These choices also had to be feasible from the seller’s perspective. Quoting a lower premium for a larger coverage would have resulted in a better response from the surveyed households but in reality, a private company would not have operated with such a low premium scheme. On the other hand, giving an option of higher coverage with higher premium would also have been impractical, simply because most people would have been unwilling to pay such a high premium given their income constraint.

**Section III: Main findings from the survey:**

<table>
<thead>
<tr>
<th>Occupational status</th>
<th>Primary</th>
<th>Secondary</th>
<th>Tertiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Status</td>
<td>Insured</td>
<td>15.2</td>
<td>84.2</td>
</tr>
<tr>
<td></td>
<td>Un-insured</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 1, illustrates the main categories into which people can be divided and the respective proportion of people in them. These categories are important for understanding how the behaviour of respondents varies with different health schemes. As the target population was slum dwellers, it is easy to see from Table 1 that most of the people were from low-income level groups. The surveyed households were further divided on the basis of their educational status. Households were classified into 3 categories – highly educated, moderately educated and low educated. Apart from these two classifications, occupational status was also used to demarcate households and analyse their behaviour. An interesting observation from the table is that in spite of being slum dwellers, a large proportion was highly educated and was working in the tertiary sectors. In spite of this, a majority of the population was un-insured.

The following section elaborates on the major findings from the survey in terms of the behaviour of the respondents. In Maharashtra, like in other places in India, people have access to both private and public health care facilities but there are profound differences between these two services in terms of ease of access, quality and cost of services etc. In this survey, we analysed the main factors that influenced the choice of getting treated from either the public or the private sector. Fig. 1 shows the choice of a health care institution with respect to the seriousness of the illness. In case of minor sickness like fever, cold, stomach ache etc., 70 per cent of the surveyed people showed a tendency to use private hospitals rather than a public sector hospital. This is because even though treatment is cheaper in the public sector but it is accompanied by lack of adequate infrastructure, long queues, careless attitude and procedural hazards (india.angloinfo.com/healthcare/health-system). People, therefore, choose to get themselves treated in a private hospital even if the expense is a little higher. But in the case of serious illness that requires surgery or are otherwise serious diseases such as malaria, dengue, etc., the cost of
treatment in the private sector is unaffordable for the poorer sections of society. Hence, they have no option but to avail of subsidised treatment in public hospitals. In our sample, sixty-one per cent expressed their preference for government hospitals in the case of a major illness.

The willingness to pay is closely related to actual amount that people end up spending for medical care. In our sample, thirty-three per cent of the surveyed population stated that they had spent huge amounts for the treatment of a serious illness in the last 5 years. Out of the households which reported spending on a major illness, 25 per cent spent more than Rs.40,000 for diseases such as of the gallbladder, cardiological problems, accidents, tumours, etc. Fig. 2 gives an estimate of major out-of-pocket expenditure for health treatment.

An analysis of the source of funding for medical treatment based on the survey revealed that about 32.7 per cent of the slum dwellers financed their treatment from their own funds while eight per cent had borrowed to meet their medical expenses. It was found that only 11 per cent of them had financed their medical expenditure through health insurance, revealing the low affiliation to health insurance among poor households as shown in Fig. 3.

A further analysis was done to assess insurance affiliation among people who have spent large amounts on major illnesses across income groups.

For instance, Fig. 4 shows that in the lowest income quintile, about 4.2 per cent said that they had spent out of their income for their medical treatment. Out of these 4.2% people, only 1.2 per cent
were insured. Insurance affiliation was low across all income groups.

A closer look at the results, as illustrated in Fig. 5 also shows a sharp difference in behaviour between the insured and uninsured households. It is seen that choice of medical institution and the amount of money spent for a particular illness is highly influenced by health insurance affiliation.

As evident from Fig. 5, among households that have health insurance, more than half (52 per cent) go to private hospitals for treatment. The picture is the opposite for households going to government hospitals; more than half of them do not have health insurance.

It is also apparent from the survey that apart from choice of institutions for health care services, the amount that is spent on medical treatment is also a function of their insurance status. The survey shows that within households that have health insurance, 62.5 per cent spent more than Rs.40000 on treatment. Therefore, it can be concluded that health insurance gives beneficiaries the opportunity to spend a greater amount for better medical treatment.

Section IV: Willingness to Pay for Health Insurance
Key X et al. (2007) stated that evidence from surveys, which cover 89 per cent of the world’s population, suggests that 150 million people globally suffer a financial catastrophe every year due to out of pocket health expenditures. Offering low-cost health insurance to low income households is one innovative method to finance health care provision and to avoid shattering out-of-pocket health expenditure. Even though the government has devised few schemes as mentioned Section I, its reach has been limited. However, the financial burden on the government has been huge. If people are willing to contribute even a minimal amount for insurance, it will go a long way in reducing the burden on exchequer. With this idea in mind, we also examined the demand and willingness to pay for health insurance.

