

# **NATIONAL RURAL HEALTH MISSION**

## **REPORT OF TASK FORCE ON EXPLORING NEW**

### **HEALTH FINANCING MECHANISMS**

#### **I. Task Force and its membership**

1. A Task Force on exploring new health financing mechanisms was set up under the National Rural Health Mission [NRHM] with the following membership:

- 1) Ms.Sujatha Rao
- 2) Dr.Ramesh Bhat, IIM, Ahmedabad
- 3) Mr.Vinod Vyasalu, CBPR
- 4) Dr.Jai Prakash Narayan, Lok Satta
- 5) Ms.Mirai Chatterjee, SEWA
- 6) Mr.G.C.Chaturvedi, J.S., DEA ( i/c Insurance)
- 7) Mr.P.K.Aggarwal, DOHFW
- 8) Mrs.Ganga Murthy, EA – Rapporteur

Amarjeet Sinha joined the Ministry of Health and Family Welfare in September 2005 and took over the responsibility of the Rapporteur.

#### **II. The suggested tasks**

2. The suggested tasks were:

- ***Review component of NRHM for exploration of health financing mechanisms;***
- ***TOR for time bound task force to include review of existing mechanisms to include health financing, human resource implications to manage health financing and risk pooling schemes, extent of subsidies required, ensuring equity and non discrimination, feasibility in various states, suggested design of pilots and sites to launch community based health insurance models, and required modifications of existing structures to introduce health financing schemes.***

### **III. Meeting of Task Force**

3. A meeting of the Group was convened by Shri Amarjeet Sinha, Director, Ministry of Health & Family Welfare on 18<sup>th</sup> October, 2005, which was attended by the following: -

1. Ms.K.Sujatha Rao, Principal Secretary (Health), Govt. of A.P.
2. Shri Jaya Prakash Narayan, Lok Satta
3. Mr.Lalit Kumar, Deputy Secretary, Insurance Division, MOF
5. Mr.Prasad, GIPSA
6. Ms.Ganga Murthy, AEA, MoHFW
7. Dr.T.Sundararaman, Chhattisgarh Health resource Centre.
8. Dr.H.Sudarshan, Karuna Trust, Karnataka [attended as a special invitee]
9. Shri Sunil Nandraj, WHO [attended as a special invitee]
10. Shri Amarjeet Sinha, Director, MOHFW

Written inputs have been subsequently received from Mirai Chatterjee of SEWA which has been circulated to members of the Task Force.

### **IV. Need for new health financing mechanism**

4. The Group expressed its desire to explore new health financing mechanisms in order to reduce the health distress of poor households. The fact that more than Rs.100,000 crores a year is spent by households, mostly out of pocket, and in times of health distress is reason enough to explore new ways of health financing. The National Commission on Macroeconomics & Health has pointed out that 3.3% of India's population is impoverished every year on account of health distress. There is also evidence to suggest that the poorest 10% of the population rely on sale of assets to meet their health care needs. A study in some of the poorest districts by Jha & Jhingran 2002 had revealed that illness of a family member is the most common reason among poor households leading to a financial crisis and causing a sense of insecurity. Nearly 40% of the Below Poverty Line families reported having faced a financial crisis during the last two years and about 69% of these was on account of illness and 11% on account of a death of a family member. Clearly poor people in rural areas are spending significant amounts on health care leading to their pauperization.

## **V. Vulnerability and risk among informal sector workers**

5. Work and social security are the central concerns of the poor in our country. Most of our nation's poor or almost 400 million workers are engaged in the informal economy, also called the informal or unorganized sector. There are a large number of agricultural labour who fall in the below poverty line category. Among these workers, women are the poorest and most vulnerable of all. Their lives are marked by a struggle to attain basic security of employment and livelihood with social security.

6. The quest to overcome vulnerability and obtain some protection from the many risks and shocks they face has to be understood all across women's life cycles, as at any time they face one or more risks. Insulating poor households from untold misery on account of high out of pocket expenditure will help households come out of poverty.

