

2006 | ASIAN DECENT
2015 | WORK DECADE



International
Labour
Organization

SERIES:

**SOCIAL SECURITY EXTENSION
INITIATIVES IN SOUTH ASIA**

**INDIA:
STATE GOVERNMENT SPONSORED
HEALTH PROTECTION PROGRAMME
(JHARKHAND)**

“PAVING THE WAY TOWARDS A UNIVERSAL SOCIAL SECURITY SYSTEM”

ILO Subregional Office for South Asia



Decent Work for All

Asian Decent Work Decade

INTRODUCTION

The fourteenth Asian Regional meeting of the ILO recently organized in Busan, Republic of South Korea (August 29th – September 1st) endorsed an Asian Decent Work Decade (2006-2015), during which concentrated and sustained efforts will be developed in order to progressively realize decent work for all in all countries. During the proceedings, social protection was explicitly mentioned as a vital component of Decent Work by a number of speakers including the employers and workers representatives. The need to roll out social security to workers and their families in the informal economy, to migrant workers and to non regular workers in the formal economy was also perceived as a major national social policy objective. The need to enter into a more intensive dialogue with respect to the design and financing of national social security systems to equip them to cope with the new requirements and challenges of a global economy also emerged as a major outcome of the meeting.

The challenge of providing social security benefits to each and every citizen has already been taken up in India. In 2004, the United Progressive Alliance (UPA) Government pledged in its National Common Minimum Programme (NCMP) to ensure, through social security, health insurance and other schemes the welfare and well-being of all workers, and most particularly those operating in the informal economy who now account for 94 per cent of the workforce. In line with this commitment, several new initiatives were taken both at the Central and at the state level, focusing mainly on the promotion of new health insurance mechanisms, considered as the pressing need of the day. At the same time, and given the huge social protection gap and the pressing demand from all excluded groups, health micro-insurance schemes driven by a wide diversity of actors have proliferated across all India. While a wide diversity of insurance products has already been made available to the poor, health insurance is still found lagging behind in terms of overall coverage and scope of benefits, resulting in the fact that access to quality health care remains a distant dream for many.

Given this context, the ILO's strategy was to develop an active advocacy role aiming at facilitating the design and implementation of the most appropriate health protection extension strategies and programmes. Since any efficient advocacy role has to rely on practical evidence, the ILO first engaged a wide knowledge development process, aiming at identifying and documenting the most innovative approaches that could contribute to the progressive extension of health protection to all. One such innovative and promising approach was the broad and ambitious health protection programme that was designed by the Ministry of Health and Family Welfare, Government of Jharkhand, in 2005-06.

BACKGROUND

In August 2005, a delegation from Jharkhand contacted the International Labour Organization and requested its technical support for the design and setting up of a new health insurance scheme that planned to cover the whole Below Poverty Line population of the state. Upon receipt of a first concept paper prepared by the Ministry of Health & Family Welfare and the Health Society of Jharkhand, ILO carried out a preliminary assessment mission in Jharkhand in September 2005. As a result of the first interaction with all stakeholders concerned, new orientations were adopted as regards the design of the health insurance scheme and further ILO technical assistance was planned. Follow-up activities allowed for the progressive shaping up of the scheme's implementation process and operational modalities. As compared to other recent state-level initiatives, the integrated health care system to be developed in Jharkhand clearly adopted distinctive innovative features allowing it to pave the way towards a broader programme that could ultimately encompass the whole population.



As it stands today, the Jharkhand's experience may already serve as a good example for replication in other states looking at ways to address the health insurance needs of the excluded groups.

TARGET POPULATION

Carved out of Bihar, the state of Jharkhand came into existence in November 2000. Its population has been estimated to be 26,9 million, predominantly rural (78%). Jharkhand is one of the poorest and most backward states in the country with low per capita income (half of the national average), 54% of the population living below the poverty line and with 28% of the population belonging to scheduled tribes. Literacy rate is also very low, particularly among women (40%). The state consists of 22 districts, 33 sub-divisions and 211 blocks, distributed over an area of 28,000 square km.



