

# **ILO/SSA/AIM STUDY ON LINKAGES BETWEEN STATUTORY SOCIAL SECURITY SCHEMES AND COMMUNITY BASED SOCIAL PROTECTION MECHANISMS TO EXTEND COVERAGE**

## **CASE STUDY: INDIA**

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## ***EXECUTIVE SUMMARY***

The Constitution of the India has in its objectives social justice, equality of treatment between men and women workers, ensuring a living wage and the social security of workers. A large number of legislations have been enacted in support of Constitutional provisions for social security and insurance, employment, protection against unemployment, and exploitation at work. Yet, the social protection mechanism in India is at best rudimentary. Only 7% of the estimated work force of about 397 million had the benefit of formal social security. The heavy toll of looking after the sick, injured, disabled, pregnant, and unemployed falls on families resulting in their gradual impoverishment. A vibrant private sector -both for profit and non-profit - have stepped in to meet the gap. The private sector accounts for 80% of India's medical service. The non-profit sector has been most innovative in reaching out to the poor and vulnerable people. The liberalisation of insurance sector has spawned new and creative linkages between health insurance companies, hospitals, third party administrators, and non profit sector. The result is phenomenal increase in micro-insurance products and services, and coverage of rural poor. As India proceeds with liberalisation of its economy, there is growing recognition that the poor have to be sheltered from economic and social shocks. In the future, India is likely to see even more concerted efforts to extend coverage of social security and social assistance programmes, be that through employment generation, health insurance, pension reforms, or strengthening of support to the aged and infirm.

# CHAPTER I

## SOCIAL PROTECTION MECHANISM IN INDIA

### **1.0 INTRODUCTION**

The concern about low coverage rates by social protection is widely shared in India. This study explores the potential for coordination, cooperation, and other linkages between statutory social security schemes and community-based social protection mechanisms in order to broaden coverage more effectively. The statutory schemes have often been successful in covering formal sector workers. The community-based schemes, on the other hand, have reached out to occupational groups, rural workers, and disabled members of community who are outside the pale of State-sponsored welfare programmes. This paper maps out strengths and weaknesses of statutory social security schemes and non-State social protection mechanisms. Opportunities for value addition are identified. The range of social security schemes are extremely wide; in order to keep our discussion focused, we have paid particular attention to health, old age security, and survivorship.

This study is part of a larger ILO project examining social protection linkages in developing countries. As part of that project, fieldwork was conducted in Delhi, Dehradun, Hyderabad, Mumbai, Bangalore, and Calcutta for three months in 2006 in India. Case studies, focusing on selected schemes, results in the researcher explaining the phenomenon in particular way without being constrained by local issues. A mixture of methods was employed, including literature review and interviews with government officials, health care providers, and academic researchers.

The study is divided in six parts. The first chapter presents an overview of social security schemes in India. Chapter II discusses the conceptual underpinnings of linkages between State, private and non-profit sector. Chapter III examines the impact of linkages on micro insurance in India. Chapter IV speculates on the future directions of social security in India. Linkages require effective systems of contracting. Chapter V outlines contracting process in India, and chronicles some efforts to improve procurement systems.



India is a poor country, ranking 127 in Human Development Index prepared by UNDP for 177 countries in 2003. Despite healthy rates of economic growth in recent years, a large percentage of the Indian population still faces serious levels of deprivation and is quite vulnerable to all types of economic and social risks (See Table 1.1). Of India's 1028 million (2001), 370 million people in India earn less than 1 US\$ a day. The figure for those earning less than 2 US\$ a day is 855 million i.e. 83% of the total population. The extent of poverty and vulnerability in India also varies quite significantly across the various states; while Andhra Pradesh, Gujarat, Kerala, Punjab, and Himachal Pradesh have benefited from significant reductions in poverty, other states Bihar, Madhya Pradesh, Orissa, Uttaranchal, Chattisgarh, and Jharkhand have achieved less success in attacking poverty.

The social protection<sup>1</sup> mechanism in India is at best rudimentary. According to a Planning Commission (2001) report, only 7% of the estimated work force of about 397 million had the benefit of formal social security protection.

<sup>1</sup> The notion of social protection is broader than social security. Social security, as expressed in the International Convention No. 102 includes nine core contingencies that lead to stoppage of or substantial loss of earnings. These are sickness, maternity, employment, injury, unemployment, invalidity, old age, death, the need for long-term medical care and for supporting families with children. In more recent years, social protection has come to include "not only public social security, but also private or non-statutory schemes with a similar objective, such as mutual benefit societies or occupational pension schemes. It includes all sorts of non-statutory schemes formal or informal, provided that contributions to these schemes are not wholly determined by market forces. These

The problems of unorganised/informal workers arise out of deficiency or capability deprivation as well as vulnerability to conditions of adversity. This gives rise to enormous social costs which are often not appreciated enough by policy makers.

**Table 1.1 – Poverty, Inequality and Redistributive Policies in Selected Countries**

		Millennium Development Goals				
		Eradicate extreme poverty and hunger	Achieve universal primary education	Reduce child mortality	Improve maternal health	
	Gross national income pc \$US ppp	Prevalence of child malnutrition % of children under 5, 2004	Primary completion rate, 2004	Under five mortality rate per 1000, 2004	Maternal mortality ration per 100,000 live birth, 2000	Births attended by skilled health staff-%of total, 2005
India	720	53	89	85	540	43
Low and middle income countries						
East Asia & Pacific	1627	15	98	37	117	86
Europe and Central Asia	4113	5	94	34	58	94
Latin America & Caribbean	4008	7	96	31	194	88
Middle –East & North Africa	2241	13	88	55	183	72
South Asia	684	45	87	92	564	37
Sub-Saharan Africa	745	29	61	168	921	42
High income countries	35,131	3	..	7	14	99

Source: World Development Report, 2007

A healthy society reflects the well being of a nation and is an important contribution to economic growth. A weak social protection system does not assure India of a healthy society and, in turn, provide impetus of economic transformation. Reforms in the social protection system, especially health care are vital investment in human capital. Despite rapid strides in the health sector since Independence: life expectancy has gone up markedly, the infant mortality rate has been halved, and 42 per cent of children receive the essential immunisations. And yet, critical health issues remain: infectious diseases continue to claim a large number of lives; babies continue to die needless deaths from diarrhoea and respiratory infections, and basic health care continue to elude the poor. Government provided health services only partially meet the needs for the rural and urban poor, and making equitable and affordable medical care accessible to this segment remains a challenge (Acharya and Ranson 2005). While the overall spending on health care, at 5.1 per cent of GDP (WHO 2004) is comparatively high, government spending at

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*schemes may feature, for example, group solidarity or an employer subsidy, or perhaps a subsidy from the government.” ILO, World Labour Report 2000, Geneva 2000*

1.7% of GDP is low compared to other emerging countries. A fee-levying private sector accounts for about 82 percent of the overall health expenditure. Nationwide health care utilization rates show that private health services are directed mainly at providing primary health care and are financed from out-of-pocket resources, which place a disproportionate burden on the poor. Adequate health care is unaffordable for the vast majority of Indian population.

<b>Table 1.2 Social Security Schemes in India</b>		
<b>Contingency</b>	<b>Organised Sector</b>	<b>The General Poor</b>
Medical Care	Free treatment in state hospitals and drugs.	Treatment through primary health centres and government hospitals. Sanitary and service in most hospitals are so pathetic, that most Indians' prefer to go to private clinics/hospitals
Sickness	Medical leave on full pay for up to 2 years in a 3 year period	Nil. Wage loss is a significant concern for the casual workers.
Maternity	Maternity leave 12 weeks on full pay	Social assistance under the National Assistance Programme.
Unemployment	Retrenchment benefits under the industrial Disputes Act	No real protection except Employment Guarantee Scheme in Maharashtra
Work related injury	Ex-gratia relief plus benefits under the ES and Workmen's Compensation Act	Assistance from welfare funds for those engaged in hazardous occupations in few states
Disability	Ex-Gratia relief plus benefits under the ESI and the Workmen's Compensation Act	Pension for the physically disabled in certain states
Old Age	Pension under the Employees Pension Scheme, 1995, and gratuity under Payment of Gratuity Act, 1972	Old age pensions provided under the NSAP and state governments for the destitute
Survivor (widow, orphan)	Subsidised group insurance for death while in service, family pension in case of death after retirement	Subsidised insurance under the NSAP and limited accident cover available; compensation under the Motor Vehicles Act
Health Insurance	Contributory schemes abound	Only a small percentage of families below poverty line are covered under universal health insurance scheme
Source: Roth et al 2005		

The health care system is characterized by co-existence of modern western and traditional systems of medicine, mixed ownership patterns, and different kinds of delivery structures. Public sector ownership is divided between central and state governments, municipal and village councils ('Panchayats'). The Central government is responsible for developing and monitoring national standards and regulations, linking the states with funding agencies, and sponsoring numerous schemes for implementation by state governments. Goals and strategies for the public sector in health care are established through a consultative process involving all levels of government through the Central Council for Health and Family Welfare (CCHFV). Public health facilities include university hospitals, secondary level hospitals, first-level referral community



hospitals, dispensaries; primary health centres (PHCs), sub-centres, and health posts. Also included are public facilities for selected occupational groups like organized work force, defence, government employees, and various parastatals (railways, mines, post and telegraph). The private profit and not for profit sector is the dominant provider with 50 per cent of people seeking indoor care and around 60 to 70 per cent of that seeking outpatient care from private health facilities. Health care in India is financed through general tax revenue, community financing, out of pocket payment, and social and private health insurance.

## **1.2 SOCIAL SECURITY SCHEMES IN INDIA**

Matters relating to Social Security are listed in the Directive Principles of State Policy and the subjects in the Concurrent List of the Constitution of India. The following social security issues are mentioned in the Concurrent List (List III in the Seventh Schedule of the Constitution of India) -

Item No. 23: Social Security and insurance, employment and unemployment.

Item No. 24: Welfare of Labour including conditions of work, provident funds, employers' liability, workmen's compensation, invalidity and old age pension and maternity benefits.

### Part IV Directive Principles of State Policy

Article 41 Right to work, to education and to public assistance in certain cases  
The State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want.

Article 42 Provision for just and humane conditions of work and maternity relief

The State shall make provision for securing just and humane conditions of work and for maternity relief.

Thus, the Constitution of the India has in its objectives social justice, equality of treatment between men and women workers, ensuring a living wage and the social security of workers. India has a rich history of bold initiatives to secure social protection through various constitutional and legislative means as well as judicial activism. The Supreme Court of India has progressively expanded the interpretation of the term 'life' in article 21 to include 'livelihood' which extends to education, health care, housing, and clean environment, all of which in the aggregate will be coterminous with emerging concept of social protection. Concern for the welfare of workers has been a recurring theme in

India. The main weakness of social protection has been under-funding and duplication of schemes, weak delivery mechanisms on the ground, and lack of systems to monitor, enforce legislations, and punish the guilty.

**Box: 1 Key Social Security Laws in India**

Laws related to Working Hours, Conditions of Service and Employment such as: Factories Act, 1948; Plantation Labour Act, 1951; Mines Act, 1952; Beedi & Cigar Workers (Conditions of Employment) Act, 1966; Contract Labour (Regulation & Abolition) Act, 1970; Inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act, 1979; Beedi Workers Welfare Fund Act 1976, Building & Other Construction Workers (Regulation of Employment & Conditions of Service) Act, 1996.

Laws related to Equality and Empowerment of Women such as: Maternity Benefit (Amendment) Act, 1995; Equal Remuneration Act, 1976.

Laws related to Deprived and Disadvantaged Sections of the Society such as: Bonded Labour System (Abolition) Act, 1976; Child Labour (Prohibition & Regulation) Act, 1986; Children (Pledging of Labour) Act, 1933

Laws related to Social Security such as: Workmen's Compensation Act, 1923; Employees' State Insurance Act, 1948; Employees' Provident Fund & Miscellaneous Provisions Act, 1952; Payment of Gratuity Act, 1972, National Rural Employment Guarantee Act, 2005.

A wide range of policy options have been attempted as formal safety nets in India. Major instruments include consumer subsidies, direct transfers, targeted employment creation, and social insurance (Chu and Gupta 1998).

- a) Consumer subsidies: Since 1951, public distribution of food grains has been the corner stone of India's food and nutritional security. The PDS seeks to provide to the beneficiaries two cereals, rice and wheat and four essential commodities viz. sugar, edible oil, soft coke and kerosene oil. Its greatest achievement lies in preventing any more famines in India. The PDS has been criticised for preventing the rich from cornering some of the benefits of subsidised food, and wasteful system of stocking cereals.
- b) Direct transfers to uninsured vulnerable social groups: The bulk of India's social assistance falls into this category. Assistance to the disabled, blind, widows, survivors have been delivered using government, NGOs, and other community groups. The extent to which such transfers actually assist in protecting the poor depends on four variables: administrative efficiency, transaction costs, political will for means testing, and overall budgetary outlays (Fritzen 2003).
- c) Targeted employment creation on public works. Public works programmes (PWPs) are an important source of social protection in rural areas as they generate employment during lean seasons, and improve household security by providing them with cash and food. PWPs in India

are labour intensive, flexibly organised and keep pay low so that only the needy participate (i.e. in order for schemes to be self-targeting). Outcome evaluations have found that EGS have succeeded in raising income and targeting the relatively poor (Pellissery 2006). Emulating Maharashtra's successful experiment in job creation, in 2005 the Government of India introduced National Rural Employment Guarantee Programme guaranteeing the right of 100 days work for every household in a year. The National Rural Employment Guarantee Act will cost about Rs 400 billion annually and eventually implemented in all the 600 districts of India.

- d) Social insurance. Social insurance refers to the financing of benefits by compulsory contributions or pay-roll taxes, and differs from private insurance in that contributions need not fully cover benefits for certain groups -such as those below poverty line - who are considered too weak to purchase insurance in the market place (Fritzen 2003). Social insurance performs a preventive function whereby all present and formerly economically active persons build up entitlements to receive protection in the event of contingencies such as sickness, maternity, old-age, invalidity, death and unemployment. The important contributory social security schemes in India include the Employees State Insurance Act, 1948, and the Provident Fund, Pension and Deposit Linked Insurance Schemes framed under the Employees Provident Funds and Miscellaneous Provisions Act, 1948. The three major non-contributory laws are the Workmen's Compensation Act, 1923, the Maternity Benefit Act, 1961, and the Payment of Gratuity Act, 1972. Under these acts, maternity benefits, and costs of lump-sum payment to the employee in case of disablement, injury, or death is paid by the Government out of contributions made by the employers. A further characteristic of social insurance is that there may be an element of public subsidy.

### **1.3 SOCIAL INSURANCE SCHEMES**

The existing schemes can be categorized as:

- a) Statutory health insurance schemes (namely ESIS, CGHS)
- b) Government Initiatives for the Unorganised Sector
- c) Voluntary health insurance schemes or private for profit schemes
- d) Other Schemes with public-private partnerships

#### **1.3.1 Statutory Schemes**

State-run health insurance schemes have four main characteristics that it is employment based; compulsory for certain groups in the population; contributory with premiums determined by income (and hence ability to pay) rather than related to health risk; and services delivered through specially

designated, often government owned, health care providers. The government run schemes include Employees State Insurance Scheme (ESIS) and the Central Government Health Scheme (CGHS).

### **Central Government Health Scheme (CGHS)**

Introduced in 1954 as a contributory plan, the CGHS was aimed at providing comprehensive medical care to central government employees, ex-Members of Parliament, journalists and others. The contribution by the employees is, however, nominal (maximum of Rs. 50 per month). The total number of beneficiaries is estimated at 4.2 million (2005). CGHS is operated out of 24 cities across India through a network of 331 dispensaries mostly in major towns. The CGHS has been criticized from the point of view of quality, non availability of medicine, and accessibility.