7. Among poor working people, and especially women, risks are varied and frequent at all stages of their lives, contributing to their vulnerability and continuing poverty. Risk pooling has to therefore, be inclusive, in order to meet specific household needs.

## **VI. Coping with shocks and women's risk management strategies:**

8. Women workers have devised their own systems to cope with the many risks in their lives. Some of them may be mentioned, others will be added as a result of the exposure experience. The first and now most well-known of these is savings. Contrary to what was widely believed a few decades ago, all women save and use their savings for a variety of purposes, including coping with risk – paying for medical expenses, funeral costs, or a leaking roof.

9. The system of "Vishi", or contributing to a central pool of money which is then drawn upon by a few of the contributors in times of need, is yet another kind of risk management, developed by women themselves. The Self- Help Groups have built on these practices.

10. Borrowing from family, neighbours, friends and moneylenders is also part of women's crisis management strategies, though often at a high social and economic cost.

11. Finally, payment in kind for risk management services provided by midwives or traditional healers, for example, as per the traditional jajmani system, is also part of coping strategies. Often these payments are deferred to the post-harvest period with the unwritten understanding of all concerned.

## **VII. The Experience with insurance so far**

12. The ESIS and CGHS are the oldest schemes for social health insurance in India. ESI Hospitals provide services to their members across the country. CGHS uses a subscription but the actual expenditure incurred is many times more than the premium collected. The principle of contribution for social health insurance being a percentage of the income is not strictly followed. In fact, the very large informal workers pool and their families (more than 400 million) makes social health insurance very difficult as the true incomes are not even known. The experience with health insurance so far has been mixed. Some policies like Mediclaim covers more than 75 lakh persons with a range of premium varying from Rs. 175 to Rs. 5770 per annum, the claims ratio being 84%. The Yeshasvini Cooperative Farmers Health Care System, the work of Karuna Trust, the Vimo SEWA, etc. are good examples of community health insurance providing protection against catastrophic health expenditure.

13. The Government of India's Universal Health Insurance Scheme (UHS) was launched in the Budget of 2003-04 and is the first broad-based health security scheme having an element of financial contribution from the State. In 2004-05 budget the UHS was revised to restrict it to Below Poverty Line families; increase the subsidy element to Rs.200 against the Rs.365 annual premium paid for individual coverage; Rs.300 for the Rs.547.50 premium for a family of five and Rs.400 for those paying a premium of Rs.730 for covering a family of seven persons. **The coverage under UHS is unsatisfactory (barely 1.3 lakh persons till 31 July 2005) indicating the ineffectiveness so far. Maternity benefit is not covered under UHS. Exclusion of essential health care needs are likely to make any policy unattractive. Perhaps a range of health insurance products developed as per local needs, improved social marketing of such products, simpler procedures for claims, and accredited facilities for hospitalization in rural areas could have helped a larger coverage under UHS. Low coverage should not be an argument for not pursuing risk pooling for the poor; it should be an opportunity to think afresh, to innovate.**

#### **VIII. The perception of Insurance Companies about UHS**

14. The General Insurers' (Public Sector) Association of India (GIPSA) have identified the following constraints in the UHS programme: **inability of BPL families to pay even the subsidized premium; low premium structure being cost prohibitive for effective canvassing and service; perception of government sponsored scheme as a free scheme; health insurance for poor as state responsibility and not commercially viable; and inadequate public health facilities, standards and system of Third Party Administrators.**

#### **IX. The perspective for improving coverage for Risk Pooling**

15. The experiences from across the world are a confirmation that **health insurance is never a substitute for a well – functioning, effective and efficient public health care system. Health insurance is also not an argument for undermining higher public investments for effective public health delivery as the success of risk pooling is dependent on the provision of health care services in governmental and non-governmental institutions. Health insurance works best when services are available in the remote corners and poor households can actually exercise choice. Health insurance has to be primarily seen as an efficient and effective mechanism for improved health care by meeting hospitalization and other health care needs of people, through cashless and simple procedures for claim settlement that create confidence among households regarding the system of health insurance.** This calls for a range of innovations in our approach to insurance.

