

Policy WATCH

Volume X, Issue 10
October 2021, New Delhi

Governance and Development

In this issue

**Panchayat Academy and
Centre for Sustainable
Growth Solutions,
Kuthambakkam,
Thiruvallur Dt,
Tamil Nadu:
R. Elango**

**A Road Map for
Universal Health Care:
Ajay Shankar and
Chitranjali Tiwari**

**Social Security for
Gig Workers:
Bharti Gupta Ramola**

**102 foot marches for
justice and peace
in 10 days:
Ramesh Sharma**





RAJIV GANDHI
INSTITUTE FOR CONTEMPORARY STUDIES

POLICY WATCH

Volume X, Issue 10
October 2021, New Delhi

3 **Panchayat Academy and Centre for Sustainable Growth Solutions, Kuthambakkam, Thiruvallur Dt, Tamil Nadu:**
R. Elango

14 **A Road Map for Universal Health Care:**
Ajay Shankar and Chitranjali Tiwari

33 **Social Security for Gig Workers:**
Bharti Gupta Ramola

41 **102 foot marches for justice and peace in 10 days:**
Ramesh Sharma

Editorial

The Rajiv Gandhi Institute for Contemporary Studies (RGICS) works on five themes:

1. Constitutional Values and Democratic Institutions
2. Growth with Employment
3. Governance and Development
4. Environment, Natural Resources and Sustainability
5. India's Place in the World.

This issue of Policy Watch cuts across several of the above themes and deals with the theme Governance and Development.

The RGICS has been conducting study of award winning Panchayats all over the country to understand what distinguishes their leadership and institutional processes from the others. While the study is ongoing, we also looked at some well-known panchayats. The first article by Dr R. Elango describes the remarkable work of the Kuthambakkam Panchayat in the Thiruvallur Dt, Tamil Nadu,

Within the Governance and Development theme, the RGICS has endeavoured to cover the education and health sectors. The second article lays out A Road Map for Universal Healthcare. It is the result of a study by Mr Ajay Shankar, Distinguished Fellow and Chairman, Centre for Policy Studies at JK Lakshmi Pat University (JKLU) and Chitranjali Tiwari, Policy Researcher at JKLU. Given its importance in the post-COVID planning for the upgradation of the healthcare system, we are republishing it with the permission of the authors.

Another sub-theme within the Governance and Development theme that the RGICS has endeavoured to cover is how our welfare programmes and delivery systems work. Due to the pandemic and the resulting lockdowns, there has been a massive loss in livelihoods. Now that the economy is reviving, a lot of the new jobs, even in the formal sector are not the old-style "permanent" or "regular" jobs, but increasingly employers are preferring to hire workers on casual, contractual basis. The new term for this is gig-work. The third article is by Ms Bharti Gupta Ramola, who was a partner at PricewaterhouseCoopers. She now serves on the Boards of a number of companies, social enterprises and works with some development NGOs. She examines how the gig-workers could be provided social security benefits such as Provident Fund, Life and Health Insurance and Pensions, using the numerous government schemes for unorganized sector workers. She argues in favour of using technology platforms to ease enrolment, mobility and benefit availment by workers.

The fourth article is a report of a set of 102 Padayatras that were organized by the Ekta Parishad all over India between 21st Sep, the international day of Peace and 2nd Oct, the International day of non-violence, by citizens asserting the need for justice and peace.

We hope you enjoy reading these articles. We look forward to your feedback.

**Vijay Mahajan, Director,
Rajiv Gandhi Institute for Contemporary Studies**

Panchayat Academy and Centre for Sustainable Growth Solutions, Kuthambakkam, Thiruvallur Dt, Tamil Nadu

R. Elango

I. The Status of Panchayats

The 73rd constitutional amendment guarantees the village level local self governments as village panchayats. The 9th schedule of the constitution empowers the panchayats by earmarking 29 areas under section 243G in order to make the panchayats to function as local self governments. The constitution also emphasises that the states should devolve the functions funds and functionaries to enable the panchayats to deliver the services to achieve social justice and economic development.

The Panchayat raj act was passed in the parliament in 1992 and it was also passed in Tamilnadu State Assembly in 1994. The first Panchayat elections were conducted in October 1996 and four terms of five year are completed. Fifth term election which was due in October 2016 was not conducted due to political crisis and the special officer's period was dragged for more than three years which was unconstitutional. This period of 2016 October to 2019 December was a dark period, because the non-availability of elected local governments lead to complete drip in the steady upward development in the villages. The corrupt practices in the official methods, tender systems, centralized purchases, meager transparency and complete breakdown of people participation became the blow in the gradual empowerment of Panchayat Raj System in Tamilnadu state. At last with the Supreme Courts intervention, the village panchayat level elections were conducted that too leaving nine newly formed districts.

According to the constitution, the state governments should form the state election commission and conduct elections for every five year term without leaving any vacancy. The

states should devolve enough powers, funds and functionaries in such a way the panchayats could function as local self governments. Except Kerala state, all other states have put least efforts in this process and the emergence of panchayats as local self governments is still a straggle in reality the system is drifting. Year by year the Panchayat system is weakened and instead of decentralisation of power it getting centralized towards district administration and stumbling at block level development administration. Still there is hope to recover and rebuild the system because is democratic process and the community system is alive in villages. There may be problems like deep caste system and other traditional backward practices, but through grama sabhas and community groups, it is possible to order come these difficulties.

2. Kuthambakkam as Model Panchayat

Long felt needs of fulfilling the basic civic needs, best educational support to all the children, caste neutral communal harmony, social justice, women empowerment and local resource centered economic growth were forged well when panchayat elections was declared in 1996 September by the then DMK lead state government. It clicked a signal in the minds of many who were dreaming to achieve the above mentioned goals and the buoyancy of election process started after more than a decade of non-existence of panchayats in the village. Of course, Shri R. Elango, who took the lead in organising the meetings among different section of the community through the community group discussions about the new Panchayat raj system. People felt the need of a good leader who could lead and make use of the system. At last it became the compulsion that Shri R. Elango should quit his scientist job and contest to win. Efforts were taken to arrive the consensus but it became election. In that he was elected with more than 2/3 majority. This became the opening for exploring the possibility of demonstrating developmental solutions in the village. Surveys and data collections were done. Meeting the families at their door step gave opportunity to understand their need and also to make them to understand their role in building the future. A planning group was constituted with Panchayat ward members and likeminded experienced elders.

The plan was discussed and validated by the gramashaba. The caption of the plan was “All fifty years felt needs should be filled in five years”. Fund mobilisation, fund utilization, resources from government schemes, resources from other options, local resource mobilization, local contributions, prioritization, year wise implementation and evaluations were thoroughly discussed. Actually it became the peoples plan at the end when it was validated by gramashaba.

3. Kuthambakkam towards Development and Sustainability

3.1. Basic profile

Kuthambakkam village is located in Poonamallee Block, Thiruvallur district of Tamilnadu state. This village is a green agriculture based village. It is situated 31 Kms west of Chennai on the Chennai- Bengaluru national highway near Poonamallee town. The name ‘Kuthambakkam’ had evolved from KoothanBagam, which refers the famous Shiva Temple here.

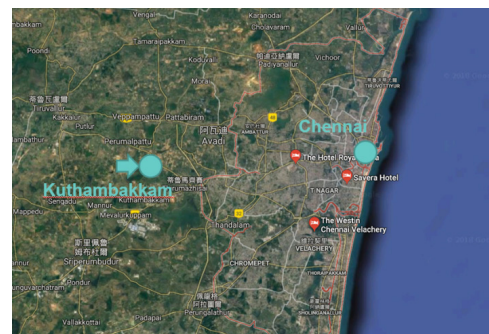


Figure 1: Location of Kuthambakkam

This village covers an area of 36 square kilometers. 700 acres of wetland and 1100 acres of dry land is the extent of land available in the village. Nemam – Kuthambakkam lake, which is located in the west, is the water source for agriculture. The comfort of water source makes this village green and good in agriculture. Around 9000 meters length of internal roads are there across the panchayat covering all the seven hamlets. A union road covering 1.6 Kms is there from Vellavedu to connect Kuthambakkam to the Thirupathi main road. Irulapalayam – Padur highway and Nemam – Chetipedu highway are connecting the village to the national highway. The population of the village is around 6500, out of which 52% are poor dalits. Kuthambakkam Panchayat has got seven hamlets. They are: (1) Kuthambakkam North (2) Kuthambakkam Centre (3) Kuthambakkam South (4) Utkottai (5) Samathuvapuram (6) Irulapalayam (7) Kanadapalayam.

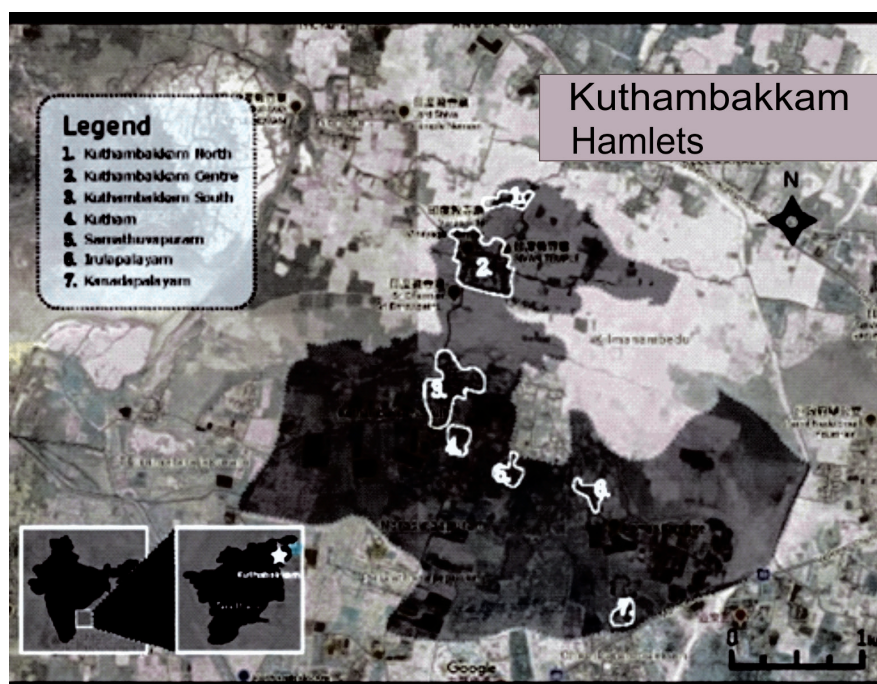


Figure 2: Seven hamlets in Kuthambakkam

3.2. Kuthambakkam before 1996

Though this village is nearer to Chennai city, there were lots of social and economic problems existed in this village. This was mainly because of landlessness of the majority schedule caste families leading their life in absolute poverty. The problems prevailed were:

- Illicit arrack brewing activities and easy availability of illicit liquor
- Caste clashes between dalits (so called lower caste) and non dalits
- Inadequate basic facilities like safe drinking water, drainages and internal roads
- No regular income due to unemployment
- No assurance to food
- Violence against women and children
- Non availability of high school or higher secondary school

Notable changes happened due to the following steps taken by the panchayat.