### **Employees State Insurance Scheme**

ESIS scheme, launched in 1952, applies to non-seasonal factories using power and employing 10 or more persons and non-power using non-seasonal factories and establishments such as shops, hotels, restaurants, cinemas etc. employing twenty or more persons. ESIS provides not only sickness benefit and free medical care but also cash benefits towards loss of wages due to disablement, maternity protection, and dependants benefit in case of death due to employment injury. In August 2005, ESIC launched a new programme providing unemployment benefits to the former employees covered by its activities. The maximum wage limit is Rs. 7,500 (US\$ 166). The scheme is financed from contribution from employers and employees. Employers and employees contribute respective 4.75 per cent and 1.75 per cent of the salary. Low paid employees drawing wages upto Rs. 40 per day are exempt of contribution. The State Governments contribute a minimum of 1/8<sup>th</sup> share of the expenditure on medical care in their respective states. ESIC currently covers some 7.1 million workers but has been plagued by high dropout rates, many workers preferring to enrol in other schemes providing better benefits. Comprehensive medical care is provided by ESIC through its network of 143 ESI hospitals, 43 annexes, 1452 dispensaries and 3000 clinics of private medical practitioners in different parts of the country. ESIS health facilities are generally found understaffed, ill-equipped and under-used. During the last five decades of its existence, the ESI scheme has been extensively reviewed by the Parliament and other statutory bodies. The main recommendations pertain to extension of the scope of coverage, organizational framework and granting functional autonomy to the ESI Corporation. Legal barriers still prevent ESIC to extend its coverage to informal economy workers and the poor quality of the services, limited outside major cities does not make it attractive enough.

<b>Employees State Insurance Scheme</b>	
Establishment Year	1948
Application	Factories
Contribution	1.75% of wage by workers 4.275 of workers wage by employer State Governments: 12.5% of medical benefit
No. of workers covered	7.9 million
No. of people covered	31 million
Contingencies covered	Medical care Sickness benefit Disablement benefit Maternity benefit Dependants benefit Unemployment allowance
Administration: Employee's State Insurance Corporation	

### **State-owned or Managed Health Schemes**

Certain ministries like Railways, Defence, Police, Mining, Post and Telegraph and Education gives health coverage to their employees as a benefit. Among these the Railways provide a model case of provision of quality health benefits through a network of 584 health units and 124 self-run hospitals. The employee coverage includes 1.6 million employees and 0.25 million retired employees.

### **Employees Provident Fund**

The EPF & MP Act, 1952 was enacted by Parliament and came into force with effect from 14th March, 1952. A series of legislative interventions were made in this direction, including the Employees' Provident Funds & Miscellaneous Provisions Act, 1952. Presently, the following three schemes are in operation under the Act:

- Employees' Provident Fund Scheme, 1952
- Employees' Deposit Linked Insurance Scheme, 1976
- Employees' Pension Scheme, 1995 (replacing the Employees' Family Pension Scheme, 1971)

The EPF Schemes is applicable to 180 industries/class of establishments employing 20 or more persons. In 2003, it covered 344508 establishments, and has a membership of 34.5 million. Coverage under the Scheme is restricted to employee drawing a salary package not exceeding Rs. 6,500 (US\$144) per month. Employees and employers make equal matching contribution. Current statutory rate of contribution is 12% of emoluments. Out of 12% of the employer's share of contribution, 8.33% is to be remitted towards pension fund. This compulsory scheme provides for both post retirement pension benefits and some disability benefits.

In January 2004, the Government launched “Unorganised Sector Workers Social Security Scheme”. The coverage, compliance, registration and benefit delivery of the scheme would be handled by EPFO, using available market intermediaries like workers' facilitation centres, Panchayati Raj institutions, NGOs and self-help groups. The fully-funded scheme would cover all workers in the unorganised sector drawing pay/wages/income of not more than Rs. 6,500 a month and be financed by the contributions from workers at the rate of Rs. 50 a month in the age group of 18-35 years and Rs. 100 a month in the age group of 36-50 years. A matching contribution from the employer is required, and a contribution from the government set at 1.16% of the monthly wage. The scheme provides triple benefits, which include a registered pension of Rs. 500 per month after retirement at age of 60 years and total disablement and family pension in case of death of the worker, a personal accident insurance cover for Rs. 1,00,000 and convergence of the benefits provided under Universal Health Insurance Scheme for a worker and his family. Unfortunately, the scheme failed to attract informal economy workers and their employers. At the end of 2004, only 3500 workers had enrolled.

### **1.3.2 Government Initiatives for the Unorganized Sector**

There are a number of models of providing social protection to the workers in the unorganized sector. These may be classified under

- Centrally funded social assistance programmes
- Social insurance schemes
- Social assistance through welfare funds of Central and State Governments

The centrally funded social assistance programmes include the employment oriented poverty alleviation programmes such as National Rural Employment Guarantee Programme, Swarnjayanti Gram Swarajgar Yojana (SGSY), and Employment Assurance Scheme. National Social Assistance Programme (NSAP) comprising old age pension, family benefit and maternity benefits to address the social security needs of the people below poverty line.

Some ministries provide social security to specific occupational groups. Women from scheduled caste and scheduled tribes groups constitute a high percentage of work forces in handloom and handicraft sector. Health Package Scheme, a centrally sponsored scheme of Ministry of Textile operated by the state government focuses on occupation health problems related to the profession of handloom weaving. Under the package, reimbursement is applicable for the treatment of TB, asthma, and inflammation of alimentary system. The coverage has been increased from 26,814 in the year 2003-04 to 72,198 during the year 2004-05. In 2005, for the first time, Health Insurance Scheme was introduced for 3,00,000 weavers. The unique features of the scheme is that it will cover not only the weaver but his wife and 2 children and will also cover

all pre-existing diseases. Out of the total premium of Rs. 1000/-, the Government of India will contribute Rs.800/- and the weaver will contribute Rs.200/-. ICICI-Lombard administers the scheme. Another 1 million weavers are protected by Mahatma Gandhi Bunker Bima Yojana, which gives coverage of Rs.50,000/- in case of natural death and Rs.80,000/- in accidental case. In the scheme, the Government of India, will contribute Rs.150, LIC will contribute Rs.100/- and the weavers contribution is Rs.80/-.

Welfare Funds clearly remain the opinion of many policy makers the best way to extend social protection to workers in the unorganized sector. The Central Government has set up five welfare funds for beedi workers, mine workers, and cine workers for whom no direct employers-employee relationship exists. These funds are constituted from the cess collected from the employers and manufacturers/producers of the industry concerned. These central funds are administered by the Ministry of Labour. These funds mainly provide medical care, assistance for education of children, and housing facilities. There are 10 major hospitals and more 168 static cum mobile dispensaries all over the country. These funds have provisions for re-imburement of expenses incurred on major surgeries and chronic illness. Maternity benefits are also available to women workers.

The welfare fund model have been successfully replicated by various States for vulnerable categories of workers. The state of Tamil Nadu is running 9 Welfare Boards for workers like construction workers, truck drivers, footwear workers, handloom and silk weaving workers. Similarly, Kerala is running 25 welfare funds for agricultural workers, cashew workers, coir workers, fisherman, tailors, automobile workshop workers etc. The States of Andhra Pradesh, Karnataka and Madhya Pradesh have enacted legislation to create welfare funds for unorganized workers.

The government also offers assistance by way of Illness Assistance Funds, which have been set up by the Ministry of Health and Family Welfare at the national level and in a few states. State Illness Assistance Funds exist in Andhra Pradesh, Bihar, Goa, Gujarat, Himachal Pradesh, Jammu and Kashmir, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Mizoram, Rajasthan, Sikkim, Tamil Nadu, Tripura, West Bengal, Delhi, Pudducherry, and Uttaranchal. Under National Illness Assistance Funds, poor patients living below the poverty line undergoing treatment in government-approved hospitals receive grants.

### **1.3.3 Voluntary Health Insurance Schemes or Private-for-Profit Schemes**

Private insurance schemes pool risks of individuals against a premium, which provides a profit to third party and health care provider institutions. Premiums

are set according to the perceived risk profile of the consumer, and not correlated to consumer's income or social status.

In the public sector, the General Insurance Corporation (GIC), and its four subsidiary companies (National Insurance Corporation, New India Assurance Company, Oriental Insurance Company and United Insurance Company) and Life Insurance Company of India provide voluntary insurance schemes. The LIC offers Janashree Bima Yojana to cover employees of shops and commercial establishments and casual workers. The premium is 50% subsidized by the State Government, and benefits include death (Rs. 20k), death/permanent disability due to accident (Rs. 50k), and permanent partial disability (Rs. 25k).

The insurance policies offered by GIC are: Mediclaim Policy, Personal Accident for individuals and family; Group Accident Insurance, Jan Arogya Bima Policy, Bhavishya Arogya Policy (Insurance for senior citizens), and Traffic Accident Policy. Mediclaim is the main product of the GIC. This scheme provides for reimbursement of medical expenses towards hospitalization, domiciliary hospitalization, and medical check-up. Another scheme, namely the Jan Arogya Bima Policy specifically targets population who are unable to pay for high cost of medical treatments. The premium for adults upto the age of 45 years is Rs. 70 and for children it is Rs. 50. The limit coverage is fixed at Rs.5000 per annum for hospitalisation or domiciliary hospitalisation expenses incurred on medical or surgical treatment.

Frustrated by the limited success of health insurance schemes offered by public sector companies, the central government in 2003 decided to redesign the Universal Health Insurance Scheme (UHS) and make it exclusive for persons and families below the poverty line. The revised premium of Rs 248 for a family of five is entirely paid by the Central and State Government. Unfortunately, like its predecessors UHS sold exclusively through public sector insurance companies did not succeed in reaching out to more than 5,000,00 households (0.18% of BPL Population) as against a target of 27 million in 2003-04. The shortcomings of UHS include inadequate coverage of tertiary illness, limited scope of benefits, and lack of awareness among individuals, health care providers and insurers.

Governments of Karnataka, Tamil Nadu, Madhya Pradesh and others are actively promoting micro insurance for health. The State Government of Tamil Nadu and Government of India have joined hands to provide health insurance cover to 2.5 million families below poverty line in the State under the Kudamasree Poverty Eradication Mission that is being operated through the Community Development. The insurance cover is being provided by ICICI-Lombard General Insurance. The premium for the health insurance cover for a family of five is Rs.399. The money contributions come from various sources. The beneficiary contribution is Rs.33 (in case of Scheduled Tribes or destitute families, the amount will be pitched in by the local Panchayats or the local



body). The local government body contributes Rs.33 and an equal amount comes from the State Government. The Union Government contributes Rs.300. The beneficiaries are identified through the Community Development Societies of the Poverty Eradication Mission.

The liberalization of health insurance market in 1999 saw the entry of private insurance companies. The IRDA bill allows foreign promoters to hold paid up capital of upto 26 percent in an Indian company and requires them to have a capital of Rs. 1000 million along with a business plan to begin its operations. Currently, a few companies such as Bajaj Alliance, ICICI-Lombard, Royal Sundaram, HDFC-Chubb, Tata-AIG, and Cholamandalam among others are offering health insurance schemes.

Both public and private insurance companies have not been very successful in accomplishing universal insurance. Universal insurance in a large and highly heterogeneous country is very difficult to achieve, since it includes all people in a particular region, irrespective of their income, sex or age. An alternative is to use community-based organisations, to reach particular segments.

**Table 1.3 Pros and Cons of Privatisation of Health Insurance**

Pros	Cons
Flexible, customer-sensitive insurance products and prices with less restrictions based on age, disease profile	Supplier induced demand which would lead to increase in cost of care.
Comprehensive and cost effective packages	Risk selection practices where the poor, disabled, aged and children would be ignored
Medical plans will be tailored as per the requirement of an individual based on pre-negotiated rates	Exclusion of pre-existing conditions and diseases
Increased competition driving prices down	Neglect of low-premium segments in favour of urban elite
Better regulation of health care providers and insurance companies	Monopoly of profit oriented insurance cartel with poor quality products.
Claim settlement would be smoother and faster	Increase in frauds

### 1.3.4 Community-based Social Protection Mechanisms for Health

Different socio-religious denominations and sects with sizeable following have been responsive to the social and developmental demands of society.

Traditional and modern forms of philanthropy co-exist in modern India.

Traditional Philanthropy involves the concept of shelter for the homeless, post-disaster relief and reconstruction, emergency relief, building temples, schools, and running soup kitchens. However organisations like the Chinmaya Mission, the Swaminarayan movement and Satya Sai trust, in keeping with the changing times, have extended their service spheres into areas such as health care,

support for disabled, rural water supply, income generation and women's empowerment. Institutions like the Satya Sai Sewa Trust, the Swaminarayan Movement, the Chinmaya and the Ramakrishna Missions, Radhasami Satsang, and Missionaries of Charity all run major hospitals around the country. Christian missionaries have been active in India for nearly two centuries and have contributed greatly in the spheres of education, health delivery and backward groups' development in remote areas. One well-known example is the service of Mother Theresa and Missionaries of Charity. Muslim institutions and *Wakf* boards are involved in social welfare and developmental activities.

The private sector plays a major role and accounts for about 80% of all primary health care and 40 percent of tertiary medical care. However because of lack of a nationwide system of registering either practitioners or institutions providing healthcare in the private and voluntary sectors, it is difficult to accurately assess impact and extent of services. Although many look to the government to improve infrastructure and implement healthcare, many more turn to provide free clinics and emergency medical treatment. There are believed to be over 7000 non profit initiatives providing healthcare services - from implementing Government programmes to providing basic health care or else specific care for diseases like Leprosy and Cancer. This excludes a host of rural based voluntary organisations for whom conducting health awareness programmes is a common activity.

Most social security schemes initiated in the voluntary sector date back to the 1990s. With the onset of structural reforms in the economy in 1990s, there is a growing perception of the necessity to extend social protection to all excluded groups through various strategies, including the promotion of micro-insurance schemes. A survey of 54 non-profit organization (NPOs) by ILO (2005) found that out of the 43 schemes for which data were available, 70 per cent were started in the nearly 1990s and 30 per cent between 2000 and 2003. This indicates that voluntary sector has only recently taken up the challenge of protective social security in a big way.

Several public institutions and agencies are also imparting various kinds of social security benefits to the selected group of workers. Among these Self Employed Women's Association (SEWA) has made significant contribution in promoting social security through the formation of women's cooperatives.

#### **1.4 ESTIMATE OF COVERAGE UNDER VARIOUS SOCIAL PROTECTION MECHANISMS**

Obtaining official data on coverage by individual schemes is beset with many bureaucratic hurdles, and long delays. Most do not place data on public domain.

It is widely believed that workers in the formal sector numbering 34.68 million enjoy a modicum of social security. The legislation backed entitlements for the unorganized sector is placed roughly around 15 million (around 5 million covered by the Central Government schemes and the remaining by State government schemes). To this one may add the 7 million members benefiting from National Old Age Pension Scheme (NOAPS). In all thus 21 million people in the informal economy is covered under various social security schemes, which is equivalent to a mere 6 per cent of the total number of unorganized informal workers of around 362million, as in 2000 (GOI 2005:20).

**Table 1.4 Health Insurance Coverage in India**

Schemes	Beneficiaries (in million)
The Employees State Insurance Scheme (ESIS)	34 <sup>2</sup>
Central Government Health Scheme (CGHS)	4.3 <sup>3</sup>
Railways Health Scheme	5.58
Defence Employees	6.6
Ex-Servicemen	7.5
Cess-based Central welfare funds for beedi workers, cine workers, and workers in mica, limestone, iron ore and other selected mines	4
Health insurance (Public sector non life companies)	11 <sup>4</sup>
Health insurance (Private sector non-life companies)	0.8
Health segment of Life Insurance Companies (Public and private sector)	0.23
Employer run facilities/reimbursement schemes of private sector	6
The Employees Provident Fund	26
National Social Assistance Programme <sup>5</sup>	
• National Old Age Pension Scheme (NOAPS)	7.28
• National Maternity Benefit Scheme (NMBS)	1.15
• National Family Benefit Scheme (NFBS)	0.21
NGO run Social Security Schemes	3.35
State Sponsored schemes, including	<0.5
• West Bengal Provident Fund Scheme for the Unorganised Workers	0.63
• Kerala Old Age Pensions for Destitutes and Rural Labourers	0.37
• Kerala various welfare funds for informal workers	4.95
• Tamil Nadu Construction Worker Welfare Fund	0.63
• Tamil Nadu Old Age Pensions	1.18
• Maharashtra Mathadi (Manual) Workers Welfare Fund	0.15
• Andhra Pradesh Labour Welfare Fund	1
Universal Health Insurance Scheme	11,408 (2005)
Micro-insurance schemes	
Source: Gupta and Trivedi 2004: 16; Government of India 2005a, Government of India 2006	

A large number of non governmental organizations and community based organizations are involved in providing a measure of protective social security

<sup>2</sup> ESIS coverage as on March 2003

<sup>3</sup> CGHS coverage figures for 2003-04

<sup>4</sup> The number of policies for Mediclaim is about 2 million, which would yield roughly 10 million lives covered.