#### **X. NRHM – An opportunity**

16. **The National Rural Health Mission (NRHM) is trying to carry out fundamental reforms in the basic health care delivery system in order to meet people's needs. Exploring new health care financing mechanisms and developing credible community based health insurance schemes is its mandate.** The NRHM envisages a strong District Health Mission with adequate technical, managerial and accounting support in managing risk pooling and health security. The NRHM is also providing Accredited Social Health Activists (ASHAs) in the EAG states for every 1000 population. The NRHM effort is to strengthen the 3222 Community Health Centres and to establish 24 hour round the clock hospital like services in every Block in the country.

Janani Suraksha Yojana support for institutional deliveries is available to every Below Poverty Line pregnant woman and is expected to meet the maternity care needs. **The strengthening of the public health delivery system and the availability of an army of health workers in the field provides an opportunity to improve risk pooling through community based health insurance.**

#### **XI. Need for State & Region specific Health Financing Models**

17. Experience with Health Financing indicates a need for decentralized approach that allows for a diversity of interventions. State Governments have been exploring the possibilities of Risk Pooling for Health Care. Government of Assam has started a Health Insurance Scheme which covers major surgeries but excludes essential maternity care etc. Government of Jharkhand is trying to design a Health Financing Product without exclusions in one block of each District with the partnership of industrial houses and Insurance Management Organization. The National Commission on Enterprises in the unorganized sector has also been examining the feasibility of Health Insurance for informal sector workers. The Ministry of Textiles has started a Health Insurance Scheme for co-operatives of weavers. Many community based Health Insurance models like that of SEWA in Gujarat, Karuna Trust in two blocks of Karnataka etc. are also there. The Task Force felt the need to promote diversity of interventions that meet the aspirations of local communities and their health needs.

#### **XII. Strengthening public health delivery**

18. The Group was aware that the prime challenge is to strengthen the Public Health Delivery System at all levels. The Community Health Activist [ASHA] at the village level will only be effective if she is able to forge partnerships with the Sub Centre, PHC and CHC in seeking health care including hospitalization needs for households. A functional Public Health System is the best guarantee for care of poor households. The Group strongly felt that the NRHM ought to make all efforts to make the Public Health System fully functional. It was aware of the challenges faced by Public Systems in delivery of quality service. It was felt that improved human resources, better availability of well trained and skilled resident health workers, improved management of procurement and logistics, and most of all improved governance of the health system with full community ownership under the Panchayat was the best way of developing an accountable Public

Health System. The Panchayati Raj Institutions have the Constitutional mandate to provide leadership to the health sector at the local level.

**XIII. Reasons for unsatisfactory progress on UHIS**

19. Slow progress on UHIS is not on account of lack of interest in risk pooling by poor households. It is because of poor social marketing and lack of facilities where the risk pooling could be guaranteed. The formal insurance organization and system of reimbursement rather than cashless transaction makes poor households wonder whether insurance will be of any use in time of need. Also, by excluding maternity care, poor households wonder whether the insurance is useful at all. The involvement of the stake holder in the risk pooling arrangement is very critical for its success. The entitlement of the household has to be clearly defined and cards provided indicating clearly where the household can go to in case of need.

**XIV. Need to do away with exclusions**

20. For poor households health and health care is related to life itself. They are not able to understand systems of exclusion which insurance arrangements undertake. Any Health Insurance Scheme for the poor has to, therefore, be designed as per their needs and without exclusion. In fact, there is a case for combining health with Life Insurance as in that case poor households feel that they are contributing towards generating a corpus of saving as well. The way to reach poor households has to be without exclusions and for doing this the entire arrangement for Insurance needs to be revisited. It is not that poor households are not willing to put their small savings for health care. It is just that they do not have confidence that the Risk Pooling for Health Care will actually be useful in time of their real need.

**XV. Need for diversity of approaches – letting a hundred flowers bloom**

21. Small but significant experiences of health insurance for the poor, both in India and abroad, reveal that coverage is indeed possible, if certain critical issues are taken in to account. The most important of these issues is developing a mechanism of implementation that is specially tailored to the reality of the poor, and organized according to their convenience.