Health indicators in Jharkhand are among the worst in the country. Infant mortality is high: of every 1000 live birth, 71 children die before they reach year 1. Maternal mortality rate is also high: 504 per 10,000 live births (more than the national average). 75% of the total deliveries are made without proper medical assistance.

Nearly 75% of women suffer from anemia and 40% of women are malnourished. More than 20% of children suffer acute diarrhea and acute respiratory infection, and less than 10% of children of all ages are fully immunized. About 85% women have not heard about HIV/AIDS.

The state is still suffering from a very large health infrastructure deficiency. The following table shows the importance of the existing gap.

	Needed	Existing	Gap	% of Gap
Community Health Centers	231	31	200	86%
Primary Health Centers	1,387	533	854	62%
Health Sub-Centers	5,548	3,495	2,053	63%

At the same time, Jharkhand has some of the richest deposits of iron, coal and manganese in the world, has 40% of the natural resources of the country, and is one of the most industrialized regions.



Having identified health as a State priority, the Government of Jharkhand developed the "Sarv Swasthya Mission", a broad concept which aimed at providing quality health care services at all levels, with effective referral mechanism. While organizing health insurance coverage for the marginalized population, the Mission was also conceived as developing a new vehicle to enhance public and private sector investment in remote and left out areas of the State.

The overall objectives of the Mission were set as follows:

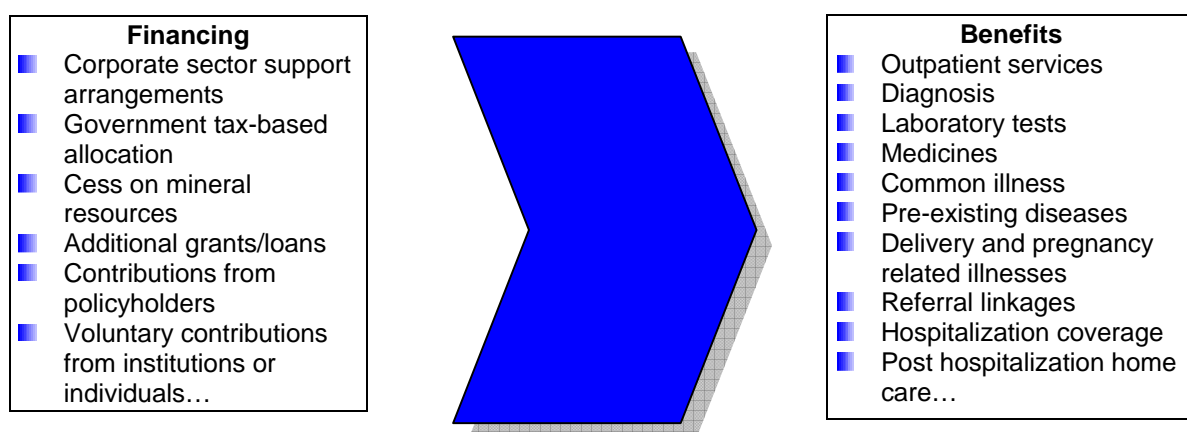
- To improve access to health care among the poor
- To protect the poor from indebtedness and impoverishment resulting from medical expenditures by spreading the health shocks among the community
- To access the community to access health care with dignity
- To encourage health-seeking behaviour by offering comprehensive health care with minimal co-payment at the time of the services
- To ensure availability of affordable quality health care services

- To enhance the feeling of ownership of the health program among all participants/ stakeholders, including the community
- To enhance the private sector investment for delivery of primary health care services

While adopting these objectives, it was clear from the outset that the Mission intended to rely on the following major principles:

- Public-private partnership;
- Empowerment of the target groups;
- Comprehensive health programme;
- Subsidized health insurance component.