<sup>5</sup> Coverage as of 2005-06

to workers and their families, mainly in the unorganized sector in the country. Moreover, such provision is embedded in a larger package of services that include promotional social security such as access to health care, microfinance, housing, and welfare services. The National Commission for Enterprises in the Unorganised Sector (GOI 2005) estimated that the voluntary sector coverage to be around two to three per cent of the total workforce in the unorganized sector. The voluntary sector also pioneers in building institutional models that are closer to fulfilling the needs of vulnerable sections and a source of knowledge, and best practices in social protection.

The predominant form of social security provided by these organizations was in terms of coverage for health-related risks. Of the total 43 schemes reported, 34 schemes provided for health insurance services, followed by life insurance (28), and disability (13). Health insurance schemes provided assistance for meeting illness-related expenses including consultation, outpatient treatment, hospitalization, and wage loss compensation. Maternity benefit (2 schemes) and old age pension (4 schemes) were low in order of popularity. The 43 schemes have already reached a total coverage of 5.2 million people, and likely to increase by some 50% in the coming years (ILO 2005:8).

Ministry of Labour of Government of India estimate that the coverage gap in India is around 370 million (<http://labour.nic.in/ss/overview.html>). The break up is as follows:

Agricultural sector	180 million
Contract, services, construction	60 million
Trade, Commerce, transport, storage & Communications	100 million
Others	30 million

## **1.5 LEGAL FRAMEWORK**

There is a considerable difference between the legal and conceptual definitions of the non profit sector in India. A major distinction used for taxation purpose is whether the organization exists to contribute for a social purpose, and how profits are reapplied to promote the objective stated in Memorandum of Association incorporating the organisation.

Legally, five types of organizations have a non-profit status in India (See Sen 1993 for a detailed discussion). These are: a society registered under the Societies Registration Act of 1860; a trust registered under the Indian Trusts Act of 1882; a cooperative under the Cooperatives Societies Act of 1904; a company under Section 25 of the Companies Act of 1956; and a trade union under the Trade Union Act of 1926. Most non-profits active in social protection opt to register as societies due to low cost of registration, convenience, and minimal bureaucratic interference in the working of such bodies.

The first four types of non-profits listed above are referred in this paper as NPOs/NGOs/VO. Community based organization (CBO) can take the form any of the above four legal non-profit entity<sup>6</sup>. A trade union is different from other types of legal NPOs in two distinct ways. First, the general fund of a trade union may be used for remunerating its staff, legal procedures, and educational activities, and for the welfare of its members. Second, a trade union has legal power to collectively bargain on behalf of their members.

Non-profit organisations in India (a) exist independently of any government; (b) are self-governed by a board of trustees or 'managing committee' / governing council, comprising individuals who generally serve in a fiduciary capacity; (c) produce benefits for others, generally outside the membership of the organisation; and (d), are 'non-profit-making', in as much as they are prohibited from distributing a monetary residual to their own members. Thus, an NGO is defined as "an independent, voluntary association of people acting together on a continuous basis, for some common purpose, other than achieving government office, making money or illegal activities." (Willett 2001).

In the absence of any centralised data bank or nationally coordinated system of information on voluntary sector today, the scale and size of the voluntary sector is at best an intelligent guess. NGO leader Rajesh Tandon (2002) estimate two million voluntary organisations registered under the Society and Trust Acts in the country. He also estimate that the total annual outlay of this vast Thus, the total annual outlay of this vast and diverse voluntary sector in India could add up to Rs.160, 000 (US\$3,555) million per year (Tandon 2002).

The Cooperative Societies Act, 1904 is the basis for several cooperative acts enacted by States. Producer cooperatives have been popular instrument in organizing the informal economy workers, particularly in Gujarat. SEWA-sponsored Gujarat State Women's Cooperative Federation is one of pioneering institution in the field of organising self-employed women in to a co-operative body. It is a Confederation of 100 women co-operatives working since 1992 for poor and unorganised women workers of informal sector. It is an outcome of SEWA's inspiration and experience that organising women into co-operatives can increase their bargaining power, capability and ownership. However, cooperatives are less popular among social activists because of high degree of interference by government inspectors and other functionaries.

Whether a trust, society or section-25 company, the Indian Income Tax Act gives all categories equal treatment, in terms of exempting their income and

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<sup>6</sup> The term CBO is used are defined as organizations formed by members of the low-income community, most of whom offer their services voluntarily (Sen 1993). The term CBO in recent years have been used to described grassroots bodies such as self-help groups, women credit and thrift groups and youth clubs.

granting 80G certificates, whereby donors to non-profit organisations may claim a rebate against donations made. Foreign contributions to non-profits are governed by Foreign Contribution Regulations Act, 1976 and the Home Ministry.

In addition, there are specific administrative and regulatory policies that govern the working of community based social protection. We will discuss about how these policies affect Government-NPO linkage in the next chapter.

## 1.5 INFORMAL ECONOMY

According to a recent estimate, 91% of India's working population is engaged in the informal economy, commonly referred as the 'unorganised sector' in official literature. Although the contribution of these units in the economy of India has been very significant (around 60 percent), there has not been any uniform definition of the sector reflecting its characteristics. The term 'unorganised sector. sector' simply refers to those engaged in the informal economy outside the formal The National Commission for Enterprises in the Unorganized Sector (2006:7) defined unorganized/informal employment as "consisting of casual and contributing family workers; self-employed persons in unorganized sector and private households; and other employees in organized and unorganized enterprises not availing any social security benefits given by the employers." In rural areas, the unorganised/informal sector mostly comprises of farm labourers, small and marginal farmers, sharecroppers, forest workers persons engaged in animal husbandry, fishing, etc., and village artisans. In the urban areas, it mainly consists of manual labourers in construction, trade, transport, and small and tiny enterprises as well as persons who work as street vendors, and hawkers, head-load workers, among others (2006:7).

Sector	Employment Category		
	Formal	Informal	Total
Organised	30.66	25.79	56.45
Unorganised	4.02	336.29	340.31
<b>Total</b>	<b>34.68</b>	<b>362.08</b>	<b>396.78</b>

Source: Computed from unit level data of NSS 55<sup>th</sup> Round, 1999-2000, Employment-Unemployment Survey, 2006:9

## 1.6 POLICY REFORMS

Social security reforms have attracted increasing attention over the past decade in the face of globalization and industrial restructuring. The critical issues highlighted in recent social debates,

- Flexible labour regimes resulting from liberalization in India, and the implications for social security and social safety nets
- conceptual issues, including global ones, concerning the reform of existing pension systems
- the importance of old age security in the unorganized sector
- extension of health, and other social protection to the unorganized work force

In India, since the early 1990's considerable work has been undertaken to social security reforms, which have involved various government, international, multilateral agencies, and other stakeholders. While initiating social sector reforms, India faces a mix of need and opportunity:

- A growing gap between Government's capacity to finance and provide social protection and the needs and growing demands of the population.
- An under-productive public health care system that has grave problems of funding, efficiency and effectiveness.
- A risk that inequity in social status, and inequity of access to social protection services will grow without effective Government intervention.
- An active, eager and growing private and non profit sector with untapped capacity to finance and deliver health care.

Health sector reforms in India are particularly concerned with re-defining the relationships between the state, service providers, users and other related organisations. The goals and principles of health sector reform is the achievement of efficiency, improving quality, preserving or promoting equity, and generating new resources for health care, sustainability of the health sector and the organisations and institutions that comprise it (WHO/SEARO 2006). While the nature and direction of health sector reforms are specific to each state, common themes, and approaches, objectives and issues are discernible. They revolve around implementation of user charges at government health facilities; introduction of insurance or other risk coverage; usage of non-governmental and private resources in a more effective manner, and introduction of decentralized planning, budgeting and purchasing for government health services.

**Table 1.6 Public Policy Interventions since 2003**

2002 Social Obligations for Insurance Companies 2003 New Pension Scheme 2004 Universal Health Insurance 2005 Unemployment Insurance (Rajiv Gandhi Shramik Kalyan Yojana) 2005 National Rural Employment Guarantee Act 2005 Micro-insurance regulations 2005 Janani Suraksha Yojana (JSY), a safe motherhood intervention programme 2005 National Employment Guarantee Act (NREGA)
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As part of its National Common Minimum Programme, the Government of India had set up a National Commission for Enterprises in the Unorganised Sector (NCEUS) to review, *inter alia*, the “social security system available for labour in the informal sector and make recommendations for expanding their coverage.” The Commission in its final report in May 2005 recommended three significant measures for social protection:

- Hospitalisation benefits for the worker and family to the tune of Rs 15,000 per year, maternity benefits to the extent of Rs 1,000 and an illness allowance of Rs 15 per day beyond three days of hospitalisation.
- Life insurance to the tune of Rs 15,000.
- Provident Fund with assured return of 10 % for workers above the poverty line and a monthly pension of Rs 200 for those above 60 years living below the poverty line.

The recommendations constitutes one of the Indian government’s most ambitious welfare initiatives that will benefit 93% of the country’s workforce and cost over Rs 250,000 million (US\$ 5,555 million) over the next five years. In 2005, the Labour Ministry of Government of India introduced a bill on the welfare of unorganized workers. The accompanying legislation being debated in the Parliament would be prepared after consultations with all the Indian states and a consideration of the recommendations of the National Commission for Enterprises in the Unorganised Sector (NCEUS) report. Given India’s slow pace of legislation process, it will be several years before some action is taken on the ground are visible.

India has embarked on the path of pension reforms after an extensive process of discussion and policy debate starting from 1998 and several Budget announcements to this effect (Planning Commission 2005). Pension benefits are not available to about 87 percent of the population and 74 per cent of the work force. Pension schemes have been hitherto limited to workers in the organized sector with severe limitations on withdrawal of pension amount, and choices of investment. The absence of choice to individuals and lack of portability limited the mobility of labour. A bill replacing the Pension Fund Regulatory and Development Authority Ordinance was introduced in the Parliament on March 21, 2005. The Standing Committee on Finance in its report to the Parliament on July 26, 2005 recommended that a comprehensive legislation is prepared to cater to the social security of the unorganized sector, inclusive of pension coverage of the workforce. The recommendations of the Committee are under consideration of the Government.

The willingness of the central government to enhance the efficiency and extend the coverage of social protection benefits to all has spawned new legal frameworks.



## CHAPTER II

### LINKAGES

#### **2.1 LINKAGES BETWEEN STATUTORY AND COMMUNITY BASED MECHANISM**

Relationships between statutory schemes and community-based social protection mechanisms vary greatly between countries on the basis of historical, political, and ideological differences. The realization that government alone cannot deliver social services<sup>7</sup> has led to emergence a number of collaborative frameworks between the State, NPOs, and even local bodies such as Panchayati Raj Institutions. These collaborations exist at central, State, and local level.

Strengthening of national social protection mechanisms involves diversification of institutional and funding base. This diversification process is governed by several factors such as political will to broaden inter-sectoral participation, public pressure for improved quality service, opportunities for collaboration with service providers, presence of incentives to collaborate and rules for benefit sharing. All these factors are quite conducive in India, and therefore, the process of institutional diversification of social protection started quite early. In particular, there has been strong growth of private sector (for profit and non-profit) in the provision of health services. However, both the public and private sectors largely grew in isolation and interface between them was confined to competitive grants-in-aid support for few schemes. The participation of NGOs and CBOs in health education, provision of care to the destitute, aged, and mentally challenged, and prevention of communicable diseases have been quite strong. The experience of developed countries shows that greater synergies can be obtained by evolving and reinforcing interface between various social service and health care providers.

However, despite their obvious potential, mobilising the private (profit and non-profit) sector to serve public health and social protection goals raises governance issues of contracting, accreditation, regulation, referral, besides the appropriate division of labour between the public and private service providers, all of which need to be addressed carefully. Where government interventions or capacities are insufficient and the participation of the private

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<sup>7</sup> The National Population Policy 2000 concedes, "A national effort to reach out to households cannot be sustained by government alone. We need to put in place a partnership of non-government voluntary organizations, the private corporate sector, government and the community."

sector unviable, focused service delivery by NGOs may effectively complement government efforts.

The existing linkages between the Government and health care providers may be summarized as follows:

- a) as a funding agency the Government provides grant/capital/asset/land to the private and voluntary sector engaged in provision of social service, on a contractual/non contractual basis.
- b) As a buyer obtains services from private providers such as medicines, hospital supplies, and consultancy services
- c) As a regulator lays down the rules for licensing of facilities, engagement of qualified professionals, standards for financial reporting, and grievance redressal mechanisms
- d) As a coordinator for receiving inputs from the private sector and other parties in policy formulation and national planning process

## **2.2 DEVELOPING FUNCTIONAL LINKAGES**

We take a broad view of community linkages. They may occur through:

- the flows of resources, services, organizations, people, and information among them;
- the functional integration and complementarities of their activities;
- the formal and informal institutions they create and share; and
- their common and complementary perceptions, values, identities, and ideologies.

These distinctions are not meant to be exhaustive, but to distinguish different mechanisms through which linkages may occur. Since the processes driving them are different, we can also expect that policies and programs addressing them would have to vary. There are large numbers of stakeholders in social protection projects, some already linked, and others who may find useful to develop mutual ties.

<b>Organizations</b>	<b>Other Institutions</b>
<ul style="list-style-type: none"> <li>• User organizations e.g. village communities, trade unions, self-help groups</li> <li>• Local, national, international NGOs</li> <li>• National and foreign research and extension agencies</li> <li>• Hospitals/clinics/medical professionals</li> <li>• Insurance companies</li> <li>• Service cooperatives</li> <li>• Donors/financial institutions</li> </ul>	<ul style="list-style-type: none"> <li>• Political parties</li> <li>• Members of legislature</li> <li>• Bureaucrats</li> <li>• Media</li> </ul>

The business rationale of linkage is in the cost savings and improved quality, as well as in the new innovation potential generated by efficient knowledge exchange and utilization of social capital. Development of organizations, contracts and markets can be examined in institutional perspectives. Firms intend to reduce transaction costs, which is affected by technological factors, economy of scale and scope and asset specificity. If cost of market transaction is high, firms usually integrate vertically. In delivering social protection, transaction cost of reaching out to customers is high, more so because of limited ability of unorganized sector workers to pay the full cost of services provided. Hence, a convenient approach has been to develop collaborative mechanisms for utilizing the strengths of each player. The linkages established between government, private commercial sector, and NPOs may be categorized under four broad heading:

**Consultative:** Consultative linkages may be short-term in nature but are extremely effective. These could be at the level of individual or institution. For example, the Planning Commission routinely consults private sector, and civic society leaders to receive inputs in the formulation of national plans. Similarly, government welfare bodies have representation of private sector, cooperatives, NGOs, academia, and media in designing social protection policies, programmes and projects. Such linkages help in building public credibility and mutual confidence.

#### **Box 2.1 Giving people their due through right linkage**

Uttaranchal Health Department has a critical illness fund of Rs. 7.5 million available to all domiciled residents of the State to meet contingencies. The fund is administered by a set of bureaucrats. Unfortunately outside this privileged group, very few people knew of the Fund's existence. Even the Chief Medical Officers of the districts, who are the nodal persons of the Fund at local level, were oblivious of its existence. The result was year after the funds lapsed due to non-utilization. Things changed when an officer at the Health Department made available the Government Orders pertaining to the Fund to several local NGOs, including SBMA. Thanks to SBMA workers, in 2005, 38 individuals suffering from critical illness were recommended and received financial aid from the fund running into several million rupees.

Non availability of information at grassroots level about social protection schemes such as old age pension, personal accident and disability, and social assurance is one of the major reasons for low level of access to the welfare schemes.

**Contractual:** These linkages are expected to be stronger in the era of intellectual property rights. Statutory authorities outsource provision of services to private companies or NGOs. The contract could be for basic medical services, maintenance of facilities, training of manpower, production of education material, conducting public campaigns, information, and training of manpower or testing of research material. The other form of contract could be hiring of private outdoor and indoor patient services by statutory bodies in privately managed hospitals.