22. Another contentious issue is the fact that most of our people, 80%, seek care with private providers. And the private health sector is unregulated especially in terms of standardizing regimens, fees and diagnostic tests. It is a growing sector. And costs are escalating in a manner that is leading to the greater indebtedness of the mass of our nation's people.

23. SEWA's experience based on insuring over 140,000 workers and their families over fourteen years suggests that for health insurance to be viable, it has to be controlled and run by the users themselves, the very women who are the insureds. Their organization then negotiates fees, treatment regimens etc. with providers, both public and private. And those providers that adopt poor quality of care or fraudulent practices are black-listed. This has already had the effect of providers improving the quality of their care and revising some of their prices.

24. It has also resulted in the public health system gearing itself up to provide the care required, with the public charitable trust hospitals serving as a back-up or alternative to the public and private-for-profit health providers.

25. Finally, the experience of SEWA with health insurance has encouraged them to develop "cashless" systems with providers, both public and private, enabling women and their families to seek quality care of their choice without having to pay upfront immediately. This new system is being tested out in eight talukas in Gujarat, as well as two working class neighbourhoods of Ahmedabad city.

26. All of the above experiences point to the need to develop appropriate mechanisms to reach health insurance to the poorest.

27. SEWA experience points to the need for a comprehensive insurance package covering both life and non-life risks. This is advisable both because a holistic approach to risks and shocks faced by the poor is required, and also because this will lead to overall viability of insurance for the poor.



## **XVI. Need for participation of government funded public health institutions**

28. The Group deliberated on the participation of Government Health Care facilities in any innovative risk pooling arrangement. The Group felt that the participation of Government Hospitals and Health Centres was very critical for any risk pooling arrangement as otherwise it becomes a system of subsidizing private health care. It was also felt that the challenge of risk pooling for remote rural households can only be met when Public Health Systems are also a part of such innovative health financing mechanisms. The example of Karuna Trust's work in Karnataka was shared by Dr.Sudarshan as how poor households are compensated for loss of wages, medicines and other costs in case of hospitalization in a Government facility in the pilot Health Insurance Programme which the Trust has currently implemented in two blocks of Karnataka. Clearly, the expenditure incurred by poor households is not only what is spent in the hospital, it is also the cost of loss of wages, cost of medicines and procedures not available in Government hospitals, cost of transport, cost of boarding & lodging for family members in case hospitalization is away from home, etc. One possibility therefore is to have a number of pilots on risk pooling for poor households through NGOs, Self Help Groups, other community organizations covering the cost of health care in Government Hospitals.

29. Any kind of Health Insurance Scheme, which does not involve the public medical facilities, would not succeed because, in majority of states, these are the only facilities available in rural areas. The involvement of the States could be worked out by designing a Plan Scheme by the Ministry of Health and Family Welfare with subsidy being passed on to the hospitals through the State Governments. In such a situation, the State Governments can invite bids on 'premium to be charged' at their level from all the insurance companies, both public and private. For availing of the subsidy from the Central Government, the minimum features of the Scheme could be decided a priori and informed to the State Governments. The State Government may add some more features to the scheme and may also provide financial assistance to the policyholders by contributing whole or part of the premium. In this scenario, the modalities of administering the scheme at different levels may be described in detail by the Central Government or may be left to the State Governments.

## **XVII. Innovative financing for efficiency**

30. The Group felt that there was still a need to use innovative health financing mechanisms to improve the accountability of health institutions. If the CHCs were to receive resources on the basis of their case load, it was likely to contribute to a more effective Public Delivery System. The Group was aware that there are a large number of non-governmental providers as well. The absence of effective standards and ability to carry out unethical practice in the absence of proper supervision, often leads to high cost of care in the Non-Governmental sector. The Group felt that there was a need to work with Non-governmental providers to develop effective systems of supervision that allow for equity and standards. The Group also felt the need to develop cost norms and equity standards so that Non-Governmental providers may also be accredited for health care. The work of the National Commission on Macroeconomics and Health on unit costs for care, basis and secondary health care package will be a useful starting point for developing standard costs and treatment protocols.