One of the innovative features of the planned scheme was to involve on a long-term basis all industrial groups in the financing of the insurance component under the Corporate Social Responsibility (CSR) principle. In August 2005, the Government of Jharkhand signed an agreement with TATA industrial Group whereby TATA would allocate for the next 30 years a yearly co-contribution to the health insurance scheme. The Government planned to conclude similar agreements with all other industrial groups operating in the state and also to levy a cess on some mineral products to further increase the necessary resources.



EVOLUTION OF THE INSURANCE SCHEME

The design of the scheme evolved in accordance with the broad consultative process that was set up. In addition to the various meetings organized with Ministry of Health and Family Welfare and Jharkhand Health Society, the consultations were extended to the following organizations:

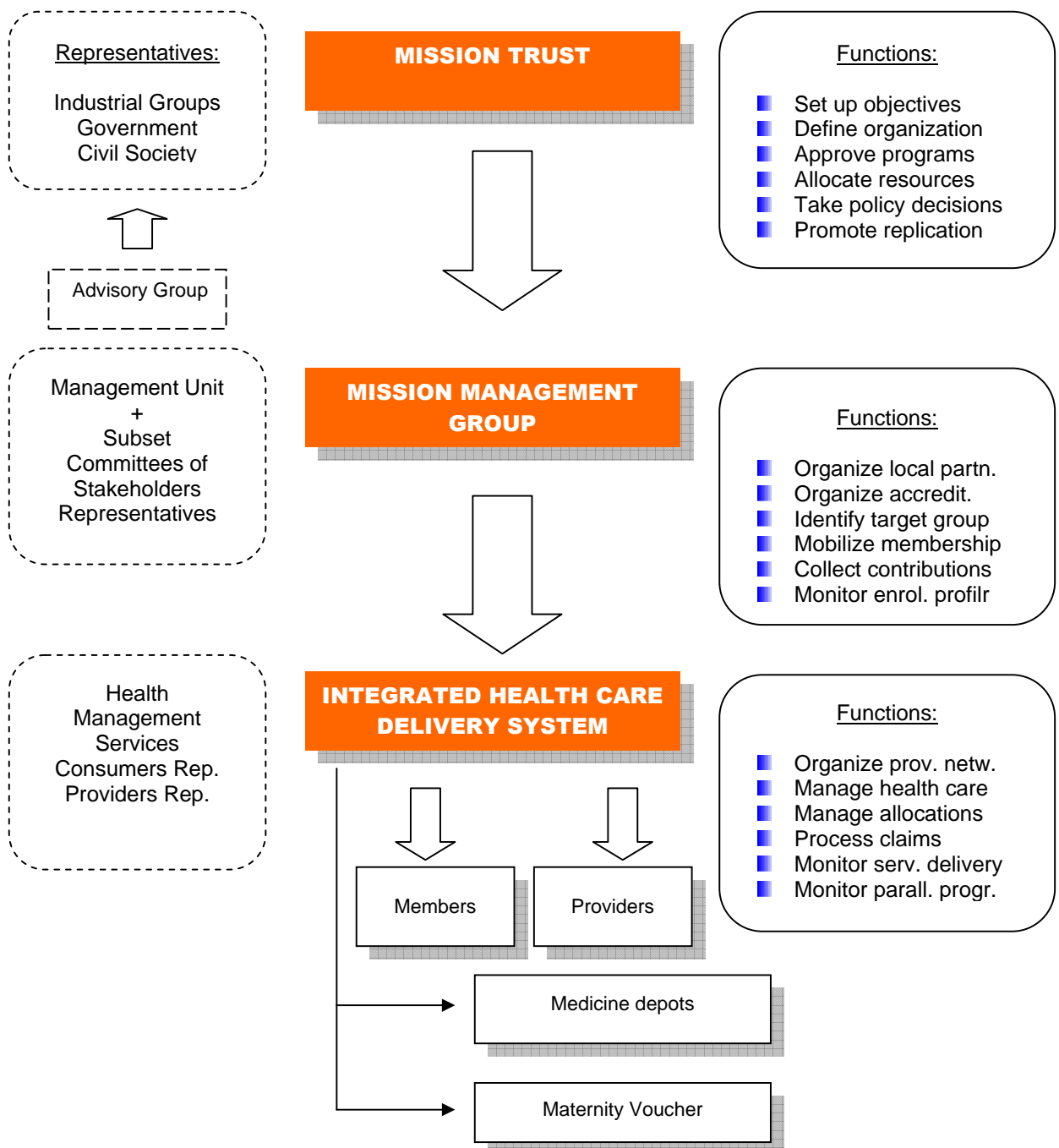
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| ■ Major public and private sector stakeholders | Round Table (22.09.05) |
| ■ Insurance companies | Round Table (20.10.05) |
| ■ Third Party Administrators | Information Review (02.12.05) |
| ■ Health providers | Round Table (20.12.05) |
| | Round Table (21.12.05) |

