FIELD RESEARCH · HEALTHCARE ACCESS · 2022–2024

Healthcare Access among Gig Delivery Riders

Field-research findings from 50+ interviews with Zomato and Swiggy riders across Bengaluru — what actually stands between gig workers and basic care, and what to build around it.

METHOD	ETHNOGRAPHIC
INTERVIEWS	55
THEMES	7
PARTNERS	Zomato · Swiggy

INTERVIEWS 55	CITY Bengaluru	DELIVERY PARTNERS 2	HUBS COVERED 7
PERIOD 2022–2024	METHOD Field interviews	TOP BARRIER Cost of meds	OUTPUT Program design

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2022–2024 FIELD RESEARCH BRIEF

I Why this matters

India's gig workforce is exploding — from roughly **7.7 million workers in 2020–21 to a projected ~23.5 million by 2029–30** (NITI Aayog) — and almost all of it sits **outside the formal health safety net**.

Delivery riders are the visible face of this economy and one of its most physically exposed. They work long hours on the road, are paid per task, have no paid sick leave, and largely fall outside functioning ESI or insurance coverage. Health is the blind spot of the gig model — and the goal of this work was to map the real barriers between riders and basic care, rather than assume them.

II Method

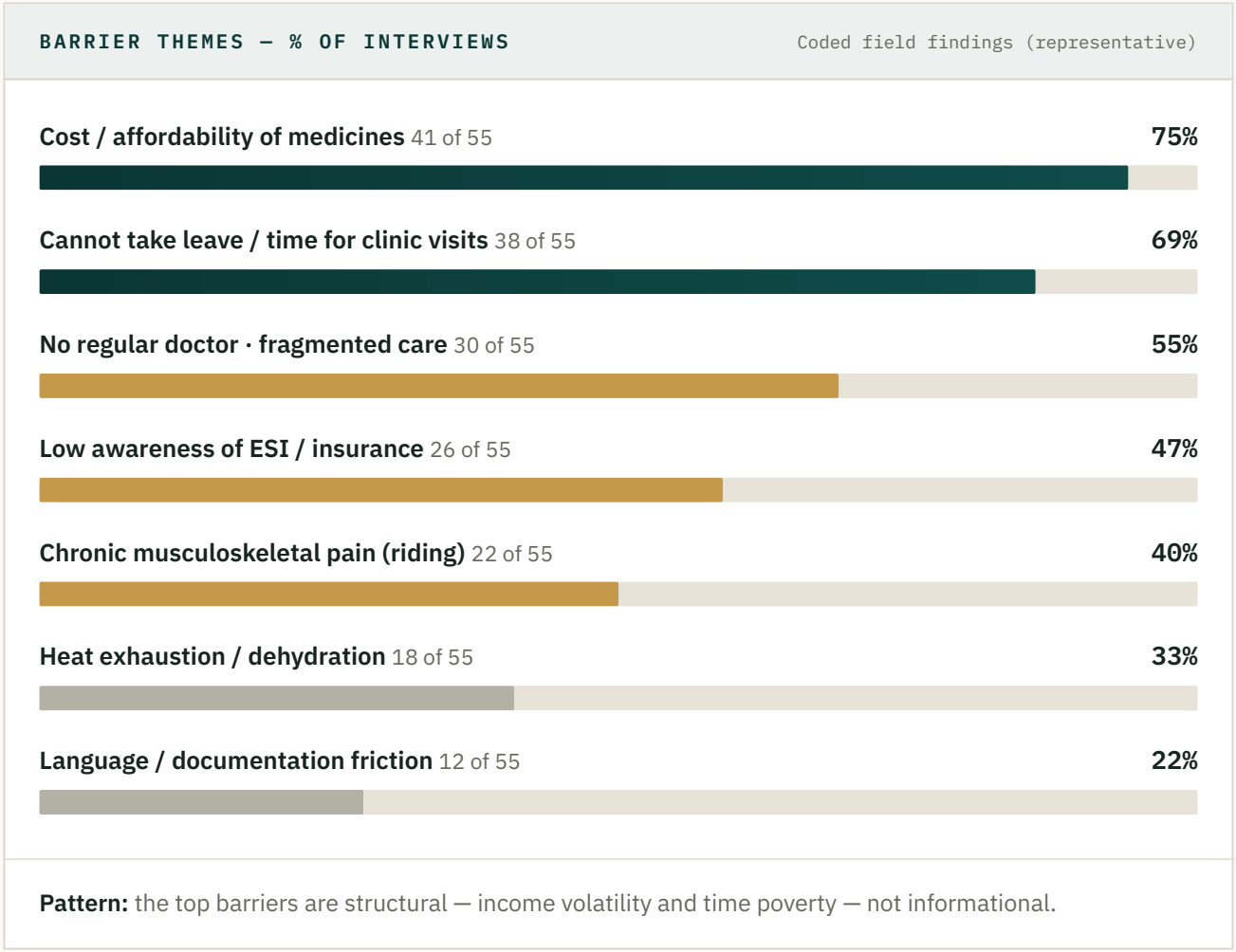
Over the program, **50+ semi-structured field interviews** were conducted with delivery riders at hubs across Bengaluru, with access coordinated through **Zomato and Swiggy**