## **XVIII. Difficulty with formal insurance organizations**

31. There was a feeling that the formal organization of Health Insurance Companies is a difficult structure for poor households to seek reimbursements for health care. Even the current arrangement of a few Third Party Administrators [TPA] to facilitate health care reimbursements does not seem to be effective arrangement for reaching out health insurance to the poor. The Group felt that there was a need for a district level body which could play the role of TPA and which could also provide resources for risk pooling. The Group felt that the District Level Board for Innovative Health Financing could even make use of the resources generated through user fees from those who could afford to pay. At some point of time provisions like social health insurance, self-help group savings etc. could also be utilized as a community contribution towards district based risk pooling arrangements. Social health insurance where premium is linked to a percentage of the income can be an equitable way of building a corpus of financial resources as households pay according to their ability for the same set of health care services.

#### **XIX. Role of Panchayati Raj Institutions**

32. Panchayati Raj Institutions have the mandate to manage the Primary Health system. The various tiers of Panchayati Raj Institutions ought to exercise control and supervision over health facilities, functionaries and functions. Communitization through ownership by Panchayati Raj Institutions adequately prepared to undertake the management role is necessary for an efficient and effective health system. The experience with Hospital Development Committees in Kerala and Rogi Kalyan Samitis in Madhya Pradesh has prompted the Central Government to mandatorily seek the establishment of such community organizations in health institutions. Innovative health financing would require active ownership of the public health system by Panchayati Raj Institutions.

#### **XX. Role for NGOs/CBOs/District Health Financing Boards**

33. Very clearly in the new approach to Innovative Health Financing, NGOs, Community Based Organizations and District Health Financing Boards have to have a new role that allows them to articulate peoples needs and to ensure that poor households do not suffer in their interactions with formal insurance organizations. There will be a need to build capacity in such organizations in both and to understand they way Risk Pooling works through the insurance arranged. NGOs and community based organizations have also to play a role in motivating communities to make small savings for life and health care. The contribution of the State towards health care of the poor can come through the District Health Financing Board. It can even come from collections made from those who can afford through user charges in government hospitals. The important role of NGOs, CBOs is to ensure linkages between Health Insurance and Public Financing of Health Care as a combination of the two is required for effective risk pooling.

34. In the notification issued on 10<sup>th</sup> November, 2005 on micro-insurance, IRDA has already formalized the involvement of NGOs, cooperatives and other community based organizations.

35. Government of Kerala has recently initiated a programme of health insurance for 25 lakh below poverty line families called Kudumbshree Scheme which tries to rectify some of the exclusions in the earlier UHIS Scheme. The comparison of the two is placed below:

**COMPARISON OF UHIS & KUDUMBSHREE SCHEME**

<b>BENEFITS</b>	<b>UHIS</b>	<b>Kudumbshree</b>
Sum Insured	Rs.30,000	Rs.30,000
Limit for Anesthesia, Blood, Oxygen, etc.	Rs.4,500	No limit
Limit for any one illness	Rs.15,000	No limit
Pre Existing Diseases	Not Covered	Covered
Waiting period	30 days	No waiting period
First Year Exclusions	Not Covered	Covered
Maternity Benefits	Not Covered	Covered
Cost of Domiciliary Hospitalization	Not Covered	Covered
Mental Illness	Not Covered	Covered
Bystander Allowance	Not Covered	Covered
Personal Accident Cover	Rs.25,000	Rs.1,00,000
Full Disability Compensation	Not Covered	Rs.1,00,000
Partial Disability Compensation	Not Covered	Rs.50,000
Premium (including subsidy for a family of five)	Rs.548	Rs.399
BPL Family Pays	Rs.248	Rs.33

**XXI. Exploring possibility of sovereign guarantees for public sector insurance companies doing health insurance/risk pooling for BPL Households**