As a result, the original design of the scheme progressively underwent several changes with the adoption of the following new principles applying to the operational modalities of the insurance scheme:

- | | |
|------------------------------|---|
| ■ Automatic enrolment | In order to avoid adverse selection, the scheme would rely on an automatic enrolment mechanism (the first in India) |
| ■ All-inclusive coverage | The scheme would also cover the people living with HIV and the groups at risk (the first in India) |
| ■ Towards universal coverage | The scheme would progressively be extended to the whole population of the State (the first in India) |

SARV SWASTHYA MISSION TOWARDS A SOCIAL HEALTH INSURANCE SYSTEM...

PHASE I TARGET: 14 MILLION PEOPLE... (WHOLE BPL POPULATION)



THE INSURANCE PLAN

Eligibility

The scheme would be open to all BPL families. It would be a mandatory scheme covering the whole family without any age bar.

Exclusions

No exclusion clause. The all-inclusive scheme would extend its coverage to people living with HIV and groups at

Plan Benefits

The plan would cover the following services:

Level	HC Facility	Services	Coverage
First	PHCs - Village medicines depots	Diagnosis, treatment, medicines, safe delivery (vouchers)	Free OPD + discount on medic.
Secd.	Public and private hospitals	Any disease	Up to Rs 30,000
Third	Private hospitals	Any disease	Up to Rs 30,000

Premium Rate

According to first estimates, the premium to be paid by each member of the family would be Rs 20 per year, along with a Rs 170 subsidy.

Plan Distribution

Village committees, village health workers and local NGOs would be involved in the distribution of the insurance plan and in all related educational activities. The strong solidarity traditions existing in tribal villages would also be used to instil a sense of ownership and thus ensure a large membership base, prompt premium collection and prevention of moral hazard.

Service Delivery

Through accredited public and private health facilities.

Administration

The scheme would be administered by a First Party Administrator (FPA), under the supervision of a Management Committee nominated by the Board of Trustees.

General Overview

Starting date	April 2008 (Est.)
Ownership profile	Private-public Trust
Target group	BPL population
Outreach	2 blocks (phase I)
Intervention area	Rural & urban
Risks covered	Single risk: Health
Premium Insured/Y.	Rs 20
Co-contribution	Rs 170
Total premium	Rs 190
No of insured	800,000 (Est. phase I)
Percentage of women	50% (Est.)