- Panchayat prepared a five year plan for a holistic development.
- Ensured people's participation in Gram Sabha.
- Pathways created for social transformation through social integration programs .
- Livelihood creations by value addition of village produces within the village and also with the local resources available.
- Housing for all the needy families.
- Organizing the poor people in to self help groups.
- Activities were planned using good database with the help of information technology.
- Village information centre was formed.
- Rehabilitation programs for those who are rescued from the illicit arrack brewing activity.
- Water bodies were deepened to increase storage capacity.
- New check dams constructed.
- The higher elementary level of school has been elevated to high school and higher secondary school.
- Samathuvapuram, a new hamlet of hundred houses with all the other facilities consisting of 50% SC families and the remaining are from other backward communities.

These programs were implemented phase by phase, which paved way for social and economical development in Kuthambakkam village.

3.3. Infrastructure Improvement

A. Road facilities

All inner roads up to 8000 meters length connecting all the residential areas of the Kuthambakkam panchayat had been converted into concrete roads by 'Nammaku Naame' scheme and Equalization incentive grant support of the state government. The remaining length of the roads were converted into asphalt roads using various schemes like MLA constituency development fund, MPLADS funds, District panchayat funds and panchayat union general fund.

B. Sanitation

Open sewage gutters in Kuthambakkam south had been converted to granite walled drains and also with the regular brick and mortar based drainages. A big storm water drain was formed in Kuthambakkam south along the Chettipedu main road which was the long felt need of that hamlet. Drainages were constructed at all the required places in all the seven hamlets.

Women toilet complex was constructed and maintained well in Kuthambakkam north. Innovative toilet cum bathrooms were provided for all the needy individual families



Figure 3: Innovative Drains



Figure 4: Dignified Toilets

C. Water distribution

Safe drinking water is ensured to all the families in the panchayat. Four new overhead tanks were constructed with the support of Tamilnadu Water supplies and Drainages Department in Utkottai, Samathuvapuram, Kannadapalayam. and Kuthambakkam south.

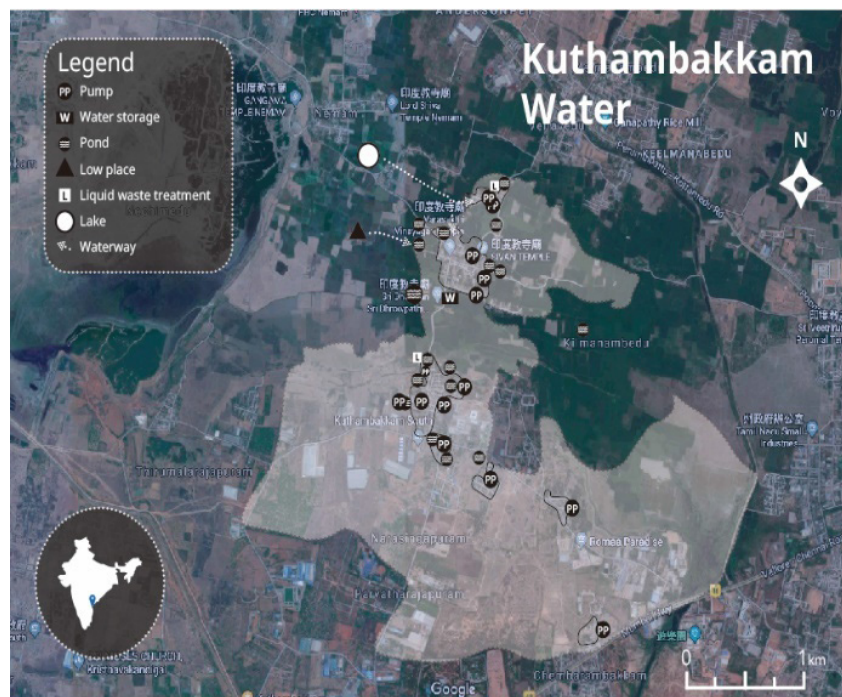


Figure 5: Water facilities in Kuthambakkam

D. Electricity supply and energy audit initiatives

Streetlights with CFL lamps and recently with LED lamps were installed to reduce maintenance cost and also to save electricity. By this way the panchayat saved electricity worth more than Rs.50,000 per month. Repairable LED light sets are produced in the village level manufacturing set-up run by women self-help groups



Figure 6: Light bulb part



Figure 7: LED Light



Figure 8: ECO-Fan



Figure 9: Solar street light

E. Housing for all

The construction of Samathuvapuram gave opportunity to use variety of cost effective and eco-friendly building materials and methods. The village people were well trained to produce these materials. After the Samathuvapuram program, number of consultations were held with the communities and a detailed plan was prepared to upgrade all houses in the village using the innovative building materials and methods.

All huts were upgraded to pukka houses with the support of Rural Development Department - Government of India, Swiss Embassy-Delhi and Trust for Village Self Governance (TVSG). The village became a hut less village and the dignity of living in a safe house was enjoyed by the poor families.

F. Eradication of illicit arrack distillation

In 1996, when the new panchayat took over charge, hundreds of families were involved in the production of illicit arrack. As a result, the illicit liquor was being sold at all the corners of the panchayat. Due to this, quarrels and violence occurred among individuals, groups and sometimes among the villages. The women and children were the worst affected by the intoxicated men. Strong efforts of the panchayat and the police with the co-operation

of the state government had stopped the arrack production. People involved in the illicit business were rehabilitated and given jobs through various development programs of the panchayat. Many kinds of alternative employments were created. More and more such programs were introduced phase by phase.

G. Establishment of Samathuvapuram (caste neutral society)

Caste system is the curse prevailing among the village societies. It divides the people and creates hatred among the village communities. The practice of untouchability, practice of providing separate tea cups for the so called lower caste people in the tea shops and no entry for the dalits in the places of worship are some of the cruel practices happening in the villages. Due to the persistent hard work the above mentioned social evils are neutralized in Kuthambakkam village and a model new colony, consisting of fifty twin houses were constructed along with common facilities like good roads, drains, play lots, public distribution systems, a community hall and a child care centre. In every twin house one side a dalit family and in the other side a non-dalit family was made to live. This became a historical one because this was the first occasion to see the dalits and the other communities were living together in the same locality. The proposal was placed before the then Chief Minister Dr.M.Karunanithi, he expressed his complete satisfaction and coined the scheme "Samathuvapuram". After Kuthambakkam initiatives more than 250 places across the state, this program was implemented with the name 'Samathuvapuram' by the Government of Tamilnadu.

3.4. Production units based on village resources

a. Energy saving burner production

Production of kerosene stove burners is done in Kuthambakkam. This provides job to the needy people, particularly women. This makes women and their family self reliant. Drilling, welding, quality checking are some of the technical works the women and the men undertook.

b. First Aid Kits package

Packaging of First Aid kits is done with almost cleanliness and in a hygienic environment. This created job to women. All kinds of First aid materials were packaged here.

c. Compressed earth mud blocks

Innovative houses were constructed with these compressed earth mud blocks. With 6 % of cement as binder, the mud blocks are highly environment friendly. These blocks are also stronger than the conventional bricks.

d. Micro concrete tiles

These concrete tiles are stronger and can withstand more weight. With small investment the village community was producing these tiles. These are cost effective and eco-friendly.

e. Concrete blocks

Different varieties of concrete blocks produced using locally designed innovative hydraulically operated simple machines.

f. Edible oil units

Different types of edible oils like groundnut oil, thill oil, coconut oil, mustered oil and other non edible oils like neem oil and pungamia oil are being extracted using cold press type expellers and also by country type wood pestal ghanies.

g. Toilet soaps and shampoos

Toilet soaps using pure coconut oil obtained from the local unit are made using simple mechanical process. Various kinds of natural additives and herbal extracts could be made and added to improve the quality of the soap. Simplified engineering set up is establishing for this.

h. Detergent powder, cakes and washing soaps

Different varieties of detergent powders with natural filler ingredients are developed and demonstrated. Less polluting natural oil based washing soaps are also developed.

i. Bio gas digester

Different types of biogas digesters are designed and operated for the effective utilization of domestic and agricultural wastes.

j. Thur dal mills

Different varieties thurdal mills are installed and operated for processing the thurdal locally.

k. Mini rice mills

Different types of mini rice mills are operated to process the paddy into rice with small power consumption and less investment.

l. Simple milk processing

Simple milk processing units are designed to operate small and viable dairy units at village level.

m. Metal pressing and deep drawing unit

Power presses and hydraulic deep drawing units are designed and installed to produce domestic utensils and press metal components for the villages and also for industrial purposes.

n. Basic engineering facilities

Basic engineering facilities like lath, welding, grinding, milling facilities are established to meet the engineering needs of the village communities.

o. Basic chemical production units

Chemical engineering facilities are established to produce basic chemicals like washing solutions, disinfectants and other basic chemical agents. Laboratory facilities also established to undertake the basic tests required for day to day village affairs.

p. Solar energy service unit

A comprehensive facility for undertaking solar installations is established. This is laboratory cum production and installation unit, which works more on energy management in the villages.

q. BLDC motors, fans and battery driven vehicles

BLDC motor production, testing and installation facilities are established to produce BLDC fans, Small BLDC motors production and to install different kinds of BLDC motors for bicycles, auto rickshaws and small four wheeler are successfully done.

r. LED bulbs production unit

Different types of LED bulbs are produced for the domestic and industrial applications. These are designed as repairable bulbs, because they can be opened and repaired and reused.