36. The Life Insurance Corporation of India (LIC) enjoys a sovereign guarantee from the Central Government, though in a completely different context. The guarantee has never been exercised as LIC makes enough money to survive on its own. Since Public Financing of Health has to go hand-in-hand with systems of community contribution towards risk pooling, it is important to explore the possibility of a sovereign guarantee for Below Poverty Line families. This is being suggested as the balance between

government contribution and household contribution can vary depending on the situation and the burden of disease in a particular area. While all efforts to mobilize resources and savings of households need to be made, there is an equally strong case for sovereign guarantees in risk pooling arrangements so that basic quality health care is available to poor households. The sovereign guarantee can also serve as mechanism that will ensure higher public financing of health care. Since the sovereign guarantee will be invoked only for BPL family households, there is a strong equality argument in its favour. Involvement of the stake holder can come through risk pooling arrangements and the effort should be to maximize service guarantees for poor households.

## **XXII. Amendments needed in the regulations on health insurance**

37. As the evidence in pilot projects and experiences with efforts so far indicate poor households need to have greater confidence in the risk pooling and health financing mechanism that will provide them cover at times of health distress. The current health insurance sector is regulated by the Insurance Regulatory and Development Authority (IRDA) and the structure of Insurance Companies and the rules framed for their operations provided for large companies to be a player in the Health Insurance sector. Similarly, licenses for Third Party Administrators are issued sparingly by the IRDA. In the new approach to health insurance, two major changes would be required: (i) to allow NGOs and local district health financing boards to manage health insurance; and (ii) to widen the network of the Third Party Administrators in order to provide such scope and possibility at the district level. For a hundred flowers to bloom for effective health financing, IRDA will have to allow arrangements that involve communities, NGOs and district health financing boards. Monopolies of the few insurance companies and a handful of Third Party Administrators will have to give way to hundreds of local level district based NGOs and organizations working through an equally large network of Third Party Administrators.

## **XXIII. Is there a case for a separate Health Insurance Regulatory Authority**

38. Clearly there is a case for a separate Health Insurance Regulatory Authority given the need to change the ways of working in this sector. Monopolies of companies have to give way to systems of community ownership and involvement in the management of risk pools cashless transactions. The present IRDA set up is geared for larger national level management of insurance systems. For poor people's participation

in risk pooling arrangement in the health sector involving government and non government facilities, there would be a need for separate Health Insurance Regulatory Authority at the national level and in the States as well. As mentioned earlier, the instrumentality of the state has to be emphasized in these partnerships and regulations as ultimately the success in the sector will depend on winning the confidence of poor households.

#### **XXIV. The challenge of accreditation, regulation and standard treatment protocols**

39. Evidently, public health facilities to provide health care guarantees are not available in many parts of the country. Non governmental facilities are also not locally available, but small Tehsil, Block, Sub-Divisional and District towns have attracted private Doctors and Nursing Homes almost across the country. In the absence of effective regulation and standard treatment protocols, many of these private providers have often been over charging and over medicating households in distress. The National Commission on Macroeconomics and Health has done a very useful task in working out unit costs for a whole range of health care needs from core, basic to secondary care. These unit costs can serve as a starting point for working out compensation arrangements wherever government/non-government providers are involved in systems of innovative health financing. Similarly, simple proformas developed in States like Tamil Nadu, that accreditation of maternity care services can be utilized to promote a more effective system of quality control and accreditation. The unit costs will have to be worked out in the context of different districts and a District Health Financing Board would be an agency which would undertake such an exercise within a broad framework provided by National Commission on Macroeconomics and Health.

#### **XXV. Need for community involvement**

40. Given the diversity of the rates for the same set of health care interventions, procedures and surgeries, the Group felt that there was a continuous need for community organizations/PRIs to be totally involved in any effort at risk pooling as there is always a hazard of some people availing more health services than needed while others are denied the same in the same Risk Pool. Similarly, the Group felt that wherever payments to Non-governmental providers are involved, it is best to involve community organizations, PRIs so that the entire process is a transparent one.