## Box 2.2 Community Participation at Village Level

The concept of community participation is contained in national health policy. The broad areas of community participation at grass roots level are seen in the village health services scheme, the *Anganwadi* scheme of Integrated Child Development Scheme, and the formation of village level committees. Community action has also been successfully used in disease control programmes such as malaria and in areas such as the provision and maintenance of drinking water schemes and sanitation. The main constraint to community action is the low priority given to health by the community in contrast to schemes that provide direct financial benefit. The active promotion of the *panchayati raj* (local administration) system from the village to the district is a measure directed towards ensuring inter-sectoral collaboration. Specific health areas that have effectively made use of inter-sectoral collaboration include malaria control; AIDS control programme, blindness control, nutrition, and water and sanitation to name a few.

**Collaborative:** In collaborative programmes both the sectors participate in programme design, research and funding support may come either from both or any of them. The activities are done under agreed terms of funding and sharing of benefits. The success of collaborative program is determined by operational mechanism, timely response and building mutual confidence. Private firms may reduce transaction cost with supporting collaborative provision of social insurance, while the public sector will be able to extend coverage to population, and provide more sophisticated set of services developed through collaborative programmes.

The main advantage and disadvantage of contractual, consultative and collaborative linkages are summarised in Table 2.2. Grant in aid is the main form of contractual linkage between Government and NPOs. Since the contracts tend to be awarded on yearly basis, these are not conducive for building economic stability and capacity in the provider organisations. Public Private Partnership models are emerging as major vehicles more collaboration on infrastructure projects, however, their application has been relatively modest in India. There exists lot of forums in India to ensure consultation of all stakeholders in social protection in formulation of policies, programmes and projects. Planning Commission has emerged as a major platform for Government-NPO consultation; two chambers of commerce namely Confederation of Indian Industries (CII) and Federation of Indian Chambers of Commerce and Industry (FICCI) periodically bring together government, industry, and civic leaders to debate on key social issues.

	Contractual	Consultative	Collaborative
Strength	-Transaction oriented -Arrangements meant for pre-defined purpose, duration, and output -Performance based payment	-Relationship oriented -Effective in receiving inputs of all stakeholders -Participatory style	-Relationship oriented -Best in building partnerships around mutual interests - Strengthens trust, and inter-dependence
Weakness	-Without adequate checks	-Forums could degenerate	-Time consuming

	and balances in the contracting, manipulation of terms and conditions of contract may lead to corruption, inefficiency, and cost over-runs -Grant-in-aid type contracts may lead to over dependence on government largesse	into 'talk shops' -Dominated by few if not carefully guided	-Interests may diverge over time leading to conflicts
Remedy	-Appoint independent bodies to provide oversight functions - External monitoring and evaluations	-Use experts to channelise inputs for specific purpose; - Follow mutually agreed rules to engage in consultation	-At the outset clarify expectations, roles, responsibilities, revenue sharing arrangement

### **2.3 BENEFITS OF LINKAGES**

The potential benefits expected from cross-sectoral linkages could be mentioned below:

- Complementary efforts based on comparative advantage of statutory, private and non-profit bodies
- Enhanced coverage of schemes to unreached groups. Social service to vulnerable groups such as disabled workers, widows, and unemployed require a great deal of commitment than sheer professional skills, which community and voluntary organizations alone can provide.
- By linking payments to performance, productivity gains and targeted coverage are expected, leading to accelerated delivery of contracts.
- Partnerships of local bodies help in devising innovative ways of recovering costs due to flexibility of decentralization, and compulsions of building consensus among multiple parties.

### **2.4 POLICY BASIS FOR LINKAGES**

The voluntary sector has been given due importance in India's planning process for the last 50 years, as emphasis was given on public cooperation in national development. In the Ninth Five Year Plan (1997-2002), it was admitted that private initiative whether individual, collective or community based, forms the essence of the development strategy and efforts to be made to remove disadvantages which prevented some segments of India's society in participating effectively in development process. Promoting and developing people's participatory bodies like Panchayati Raj Institutions, cooperatives and self-help groups was one of the objectives of the Ninth Plan.

The Tenth Five Year Plan (2002-2007) institutionalized the growing linkages between voluntary sector and Government. The theme of encouragement to voluntary sector was felt necessary for increasing efficiency of public interventions in the development process. The voluntary sector, given their

non-bureaucratic, flexible structure and operations was seen as effective tool for bring people's participation. They held significant comparative advantage in innovating new ways to work in a multi-sectoral framework. In a significant move, the Government of India in March 2000, appointed Planning Commission as the nodal agency for the GO-VO interface. This was a step needed to channel VO inputs in an integrated and holistic manner in national development.

The diversity of linkages between VO and GO is evident in the growing list of schemes inviting their participation. It is estimated that there are about 250 such schemes under operation of more than 20 Ministries/Departments (Planning Commission 2002). A partial list of schemes for voluntary sector of some of the Ministries/Departments related to social protection may be seen at Annex I.

The contribution of private sector in the social sector has been synonymous with that of the voluntary sector. However, new models of public-private partnership and corporate-voluntary organization partnership are now emerging in India.

#### Public-Private Partnership (PPP)

PPP is a mode of implementing statutory programmes/schemes in partnership with the private sector. The underlying idea of PPP is to use Government resources to attract private investments, and improve efficiency in service delivery. Through PPP, Government expects private sector financial investments, improved technologies, and service delivery management. The private sector, in turn expects public sector contribution for financial gap funding to make projects commercially viable; and providing institutional support guidance & regulation. Though PPP can take five forms viz. service contract, management contract, lease, concession, BOT/BOOT, in India the commonest form is service contract to execute specific project. Some health facilities such as leprosy clinics are placed under management contract of NPOs/private companies, however such instances very few. Under PPP, we are beginning to see leasing out of PHCs in remote areas. Tamil Nadu has taken a lead in this area.

Table 2.3 Main Forms of PPP in Health Sector					
Types of Contracts	Asset Ownership	O&M	Capital Investment	Commercial Risk	Duration (Yrs)
Service Contract	Public	Private & Public	Public	Public	1-2
Management Contract	Public	Private	Public	Public	3-5
Lease	Public	Private	Public	Private	8-15

A Working Group on Public-Private Partnership was set up by the Prime Minister's Office in January 2002 with representations from select Ministries and the Planning Commission. The Working Committee favoured PPP on the grounds that involvement of community and neighbourhood organizations led to empowerment of citizens, and held the potential for improvement in both efficiency and effectiveness in service delivery.

The term private sector encompasses all non-government organization such as the corporate sector, voluntary organizations, self-help groups, partnership firms, individuals and community-based organizations. The PPP model represents a shift in emphasis of the Government delivering services directly, to service management and coordination. While earlier VO-Government relied on public funding with private service delivery and private management, the new models exhibit greater flexibility in funding, service delivery and management options. There has been great deal of interest in India in evolving public/private service delivery of social services through public and private funding and public/private/joint management.

The enabling conditions for PPP noted by the Working Committee were a) partnership based on well articulated contract; ii) a long term relationship between the public and private sector; and iii) flexibility and responsiveness in decision making. While the collaboration between the statutory bodies and private sector may take various forms like buyer-seller relationship, donor-recipient relationship, the most stable form of partnership is 'contract' binding on both the parties.

The PPP model in India has gathered momentum in Southern States. Notwithstanding the criticism of high costs, its reluctance to reach rural areas because of the risks involved and therefore only catering to selective selection of the population, PPP is thriving in states of Tamil Nadu, Karnataka, and Andhra Pradesh. These States have fostered partnership through cooperation, inter-reliance, dependence and mutual benefit.

A partial list of schemes available for PPP may be seen at Annex II.

### **Box 2.3 Private Adoption of Primary Health Care Centres in Tamil Nadu - A Way Forward**

The Tamil Nadu government has taken certain proactive measures to involve the corporate sector in improving the health infrastructure and provide better services to the people. In June 1998, it invited corporate houses to adopt and maintain primary health centres and government hospitals in the state at their cost. A special cell in the State Secretariat processes their requests. Three models of adoption have been suggested to the industrialists (GoI 2005c). One is total adoption where the full cost of running a PHC/district hospital (including salary of the staff, cost of drugs, purchase of equipment, civil work and maintenance, repairs and construction of staff quarters), are met by the industrial house. The second model is partial adoption where the industrial house meets all costs except staff salaries. The third limited adoption model involves provision of civil work, maintenance and repairs and provision of buildings.

The results of PPP are:

- Upto March 2005, 34 industrial units have adopted 70 (5%) of PHCs
- Model 3 was the most preferred (82%) option
- More than asset base created by the intervention, it has helped to improved capacity utilization, quality of care and widened range of choice for the patients
- Management of training of PHC staff by NGO
- Higher job satisfaction and better work environment for PHC staff

### Corporate Social Responsibility

Today enlightened companies in India understand the need for having a comprehensive corporate social responsibility (CSR) agenda. The Corporate Sector has opened a number of charitable hospitals like the Escorts Heart Institute and Research Centre in New Delhi, Lupin Human Welfare and Research programme which runs an effective TB programme and Tata Memorial Hospital, premier cancer hospital in Mumbai. India. Majority of these institutions have a dual policy of collecting high fees from those who could afford and providing concessions or free medicines to the economically weaker groups.

A recent survey conducted by Partners in Change (2004) reveals that, of the 536 companies (sample size) across India, philanthropy is the most significant driver (64 %) of corporate social responsibility (CSR), followed by image building (42 per cent), employee morale (30 %) and ethics (30 %) in that order. The 2004 survey findings present a marked increase in the number of companies developing and adopting CSR policy as against the earlier findings in 1999 and 2000 (Arora & Puranik).

### **Box 2.4 Private and NGO Partnership**

Biocon one of India's premier biotechnology company, teamed up with Narayana Hrudayalaya, a health NGO to launch Arogya Raksha Yojana, a unique healthcare scheme for rural India. The first ARY centre with a clinic, office and Biocare Pharmacy was launched in 2004 in collaboration with ICICI Lombard General Insurance Company at Huskur Village, Anekal Taluk, Karnataka.

ARY is a comprehensive healthcare scheme that offers people of rural India affordable access to high



quality healthcare provided by a network of renowned hospitals and clinics supported by leading doctors and surgeons. Starting at Rs. 120/- per year per person, this innovative scheme not only covers people against critical illnesses and surgeries but also entitles them to free or subsidized medical examinations and low cost medicines. With the Arogya Raksha Yojana, rural India can avail of free outpatient consultation, generic medicines at special rates from Network Hospital pharmacies and *BioCare Pharmacies*, Diagnostic tests at discounted rates at Network Hospitals, upto three days of hospitalization (without surgery) and free surgical interventions. The aim is to be able to replicate this nationwide and eventually worldwide.

## **2.5 LEGAL BASIS FOR LINKAGES**

Linkages between various entities must operate within the legal framework established by Government of India and State Governments in statute. Partnerships, and other collaborative arrangements also must comply with applicable regulations and policy guidance. As a result, government, private, and NGO partners should understand the legal underpinnings of the partnership, to enable an efficient, effective, and legally compliant partnership.

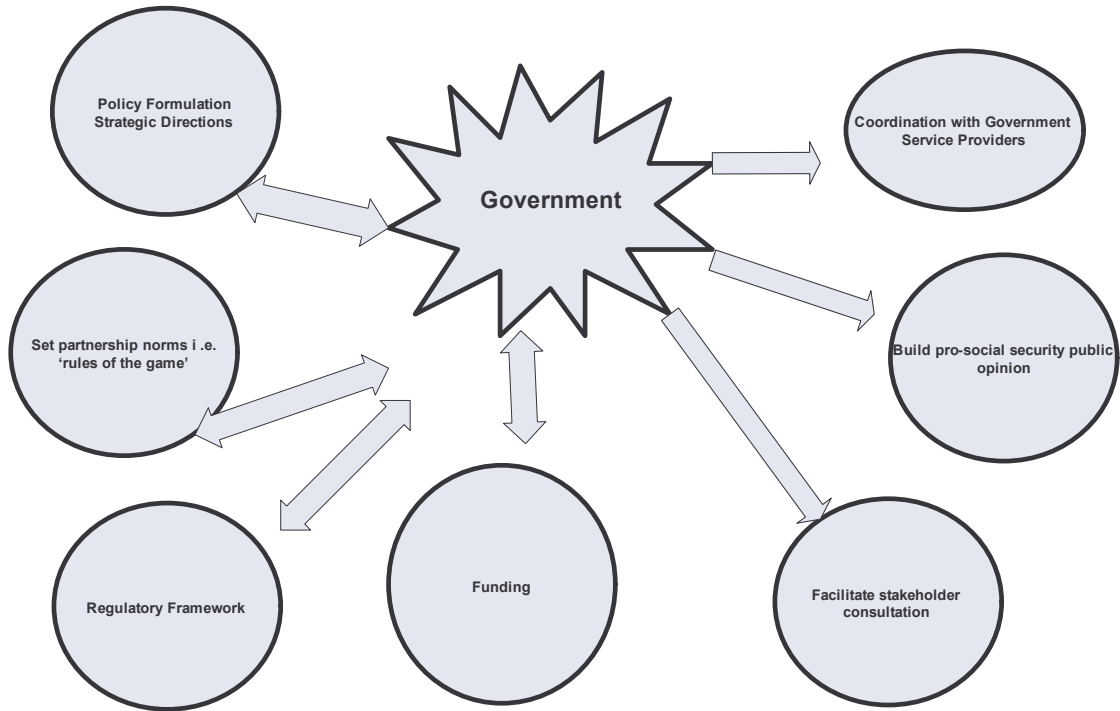
The easiest way to begin to explore the legal and practical aspects of developing, executing, and closing out linkages is to follow a basic time line: starting with the plan, idea, or proposal for a partnership; through the initial stages of development, including arranging funding, establishing agreements or other means to accomplish the goals, and addressing the practical aspects of how the partnership will perform; considering issues that arise as the partnership operates; and finishing with matters associated with wrapping up partnership activities and terminating the partnership.

In India, the relationship between Government, NPOs, and private sector is mainly governed largely by contractual obligations specified under various schemes. The issues related with contracting are discussed in detail in Chapter IV.

## **2.6 KEY ROLE OF GOVERNMENT IN LINKAGES**

In our view, government is uniquely placed to act as the pivot which makes linkages across all stakeholders work. More so in India where it holds great sway on designing and financing statutory social protection mechanisms. The Government's role can be summarised as the facilitator, funder, regulator, and arbiter (see figure 2.1 below).

Figure 2.1 Key Role of Public Partner In Linkage Building



## CHAPTER III

### IMPACT OF LINKAGES ON MICRO INSURANCE IN INDIA

This chapter aims, in the first place, to decipher the concept of micro insurance which, which forms an exciting component of social inclusion strategies in India. The second objective is to describe the importance of policy and regulatory framework in shaping linkages, and extending coverage. The third objective is to provide a detailed overview of the whole range of actors and their initiatives: international institutions and networks, governments and public administrations, workers' and employers' organisations, community initiatives, etc. Finally, we highlight the current debate on strengthening micro insurance activity in the country, and suggest ways that can help promote insurance to the target segment.

#### **3.1 MICRO INSURANCE IN INDIAN CONTEXT**

Informal insurance schemes abound in India. These schemes are often small, run by cooperatives, temples, and non-governmental organization, which pool their members' contributions to create an insurance fund for a specific purpose, for example, to cover hospitalization costs.

Micro insurance products are basically small premium policies that range between Rs. 5,000 to Rs. 50,000. They are subject to much more liberal norms and are targeted to underprivileged group. The entire process of Micro Insurance involves very low premium and easily comprehensible plans, frequent modes of payment, partnering with social sector organizations for doorstep delivery and servicing in remote and far-flung areas, simple to administer front end and back end processes with vernacular content, innovative awareness and capacity building interventions etc.

Insurance is a federal subject in India. Insurance business in India is governed by two principal acts: Insurance Act, 1938, and Insurance Regulatory & Development Authority Act, 1999. In the 1990s the Indian government set about liberalizing its previously nationalized insurance industry. The creation of the Insurance Regulatory Development Authority (IRDA) in 1999 laid the framework for the entry of national and foreign private insurance companies. At the beginning of 2006, there were 15 life and 14 non-life insurers operating in India ([www.irdaindia.org](http://www.irdaindia.org)). Tariff Advisory Committee (TAC) of IRDA lays down tariff rates for some of the general insurance products.