The Mumbai survey revealed that 17.6 per cent of the households were willing to get insurance for an annual coverage of Rs.50,000 for their family members by paying a premium of Rs.1500. The percentage of households interested in annual coverage of Rs. 100,000 for the premium of Rs. 2500 was only 4.8 per cent. Obviously, the willingness to pay for health insurance is low among low income households. This is illustrated in Fig. 7, which shows how this willingness increases with increase in income. The willingness to pay premium for health insurance is higher in middle income groups and again low in the highest two income group. This is because health insurance coverage depends on the percentage of income. Households earning more than Rs.40,000 can afford to pay higher premium and thus they go for better health insurance scheme with high coverage.

Our survey also revealed that willingness to pay for health insurance premium for senior citizens was much lower. Only 4.8 per cent of the households showed eagerness to pay Rs.2000 premium for coverage of Rs.50,000 per year. For an annual coverage of Rs.100,000, only 1.8 per cent of households showed an interest in paying Rs.2500 as premium. The study shows that willingness to pay for health insurance for the older family members is almost nil in the lowest
income group. This shows that only people who are aware of the benefits of health insurance and can afford to pay would like elders to be insured.

**Factors impeding health insurance affiliation**

It is evident from the above section that the penetration of health insurance is still very low and it is more so in the case of people with limited means. But is the low income by itself an important factor or is it a proxy for other reasons, which inhibit people from accessing health insurance? Anita (2008) observes that increased income and health consciousness among the majority of the classes, price liberalisation, reduction in bureaucracy, and the introduction of private healthcare financing are important factors that can drive the change. We try to understand the role of different factors by carefully looking at the details available from the survey.

Fig. 8 highlights the various reasons stated by people for not being insured. While half of the surveyed households pointed out that they could not afford to pay the required premium, it is surprising to note that about one-fourth of the study sample was not even aware of the importance of being insured. Another major reason for aversion to insurance is the tedious procedure one has to go through to get insured. This provides an opportunity to improve access to health insurance by resolving some of the issues that have been raised by the sample population.

**Affordability:** Fig. 9 clearly shows that insurance coverage is higher in the high-end monthly income groups. Sixty per
cent of insured households have a monthly income of more than Rs. 40,000.

Since affordability is one of the major determinants of health insurance, occupational status, on which affordability is dependent, also plays an important role in the decision to opt for health insurance. There are several reasons why occupational status may be related to health. First, persons in highly paid occupations have a greater ability to finance health investments and higher incentives to undertake them (since periods of poor health impose higher opportunity costs). Second, workers in some occupations may have differential access to information related to health behaviour or methods of alleviating health problems. Third, peer effect may be important and could differ across occupations due to variation in co-worker characteristics. Fourth, the rate of health depreciation is likely to be heterogeneous, being particularly high, for example, in physically demanding jobs. Finally, the rate of stochastic health events may vary; for instance, negative shocks will be especially common in occupations with high accident rates as per Morefield et al (2011).

**Awareness:** After affordability, lack of awareness is one of the major reasons for not getting insured among the poor. Awareness depends on education amongst other factors. One of the undisputed facts in economics is that education and health are very highly co-related, so much so that Grossman and Kaestner (1997) referred to education as the most important socio-economic co-relate of good health. Education is thought to raise the demand for health, both because health is a normal good and because individuals have an incentive to invest in health to protect their educational investments. In order to substantiate this co-relation, we
look at the influence of education levels on health insurance coverage. The graph (Fig.11) shows that households with higher educational level have a tendency to invest more in health insurance schemes.5

An analysis of survey results suggests that out of the total uninsured households, about one-fourth is not even aware of health insurance facilities. As a result, many of these uninsured individuals either end up with poor quality of health care or have to bear the financial hardship themselves.

Section V: Conclusion and Policy

The study re-establishes the fact that when it comes to treatment of health problems, the economically weaker sections of society end up paying out of their own pockets, depleting their savings and other household assets, which pushes them into impoverishment. Their expenditure behaviour on health care reveals that 32.7 per cent of the surveyed households spend their own savings and only 11 per cent of households who spent a large amount on major sickness were insured.

This paper also traces the variation in behaviour between insured households and non-insured households. Health care costs have soared while health facilities in government hospitals have remained poor, resulting in more and more people turning towards private health care institutions for treatment. But the privatised health care system puts increased pressure on the finances of the relatively poor. Hence, people who are insured are the ones more likely to prefer going to private hospitals rather than government ones. Fifty-two of insured households reported that they had been treated in private institutions.