## **XXVI. Suggestions on the Implementation mechanism**

41. Mirai Chatterjee of SEWA has suggested an implementation model for informal sector workers that may work for other categories of the poor as well. The approach suggested is as follows:

42. In order to ensure that as many workers as possible can obtain the services, we should adopt and adhere to an approach which

- a) Is as close as possible to the workers—i.e. decentralized, and preferably at their doorsteps.
- b) Involves workers directly in ensuring that the services reach them—either through implementation by tripartite/multipartite boards and committees or by workers' organisations (unions, cooperatives), membership-based organizations of the poor (MBOPs) and NGOs.

43. In keeping with the above, all sources of social security services (worker's welfare funds, general social security fund and social assistance) should be decentralised to the states. Direct state-level contributions should be actively solicited and added to the funds available from the centre.

44. In order to plan, implement and monitor the outreach and quality of social security, each state will constitute a state-level Social Security Board with the following representatives:

- Workers' unions and cooperatives
- Employers and their associations
- State Labour, Health, Social Welfare, Rural Development & Finance representatives
- Central Labour, Health, Social Welfare, Rural Development and Finance representatives
- NGO representatives

45. As indicated earlier, while prescribing a Scheme from the Ministry of Health and Family Welfare, the State and District level structures could be indicated along with the tasks to be entrusted to them. Similarly, the fund-sharing mechanism would also have to be clearly defined.

46. Since IRDA has recently notified micro Insurance Regulations 2005, clearly defining 'micro-insurance products' and 'micro-insurance agents', we may take advantage of these to include 'health insurance' as a part of the package and use grass-root organizations to market and service them.

47. This Board will be employed to make all decisions relating to the provision of social security in the state. It will strictly monitor all activities. However, the actual planning and implementation will be conducted at district-level.

48. A district-level committee will be constituted for planning, implementation and monitoring of social security provision. It will be tripartite or even multipartite in nature, with the Collector as convener.

**XXVII. The committee will include:**

- Members of workers' organisations
- Representatives of employers
- Representatives of Panchayati Raj institutions.
- Other Government representatives.
- District labour officer
- NGO representatives

49. There are a large number of examples of Community Health Insurance in India like Accord-AMS-Ashwini Health Insurance Scheme, Jawar Health Assurance Scheme, Medical Aid Plan of Voluntary Health Services, Students Health Home, Medical Insurance Scheme – RAHA, KKVSH Health Insurance, Yeshasvini Co-operative Farmers' Health Care Scheme, Self Help Association for Development and Empowerment, Community Health Insurance – Karuna Trust, Vimo Sewa etc. are provider based models, some are insurer models and some are linked models. Many of these experiments of NGOs provide useful insights on how a Community Based Health



Insurance Programme can be developed in local contexts. The Kerala Kudumbshree Scheme referred to above also provides useful ways of involving the self-help group movement to build thrust between the communities and the insurance companies.

**XXVIII. This district-level committee will undertake the following:**

50. Issue identity cards to all workers in the district. This identification, preferably through smart cards, will help workers get social security services even when they migrate to other districts and states.

- (i) Implement workers' welfare schemes of the workers' welfare funds, ensuring timely and whenever possible, provision of services at workers' doorsteps.
- (ii) Implement other social security services from the Social Security Fund.
- (iii) Ensure that support under social assistance programmes reach the poorest of workers.
- (iv) Collect contributions from workers and employers towards the contributory workers' welfare fund as well as the general social security fund. These contributions, topped up with funds made from the centre and the state, will be maintained at district level. All financial records will be maintained at the district level.
- (v) Maintain all financial records for the above programmes and present these at monthly committee meetings.
- (vi) Invest funds collected from contributions to maximize returns and maintain the solvency and security of all funds.
- (vii) Strictly monitor the implementation from the point of view of efficiency, quality and full benefits reaching the poorest of workers, especially women.
- (viii) Provide a forum for feedback from workers, employers and others, and undertake necessary action to maintain high performance levels.
- (ix) Collect and collate data to be presented to the State Social Security Board and to the national advisory board. Also ensure that desegregated data from other districts, as well as aggregate figures, reach committee members so as to monitor progress.
- (x) Suggest changes and improvements in the schemes of the welfare funds, general social security fund and social assistance. Also suggest new, locally relevant social security programmes.