Two central regulations have shaped micro insurance in India. The first is a policy-induced intervention makes it mandatory for all formal insurance providers to service the low-income and disadvantaged segments of population in India. Accordingly, formal insurance providers have introduced a range of 'micro insurance' products targeted at the informal economy workers and their family members. This is essentially a quota system, which compels private insurers to sell a percentage of their policies to socially excluded groups and marginalized communities. In their drive to meet their micro-insurance sales targets, a few insurers are developing new products, delivery channels and innovative institutional tie-ups.

**Table 3.1 Obligations of Insurers to Rural and Social Sectors**

Rural areas: density of population <400/sq. km or 75% of men working in agricultural pursuits
<ul style="list-style-type: none"> <li>• Life Insurance: 5% of total policies in year 1, upto 15% in year 5</li> <li>• General Insurance: 2% of gross premium income for year 1, 3% in Year 2, and 5% thereafter</li> </ul>
Social sector: unorganized sector, informal sector, economically vulnerable or backward classes, and persons with disability
<ul style="list-style-type: none"> <li>• 5000 lives in Year 1, upto 20,000 lives in Year 5 for both life and general insurance</li> </ul>

Failure to fulfil social obligations will attract a fine of Rs. 2.5 million; in case the obligations are still not met, license would be cancelled. In the year 2003, the Insurance Regulatory and Development Authority (IRDA) had slapped notices on five life and two non-life insurers belonging to both public sector and private, who failed to meet the stipulated levels of obligations in rural and social sectors. The failure was more in meeting the social sector obligations.

The second central regulatory document is a paper published by the IRDA in August 2004 entitled Concept Paper on Need for Regulations on Micro-insurance in India. IRDA has conducted extensive discussion on the proposed regulation with insurance companies, and NGO leaders. The draft regulation has been criticized for restricting micro-insurance to the partner-agent model, prescriptive approach to product design, and allowing intermediaries to collaborate with one life insurance company and one general insurer - at present many Indian NGOs have their needs of their clients by linking with a variety of insurance providers.

**Table 3.2 Milestones of Insurance Regulations in India**

1938	The Insurance Act to regulate insurance business in India
1956	Nationalisation of life insurance business in India
1972	Nationalisation of general insurance business in India
1993	Setting up of Malhotra Committee
1994	Malhotra Committee recommends entry of private insurers
1996	Setting up of (interim) Insurance Regulatory Authority (IRA)
1998	The Standing Committee headed by Murli Deora decides to restrict foreign equity in private insurance should be limited to 26%.
1999	Cabinet clears IRDA Bill
2000	President gives Assent to the IRDA Bill

2000	Obligations of Insurers to Rural and Social Sectors Regulations issued by IRDA
2003	Mukherjee Committee appointed to examine remuneration structure of insurance agents and brokers
2004	Concept paper on Need for Regulations on Micro-Insurance in India issued
2006	Parliament considers proposal to raise the foreign direct investment cap in insurance sector from 26 per cent to 49 per cent

### **3.3 MICRO-INSURANCE SCHEMES**

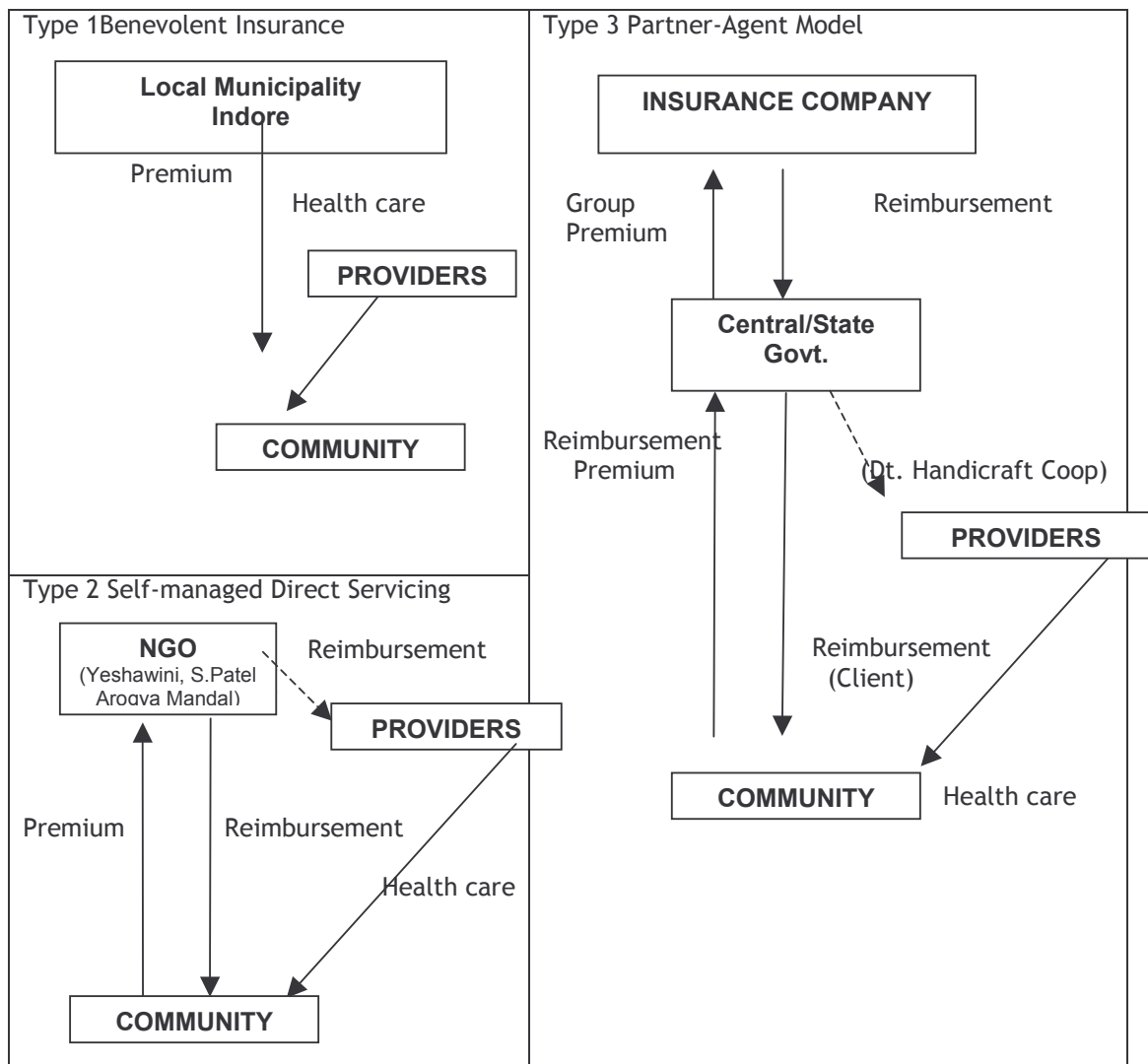
Micro-insurance schemes have proliferated in recent years, operating first as in-house schemes. The recent intervention of private insurance companies encouraged many of them to adopt the partner-agent model in order to transfer the risk to the insurance company. Three main patterns of scheme ownership and management have emerged each with its linkage with insurance and health care providers.

*In the benevolent insurer model (type 1)* a State agency takes the unilateral decision to insure a specific target group, pays the premium for all members from its own sources and appoints a TPA to handle administrative work related to claim settlement. Private and Government facilities are utilized to provide a range of health services. Example: Indore City Municipality in Madhya Pradesh has provided insurance cover all senior citizens aged over 60 years. Currently, the annual premium is Rs. Xx per person. The senior citizens are required to register themselves with the city authorities to avail cashless health services. M.D. India, an authorized TPA provides administrative services to all claims placed by network hospitals numbering xxx.

*In the self-managed model (type 2)* a provider -usually a NGO health care agency provides health insurance for the community around. Example: Both Yeshashvini in Karnataka and Sardar Patel Arogya Mandal, Gujarat offer outpatient and hospitalisation services to cooperative members at a discounted price.

*The partner-agent model (type 3)* is where the NGO/Cooperative acts as the intermediary between the target population and an insurance company. The NGO collects the premium, but passes it onto a formal insurance company. This company then takes the risks of running the insurance. Example: health package insurance for handicraft artisans being implemented by District Handicraft Cooperative in collaboration with United India Insurance Company, a state parasitical.

**Figure 1 Models of Community Health Insurance in India**



The deregulation of the insurance market has seen a spurt in partner-agent models, increased tie-ups between Indian and foreign companies, boosted competition and consequently triggering innovations in keeping with client demand. Some of these companies have had the foresight to recognize that micro insurance was not simply a matter of selling existing policies cheaply, but required new products, distribution mechanisms, and claim verification and settlement processes. An important innovation in this regard is growing cooperation between NGOs and insurance companies. In this insurer-agent model, the NGO identifies members of the community who could be good agents for micro insurance policies (micro agents), aggregates the premiums and sending them on as a single sum to the insurer, allowing the agents to use their offices to conduct business, playing a role in the training of micro-agents, and helping to distribute benefits (Roth and Attreya 2005).

### Box 3.1 Life Insurance Corporation and Micro-Life Insurance

State owned Life Insurance Corporation of India is one of the large insurance companies in the world with over 190 million policy holders. LIC has introduced in September 2006 a micro-insurance product for economically Under-privileged segments of the society. The policy, Jeevan Madhur, will cover individuals between 18-60 year age group. The policy is simple to understand and comes with an affordable premium as low as Rs 100 a month. LIC will offer a life coverage in the range of Rs. 5000 (US\$111) to Rs. 30,000 (US\$667). The premium can be paid weekly, fortnightly, monthly, quarterly, half-yearly and yearly. The policy is simple to understand and comes with an affordable annual premium as low as Rs. 1200 (US\$27). The policy marks the beginning of a massive intervention to curb financial risk exclusion. The policy will be sold through NGOs, SHGs, and microfinance institutions.

The cumulative impact of insurance deregulation, social sector and rural obligations on insurance companies, conscious efforts to establish linkages with private, non-profit and government agencies is easily discernible. With entry of large number of private insurance companies, emergence of private-public partnership in health field, and tax-financed but privately delivered insurance schemes, Indian consumers have more choice of products, and services.

- In 1999, there were only one life insurance and four nationalized non-life insurance companies. In 2006, 16 Life Insurers, and xx non-life insurance companies.
- In 2004, Indian insurance companies mobilised over \$21 billion, nearly three times as much as in 1999 (\$8 billion). This kind of capital mobilisation could be invested in health infrastructure, water supplies, and municipal projects.
- Life insurance penetration in India was less than 1 per cent in 1990-91, in 2003-04 it was 2.4 per cent. The impetus for increase is due to the active role played by IRDA in licensing private players and allowing linkages with TPAs, brokers, micro-insurance agents, health professionals, and hospitals.
- The size of the insurance market increased on the strength of growth in economy and concomitant increase in per capita income. Private sector players are creeping into business of erstwhile public sector monopolies. The share of LIC slipped from 95.32% in 2003-04 to 90.67% in 200-05.
- Innovative products, smart marketing and aggressive distribution have enabled fledging private insurance companies to sign up Indian customers faster than anyone expected. In 2002-03, there were 42 life insurance and 41 non-life insurance products in the market. However, overall private insurance companies have three times more products than the public companies.
- The burden of rural and social sector obligations weigh heavily on public sector insurance companies. In 2002-03, there were 13.2 million new rural policies from public companies and the corresponding figure from private companies are 0.65 million. Public companies account for 36.8 million policies in social sector, while private companies have 1.05 million policies in this sector.

### **Box 3.2 Micro Insurance Schemes by Non Profit Organisations**

ILO (2006) India: Inventory of Micro-insurance Schemes reveals

- Out of the 54 organisations reviewed, half of them work in collaboration with a formal insurance company for providing the insurance package.
- Most of the social security package consists of health insurance. A majority of the schemes provide assistance for meeting illness-related expenses including consultation, outpatient treatment and hospitalization.
- The 43 schemes surveyed reached a total coverage of some 5, 20,000 people.
- Thirteen of the voluntary organizations club healthcare with life insurance and disability, covering 0.72 million beneficiaries including 4000 families and 1200 couples.

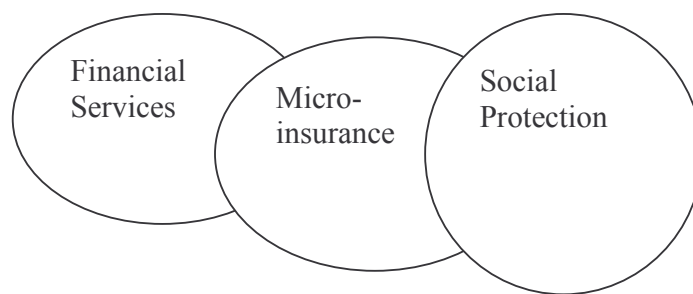
### **3.4 LESSONS LEARNT**

- a) Convergence of multiple social security programmes: Innovative institutional linkages are bringing about convergence of “promotional” and “protective” types of social security. Broadly speaking, social security programmes in India, consist of two parts. The first is the “protective social security” measures, largely for the organised sector, which include benefits relating to sickness, old age, maternity etc., and the second “promotional social security” for the unorganized/informal sector in terms of self-employment, wage employment and provision of basic needs like food, shelter, health and education. In the context of a large (91 per cent) and growing workforce in the unorganised sector, there is bound to be more workforce in the category of deprived and vulnerable, necessitating a great deal of increase in the “promotional social security,” which invariably needs a strong commitment on the part of the state.
- b) Right to Social Protection: One of the most important impacts of linkages have been broadening of conceptual horizon of social protection. The traditional work based approach to social security has been complemented by a citizen-based approach to address the issues of common people. The citizen-based approach (Jhabvala and Sinha 2001, ILO 2005) is based on the “rights” of citizens, entitling every person, by virtue of his/her citizenship of a country, to access certain services, in particular, the public distribution, the health care, employment, education, and non-discrimination in access to benefit. The citizens-approach is a derived construct of Rights to Development approach. The RTD approach is structured upon the primary thesis of the holistic approach, which stresses the indivisibility and inter-relatedness of all human rights (Marks 2005) , negating the traditional distinction between categories of rights and prioritization of one set of security needs over others. The value addition of citizens-based approach includes a) the viewing of social protection and social security as a process facilitating the realization of human rights; b) ensuring that organs of the State, private sector, CBOs, and individuals share a duty and responsibility in extending the contours of social



protection, and iii) the recognition at both a constitutional and instrumental element of the process that must be planned, implemented, monitored and evaluated in an open, and transparent manner.

- c) Universalisation of Health Insurance: India's experience suggests micro-insurance is a bridge between financial services and social protection, incorporating elements of both. Like other financial services, it must be run in a financially viable manner, but it needs the universalisation that comes with the social protection approach. Universalisation—making insurance available to all citizens regardless of socioeconomic status, especially the poorest, is not only equitable, but also makes 'good business sense' from an insurance viewpoint (Chatterjee 2004). The larger and more diverse the pool, the greater is the spread of risk and, consequently the greater the chances of viability. Imposing obligations on insurance companies to serve unorganized sector is a way of encouraging cross-subsidisation and broadening of risk pool.



- d) Administrative Decentralisation at Local Level Improves Targeting: Social protection institutions are governed by financial and administrative rules of the government, perhaps because of their dependence on government funds. Although this system of governance has its own advantages, transaction cost of bureaucratic regulations is often very high. Efforts are underway to reduce the transaction cost by decentralizing the system, promoting autonomy, and simplifying rules and procedures of collaboration. To speedup this decentralisation process some degree of political support is essential. The economy-wide reforms are introduced to liberalise the industrial sector; in some cases privatisation of public sector organisations is also done. But very little is being done to improve the efficiency of primary health centres, district and state hospitals. There is a need to make these organisations more autonomous and decentralised for greater efficiency. The functional structure should be more compatible with the private sector for improving the possibility of better public-private interface.