3.5. Self Help Groups (SHGs)

To empower women, the panchayat took initiatives to form women Self Help Groups (SHGs). For this, efforts were made to organize SHGs in coordination with TVSG and village volunteers. Now there are 78 women SHGs functioning very successfully in the village and more than 1000 women are involved in variety of programs. Various trainings were organised by TVSG to empower them towards social and economic development. On these lines small industries have been started in Kuthambakkam. They are using the village produces like Paddy, Dhal, Coconut and Groundnut to produce edible oils, cereals, soaps and coconut oil based hair oils.

3.6. TLUD (Top Lift Up Draft) gasifier

This is a very cost effective stove for villages. Small wooden sticks and other wastes in the village can be used as fuel for this stove. Mr. Paul Anderson, who works on rural cooking problems across Africa and other communities, has developed this gasifier. The waste materials are the fuel for this gasifier stove which are very much freely available in villages. Cooking is made without any expense for fuel.

4. Trust for Village Self Governance (TVSG)

TVSG was started in the year 2001 to support the Kuthambakkam Panchayat and also other panchayats primarily in the state of Tamilnadu. The programs and packages are designed to strengthen the Panchayat raj institutions by networking them and also by organizing different types of trainings. TVSG also involves in developing and demonstrating the appropriate technology solutions for villages in the fields of agriculture, village industries, housing for the poor, energy audit and non conventional energy utilization. TVSG also under take R&D programs on local economy based on local resources and local demand.

5. Panchayat Academy – as Centre For Sustainable Growth Solutions

Twenty five years of sincere efforts in building Kuthambakkam as a model village has become a vibrant experience and this could be or should be taken to hundreds and hundreds of good and aspiring Panchayat leaders, women leaders and village youth for replication or for appropriate adoption. Apart from experiments and development of programs, efforts were put to network other panchayats and organizations to take it to more and more villages.

Every person whoever visits the centre with zeal will get energy to work for his / her village with few of these economic packages. Fine tuning their interest and aligning their ideas with Sustainable Development Goals (SDGs) will put them in to action by showcasing the Kuthambakkam experience. This will create huge impact in hundreds of villages.

5.1. Training Programs

Five types of training programs are planned as follows:

1. Training for the elected panchayat personals like Panchayat president, Ward members and Panchayat employees.
2. Training for women SHG leaders, women development workers and women entrepreneurs.
3. Training for village youth and volunteers.
4. Training for voluntary organizations and development workers.
5. Training and internship for students from different disciplines from colleges and institutions.

Basic training materials will be provided to the participants but mostly will be based on live experience sharing methods. Theories on governance, legal information, formulations and formats will be provided. Along with the talks, opportunities will be given to operate suitable packages which will enable the participants to have hands on experience on village industries and village economy. Focus will be given on green methods so that environmental consciousness will be built in every person who participates. This training will be a fully participatory and will cover variety of emotional and practical aspects in planning and resource mobilisation. Focused discussions on social justice and sustainable economic development will be held. Same way the programs will emphasize the participants to understand the SDG goals and will drive them to take their family as a demonstrating unit by tracking the goals. For this they will get the knowledge of SDG tracking Calender here. This training or meeting will enable them to add their ideas as innovations and will make them to get suitable partnering people. They will be able draw an action plan and will be starting this as soon as they reach their villages. Learning Kuthambakkam as a model for sustainable development and the other working models across Tamilnadu and also from other states will create impact among the village level leaders.



A Road Map for Universal Health Care

Ajay Shankar¹ and Chitranjali Tiwari

Wake Up Call on Health Care

The COVID pandemic starkly highlighted the inadequacy of government health care capacities and hospital beds in the country as well as the wide disparity among states.

Private health care facilities and hospitals have been growing rapidly and are getting better. But these are expensive and unaffordable for most Indians.

Bangladesh now has better health parameters of life expectancy and infant mortality than India. China is near the level of developed countries.

Way Forward

1. **Hospital Development.** National Program for increasing hospital bed capacity to 1.5 per thousand in each district in five years may be launched. The Central government should fully fund the building and equipment costs of individual district projects with the condition that the state governments commit themselves to bearing the operating costs of staff and maintenance. Central government would need to provide about 5 lakh crores for this over five years. This is feasible.
2. **Full Holistic Free Public Health Care.** Health Care is a fundamental right. India needs to move from the Insurance for procedures to full free lifetime holistic public health care for all. This would enable greater focus on preventive health care which is the key to better outcomes at lower costs. The CGHS model for central government servants in India and the NHS (National Health Service) model of the UK are good successful examples. For this government expenditure on health needs to be raised to 3% of GDP at the earliest. Health care should have the highest claim on the resources of the state. Resources may be augmented through a new health cess on Income and Corporate Taxes
3. **Modernization.** The use of digital technology offers great promise. It would increase efficiency and productivity. Quality of service especially in rural areas would be transformed. A

¹ Ajay Shankar, Distinguished Fellow and Chairman, Centre for Policy Studies at JK Lakshmi Patil University (JKLU) and Chitranjali Tiwari, Policy Researcher

Centre for Policy Studies at JK Lakshmi Patil University (JKLU) is an independent think-tank established with the vision of providing thought leadership and excellence to inform policymaking in India. The Centre aims to promote dialogue, conduct research, develop, and publish actionable ideas on critical policy issues. It hosts scholars, researchers and thought leaders round the year in addition to organising roundtables and events.

The Centre is led by Mr. Ajay Shankar, former Secretary to Government of India, who serves as Chairman and Distinguished Fellow. For information, contact policycentre@jklu.edu.in

Digital Health Technology Mission may be launched to facilitate a rapid transformation. The cost saving potential is also huge.

4. Reform Private Health Care and Insurance. A competitive industry structure where service providers compete both on quality as well as costs has evolved. It needs to be nurtured to get a share of the global market. Private health insurers jointly with health care providers need to offer lifetime health care covering all costs. This needs to be introduced as a new health insurance product and should be mandated by the Regulator. This would be in addition to the present system of insurance for coverage of the cost of treatment and procedures subject to caps.

I. Introduction

The National Health Policy 2017 has as its goal “the attainment of the highest possible level of health and well-being for all at all ages through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence” (Singh, 2017). The Covid pandemic, especially the vicious second wave this year, has starkly brought into focus the shortcomings on the provision of healthcare and the need to overcome these at the earliest.

In this paper we look at the existing state of health care in the country. Taking the current situation and capacities into account we suggest a feasible road map for achieving the goals of the National Health Policy, fully within this decade and substantially within five years.

2. State of Healthcare

Health care has been a priority since independence. There have been major achievements in the key parameters of life expectancy, infant mortality, and maternal mortality. But there is still a significant gap between us and the developed countries. India’s immediate neighbour Bangladesh has done better. Sri Lanka and China have done far better.

Country Name	2000	2019-20
Bangladesh	65	73
China	71	77
Sri Lanka	71	77
India	62	70
Japan	81	84
United Kingdom	78	81
United States	77	79

Table 2: Infant Mortality Rate³ across countries

Country Name	1999	2019
Bangladesh	67	26
China	32	7
Sri Lanka	15	6
India	69	28
Japan	3	2
United Kingdom	6	4
United States	7	6

Table 3: Maternal Mortality Rate⁴ across countries

Country Name	2000	2017
Bangladesh	434	173
China	59	29
Sri Lanka	56	36
India	370	145
Japan	9	5
United Kingdom	10	7
United States	12	19

3. Healthcare across States

Health is a state subject under the Constitution. There is wide variation in key health parameters across states with Kerala at one end, being almost at par with developed economies, and UP at the other end having a lot of catching up to do.

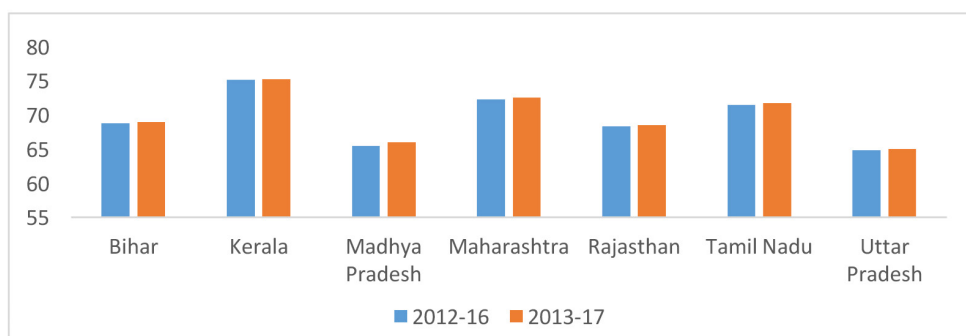


Figure 1: Life expectancy in years (Reserve Bank of India - Publications, 2020)

³ The infant mortality rate is the number of infant deaths for every 1,000 live births.