- (xi) Periodically undertake performance reviews.
- (xii) Identify training and capacity-building needs of workers and others.
- (xiii) Identify people's organizations and NGOs to actually implement social security programmes. For example, local midwives' cooperatives to implement maternity benefits and health programmes.

51. Administrative expenses for the state and district boards will be met through a combination of resources: 50% from the centre and 50 % from the state. Special financial arrangements may be considered for the poorer states of India.

52. Each state board will develop norms for functioning and a manual which will be discussed in the central Social Security Board before finalization and adoption.

53. In sum, the overall approach to implementation is a decentralised, flexible one with district-level control over both the finance of programmes and the implementation itself. Programmes will be tailor-made for the workers. At all times, fullest efforts should be made towards maintaining both the quality of social security services and their outreach. Speed and efficiency of district-level committees should be suitably recognised and rewarded. Also, the implementation of social security must be in a manner which encourages organizing of workers in the district and the building of their own people's organizations. This would be significantly facilitated if the actual implementation of services is delegated to local membership based organisations of the poor (MBOPs) and NGOs.

54. In respect of any health insurance scheme, it is necessary to be very clear and very precisely articulate:

- (i) Cost of the benefit package;
- (ii) How do you proposed to operationalize it – identification of the instruments, etc.
- (iii) What are the constraints or issues that need to be addressed for implementing it;
- (iv) The target group; and
- (v) The road map as it exists today.

55. The Group felt that a diversity of insurance arrangements made in region/district/State specific contexts, was best suited to meet the challenge of diversity.

**XXIX. Need for detailed costing exercise**

56. The Group felt the need for carrying out detailed costing exercise to arrive at district specific cost norms for health services. It was felt that the current arrangement of exclusions in Health Insurance policies for basic health care, OPD, Maternal & Child care etc is not in the interest of the poor as poor households seek total health care through a risk pooling arrangement.

**XL. Strengthening public health delivery**

57. The Group strongly supported strengthening of Public Health Delivery System under the NRHM. It felt that a provision of at least one round the clock functional CHC/Block Level Hospital in every block of the country supported by an army of community health activists, ANMs, SHCs, PHCs etc. would go a long way in making the Public Health System accountable and effective. The Group felt that communitisation of Public Health delivery through involvement of PRIs, Hospital Development Committees, Rogi Kalyan Samiti etc. was necessary for Public Health Institutions to become autonomous and be responsible for outcomes. The Group felt that a strong monitoring system for measuring progress of every SHC, PHC, CHC towards an agreed Public Health standards would go a long way in making the Public Health System outcome focused.

**XLI. Exploring New Health Financing Mechanisms**

58. The Group was of the view that New Health Financing Mechanisms were required to improve the quality of the Public Health Delivery System. Strengthening the Public Health System is a priority for improved systems of Health Care. The Group also felt that in spite of increasing public expenditure to 2 to 3 per cent of GDP, there would still be a need to access innovative Risk Pooling arrangement as the out of pocket expenditures made during health distress would still be large. The Group felt that new Financing Mechanisms involving Government budgets, user charges, social health insurance contributions, community based health insurance efforts, etc. were effective means of making the Public Health Delivery more efficient and effective. Partnerships with Non-Governmental sectors within a robust framework of standard treatment

protocols, accreditation on the basis of quality health services, and standard costs for services, will help in enlarging access to health care for poor households. The Group strongly felt that new Health Financing Mechanisms have to be decentralized right down to hospitals and districts and new ways of developing financing and Third Party Administration with the involvement of NGOs, PRIs and CBOs will have to be worked out. The Group was of the view that Health Insurance must cover Government Health facilities as well and systems of money following the patient could be institutionalized then over a period of time. The Group was unanimous that increased public funding must lead to increased health institution autonomy, community accountability and most of all new ways of financing health care. The need to segregate budget of Government and combine them with contributions of those who can pay along with State subsidies for those who cannot, will help in making the health system more accountable. The Group was sure that there was no substitute to developing credible health facility all over the country either directly under Government or in partnership with the Non-Governmental sector.

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