**Box 3.3 Different Types, Same Goal**  
**VIMO SEWA, Healing Field and Yeshaswini**

One of the oldest member based organisations to link up with formal insurance companies to provide comprehensive insurance cover is Vimo SEWA. Initiated by SEWA in 1992, the main objectives were to protect women from indebtedness resulting from sickness, hospitalisation, death of a spouse, or loss of working assets. As of January 2005, SEWA insurance had a membership of 133,000 women, their husbands and children. Over 25,000 insured members have received claims worth Rs. 50 million so far. SEWA members use and manage their own insurance service - VIMO SEWA. It is currently linked with AVIVA Life Insurance for life insurance and ICICI Lombard for health, asset, and accidental death insurance. Vimo SEWA allows the patient to go to any hospital or qualified medical practitioner for care. The breakdown of the premium and benefit package is as follows:

Premium and Benefit (in Rs)				
	Member	Husband	Child	Family
Annual Premium	100	70	100	250
Natural Death	5000	5000		
Sickness	2000	2000	2000	
Household assets	10000			
Accidental death	4000	2500		

The Healing Field Health Insurance Scheme run by Healing Fields Foundation, along with grassroots micro-finance institutions and HDFC Chubb General Insurance is a new generation micro-health scheme. It covers 25,000 lives in seven districts of Andhra Pradesh. The Scheme is run with 18 network hospitals and several self-help groups managed by 15 NPO partners. Members pay Rs 285 (just 16 paise per day per person) to cover health insurance (Rs 20,000) for a family of five and Rs 35 for Personal Accident Benefit (Rs. 25,000 each member and spouse). The policy includes pregnancy and covers 43 listed common illnesses. In case of a hospitalisation, up to 25 percent is paid by the patient as co-payment.

Yeshaswini Cooperative Health Insurance Scheme of Karnataka is the largest micro-health insurance scheme in the country covering over 20 million members of cooperatives in Karnataka. It is an initiative by the Department of Cooperation, Government of Karnataka and Narayana Hrudalaya. The scheme covers members of farm co-operatives, his/her spouse and children. The premium contributed per person was Rs. 5 per month with Rs. 2.5 subsidy from the government of Karnataka in the first year. The Yeshaswini beneficiary is entitled to receive the following benefits: free outpatient services at a network hospital including consultation fee and registration fee, investigation at special discounted rates, over 1600 listed surgeries done free of cost at network of hospitals. The providers are 114 private sector hospitals that have enrolled in the scheme on a voluntary basis in 26 districts.

### **3.5 ENABLING FACTORS AND BARRIERS TO LINKAGES**

The enabling factors to multi-sectoral linkages are embedded in strong legislative and democratic process in India. The democratic space has encouraged dialogue and participation of social activists, industry leaders, local politicians, and professionals to formulate innovative solutions to India's social problems. Political support is required to end monopoly provision of services by departments and tackle vested interests. At the national level, there is strong political will to extend protection to the poor. Compulsions of electoral politics favour vote-catching populist schemes. While new schemes have been launched with vengeance, often financial support and administrative mechanism to implement schemes have been lacking.

In States, where civic society and government authorities have worked together, the results have been extremely positive. Kerala is a noteworthy example, where political action at the grassroots level, strong support among elected officials, and availability of seasoned bureaucrats has seen the State pioneering many innovative projects. Today, 'Kerala model' beacons rest of the country. Civic pressure plays a limited role in initiating social protection measures, but critical in preventing a roll back of reform. Media plays an important role in minimising resistance from vested interests and galvanising support for reform.

In spite of all declarations the actual situation across India is heterogeneous. In some, but not all States one will find infrastructures and services covering all or part of the total healthcare sector and allowing collaboration, communication, and exchange between the various elements of the health sector. Reasons are many. Some are:

- Unclear goals, roles, and procedural difficulties
- Limited channels of communication and mistrust in official bureaucracy.
- Lack of administrative infrastructure to ease inter-sectoral dialogue  
physical infrastructure of sufficient capacity

**Box 3.4 Sardar Patel Aarogya Mandal, Gujarat**

Sardar Patel Arogya Mandal, a charitable trust, runs a community-based health insurance scheme on behalf of the AMUL dairy company in Anand and Kheda district of Gujarat. It is not a formal insurance scheme but a way of ensuring that members of the dairy cooperative have the means to pay their health bills.

The scheme is open to all members of AMUL's dairy cooperative. Currently, the scheme has 83,000 family members. It charges a premium of 1.5 paise deducted from each litre of milk deposited plus one rupee per family per year. Members must deposit a minimum of 300 litres of milk per year and are not allowed to sell to AMUL's competitors. It covers inpatient and outpatient care and free hospitalization at selected referral hospitals. Members must go for treatment at the Tribhuvandas Foundation (TF) (a trust also set up by Amul's founder chairman to provide health services to its members) or any of its sub-centres for referral to hospital. It has signed a Memorandum of Understanding (MoU) with 9 hospitals (all trust hospitals) and patients are admitted by showing a membership card containing the names of all family

members. Bills are then sent directly to the Sardar Patel Arogya Mandal office on a monthly basis so the patients are not out-of-pocket at any stage. There is a cap of Rs. 7 to 10,000 on average on reimbursement but at the discretion of the management, reimbursements of up to Rs. 0.1 million can be made. Services excluded include angiography, angioplasty, bypass surgery, all cancers, major orthopaedic operations (joint replacement) kidney transplant, AIDS and TB. In 2004, the scheme collected INR 2.7 million through premiums but the total cost of hospitalization exceeded INR 12.5 millions. The cost was borne by AMUL.

## **CHAPTER IV**

### **FUTURE DIRECTIONS**

#### **4.1 INDIA IN GLOBAL CONTEXT**

Nobel Laureate Dr. Amartya Sen and Jean Dreze opined that " While the case for economic reforms may take good note of the diagnosis that India has too much government interference in some fields, it ignores that fact that India also has insufficient and ineffective government activity in many other fields, including basic education, health care, social security, land reforms and the promotion of social change. This inertia, too, contributes to the persistence of widespread deprivation, economic stagnation and social inequality."

The future of social safety nets depend in large measure on how India is going to balance calls for economic liberalization on the one hand and strengthening social safety nets for those who are excluded in the development process. The battle so far has been an even one; there is a growing realization that excluding the poor from the fruits of liberalization is sowing the seeds of discontent, and social unrest. Critiques of liberalization have pointed out that it aims minimizing the labour participation and downsizing the workforce in the industry in the name of removing dead wood to maximize efficiency (Rao 2003). The initial rounds of liberalization have led to casualisation of employment, increase in the organized work force, and growth in unemployment. In 1971, there were 11 workers in the unorganized sector for every new worker in the organized sector. This grew to 14 in 1994, and 27 in 1998. In 2000, with the growth of employment in the organized sector, the ratio between organized and unorganized workforce dropped to 6.

	Organised	Unorganised
1973	18.82	217.48
1978	21.24	249.46
1988	25.71	396.29
1991	27.38	315.17
1994	27.38	344.72
1998		371.63
2000	56.45	396.78
Data for 191-98 compiled on the basis of figures from DGE&T; 2000 figures from NSS 55 <sup>th</sup> Round, 1999-200 Employment Unemployment Survey, 2006		

A higher investment in social safety nets would entail larger outlays, and perhaps more stringent tax regimes. India's corporate and personal tax rates at 33% are among the highest in the world. Hence, any further attempts to load the tax base with further 'cess' or 'surcharges' are likely to increase

resistance. Ironically, with the liberalization Government has to be much more mindful in creating favourable environment for corporate investors, which further restricts government's options to fine tune interest structures, and investment pattern which squarely influence the social security funding patterns.

There is a growing in certain circles that India's ambitious social security programmes are putting pressures on India's fiscal discipline. THE Government has expressed confidence over meeting the revenue as well as fiscal deficit targets budgeted for the current fiscal, despite the emergence of new expenditure commitments from development programmes such as the National Rural Employment Guarantee Scheme (NREG). The Centre's fiscal deficit for April-July 2005 stood at Rs. 7, 74, 800 million, which is more than 50 per cent of the budget estimate of Rs. 1,511,440 million for 2005-06. The revenue deficit for April-July 2005 stood at Rs. 68,9290 million, which is about 72.3 per cent of the budget estimate of Rs. 953,120 million for 2005-06. Concerns about spiralling fiscal deficit is one reason why the Government is going slow with another even more ambitious social provision of Unorganised Sector Workers' Bill. The cost of the schemes proposed in the Bill is said to be Rs 73,670 million (0.20 per cent of GDP) in the first year and Rs. 254,010 million (0.48 per cent of GDP) in the fifth year when it covers 362 million workers in the unorganized sector.

## **4.2 MAJOR TRENDS**

- i) **Good Governance and Decentralisation:** In the changed global conditions, Government is finding new ways to reinvent itself. The Tenth Plan document identified good governance as the single most important factor in ensuring that the Plan objectives are achieved. Among other things, decentralization of power and citizen's empowerment, effective people's participation through state and non-state-mechanisms, greater synergy and consolidation among various agencies and programmes of government, and rationalization of government schemes and mode of financial assistance to state states have been identified as the key priorities. This trend towards good governance is likely to gather even greater momentum in the coming years.
- ii) **Partnership with Private and Voluntary Sector:** There is a perceptible move towards market-led solutions in many areas of welfare provisioning, traditionally reserved by the government. This is consistent with improving Government's administrative efficiency, reducing overheads through outsourcing, and encouraging participation of non-state actors. Given the predominance of informal transfer, the large role played by civil society, and budgetary limitations, progressive state governments are creating facilitative environment for private transfers and civil organizations to plug gaps in welfare provisioning. While

informal safety net assistance is currently being supplied by many private and voluntary groups, there is also evidence of “community failure” in reaching out certain vulnerable groups such as mentally challenged, scheduled castes and tribes. Incentives such as direct public subsidies for civil-society based care giving arrangements might be considered.

iii) **Thrust towards Universal Coverage:**

In short-span of fifty years India has developed four generations of social protection tools. The first generation characterized a patron-client relationship where the state and charities offered to groups-at-risk some degree of benevolence under various welfare funds. The beneficiary had little or no say on the terms of offer. The bureaucracy ran the show for the beneficiary. The second generation schemes though were largely subsidized allowed some amount of participation in the governance and funding pattern of the welfare interventions. ESI, and EPF are examples of this generation. Both had some degree of participation of employers and employees. The third generation schemes focused on bringing the unorganized work force into the safety net by offering packages which were specific to certain income level or occupations. Universal Health Insurance Scheme offered free hospitalization and personal accident benefits to families below the poverty line, and for certain occupation groups such as handloom weavers, a scheme which sought contribution from the beneficiary. The fourth generation, universalizes coverage to all; balances portfolio with fully subsidized and contributory type beneficiaries; provide not only medical and accident benefits but other products such as old age pension and savings; and organizes finance from contributions of corporate houses, taxes, and internal accruals from savings.

<b>Generation</b>	<b>Characteristics</b>	<b>Example</b>
1st generation	<ul style="list-style-type: none"> <li>• Employment based</li> <li>• Poor and needy</li> <li>• Charity financed</li> </ul>	Welfare Funds for destitute, needy
2nd generation	<ul style="list-style-type: none"> <li>• Employment based</li> <li>• Organised sector</li> <li>• Contribution of employees and employers</li> <li>• Board level participation of beneficiaries</li> <li>• Partially state finance</li> </ul>	EPF, ESIS
3 <sup>rd</sup> generation	<ul style="list-style-type: none"> <li>• Income based</li> <li>• Unorganised sector</li> <li>• Mix of both fully state financed or partially subsidized</li> </ul>	Universal Health Insurance Scheme, Handloom weavers health insurance scheme
4 <sup>th</sup> generation	<ul style="list-style-type: none"> <li>• Universal coverage</li> <li>• Focus on poor</li> </ul>	Jharkhand Comprehensive

	<ul style="list-style-type: none"> <li>• Income based</li> <li>• Unorganised sector</li> <li>• Mix of portfolio of fully subsidized and contributory category of beneficiaries</li> <li>• Financed by state taxes, corporate contributions, and earnings from beneficiary savings</li> </ul>	Health Programme
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iv) **Diversity of Financing Mechanisms**

One can expect a diverse range of financing methods applied to fund social protection schemes. These would include tax financed payments, user-fees, and cost-sharing arrangements between government and private sector in PPP projects. There is also a move towards creating earmarked funds through 'cess' to support well-defined activities such health insurance.

**Box 4.1 Health Insurance Cess**

Under the new drug policy for 2006-10, the Centre has planned to impose 2 per cent health cess to mobilise Rs. 30,000 million for a Rashtriya Swasthya Bima Yojana (National Health Insurance Scheme) for families below poverty line (BPL). The scheme proposes to provide medicine almost free of cost to below poverty line families at their doorsteps. Under the scheme, each BPL family will get Rs. 15,000 and Rs. 5000 per annum as hospitalisation and non-hospitalisation expenses, respectively. The scheme might eventually be extended to families above the poverty line as well, once the eligibility criteria are set. One such scheme called the 'Universal Health Insurance Scheme' is already operational, but it has not yielded expected results as it requires each family member to contribute Rs. 1 per day as premium amounting to Rs. 365 a year. Therefore, the new proposed health insurance scheme is now expected to bring positive results. While the Ministry of Chemicals and Petrochemicals has mooted health cess in a draft pharmaceutical policy, the committee comprising secretaries of Ministry of Finance, Chemicals and Petrochemicals and Health are also considering separate budgetary allocation for the scheme.

- v) **New Mechanisms to Mitigate Social Costs of Economic Reforms:** As India prepares to deepen structural reforms to the economy, there are concerns about transitional unemployment, which the Government can help alleviate. There are three main policy levers available. The first is transitional assistance to unemployed organized-sector workers, including various employment relocation programmes, vocational re-tooling, and business development services. The second is to compensate and provide employment to families displaced by setting up of Special Economic Zones, and major infrastructure projects. The cost of absorbing SEZ displaced persons would largely fall on the private enterprise. The third policy lever is unemployment insurance program funded by some combination of worker and employer contributions. Liberalisation of labour law, as well as continued economic reforms and structural adjustments will require new innovations in minimising social costs.
- vi) **Focus on community-wide vulnerabilities**



The Asia-Pacific region experiences nearly two-third of the world's natural disasters. India, on account of its geographical location, size, climate and geological setting, is one of the worst-affected countries in Asia. Drought and floods, tsunami, earthquakes and cyclones devastate the country with grim regularity year after year. They are escalating out of control, growing in viciousness, causing more and more injury, disability, disease and death, adding to the health, economic and social burden of an already impoverished nation. India is likely to rely on independent contingency fund such as Prime Minister's Relief Fund and central transfers to affected states. Better disaster preparedness and better coordination with international agencies will feature heavily in future social agenda.

vii) **Reduce household-risks and vulnerabilities**

There seemed to renewed emphasis on strengthening household coping mechanisms. Electoral politics demand roll out of ever new schemes which generate employment, cash, and visible impact. Several options are available within this category:

- a. To expand work-based, self-targeted (to poor because of low daily wage rates) employment generation schemes, linked to public infrastructure creation. The increased availability of publicly-provided employment on rural infrastructure projects (viz. roads, canals, community buildings) will remain a vital piece to government's effort to reduce seasonal unemployment. In future, as India's urban population grows, there will be clamour for urban employment generation schemes. At present a number of agencies and levels of government implement employment generation schemes; more concerted effort to systematize their contribution to safety net coverage is expected on the grounds of better administrative efficiency.
- b. A second measure is to explore mechanisms to increase household access to subsidized and non-subsidised credit and savings facilities. The spate of suicides by cash-strapped farmers in Andhra Pradesh and Vidarbha in Maharashtra have renewed interests in improving access to credit and saving to reduce vulnerability to shocks.

The challenge of protecting the poorest and most vulnerable members of society from economic and other shocks will continue to remain in India for a very long time. The means to achieve effective protection also will remain limited by both low public expenditure and low administrative capacity. Social

protection cannot be divorced from the broader set of economic and social policies affecting the rate and distribution of economic growth and human capital formation. India after decades of low economic growth rate of 4-5% is looking forward to double digit growth in the coming years. This provides an opportunity to do things differently than in the past. Successful pursuit of social safety agenda requires political support. Costs figure in terms of bureaucratic opposition to reorientation and elite (middle-class) interests supporting a 'growth-only' agenda will hinder extending social protection. Political benefits would potentially accrue to the national and local leadership, who by adopting the strategy would reaffirm commitment to broadly-based, equitable growth as defining element of a new, shining India. Will this strategy generate votes? Will the political benefits outweigh potential political costs? If political leadership finds social protection as win-win for their constituency, then we can expect more accelerated phase of social protection in the country.