It is also evident from the analysis that income is one of the factors influencing the willingness to pay for health security schemes. The other important factor was lack of information. This indicates that the demand for health insurance schemes can be developed.
The main motivation of the study was to introspect and answer the extent to which individuals who are from economically weaker sections end up paying for health care services and what can be done to relieve this burden. As seen from the survey results, individuals are heavily dependent on costly private services, which depletes their earnings. And this burden became too onerous as most of them were not insured. This was mainly because it was either too expensive for them or they were not aware of the facility. The way out is to provide some health insurance, but should the government provide it free of cost, which might not be feasible, or should it provide insurance cover at a nominal charge? To answer this it was important to ascertain willingness to pay for these services. The results show that in the choice of two different financing systems, on an average 63.6 per cent of the households preferred out of pocket expenses while only 17.6 per cent of the uninsured households seemed interested in shelling out a premium of Rs.1500 premium for a health security scheme that offers an annual coverage of Rs. 50,000 as opposed to the other option where they had to pay Rs. 2500 for the coverage of Rs. 1 lakh.

In a nutshell, it is found, first, that the poor realise the necessity of a health insurance scheme and its benefits but cannot get insurance because they lack the resources to do so. This is mainly because there is a lack of health insurance schemes designed to suit the needs of the economically weaker sections. Therefore, the government needs to intervene in the design of health insurance schemes, revenue collection, pooling of funds and purchasing care in order for the schemes to be equitable, efficient and effective. Government must revisit the decision to bear the dual financial burden of funding the network of public hospitals and national insurance (PHFI, 2011). If the government invests more in nationalised insurance schemes, then the poor can be offered insurance schemes at lower premiums. This will make health insurance scheme more affordable for lower income groups.

Second, a lot of people have reported not being fully aware of health insurance schemes. This impedes the market for health insurance schemes in India. Campaigns and other measures to improve awareness of health insurance schemes and their benefits, therefore, need to be conducted. The poor should be informed through local elected bodies and civil society organisations about health insurance policies for them. The participation of the poor should be
solicited in their design, management and implementation, according to Ghuman and Mehta (2005).
Bibliography


1. Education Status of Households has been calculated using the following method. It takes into account both age and education level of the individual. Educational level has been categorised into three types:

1. **Low Education** includes members who are illiterate or have studied up to primary level

2. **Medium Education** consists of members who have studied till secondary level i.e. they have studied until any class between classes 6 to 10.

3. **High Education** comprises members who have studied up to class 12 or have pursued higher education.

This classification has been made to determine the household education level from individual education level. This type of classification only takes into consideration household members who are of 15 years of age or above. Therefore, this classification only includes educational level of the working age group and senior citizens of any household. After classifying each member’s education level, weights have been assigned to each category according to their education level such that the sum of the weights of 3 categories is 1. The assignment of weight is as follows:

- Any member of the household of 15 years of age or above classified under low education level is assigned a weight of 0.2.
- Any member of the household of 15 years of age or above classified under medium education level is assigned a weight of 0.3.
- Any member of the household of 15 years of age or above classified under high education level is assigned a weight of 0.5.

After assigning weights to each member of the household, according to the category of education level they fall in, weights are multiplied with the total number of members falling under same category in a household. The category which records a higher value would determine the educational status of the household. In case a household has two categories where the values are the same, then the value of higher education level would prevail.

For example there are two Households – A and B.

Household A has 8 members where 2 members fall under low education, 3 members fall under medium education and 3 members fall under high education level. Household B has 5 members where 3 members fall under low education and 2 members fall under medium education.

Therefore,

<table>
<thead>
<tr>
<th>Household Name</th>
<th>A</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Education</td>
<td>2*0.2=0.4</td>
<td>3*0.2=0.6</td>
</tr>
<tr>
<td>Medium Education</td>
<td>3*0.3=0.9</td>
<td>2*0.3=0.6</td>
</tr>
<tr>
<td>High Education</td>
<td>3*0.5=1.5</td>
<td>0*0.5=0</td>
</tr>
<tr>
<td><strong>Educational Status</strong></td>
<td>High Education</td>
<td>Medium Education</td>
</tr>
</tbody>
</table>
Occupation status of the household has been calculated using the following method:

Occupational status has been categorised into three groups – primary, secondary and tertiary. This classification includes the members of working population and this category has been defined according to the NSS definition.

If a household three working members and the major income is from one sector (for example, in a household with three working members, one member is working in primary and two in the tertiary sector and the household income is more from tertiary sector), then the occupational status of that household is defined as tertiary. In this way occupational status of all the surveyed households has been defined.
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