⁴ MMR is the number of maternal deaths per live birth. Defined by the WHO as the death of a woman from pregnancy-related causes during pregnancy or within 42 days of pregnancy, as a ratio to 100,000 live births

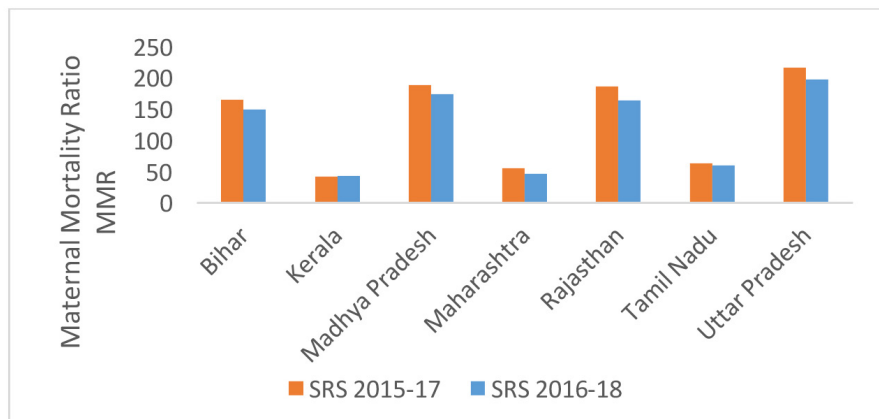


Figure 2: Infant mortality Rate (Reserve Bank of India - Publications, 2020)

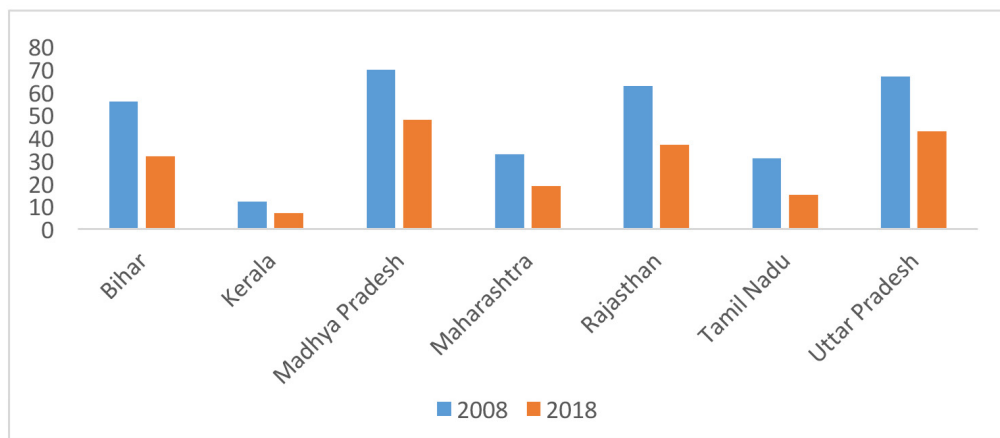


Figure 3: Maternal Mortality Rate (MMR), 2021

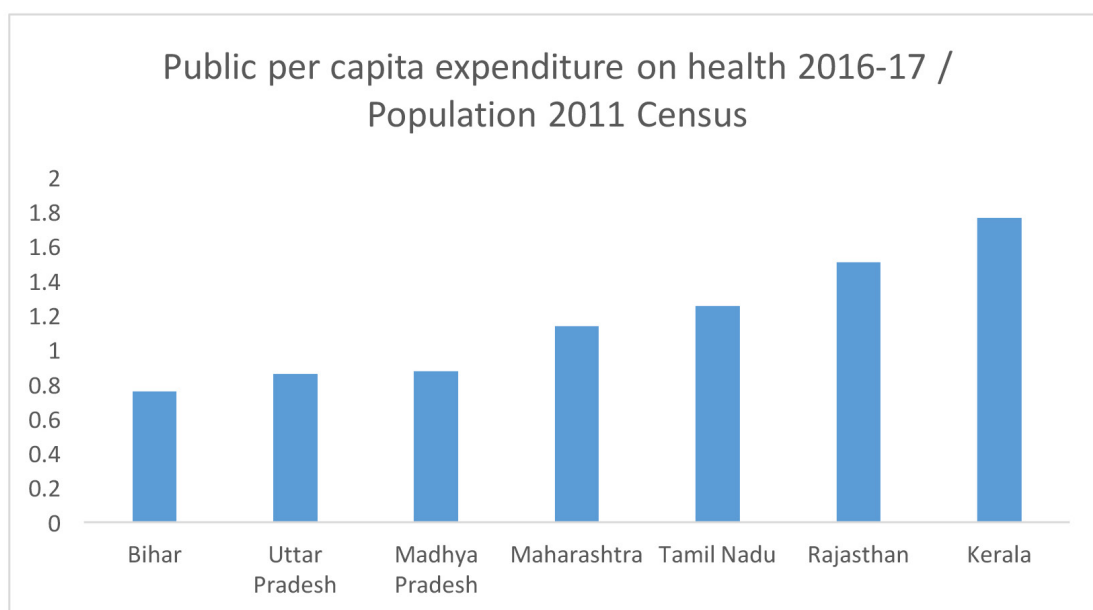


Figure 4: Per capita healthcare expenditure across States/ Total population in 2011 census⁵

⁵ Calculated using Public Expenditure in Health 2016-17 (Rs. in 000) and 2011 census (population)

4. Public Healthcare

The state, in keeping with the spirit of the Directive Principles in the Constitution and in response to the expectations of the people, has from the outset been endeavouring to provide medical treatment to all. In rural areas a network of Primary Health Care Centres (PHCs), one for each Block, were created. Now there is one community health worker, ASHA, in each village. There are district hospitals for treatment of most categories of ailments. Government run medical colleges have attached hospitals which provide the full range of specialised diagnosis and treatment. This network aimed at providing free treatment. As resources became an increasing constraint, the patient has to now buy more specialised medicines on his own though testing, diagnosis and surgical procedures remain practically free.

The quality of free public medical care varies sharply across states. At one end there is Kerala where health parameters have been comparable with those of the developed countries. At the other end are the large states of UP and Bihar where there is still a huge shortfall in public health care capacities. In some states, the confidence of ordinary people in the availability and quality of service from government facilities has been declining. They have, in increasing numbers, been choosing to opt for private treatment even though high private health care costs impose a strain and in cases needing major treatment the burden is unaffordable leading to impoverishment.

To address this problem and alleviate the distress among ordinary people in case of major illnesses, the central government has launched the ambitious national public health insurance program - Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) in 2018. It provides free access to health insurance coverage for low-income earners, the bottom 50%, in the country. It is a centrally sponsored scheme, jointly funded by both the union government and the states. The program is in its initial phase and would need to be scaled up rapidly with substantial increase in funding. The key features of the PM-JAY are the following:

- Providing health coverage for 10 crore households or 50 crore Indians.
- Providing a cover of Rs. 5 lakh per family per year for medical treatment in empanelled hospitals, both public and private (Sharma, 2019). All public facilities, from Community Health Centres to medical college hospitals would be automatically empanelled and private hospitals would be linked to specific service packages.
- It covers 3 days of pre-hospitalisation and 15 days of post-hospitalisation, including diagnostic care and expenses on medicines.
- The beneficiary can avail medical treatment at any PM-JAY empanelled hospital anywhere in the country (Sharma, 2019).
- The beneficiary gets free treatment. The hospital gets direct payment from the Insurance Fund

The central government allocation to Ayushman Bharat is Rs. 6400 crores for FY2020-21. The revised estimates for FY2019-20 were half (Rs. 3200 crore) of this (Kaur, 2020).

5 National Programs

India has successfully run national programs. These have been designed and financed by the central government and implemented by the states. These successes demonstrate state capacity to implement and deliver positive outcomes. The following are some examples.

The National Immunization programme was launched in 1978 which was renamed as Universal Immunization Programme (UIP). It is designed to cover all expecting mothers and infants in the country. Under UIP, immunization is provided free of cost against 12 vaccine preventable diseases⁶. The two major milestones of UIP have been the elimination of polio in 2014 and maternal and neonatal tetanus elimination in 2015.

With Multi Drug Therapy (MDT), the National Leprosy Eradication Programme was introduced in 1983. India achieved the goal of elimination of leprosy as a public health problem, defined as less than 1 case per 10,000 population, at the national level in December 2005.

The Revised National TB Control Programme (RNTCP) (MoHFW, 2021) was launched in 1997 and full nation-wide coverage was achieved in March 2006. Under the programme, diagnosis and treatment facilities are provided free of cost to all TB patients. Treatment success rates tripled from 25% in pre-RNTCP era to 87% by 2014 and TB death rates have been reduced from 29% to 4% during the same period.

The Jeevan Suraksha Yojana (JSY) was started in 2005 to promote institutional deliveries. Communication and tracking of each pregnancy along with cash incentives for the expecting mothers from poor families and the ASHA worker have made a material difference. This is seen in the sharp decline in maternal mortality rates in recent years.

6 Full Healthcare for Employees

Health Care for Central Government Employees (Nagarajan, 2017)

The Armed Forces and the Railways had from the outset put in place an efficient full and free life-time medical treatment system for their employees with in-house doctors and hospitals.

The CGHS (Central Government Health Scheme) provides full life-time health care for Central Government employees. Approximately 38.5 lakh beneficiaries are covered by CGHS in 74 cities all over India. The government's expenditure on CGHS was Rs. 2,300 crore which is approximately Rs. 6,300 per beneficiary (2015 Data).

The CGHS has for some time been using the private sector through outsourcing to supplement in house capacity of CGHS doctors and government hospitals. It has settled rates for private consultation with specialists, testing and for treatments in empanelled diagnostic centres and hospitals. The patient does not have to pay to the service provider for consultation, tests, or treatment. She is also free to choose from among those authorised to provide services on getting a referral from the CGHS.

Health Care for Organised Sector Workers

India adopted the international practice of a contributory system of social security, including health care, for industrial workers. A network of health care facilities came up to provide

⁶⁰ Nationally against 9 diseases - Diphtheria, Pertussis, Tetanus, Polio, Measles, Rubella, severe form of Childhood Tuberculosis, Hepatitis B and Meningitis & Pneumonia caused by Hemophilus Influenza type B. Sub-nationally against 3 diseases - Rotavirus diarrhoea, Pneumococcal Pneumonia and Japanese Encephalitis; of which Rotavirus vaccine and Pneumococcal Conjugate vaccine are in process of expansion while JE vaccine is provided only in endemic districts.

medical treatment to workers covered under contributory health insurance. The growth of the organised industrial sector and its workers has been modest in India. Around 10% of workers are in the organised sector and have the benefit of free medical treatment. This system is also not seen by its beneficiaries very positively.

The practice in large firms and public sector undertakings on health care for their employees from private doctors and hospitals varies. It ranges from full cost reimbursement at one end to the other where the employee is paid well and is expected to meet his healthcare costs on his own and by taking health insurance.

8. Private Health Care

Market based private medical services have been growing rapidly, especially in the last few decades. The industry leaders are globally competitive in terms of the latest technologies of diagnosis and treatment and at costs far lower than that of their peers in the US. The phrase “medical tourism” has gained currency. This service industry has the potential of having a significant presence in the global market.

Nearly 58% of the hospitals in the country with 29% of beds and 81% of doctors are now in the private sector. According to National Family Health Survey-3, the private medical sector is the primary basis of health care for 70% of families in urban areas and 63% of families in rural areas (AIHMS Blog, 2020).