**Box 4.3 Comprehensive Health Programme in Jharkhand : Government and Tatas Dance A Tango**

Jharkhand is one of the poorest and most backward states in India with per capita income half of the national average, some 54% of the population living below the poverty line and with 28% of the population belong to scheduled tribes. In one of the country's major public-private partnership, the Sarva Swasthya Mission Trust is being formed by Jharkhand Government in partnership with the major corporate groups. Independently run by a mission management group reporting to the trust, the new concept of health security would protect the poor from borrowings and indebtedness to bear the high cost of medical treatment. The service would have OPD, diagnosis, medicines, referral linkages, hospitalisation and specialised treatment. While the state government has committed to make a handsome contribution, The trust, with its own executive organisation, would run on the principles of accessibility, affordability, availability and accountability for the services to be offered to the BPL population.

One of the innovative features of the Mission is to involve on a long term basis industrial groups in the financing of the insurance component under the Corporate Social Responsibility (CSR) principle. The State and Tata Steel will jointly fund 50 per cent of the Rs. 1200 million schemes which will enable every member of the BPL families of the state to avail of medical care. The scheme will be effective for a period of thirty years and the company's annual contribution will be Rs. 250 million during the duration of the scheme.

Additional means of financing the mission are government tax based allocation, cess on mineral resources, grants/loans, and contribution from policy insurance policy holders.

### **4.3 BUILDING LINKAGES WITH OTHER COUNTRIES**

India is keen to develop mechanisms for transfer of knowledge, technical know-how, and import management capacity in social security. Individual experts admit that social security is a relatively new and growing area of state activity to which the administrative system must respond with alacrity, sensitivity and efficacy. The recent enactment of the national employment guarantee law, the

efforts in the pipeline to extend a measure of social security to the unorganized sector workers and many health-care risk-pooling mechanisms contemplated require effective delivery system, which can address the special challenges posed in this emerging sector of state activity. The need here is to build administrative capacity of senior State and Central officials through systematic training, mentoring, and high level conferences.

The second area where linkage with foreign institutions might be useful is to exchange experiences on global best practices, information, and learning material.

Most of the micro-insurance schemes found operational in India are still very young and as such are much in need of expert advice on designing gender-sensitive community-based schemes, and developing sound commercial approaches to sustain business. In addition, specificity of local contexts, actors, approaches and operational mechanisms require the need to adapt tools, organizational systems, and other details. Placement of foreign experts to fledging micro insurance organizations will help in transferring knowledge and absorption of know-how where it is needed most.

## **CHAPTER V**

### **CONTRACTING WITH HEALTH CARE PROVIDERS**

#### **5.1 BACKGROUND**

A national effort to reach out to extend social protection to millions of households cannot be sustained by government alone. A partnership of non-government voluntary organizations, the private corporate sector, government and the community is essential to broaden coverage. Triggered by rising incomes and institutional finance, private health care has grown significantly, with an impressive pool of expertise and management skills, and currently accounts for nearly 75 percent of health care expenditures. However, despite their obvious potential, mobilizing the private (profit and non-profit) sector to serve public health goals raises governance issues of contracting, accreditation, regulation, referral, besides the appropriate division of labour between the public and private health providers, all of which need to be addressed carefully. Where government interventions or capacities are insufficient and the participation of the private sector unviable, focused service delivery by NGOs may effectively complement government efforts.

#### **5.2 LEGAL FRAMEWORK**

The general law of contract in India is contained in the Contract Act 1872. English decision's (where relevant) are also cited in the courts. The Indian Contract Act really codifies the way we enter into a contract, execute a contract, and implement provisions of a contract and effects of breach of a contract. Basically, any person or organization recognized under law person is free to contract on any terms he chooses. The rights and duties of parties and terms of agreement are decided by the contracting parties themselves. A contract is a "promise" or an "agreement" made of a set of promises. Breach of this contract is recognized by the law and legal remedies are provided under civil laws. The court of law acts to enforce agreement, in case of non-performance.

Under the Indian laws, even the Government can be sued for breach of contract.

Contracts essentially take its cue from the basic objective of collaboration; it codifies in clear terms the tenure of agreement, the funding patter, sharing of risks and division of responsibilities. In India, contracts may be broadly classified under three heads namely a) service contract, b) operations and maintenance management contract, and iii) capital projects, with operations and maintenance contract.

### **5.3 BASIS OF CONTACTING**

A contract is an oral or written agreement with four fundamental characteristics:

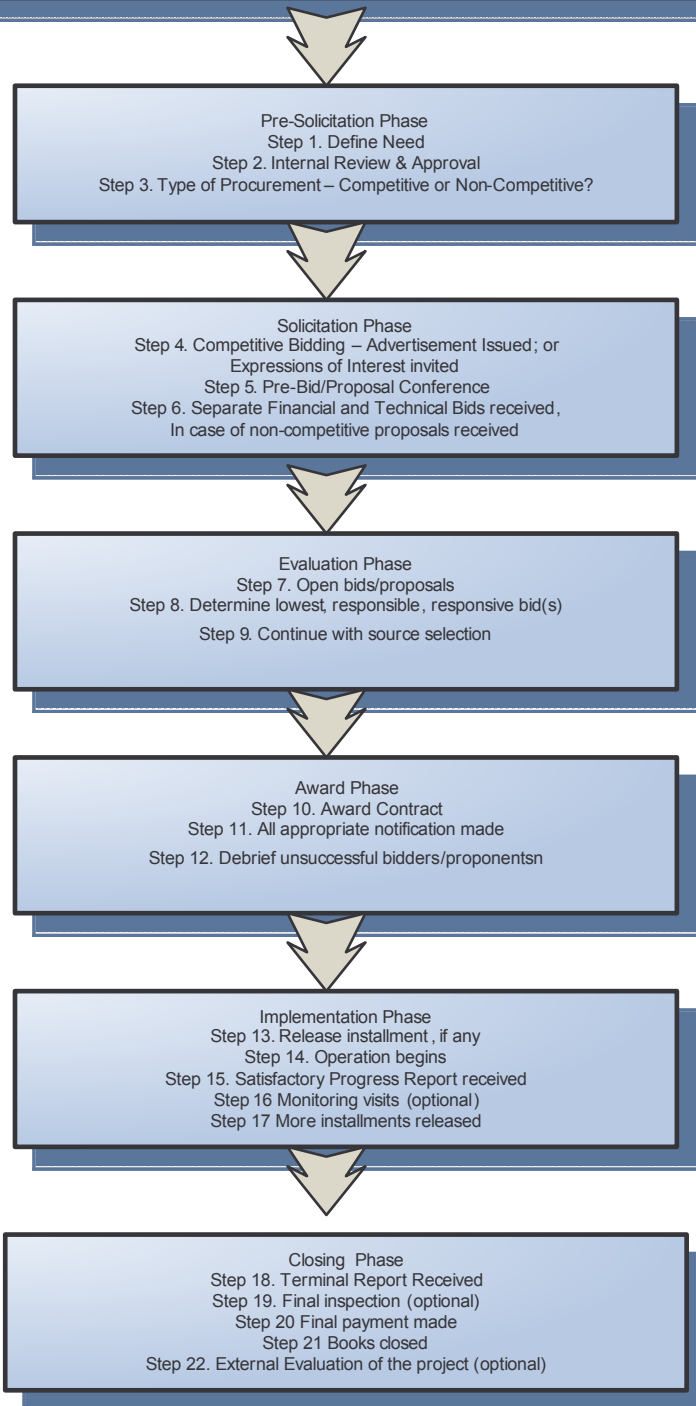
- (a) Intention to create a contract;  
To be enforceable, the parties must intend his/her promise to be contractually binding.
- (b) Capacity  
Only persons of suitable age, intelligence, and ability can enter contract.
- (c) Agreement  
An agreement requires both an offer and acceptance of that offer. An offer must express the material terms of the agreement: price, quantity, and subject matter. Acceptance denotes agreement with the terms of offer. Once agreed, a contract cannot be unilaterally changed or cancelled.
- (d) Consideration  
The law of contract enforces exchanges. Almost anything that provides the other party with a benefit can be viewed as consideration, including a performance of a consultancy, or delivery of goods in return of money.

### **5.4 CONTRACTUAL FRAMEWORK**

Contracts with health care providers may broadly be classified under three heads, namely

- i) Service contract viz. conducting vasectomy operations etc.
- ii) Operations and maintenance contract viz. staff cafeteria, laundry etc. and
- iii) Capital projects, with operations & maintenance contract viz. building clinics, hospitals etc.

Figure 6.1 Generic Contracting Process



## 5.5 SELECTION OF SERVICE PROVIDER

Three ways are used in selecting private service providers:

- a) Competitive bidding
- b) Selective invitation
- c) *Suo-motto* proposals from private entrepreneurs

### a) Competitive bidding

This involves a well publicized and a well designed bid process to ascertain financial, technical and managerial capabilities of the service provider. Sealed tender bids specifying technical and financial details are received by the authorities before closing period.

The final selection of the service provider depends upon one or a combination of the following: a) satisfaction of eligibility conditions; b) lowest value of bid; c) assessment of technical capacity of the bidder; and d) time taken for performing the tasks outlined in the tender document.

In case, no bids are received, selection of the service provider may be done through competitive negotiation.

### b) Selective Invitation

The government specifies the service objectives and invites proposals, or expressions of interest through advertisements, selective mailing, or verbally from organizations of repute. The Government agency may select the service provider through competitive negotiation in the following cases:

- i) social sector projects involving NGOs/Local Community
- ii) projects and programmes which failed to solicit any response to a bidding process

The Government may simply negotiate and award contract to the NGO. In the case of larger projects, the government has appointed Mother NGOs, to act as the master contractor for all dealings with sub-contractors/field NGOs. The Mother NGO is accountable to the Government and monitors the performance of the scheme through regular reporting, field supervision, and random checks. The use of Mother NGOs offers administrative convenience and better control in dealing with less number of service providers.

Selective invitation and contract negotiation are less transparent than competitive bidding.

### c) *Suo motto* proposals or Swiss Challenge Approach

Under this approach, proposals are made by private participants to the government. The proposals provide details regarding its technical, financial, and managerial capabilities, and importantly, all details regarding expectation from the government.

Upon receipt of the proposal, the government may invite competing counter proposals from other parties. In the event of a better proposal being received, the original proponent is given opportunity to modify its proposition. Finally, the best among the proposals are selected, funded, and supported. *Suo motto* proposals are not very popular in India, because the selection process is subject to manipulation, and horse trading.

## **5.6 TYPES OF CONTRACT**

- Lump Sum - These contracts are used for assignments in which the content and duration of work is clearly defined. Payment is made upon delivery of outputs. The main advantage of this contract is the ease of administering the contract and clarity about expectations of payment. Examples of lump sum contracts include surveys, area studies, and management of facilities. This is a very popular form of engaging CBOs/NGOs in India.
- Percent contracts relate to the fee paid to the NGO/CBO based upon the estimated or actual value of products sold. Percentage is established based upon market norm or according set administrative norms. Examples of percent contracts include agents premium in sale of health insurance contracts, engineering services, procurement services etc.
- Time based - these contracts are used for assignments in which it is difficult to define the scope and the duration of the work to be performed. Payment is based upon an hourly, daily, or monthly rate, plus reimbursable expenses using actual expenses or agreed-upon unit prices. Examples of time based contracts include training assignments, preparing health campaigns, monitoring and evaluation missions etc.

## **5.7 PAYMENT MECHANISM**

Payment to the private sector could take the form of: contractual payments; grants-in-aid; and right to levy user charges for the asset created/leased in.



Grant-aid can take different forms such as a block grant, capital grant, matching grant, and institutional support. Grants may be made on an annual basis, or on multi-year basis.

Lease agreement license, similarly may allow the concessionaire to recover the cost of construction, operation and maintenance through levying user charges. A more popular form of leasing is hand-over of primary health centers to private operators for a fixed period of time. For example, Narayana Hrudyalaya, a NPO has been leased 16 primary health centres in Amethi, U.P. where it provides primary health care services at its own cost. The use of asset is subjected to conditions of lease; the asset reverts back to the government after the expiry of the contract.

## **5.8 MONITORING AND EVALUATION**

Payments for outsourced services are linked to performance, which in turn requires monitoring. A general trend is to appoint external independent parties to monitor performance using mutually-agreed criteria, and feedback received from the beneficiaries. Involvement of third party agencies offer non-biased source of information.

### **Box 6.1 Essentials of Contract Between Health Care Provider and Third Party Administrator**

Contracts between health care hospitals and third party administrators are a critical part of the health insurance system. Such contracts are crucial to the professional and financial health of the Health Care Provider. A Service Care Contract is a service level agreement that establishes the legal standards and service duties of the Provider towards the clients and beneficiaries entrusted by the insurance company to the TPA. The Contract specifies how the Providers would be paid, their right to dispute decisions and most importantly, the ability to manage the patient in a professionally ethical fashion.

A Service Care Contract articulates the following:

- The rights and responsibilities of parties to the agreement
- Admission Procedure
- Fee Schedule
- Flow of funds and assignment of critical administrative responsibilities
- The level and type of healthcare
- Agreement termination
- Arbitration and adjudication in case of dispute

## **5.9 DISPUTE SETTLEMENT**

Procedure for settlement of disputes is a civilised way of handling claims and counter-claims. Many contracts provide that all contract disputes

must be arbitrated<sup>8</sup> by the parties to the contract, rather than litigated in courts. In India, a contract may be enforced by use of a claim, or in urgent cases by applying for an interim injunction to prevent a breach.

Unfortunately, many contracts between the Government and Civic Society do not provide fair ways of settling disputes. For instance, a contract between the Department of Health & Family Welfare, Government of Assam and Marwari Hospital, Guwahati (a NPO) states:

“In case of any dispute between interpretation of any clause/clauses of this agreement the decision of the Health & Family Welfare Department will be binding on both parties.”

Such clauses shows how the bureaucracy is willing to deny a fair say to the other party, and usurp the role of final arbiter and judge, even though the complaint may be against its own conduct. This may be motivated by fear of adverse comments by courts<sup>9</sup>.

The new Procurement Guidelines for RCH-II prepared by Ministry of Health and Family Welfare, Government of India stresses that dispute resolution methodology should be clearly indicated in the contract document, and disputes may be resolved with mutual agreement between purchaser and buyer through alternate dispute resolution to avoid going through arbitration and litigation stage.