Operational Mechanisms

Type of scheme	Social Security Scheme
Insurance company	No
Insurance year	Fixed (April to March)
Insured unit	Family of five
Type of enrolment	Mandatory
One-time enrolm. fee	None
Premium payment	Yearly – upfront
Easy payment mechanisms	Soft loans, access to local health funds

Scope of Health Benefits

Tertiary health care
Hospitalization
Deliveries
Access to medicines
Primary health care



Level of Health benefits

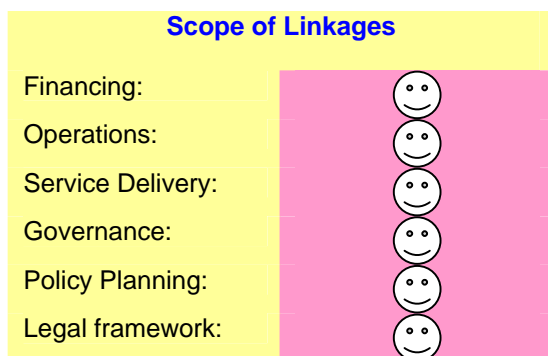
Hospitalization	Up to Rs 30,000
Medicines	50% disc. through VMD
Maternity benefits	Maternity vouchers

Service Delivery

Health prev/educ. programmes	Health camps, wider health education progr.
Prior health check-up	No
Tie-up with H.P.	Yes
Type of H.P.	Public & private
Type of agreement	Formal agreement
N° of associated HP	To be determined
TPA intervention	No
Access to health care services	Pre-authorization Required
Co-payment	Yes
HC payment modality	Pure cashless

THE LINKAGE EXPERIENCE

Developing efficient partnership arrangements is already seen as a key element for the successful implementation of any health insurance scheme targeting the disadvantaged groups. Evidence also suggests that building efficient linkages between community-based initiatives and governmental programmes in order to exploit their respective strengths is another major requirement. This necessary synergy may be developed at various levels.



If it were to be implemented, the Jharkhand health insurance scheme would become the very best linkage model allowing all concerned public and private stakeholders to play an active role.

Its unique and innovative features based on a rights-based approach would also provide another health protection model for the various State Government sponsored initiatives expected to be developed in the wake of the recent decision taken by the Government of India to extend health security measures to the disadvantaged groups of the population.

1. Financing

The scheme would rely on a mix of public and private financing including the levy of a special social security cess, regular budgetary allocations, corporate sector co-contribution and minimal premium to be paid by each family covered under the scheme

2. Operations

The insurance scheme has been designed as a component of a much broader health development programme supported by the whole State machinery. The scheme would involve from day one, the multiple stakeholders including the entire public health staff, the private sector, the community-based organizations and all other support organizations operating at the local level. This much broader public-private-community partnership (PPCP) approach, would allow for the setting up of a cost-free premium collection mechanism, the development of a wide insurance education programme, and the organization of Village Health Committees empowering the communities to take additional local health development initiatives.

3. Service Delivery

The scheme would set up a broad network of public and private health facilities, duly accredited to observe common standards of quality. It would facilitate the progressive integration into the network of government run healthcare facilities having up-graded their services to match the accreditation standards set by the scheme. It would also encourage, through a set of incentives and accompanying measures, private health care sector investments in remote parts of the State to provide proximity services to the insured population.

4. Governance

Under a new type of "Private-Public Partnership", the scheme would be administered by a Trust in which representatives of the private sector and the civil society would outnumber the state officials.

5. Policy Planning

The Ministry of Health and Family Welfare of the Government of Jharkhand, in collaboration of the Jharkhand Health Society already published two booklets providing information on the planned scheme. The scheme was presented in an international conference organized in Lisbon in October 2006. The scheme was also referred to in the report submitted in November 2006 to the Government of India by

the Working Group “Health Care Financing Including Health Insurance” set up by the Planning Commission in August 2006.

6. Legal Framework

The scheme would be the first one to build a new social health insurance model in India, paving the way towards a possible universal health insurance scheme covering the whole population.

CONCLUSION

The ILO is fully committed to support the Government of Jharkhand’s health protection initiative, both in its additional preparatory efforts as well as in its implementation phase. As of today and due to various reassignments having affected the Ministry of Health and Family Welfare and the Jharkhand Health Society, any further development of the scheme has been delayed.