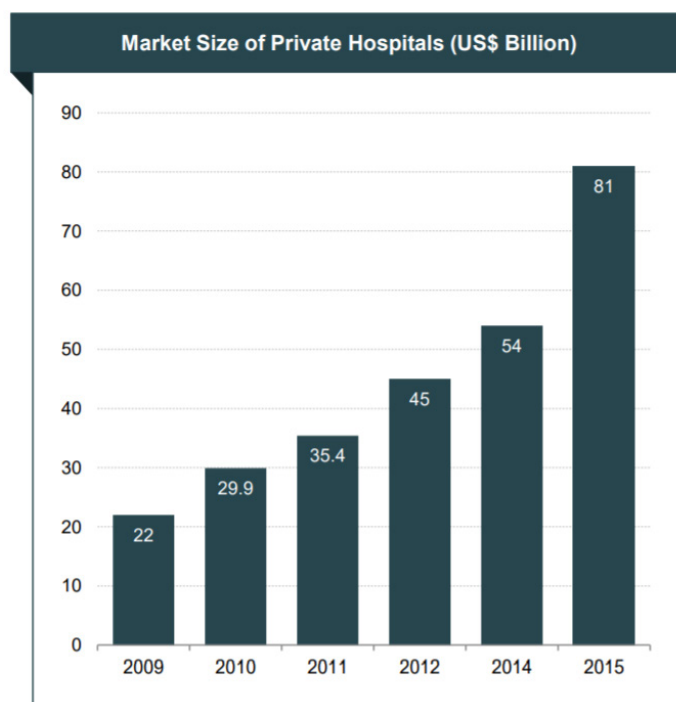


Figure 5: Market size of private hospitals

Large investments by private sector players are driving the growth of India’s hospital industry. During 2009–15, the market size of private hospitals is estimated to have had a CAGR of 24.2 per cent. Increase in number of hospitals in Tier-II and Tier-III cities has further fuelled growth. (IBEF, 2018).

9. Health Insurance

Health Insurance has grown to take care of the growing market need for insurance for expensive treatments. Health insurance premiums increased at a CAGR of 21.15 per cent between 2008–09 and 2016–17 (IBEF, 2018).

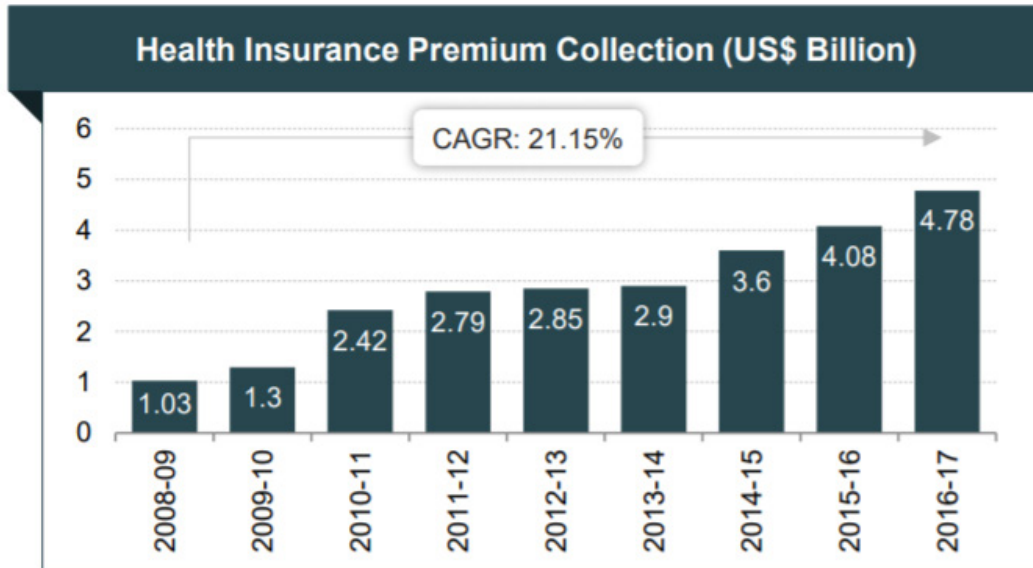


Figure 6: Health Insurance Premium Collection

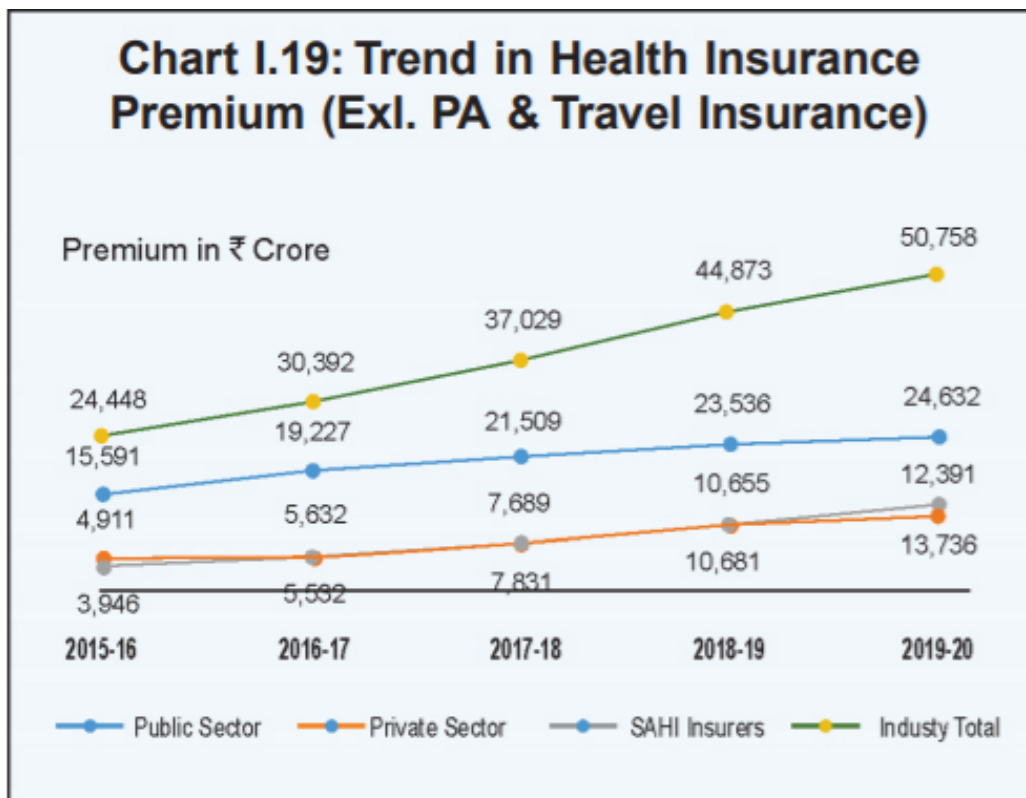


Figure 7: Trend in Health Insurance Premium

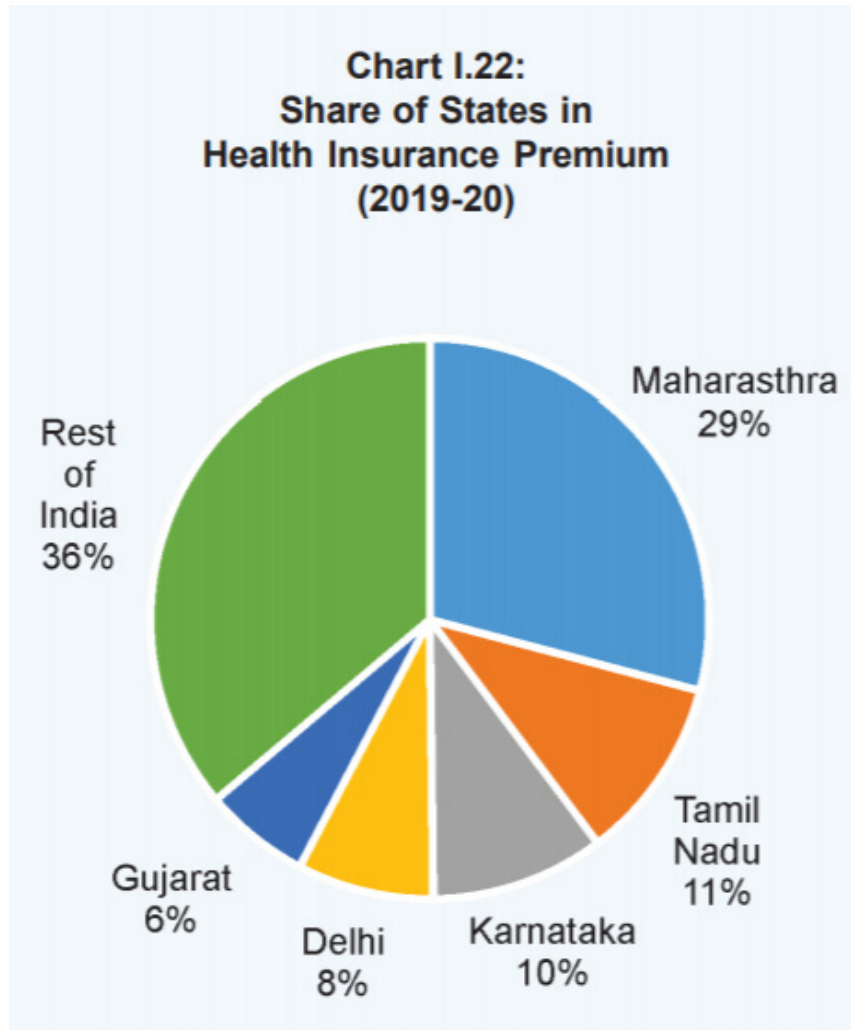


Figure 8: Share of states in health insurance premiums

A competitive industry structure has emerged. Currently, there are 30 insurance companies in India that offer health insurance products. Out of these, 25 are general insurance companies and 5 are standalone health insurance companies. The Health Insurance industry is regulated by the Insurance Regulatory and Development Authority of India (IRDAI).

A health insurance policy provides for reimbursement of cost of treatment for ailments covered under the policy subject to a maximum in a year. With higher insurance premia, the ceiling on reimbursement becomes higher. In the present system of full reimbursement, the hospital providing treatment has no incentives to control or lower the cost of treatment. There are higher returns for the health care provider if costs rise. These in turn result in insurance premia going up with higher returns for the insurer. Both gain by being on an escalating cost curve.