A robust dispute settlement is essential in India where trust in bureaucracy is not high, rampant corruption<sup>10</sup> in contracting process rampant, and arbitrariness in decision-making is not uncommon. All parties involved in the contract should have a level playing field so that the objectives of the contract is achieved

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<sup>8</sup> Under the Arbitration and Conciliation Act, 1996

<sup>9</sup> Chief Justice of India Hon'ble Mr. Sabharwal has observed that “Government is the biggest litigant whether as petitioner or as respondent. Large number of appeals/revisions and other proceedings filed by the Government are dismissed as frivolous and unwarranted. .. The cause of such large litigation is unwillingness on the part of the government officers to take decisions which invariably have financial implications.” In Justice Sobhag Mal Jain Memorial Lecture On Delayed Justice Delivered By Hon'ble Shri Y.K. Sabharwal, Chief Justice Of India, On Tuesday, The 25th July, 2006

<sup>10</sup> India ranked a low 88<sup>th</sup> – much lower than many Sub-Saharan countries – 2005 Corruption Perception Index prepared by Transparency International

### **Box 6.2 New Procurement Guidelines by Ministry of Health and Family Welfare**

The structure of the service providers that Government uses has developed haphazardly and not homogeneously in regard to performance, compensation, and runtime. Simultaneously, it is often questionable whether the most effective, available cost-performance-ratio was selected for each performance. The implementation of various National Programmes in the Health Sector entails procurement of drug-kits, vaccines, equipments, hiring of experts for specific tasks, and civil works. A major attempt has been made by the Ministry of Health and Family Welfare to plug the loopholes which plague large-scale procurement operations. The Ministry has issues Procurement Guidelines (July 2006) with the aim to achieve the uniform system of procurement in all the States. The procurement procedure broadly consists of the following steps:

- Assessment of requirement
- Deciding procurement strategy including technical specifications
- Mode of procurement
- Preparation of tender document
- Advertisement of the tender
- Issue of tender documents
- Opening of the tender
- Evaluation of the tender
- Clearance of World Bank/DFID, wherever required in case of externally aided projects
- Award of contract
- Notification of delivery to consignee
- Inspection and testing
- Receipt of consignment
- Acceptance and storage of the consignment
- Resolution of disputes, if any

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## ***Annex I***

### ***List of Schemes for Assistance to NPOs implemented by some of the Ministries***

#### Ministry of Human Resource Development

##### **Department of Women and Child Development**

- National Creche Fund Scheme
- General Grant-in-Aid for Voluntary Organisations in the field of Women and Child Development
- Grant-in-aid for Research and Publications

##### **Central Social Welfare Board (CSWB)**

- Awareness Generation Programme
- Working Women's Hospitals
- Creches/Day Care Centres for Children of working/ailing mothers

##### **Rashtriya Mahila Kosh (National Women's Fund)**

- Main Loan Scheme of Rashtriya Mahila Kosh
- Death Relief and Rehabilitation Fund Scheme

#### Ministry of Rural Development

##### **Department of Rural Development**

- Swarnajayanti Gram Swarozgar Yojana (Rural Self-Employment Scheme)
- National Social Assistance Programme

#### Ministry of Health and Family Welfare

##### **Department of Family Welfare**

- Scheme for Reproductive and Child Health
- Social Marketing Scheme

##### **Department of Health**

- Scheme for Improvement of Medical Services
- Scheme for treatment of Tuberculosis
- Scheme for Control of Aids
- Special Health Scheme for Rural Areas

#### Ministry of Tribal Affairs

- Scheme for Grant-in-Aid to Voluntary Organisation Working for the Welfare of Scheduled Tribes
- Scheme of Financial Assistance to Voluntary Organisations for Development of Primitive Tribal Groups

#### Ministry of Social Justice & Empowerment

- National Scheme of Liberation and Rehabilitation of Scavengers and their Dependents
- Grant in Aid to Voluntary Organisations working for the Development of Scheduled Castes
- Scheme of Micro-Financing to Minorities through NGOs
- Scheme to Promote Voluntary Action for Persons with Disabilities

- Scheme for Financial Assistance to NGOs under Science and Technology Project in Mission Mode on Application of Technology for the Welfare of the Handicapped
- Schemes of Assistance under National Handicapped Finance & Development Corporation
- Scheme for Integrated Programme for Older Persons
- Scheme for Assistance to Panchayati Raj Institutions/Voluntary Organisations/Self-Help Groups for Construction of Old Age Homes/Multi Service Centres for Older Prsons
- Schemes of Integrated Programme for Street Children



## Annex II

### Government Social Security Schemes being implemented through PPP

Name of Programme	Service Provider	Contract Structure	Selection Criteria	Payment Mechanism
<b>Ministry of Health and Family Welfare</b>				
The Revised National TB Control Programme	Private medical practitioners, hospitals, NGOs, Corporate sector health care institutions	MoU between District TB Control Society and NGO	Voluntary offer/Negotiation	Grants-in Aid approved by Government of India
National Programme for Control on Blindness	Government hospitals and NGOs with eye care facilities	Public funding with private service delivery/ management	Voluntary offer/Negotiation	Grants-in Aid approved by Government of India and District Blindness Control Society
National Aids Control Programme	Public health institutions and NGOs	Public funding with public/ private service delivery and public/private management	Voluntary offer/Negotiation	Grant in Aid
Central Government Health Scheme (CGHS)	Private hospitals/ diagnostic centres/local authorized chemists	Public funding with private service delivery/ management	Competitive negotiation and bidding	User directly pays to the service provider; later reimbursed by CGHS
Mother NGO Scheme (to provide medical services in remote areas)	NGOs	Public funding with private service delivery/ management	Competitive negotiation and bidding	Grants-in-Aid through State Governments
<b>Ministry of Social Justice &amp; Empowerment</b>				
Scheme for Assistance to Voluntary Organisation for the welfare of Scheduled Castes and Other Backward Castes	NGOs	Public funding of 90% of costs; 10% borne by NGO. MoU is based on annual basis as the Financial Rules in Force.	Invitations to NGOs with proven capability. Selection through direct negotiation.	Grants in Aid
Scheme to Promote Voluntary Action for Persons with Disabilities	NGOs	Public funding of 90% of costs; 10% borne by NGO.	Invitations to NGOs with proven capability. Selection through direct negotiation.	Grants in Aid
Integrated Programme for Street Children	NGOs and government run institutions	Public funding of 90% of costs; 10% borne by NGO.	Invitations to NGOs with proven capability. Selection through direct	Grant in Aid

			negotiation.	
Integrated Programme for Older Persons	NGOs	Public funding of 90% of costs; 10% borne by NGO.	Invitations to NGOs with proven capability. Selection through direct negotiation.	Grant in Aid
<b>Ministry of Labour</b>				
Welfare of child labourers through Special Schools	NGOs/Universities/Trade Union/non profit companies	Public funding of 75% of costs; 25% borne by NGO. Max. duration of project – 3 years	Interested organizations will apply on their own to Department of the concerned State Government. A Committee headed by Joint Secretary, In-Charge of Child Labour and Women, Ministry of Labour, Govt. of India selects application.	Grant in Aid
Preventive measures to discourage further accretion of children into employment	-do-	-do-	-do-	Grant in Aid
Legal aid to working women	-do-	-do-	-do-	Grant in Aid
Training and skill development with a view to provide gainful employment	-do-	-do-	-do-	Grant in Aid

## ***Annex III***

### ***Other Schemes for Old Age, Survivoship, Mental Health***

#### **NATIONAL RURAL EMPLOYMENT GUARANTEE PROGRAMME**

The Prime Minister of India launched National Rural Employment Programme on 2<sup>nd</sup> February 2006. At present, a total of 200 most backward districts have been identified across the country for the first phase of implementation of the programme. There are five crucial components of this scheme: 100 days of work to earn a livelihood; payment of wages once a fortnight; equal wages for men and women; only works approved village Panchayats (elected village councils) will be undertaken; and works related to water conservation, watershed management, drought and flood proofing, forestry, land development, rural connectivity and wasteland development will be carried out under this scheme. Rural public works programmes are an important tool of social protection as they contribute towards job creation, food security, poverty alleviation, and building community assets. The Maharashtra Employment Guarantee Scheme on which NREP is modelled, was the first piece of legislation to operationalise the Indian Constitution's directive policy regarding the 'right for work for all' Article 41. 60% of the cost of a project goes toward wages for unskilled labour and 40 for skilled labour/material. A number of additional benefits were included for the workers on EGS such as crèches, shelter for children of labourers, maternity benefit for women labourers, death/injury benefit for workers, and guaranteed availability of work within eight kilometers of the workers residence. In 2006-07, the NREP has provided 90% of the 7.23 million BPL households who demanded jobs. The National Rural Employment Guarantee Act will cost about Rs 400 billion annually and eventually implemented in all the 600 districts of India.

#### **MEDICAL CARE OF SENIOR CITIZENS**

Populations worldwide are ageing. In India, while the total population is expected to rise by 49% (from 846.2 million in 1991 to 1263.5 million in 2016), the number of aged (persons aged 60 and above) is expected to increase by 107%, from 54.7 million to 113.0 million, in the corresponding 25 year period. In other words, the share of the aged in the total population will rise to 8.9% in 2016 (from 6.4% in 1991). Today, males and females in India at age 60 are expected to live beyond 75 years of age. Thus, on an average, an Indian worker must have adequate resources to support himself for approximately 15 years (and his wife for an even longer duration) after his retirement.

Ministry of Social Justice & Empowerment is the nodal Ministry responsible for welfare of the Senior Citizens. The National Policy on Older Persons 1999 has identified a number of areas of intervention: financial security, health care and nutrition, shelter, protection of life and property etc. for the wellbeing of older persons in the country. Amongst others the policy also recognises the role of the NGO sector in providing user

friendly affordable services to complement the endeavours of the State in this Direction. A National Council for Older Persons under the Chairmanship of the Minister for Social Justice and Empowerment has been set up to operationalise the National Policy. The Council has representation of NGOs, academic bodies, media and experts. An integrated programme for older persons has been formulated and financial assistance upto 90% if the project cost is provided to the NGOs for establishing and maintaining centres for emotional and medical care of the elderly. Ministry of Health (on request from the Ministry of Social Justice and Empowerment) has issued instructions to all state governments to provide separate queues for older persons in hospitals for registration and clinical examination in 16 hospitals around the country. The State Governments of Goa and Gujarat provide for distribution of free medicines and spectacles to the destitute senior citizens as per rules.

## **BUILDING & CONSTRUCTION WORKERS**

There are about 17.62 million building and other construction workers in India as per the estimates of National Sample Survey (1999-2000). To promote their welfare, the Labour Ministry has been pressing the state governments to constitute State Welfare Boards/ Welfare Funds, and State Advisory Committees and frame rules to implement the Building and other Construction Workers Act and Welfare Cess Act. As a result, the government of Andhra Pradesh, Maharashtra, Uttar Pradesh, Madhya Pradesh, Manipur, Punjab, Goa and West Bengal are in the process of completing the necessary action to implement the Act. Kerala, & Tamil Nadu have constituted Welfare Boards while Pudducherry and Delhi have framed rules under the Act.

## **WELFARE FUND FOR OVERSEAS INDIAN WORKERS**

Overseas Indian Workers (OIW) often face exploitation and abuse at work. There are 4-5 million Indian workers overseas, working mainly in the Gulf countries. These workers are mostly semi-and-unskilled and appreciated for their sincerity, hard work and non-interference abroad. The OIW remittance into India is \$ 21 Billion annually. The Ministry of Overseas Indian Affairs is currently in the process of initiating action on issues like streamlining the procedures for migration, better control and supervision of the Recruiting Agents, expanding the scope of the Overseas Indians Insurance Scheme (Pravasi Bhartiya Bima Yojana), providing legal assistance to migrant workers, introducing pre-departure training through NGOs/professionals etc. It has adapted training material developed by ILO/IOM for specific State/country and gender. The Labour Ministry also initiated a move to set up Central Manpower Export Promotion Council. The proposed Council would play a role of promoting employment opportunities for emigrants, projection of manpower services from India in major labour markets abroad, liaison with other export promotion agencies and administration of the Indian Overseas Workers' Welfare Fund. The Welfare Fund would be set up by collecting a fee from each worker leaving the country for overseas employment. It would be utilized for repatriating

the workers stranded in foreign countries, providing financial assistance to the kin of workers who die during foreign employment, etc.

## **ELIMINATION OF CHILD LABOUR**

The government has made efforts to prohibit child labor by enacting Child labor laws in India including the 1986 Child Labor (Prohibition and Regulation) Act that stated that children under fourteen years of age could not be employed in mines, factories, and hazardous occupations. This Act was the culmination of efforts and ideas that emerged from the deliberations and recommendations of various committees on child labor. Significant among them are the National Commission on Labour (1966-69), Gurupadaswamy Committee on Child Labour (1979), and the Sanat Mehta Committee (1984). Children under fourteen constitute around 3.6% of the total labor force in India. Of these children, less than 9% work in manufacturing, services and repairs. The number of occupations where child labour is prohibited continues to be 13. The National Child Labour Projects, NCLPs, to rehabilitate children withdrawn from employment has been increased to one hundred. Over 3000 special schools/ learning centres have been set up in 100 districts in 13 child labour endemic states under the NCLPs to rehabilitate about 0.21 million child labourers. Over 70 projects by voluntary organisations are also under implementation under the grants-in-aid scheme. The Labour Ministry meets 75 percent cost of these projects by way of grants.

## **MENTAL HEALTH**

Mental health gets a low priority all over the world but much more so in developing countries. In 1966, the Mental Health Advisory Committee to the Govt. of India suggested a prevalence rate of mental illnesses of 2 per 100 populations with 1.4 per 100 in rural areas (Elnagger et al 1974). A more recent study by Madhav (2001) estimated overall prevalence of all mental disorders analyzed to be 6.54 per 100 populations. The burden of caring of mentally challenged persons rests heavily on the households. The burden of mental disorders is highest among young adults aged 15-44 years, which is the most economically productive section of the community (Pathare 2005). In India, modern psychiatric facilities are available only in the cities. . In view of paucity of facilities, 80% of the population has to depend on indigenous treatments consisting of Ayurvedic and Unani systems of medicine, religious treatments consisting of prayers, fasting, etc. and various witchcraft and magical rituals.

It is estimated that there are 2.8 million adults with common and severe mental disorder in Gujarat. The total allocation towards mental health works out to Rs 82 million out of a total health budget of Rs 8,562 million i.e. Rs. 29 per mentally challenged person. In order to bring more effective service to the affected population, Gujarat Government adopted a policy on mental health based on the recommendations of a Mission to outline Priorities for Mental Health Sector Development in Gujarat. The policy is aimed at ensuring availability and accessibility of minimum health care for all in the near future, and promotes community participation in mental health service and stimulates efforts towards self-help in the community. The Department of Health and Family Welfare

(DoHFW) has set up a separate organization, Gujarat Foundation for Mental Health and Allied Sciences, for implementing the activities of mental health programme.

In order to overcome the constraint of trained manpower, and use the resources of private medical professionals, service provision arrangements would link government, private and household care givers for different type of interventions. The programme is supported by Gujarat exchequer, private philanthropies, and NGOs.

## **NATIONAL SOCIAL ASSISTANCE PROGRAMME (1995)**

### **Introduction**

The NSAP is considered to be the first programme of a cash transfer nature implemented through the country. The objective of the Programme is to extend financial assistance to old persons having little or no regular means of subsistence, to households living below the poverty line in case of death of the primary breadwinner and to pregnant women of households below the poverty line upto the first two live births. The scheme is a 100 percent Centrally funded to provide a modicum of social protection to poor families. The NSAP comprises three separate Schemes, namely, National Old Age Pension Scheme (NOAPS), National Family Benefit Scheme (NFBS) and National Maternity Benefit Scheme (NMBS).

### **Objective**

#### **Target Groups**

The assistance under the National Social Assistance Programme NSAP is available to the destitutes the poorest of the poor and families below the poverty lines. The Scheme wise target groups are as under:-

- National Old Age Pension Scheme(NOAPS)
- Old persons who are destitutes in the sense of having no regular means of subsistence from their own sources of income or through financial support from family members or other sources.
- National Family Benefit Scheme(NFMS):
- Households below the poverty line on the death of the primary breadwinner. The 'primary breadwinner' has been defined as the member of the family whose earnings contribute substantially to the total household income.
- National Maternity Benefit Scheme(NMBS):
- Pregnant women of the households living below the poverty line upto the first two live births.

#### **Salient Features**

##### National Old Age Pension Scheme (NOAPS):

- Age of the applicant (male or female) should be 65 years or above.
- The applicant must be a destitute in the sense of having little or no regular means of subsistence from his /her own sources of income or through financial support from family members or other sources.
- The amount of pension is Rs.75/- per month per beneficiary. The State Government may add to this amount from their own sources
- Upper ceiling on the number of beneficiaries for a State/UT is prescribed by the Central Government

##### National Family Benefit Scheme (NFBS)

- Central assistance for a lump sum family benefit is available for the households below the poverty line on the death of the primary breadwinner in the bereaved family.
- The amount of assistance is Rs. 10000/-.
- The primary breadwinner is a member of the family whose earnings contribute substantially to the total household income.

- The death of the primary breadwinner due to natural or accidental causes should have occurred while he or she is in the age group of 18 to 62" i.e. more than 18 years of age but less than 65 years of age.
- The maximum limit of the total number of beneficiaries of a State/UT is prescribed by the Central Government.
- The family benefit is paid to such surviving members of the households of the deceased who, after local enquiry, is determined to be the head of the household.

#### National Maternity Benefit Scheme (NFBS)

- A lump sum cash assistance of Rs. 500 to the pregnant woman of the household living below the poverty line is given provided she is 19 years of age or above.
- The benefit is available upto the first two live births.
- The benefit is disbursed several weeks prior to the delivery. In case of delay, the benefit may be given even after the birth of the child.

#### **Achievement**

The achievement made by the States/UTs through the financial assistance as above in extending benefits to the target groups during 2005-06 is being assessed. The provisional position in this regard is as the following:

- NOAPS : 7.28 million beneficiaries; expenditure Rs. 1956.6 million
- NFBS : 0.21 million beneficiaries; expenditure Rs. 806.2 million
- NMBS : 1.52 million beneficiaries

#### **Implementing Agency**

The programme is implemented by the district level implementing authorities headed by the District Collector/Magistrate/Deputy Commissioner. It is implemented with the assistance of the Panchayats and Municipalities in the delivery of social assistance to make it more responsive and cost effective.