partnerships. Conversations covered health history, care-seeking behaviour, costs, time, and coverage. Responses were **coded into recurring themes**; riders frequently named more than one barrier (multi-response), so theme frequencies sum to more than 100%.

III Who the riders are

The sample skewed to a consistent profile that shapes every finding: **young men, often recent migrants**, working **10–12 hour days** on piece-rate earnings with high day-to-day income volatility, no employer health cover, and physically demanding routines (long riding hours, heat exposure, irregular meals). For this worker, time and money are the two scarcest resources — which is exactly where the barriers cluster.

IV What riders told us



01 **Cost (75%).** Every medicine purchase competes directly with the day's essentials; riders routinely defer or skip prescriptions they can't afford that week.

02 **Time (69%).** A clinic visit means unpaid hours lost. For a piece-rate worker, seeking care has a direct cash cost on top of the medical one.

03 **No regular doctor (55%).** Care is episodic and fragmented — whoever is nearest and cheapest in a crisis — with no continuity, follow-up, or prevention.

V Synthesis

The findings invert the usual assumption that access is an awareness problem. These riders understand their health needs perfectly well; what they lack is **time and money slack**. Every hour at a clinic is unpaid, every medicine cost competes with daily survival, and most sit outside any working insurance net despite nominal ESI eligibility.

In other words, **the access gap is manufactured by the work itself.** Any intervention that ignores this — and simply 'raises awareness' or sets up a distant clinic in clinic hours — will reach the people who need it least and miss the people who need it most.

VI Recommendations

INTERVENTION FRAMEWORK — WHAT TO BUILD

INTERVENTION	BARRIER IT REMOVES	PRIORITY
Bring care to the hub	Unpaid travel time (#2)	High
Async / after-hours access	Shift-incompatible clinic hours (#2)	High
Medicine-cost relief / kits	Affordability (#1)	High
ESI / insurance navigation	Coverage gap (#4)	Medium
Aggregator distribution	Reach at scale	Enabler

The design rule that falls out of the data: **meet riders at the point of work, on their schedule, and attack cost directly.** Point-of-work screenings remove the travel-time tax; after-hours and on-demand access fit shift patterns; subsidised or kitted essentials hit the #1 barrier head-on; hands-on ESI navigation converts nominal eligibility into real coverage; and aggregator partnerships are the only realistic way to reach riders at scale.

VII Limitations

- **L1** **Sample.** 55 interviews in one city — directional, not statistically representative.
- **L2** **Geography.** Bengaluru-specific; barriers may differ across cities, platforms, and seasons.
- **L3** **Self-report & recall.** Findings reflect what riders chose to share in a single sitting, with the usual recall and desirability effects.

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Field-research synthesis prepared as an analytical work sample. The program, partnerships and interview count reflect real fieldwork; coded barrier frequencies are representative of the findings and shown for illustration. Gig-workforce figures are from public sources (NITI Aayog) and approximate. For demonstration only.