While private health care is improving in quality, it is also becoming more expensive. The following illustrates this:

- Hospitalisation for any ailment in a private hospital costs nearly 7 times more than in a government hospital. A one day stay in ICU (Intensive Care Unit) in Bangalore

at government facility costs Rs. 1,500 while in a private hospital it is around Rs. 30,000 (Times of India).

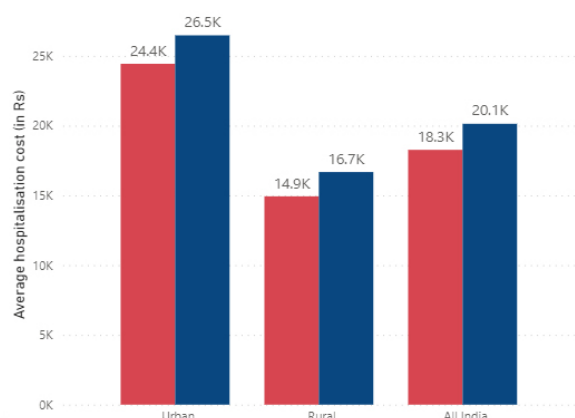
- The cost of Covid care in a private hospital is about Rs 2 lakh for a mild to moderate case for one week and up to Rs 5-6 lakh for a severe infection (Punj, 2021).

Cost of hospitalisation

Private hospitals have grown more expensive over time

Average hospitalisation cost (Includes govt, pvt and charitable hospitals)

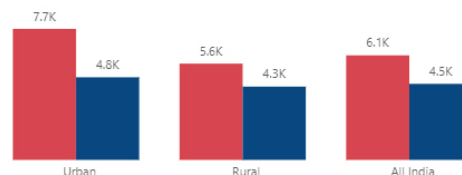
NSS round ● Jan-June 2014 ● July 2017-June 2018



Source: 75th NSS round Health in India. Data period: 2017-18

Hospitalisation cost in government hospitals

NSS round ● Jan-June 2014 ● July 2017-June 2018



Hospitalisation cost in private hospitals

NSS round ● Jan-June 2014 ● July 2017-June 2018

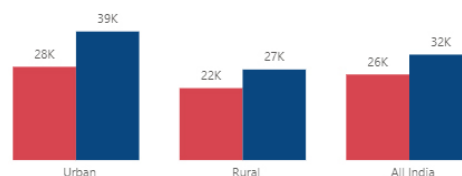


Figure 9: Cost of Hospitalisation in Private versus Public healthcare facility (Sengupta, 2020)

10. Major Challenges

- o Shortage of government hospitals and treatment facilities, acute in less developed states and districts.
- o Declining faith in public health care among the people of many states.
- o Weak preventive health care.
- o Slow Modernisation.
- o Rising and unaffordable private health care costs.

We need action on all these immediately through a comprehensive and holistic set of policies and programmes.

11. Hospital Capacity Development

The COVID-19 crisis has driven home sharply the inadequacy of hospital bed and care capacity in the country. India has only 0.53 beds available per 1,000 people. There is also huge disparity among states and districts. Only the metros are well provided.

The shortage of hospital beds and related facilities in less developed districts is acute. So is the shortage of doctors, para medical staff and equipment in these districts.

A national program to raise health care infrastructure in the country to a minimum level is an immediate necessity. This needs to be funded by the central as well as state governments. A major pillar of this should be the provision of the minimum number of hospital beds in each district.

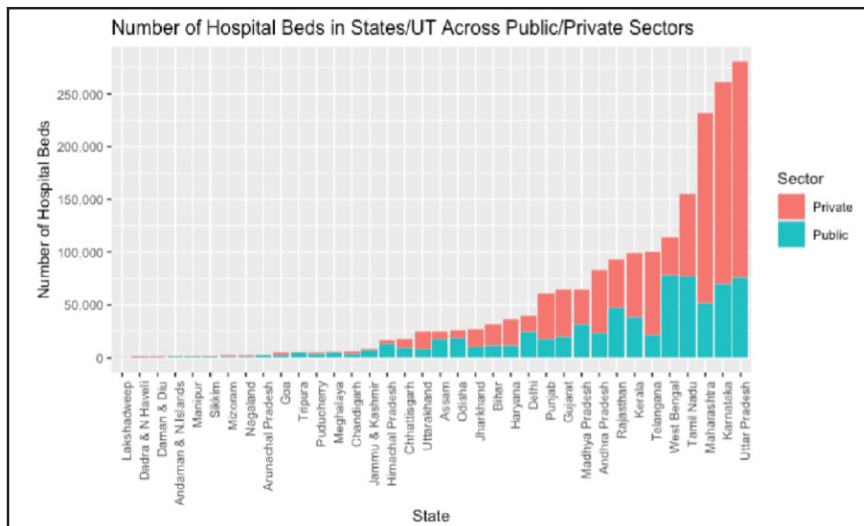


Figure 10: Number of Hospital Beds in states/UT Across Public/Private Sectors

The Central government should provide full funding for construction and equipment for district wise projects and the State government should accept the responsibility of providing staff and meeting operational costs of these district wise projects. The state governments should have flexibility in managing these by themselves fully as well as with varying degrees of private partnerships.

India currently has about 5 beds available per 10,000 people which is total 6,76,300 beds. To achieve at least 1 bed per 1000, the country needs to fulfil the unmet demand of around 6,76,300 beds. This would require an investment of Rs. 2,47,977 crores. To achieve a level of 1.5 beds per 1000, the country needs to fulfil the unmet demand of around 13,52,600 beds requiring an investment of Rs. 4,95,953 crores over a period of 5 years. Commitment of this level of expenditure is feasible. This should get the highest priority in the Infrastructure Pipeline investment.

INDIA HAS 8.6 DOCS PER 10,000					
Countries/ categories	Hospital beds per 10,000	Doctors per 10,000	Countries/ categories	Hospital beds per 10,000	Doctors per 10,000
Very high*	52	31.2	Myanmar	10	6.8
High*	31	17	Bangladesh	8	5.8
Medium*	7	7.9	Pakistan	6	9.8
Low*	5	1.9	Afghanistan	4	2.8
China	43	19.8	Nepal	3	7.5
Sri Lanka	42	10	India	5	8.6
Bhutan	17	4.2			

*Development

Figure 11: India has 8.6 doctors per 10,000

12. Augmenting Human Resources

A crash program for recruiting and training para medical personnel needs to be started now to see that as hospital beds get created, they are not understaffed. In our view an altogether different approach should be tried. Direct recruitment for para medical positions in individual hospitals at specific locations may be undertaken on contract. Training for skill and certification may be undertaken after recruitment and the employee may be given a modest student stipend for personnel expenses. He may be provided board and lodging in the training facility.

The educational qualification needed for admission to a para medical training institution should be the eligibility criterion for such recruitment. The contract should be for, say, seven years after training with the condition that if the employee leaves earlier she would pay the government the full cost of her training and a penalty. After successful completion of training and certification, the para medic would get her full salary. This would be somewhat similar to what the Armed Forces do. To the extent local youth get recruited and trained there would be greater probability of their staying and serving for longer periods. Recruitment on contract for a particular hospital or a rural health care facility would insulate the system from political and other kinds of mobilisation for a shift from a backward district to a better place.

Getting doctors would need a slight variation in this approach, Campus visits and recruitment may be undertaken among students in, say, the second or third year, on similar conditions of their educational expenses including board and lodging being fully funded on recruitment. They may be given the added incentive that if their performance during the contractual period is good, they would join the state medical cadre at an appropriate level and seniority. This would be a reward for serving in a remote place.

The central government while financing the construction of hospital beds and related equipment can get the commitment of the state governments on milestones for creation of posts and recruitment to ensure that when the hospital beds are ready, and equipment has been installed the staff is also in position.

13. Preventive Health Care

It is now axiomatic that preventive health care should get the highest priority. It costs the least and the returns are very high. But surprisingly preventive health care gets emphasised in policy documents but does not get the requisite priority when it comes to programs and outlays.

There are many low hanging fruits in preventive health care. Part of the problem lies in the absence of a holistic system of analysis of the different dimensions of preventive health care, their costs and benefits, and pathways to desired outcomes. The canvas of preventive health care in India is quite wide. Many are what economists call “public goods” and only government action can be effective.

There are public goods which effect health and impose huge and avoidable costs on large

sections of the population. The most critical in North India is air pollution. Air pollution levels are estimated to be shortening lives in Delhi by 9.4 years. Air can be made clean in five years. This is affordable. This needs to get priority and coordinated action with adequate resources.

Malaria, dengue, and encephalitis are endemic. Better management of drainage and wastewater could free us of these. The health benefits would far outweigh the costs. Malaria has been eliminated from Sri Lanka.

Putting industrial waste with toxic chemicals as municipal waste is another health hazard. They evaporate and pollute the air in the below 2.5PM range and many are carcinogenic. The public cost of collecting and treating this waste separately is far lower than the health care costs this imposes on society.

Then there are free preventive health care practices which only need communication and changes in lifestyles and where the health benefits and cost savings are huge. Mass communication in all our regional languages and dialects through the enhanced power of social media and the internet is a low-cost powerful instrument.

To illustrate, the diabetes epidemic could be arrested and reversed with changes in diet by reducing sugar, and Maida based processed food consumption and returning to regional traditional foods. Then there are regional affordable foods which can be popularised to reduce the widespread prevalence of anaemia in women.

I4. Modernisation and Cost Reduction

The new digital age offers enormous possibilities of increasing the efficiency of delivery of total health care as well as its costs. India can leapfrog. It has taken a pioneering initiative with E-Sanjeevani⁷. A full-fledged Digital Health Technology Mission is needed. Some possibilities are indicated below.

Creation of guidelines in all our regional languages which, say, adapt the National Health Service (NHS) guidelines of UK. These are comprehensive, user friendly and cover the entire spectrum. These would be of great value to all. There would need to be a system of continuous updating.

SOPs (Standard Operating Procedures) for doctors modelled on the NHS pattern would help. A system of seeking guidance digitally in more difficult cases from specialists higher up in the hierarchy would obviate the need in many cases for the patient travelling to the state capital for diagnosis.

Surgery and other medical procedures can be more efficiently scheduled. Reference to super speciality hospitals would come down to very difficult and complicated cases.

SOP effectiveness and compliance can be audited with digital record keeping. Human audit would evolve into appropriate data analytics. Audit should reduce inappropriate but widespread prescription of antibiotics. This would need to be supported by mass communication so that patients do not needlessly expect and demand antibiotics.

Tele consulting and prescription has emerged during the Covid lockdown. E-Sanjeevni has been a good beginning. The states could introduce this and scale it up. It would be a great boon for rural and remote areas.

Digital health record keeping is emerging. It can be extended to cover all. It's benefits in better and speedy diagnosis are well recognised. Privacy should be adequately safeguarded

Para medical and nursing staff can be guided remotely through digital communication in giving patients better care. They can also be given greater responsibilities.

The need for stay in hospitals can be minimised with the development of homecare capacities with the guidance of doctors, visits by paramedical staff and training of family members. Out of necessity a good beginning was made for Covid patients recently. In terminal cases supervised homecare is psychologically better both for the patient and the family. This would reduce the requirements of hospital bed capacity as well as costs.



Source: https://mediaindia.eu/mig_2015/wp-content/uploads/2015/11/health.jpg

15. Universal Free Public Health Care

The fundamental transition that is now needed is provision by the state governments of free and full lifetime public health care including the cost of medicines.

The NHS is a good model to emulate. It provides free lifetime health care to all. It is cost effective. UK's expenditure on health care as a percentage of GDP is among the lowest. It

is only 9.5% of GDP for health outcomes which are comparable to those of the US which spends 17.5% of GDP on health care.

The full free care system of the central government for its employees through the CGHS provides a useful template for use by the state governments.

Those with higher incomes may continue to use private health care. They have the freedom to choose in the market for supply of private health care.

From the present 1.26% of GDP expenditure on public health care, an additional 1% of GDP, may be provided in the next two years. This may be raised to 3% of GDP at the earliest. Only such a quantum increase would lead to a qualitative transformation and a time bound movement to full free health care for all. Going forward expenditures would need to rise further.

The right to health is a fundamental right. Budgetary resources would have to be found for it and should get the highest priority. A health care cess on personal and corporate incomes to generate additional resources should be imposed. It would be amply justified. . On the other hand, it is neither reasonable nor fair to ask the poor to pay for health care.

The cost implications of full free care can be seen by extrapolating the cost of about Rs 6,000 being incurred per year for each CGHS beneficiary to 80% of the population of the country. The total would be approximately 6 lakh crore per year. It is likely that in implementation actual costs would be lower if at the same time preventive health care and other cost reduction ideas being suggested are implemented.

Over the medium term, full care with timely preventive measures through lifestyle changes, early detection and treatment should result in lowering overall costs compared to a system which provides only insurance-based cover for treatment of specified diseases and procedures.

The national ambition should be to achieve effective universal free public health care in the next 5 to 7 years. The Indian state must deliver on this fundamental human right within this decade to comply with the SDG (Sustainable Development Goals). The economic returns from higher productivity of a healthy population would also be very high. This would naturally facilitate the achievement of higher growth rates.

16. Private Health Care Reform

Private provision of health care has been growing rapidly. A competitive industry structure has emerged in response to market demand. At one end the metropolitan centres have world class super speciality hospitals which are globally competitive in quality and price. Private hospitals, diagnostic centres, and maternity nursing homes are all increasing in numbers in other cities. The inadequacy of government facilities combined with the public perception about the indifferent quality of service has fuelled increase in demand for private facilities.

This is a free and competitive market with service providers at different price and quality points. But once the initial choice is made, the patient (consumer) begins to face a virtual monopoly

situation as he would usually stay with his hospital and doctors (the service provider) and his demand becomes inelastic. Even in terminal cases the patient usually continues in hospital, in its ICU and a ventilator, at great cost. This characteristic was highlighted starkly during the recent Corona pandemic where so many relatively better off families have not only lost some one dear to them but have also been considerably impoverished.

Taking a broader perspective, health care costs in a society decline as preventive health care improves. At the same time people live longer and health care costs rise for the elderly.

One reasonable view would be to let market forces alone. India could evolve into a global hub for medical treatment. To the extent India succeeds in becoming a cost-effective attractive destination for high quality treatment, we would be creating jobs and incomes. With an ageing population in the advanced countries the demand potential is enormous. This sector could grow as a sun rise services sector, as software was a generation earlier. For this to be facilitated, the industry on its own as well as at the behest of the Regulator needs to move towards creating greater transparency in its fees structure along with an Ombudsman system for consumer grievance redressal. Going forward the emergence of a credible star rating system which consumers could trust would be a good development for the industry.

There is also the need for reorientation towards cost control, getting desirable outcomes at lower costs. This is something that regulatory and policy instruments should attempt. Such a shift would not be easy as the present incentives do not favour controlling costs. The more the number of tests and surgical interventions with full reimbursement by insurance companies, the greater the returns for the service providers. In turn the insurance companies can charge higher premiums with higher reimbursement caps. This becomes a mutually reinforcing trajectory of higher costs. The turnover and profits for both, the health care service providers and the insurance companies grow in tandem.

Weaning away the system from prevailing high costs to lower costs without any negative impact on outcomes is something easy to prescribe but bound to be challenging when specifics are being worked out. The transition is not going to be easy. Competition amongst multiple insurers and service providers would be desirable.

Cost control would be a management concern only if the insurance cover was for full health care, including consultations, tests, medicines, and treatment for life, rather than for reimbursement for treatments with a cap. Once full insurance is provided, competing insurers would tie up with competing health care providers encompassing the full-service delivery chain; the primary GP (General Physician) who with timely advice on lifestyle and dietary changes and early detection of problems would reduce the numbers who would need specialised diagnosis and treatment, to the specialists and hospitals to whom patients would go for treatment and surgical interventions.

With medicines being fully covered under insurance, the needless prescription of antibiotics and expensive drugs would hopefully come down. The use of cheaper generics would increase. The percentage of Caesarean births and hysterectomies among better off families would decline. These are far too high in India at present. At the other end of the spectrum the

practice of routinely putting terminally ill patients in their last days in the ICU with ventilators for many days would decline. In a competitive market, reputations would emerge regarding quality and price. Consumers should get a choice in the market of both, insurance with caps as well as a new market for insurance for full coverage.

The regulator and government after stakeholder consultations could fine tune the incentives for such a transition. The instruments used elsewhere suggest themselves. A higher tax break for a customer who buys comprehensive insurance could be one way of nurturing the emergence of this market. The Regulator may mandate that the Insurance Companies must begin providing this new product of comprehensive full health care, say, within three years.

17. Conclusion

India needs to give the highest priority to taking public health provision for its people to the next level and achieve health outcome parameters comparable to those of the developed countries by the end of this decade. Public expenditure on health care needs to rise to approximately 3.5% of GDP per year. This is essential and should get the highest priority.

Holistic health care with emphasis on prevention and cost-effective treatment would result in lower per capita costs with better outcomes. Preventive health care including lifestyle and dietary changes need greater priority. The use of digital technology offers great promise in improving efficiency as well as in reducing costs.

The emerging silos between primary and preventive care on the one hand and insurance-based reimbursement for treatments in hospitals needs to be reversed. Every citizen should get free life-time health care as a right. Those whose incomes are large enough to pay Income Tax, should pay a cess for health care. Similarly, firms should also pay a cess for health care over and above the taxes on their profits.

Those who have the resources to use private health care should continue to have the full freedom to choose in the market from competing suppliers of health care. The health care industry has been growing rapidly and is globally competitive. It should be supported in getting a rising share in the global market.

The health care industry and its related insurance industry need to be incentivised to jointly provide full lifetime health care, without any linkage to procedures or caps on treatment for an ailment or for a procedure. The emergence of a competitive industry structure for full free lifetime health care to be provided through insurance policies with monthly payments is a desirable and necessary transition. The present full reimbursement system with caps incentivises higher costs and not cost control.

18. References

AIHMS Blog | Explore Public Health. 2020. The Growth of Healthcare and Hospital System in India | AIHMS Blog. [online] Available at: <https://aihms.in/blog/the-growth-of-healthcare-and-hospital-system-in-india/> [Accessed 14 September 2021].

Dghs.gov.in. 2021. NATIONAL LEPROSY ERADICATION PROGRAMME - DIRECTORATE GENERAL OF HEALTH SERVICES, Ministry of Health & Family Welfare, Government of India. [online] Available at: https://dghs.gov.in/content/1349_3_NationalLeprosyEradicationProgramme.aspx [Accessed 14 September 2021].

Dghs.gov.in. 2021. Revised National Tuberculosis Control Programme - DIRECTORATE GENERAL OF HEALTH SERVICES, Ministry of Health & Family Welfare, Government of India. [online] Available at: https://dghs.gov.in/content/1358_3_RevisedNationalTuberculosisControlProgramme.aspx [Accessed 14 September 2021].

IBEF.org. 2018. Healthcare – India Brand Equity Foundation (IBEF). [online] Available at: <https://www.ibef.org/download/Healthcare-February-2018.pdf> [Accessed 14 September 2021].

Kaur, B., 2020. Union Budget 2020-21: No increase in Ayushman Bharat allocations. [online] DowntoEarth. Available at: <https://www.downtoearth.org.in/news/health/union-budget-2020-21-no-increase-in-ayushman-bharat-allocations-69092> [Accessed 14 September 2021].

M.rbi.org.in. 2020. Reserve Bank of India - Publications. [online] Available at: <https://m.rbi.org.in/Scripts/PublicationsView.aspx?id=20000> [Accessed 14 September 2021].

M.rbi.org.in. 2020. Reserve Bank of India - Publications. [online] Available at: <https://m.rbi.org.in/Scripts/PublicationsView.aspx?id=19999> [Accessed 14 September 2021].

N.A., 2018. PM unveils Ayushman Bharat; 50 cr to get health cover of Rs. 5 lakh – The Hindu BusinessLine. [online] www.thehindubusinessline.com. Available at: <https://www.thehindubusinessline.com/news/national/pm-unveils-ayushman-bharat-50-cr-to-get-health-cover-of-5-lakh/article25022030.ece> [Accessed 14 September 2021].

Pib.gov.in. 2021. Maternal Mortality Rate (MMR). [online] Available at: <https://www.pib.gov.in/PressReleasePage.aspx?PRID=1697441> [Accessed 14 September 2021].

Punj, S., 2021. The financial burden of Covid care. [online] India Today. Available at: <https://www.indiatoday.in/india-today-insight/story/the-financial-burden-of-covid-care-1817504-2021-06-21> [Accessed 14 September 2021].

Rao, S., 2020. Hospitalisation is 6 times more expensive in private sector: Study. [online] Time of India. Available at: http://timesofindia.indiatimes.com/articleshow/73052991.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst [Accessed 14 September 2021].

Sengupta, R., 2020. Private hospitals grow more expensive even as insurance coverage remain low: NSSO. [online] DowntoEarth. Available at: <https://www.downtoearth.org.in/news/health/private-hospitals-grow-more-expensive-even-as-insurance-coverage-remain-low-nssso-72434> [Accessed 14 September 2021].

Shankar, A. & Tiwari, C., 2020. A Plan to Accelerate Recovery. [online] Centre for Policy Studies, JKLU. Available at: <https://www.jklu.edu.in/wp-content/themes/jklu/images/centre-policy-studies.pdf> [Accessed 14 September 2021].

Sharma, N., 2019. Over 40,000 people availed portable treatment under Ayushman Bharat. [online] Mint. Available at: <https://www.livemint.com/politics/policy/over-42-000-people-availed-portable-treatment-under-ab-pmjay-1569476280775.html> [Accessed 14 September 2021].

Sharma, Y., 2019. Labour ministry to provide cashless secondary and tertiary medical care services under AB-PMJAY. [online] The Economic Times. Available at: <https://economictimes.indiatimes.com/industry/healthcare/biotech/healthcare/labour-ministry-to-provide-cashless-secondary-and-tertiary-medical-care-services-under-pmjay/articleshow/71114979.cms> [Accessed 14 September 2021].

Singh, S., 2017. India's National Health Policy 2017 and 2030 Agenda for Sustainable Development - International Institute for Global Health. [online] iigh.unu.edu. Available at: <https://iigh.unu.edu/publications/blog/indias-national-health-policy-2017-and-2030-agenda-for-sustainable-development.html> [Accessed 14 September 2021].

Social Security for Gig Workers

Bharti Gupta Ramola⁸

India has long striven to give itself a labour code that is good for labour and good for growth. By many accounts, historically, the labour code and the inspector raj it has spawned in implementation has had the effect of disguising employment/ driving employment into the informal unorganized/sector and some say even in driving large employment industries like textiles out of India. Less than 10 percent of employment is in the organized sector. For the balance 90 percent workers, working conditions are nowhere near what the country's labour laws require them to be. E-commerce and platform workers, sometimes called gig workers, like those working with large and small companies delivering your daily or monthly requirements home or through taxi platforms, or food delivery (from restaurants) platforms etc. are similarly situated.

A new national employment policy is expected soon and is expected to go some way to include unorganized and gig workers. This policy may or may not set out a framework and rules for inter alia wage parity protection, working conditions, hours of work and leave etc. On the other hand, with increased longevity, massive migration and nuclear families, the need for social security and safety nets has increased manifold. The Government has come up with a whole slew of schemes to provide some social security for unorganized sector and gig workers on self-help basis supported by limited guarantees by the central Government (please see appendix for a description). The uptake has been patchy even as we don't appear to have good quality data in this regard. Some platform players have been trying to think through this issue and a few have made some beginnings particularly in buying accident insurance and piloting life and medical insurance coverage paid for by the platform players. A petition has recently been filed in the Supreme Court asking the Court to direct the Central Government to extend social security benefits to platform/ gig workers.

The larger question of whether a broadening of the labour code in its current form to include platform/ gig/ unorganized sector workers at this time will be good for labour and business or should the Government nuance the new employment policy to push for graded mandates to have a better chance at improving formalization is very important and we should get a real conversation going on it among labour, contractors, platform workers and businesses that ultimately need this labour. Here we are limiting ourselves to focus on how e-commerce/

⁸ Bharti Gupta Ramola was a partner at PricewaterhouseCoopers. She now serves on the Boards of a number of companies, social enterprises and works with some development NGOs.

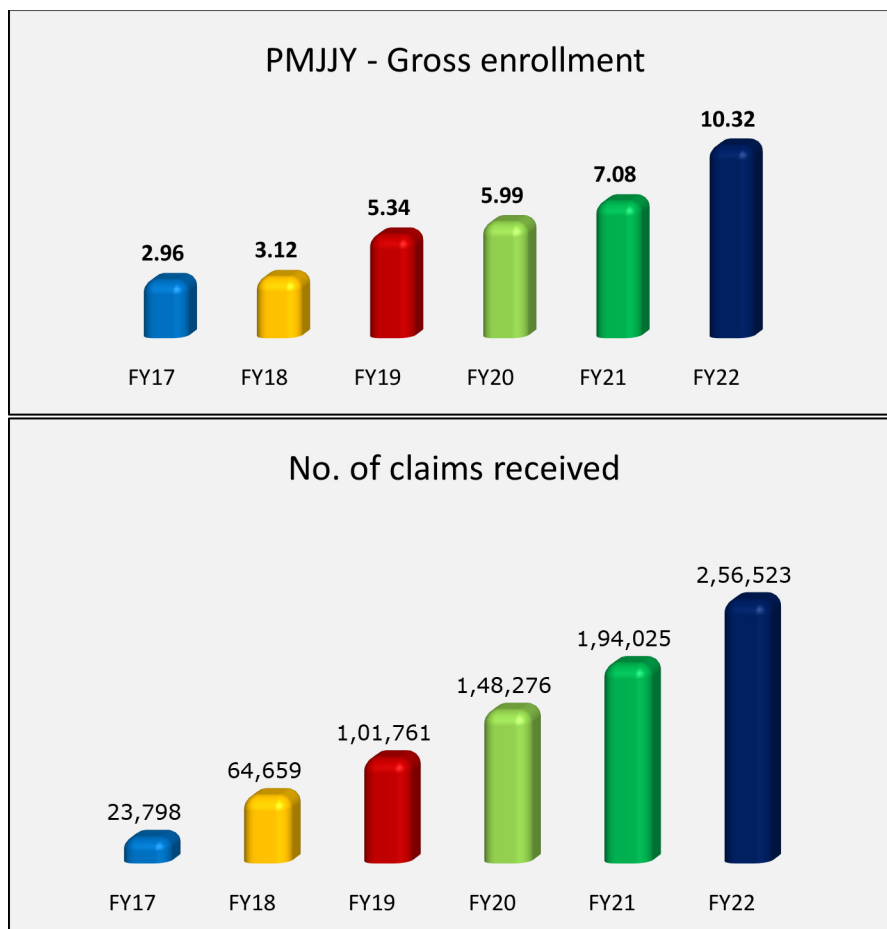
jobtech/platform companies might start to provide social security benefits to gig workers including leveraging Government schemes and the newly launched e-Shram portal (launched on Aug 26, 2021).

The overall cost of retirals (ESI/Medical, EPF/NPS, gratuity) works out to over 20% (some estimate this at up to 28%) of salary for blue collar workers in manufacturing industry and frontline workers in other industries in the organized sector. This does not include the cost of holidays, leave and days not worked whereas a gig-worker is often paid for actual days worked. At a high level, perhaps we need to explore two areas to make gig work equivalent in social security benefits to full time employment even as we preserve flexibility for workers and industry:

- Can gig workers be mandatorily enrolled into Government schemes without negatively affecting the growing employment opportunity through digital/platform play?
- Can we develop social security in sachets (or drops perhaps) and apply it to each unit of gig work.

I. Government Schemes

Life and Disability cover is available through PMJJBY. The data on the numbers enrolled is different on Department of Financial Services and IRDA site .



Source: Department of Financial Services. (<https://dfs.dashboard.nic.in/>). Data is cumulative.

Year	No. of Lives and Premium				Claims	
	No of lives renewed	New Lives Added	Total Lives covered	Premium received (in Rs. Cr)	Claims paid	Amount of claims (in Rs. Cr)
2015-16		2,73,54,338	2,73,54,338	790.55	41,231	824.62
2016-17	2,25,06,952	28,70,150	2,53,77,102	733.42	42,662	853.24
2017-18	2,07,17,415	46,23,891	2,53,41,306	732.42	37,811	756.22
2018-19	2,26,88,625	71,89,251	2,98,77,876	788.50	42,191	843.82
2019-20	2,49,38,631	1,27,16,717	3,76,55,348	977.81	45,037	900.74
2020-21	3,13,25,444	1,82,78,438	4,94,39,306	1309.56	60,908	1218.16
Total				5332.27	2,69,840	5396.80

Source; IRDA (Response to RTI question in Parliament). Year means policy year ie June 1 to May 31. For 20-21, Claims are likely to be understated as the policy year is different and there is normally some delay in lodging claims.

IRDA numbers appear to reflect year on year data so based on this it would seem that about 5 Crore workers were covered as on March 31, 2021 under PMJJBY. The scheme is implemented by LIC and 9 private insurers for workers with bank accounts with 1200 banks (most of the coverage is through 28 large PSU banks and a few large private sector banks) that the insurer has a tied up with. The banks keep Rs 41 of the Rs 330 charged to the insured for a renewable life cover of Rs 2 lakhs. The insurance company pays for stamping etc (approx. Rs 40 one time) but otherwise has minimal operational expenses. Most insurers are likely losing money because as we can see collections are marginally less than pay outs, even without any margin for operational expenses.

Banks also apparently do not find the proposition remunerative perhaps because the unit cost of onboarding and operations are not covered by Rs 41 per person per annum. If we are to try to universalize this coverage, we will have to figure out how to reduce the operational costs of banks and insurance companies and perhaps also to raise premia to some extent (one estimate puts the requirement at 25% higher so a premium of Rs about 400 instead of 330). There is also the matter of the adequacy of the life cover at Rs 2 lakhs. There does not appear to be any explicit or implicit Government guarantee involved and apart from some losses being borne by banks and insurance companies, the worker is paying for this herself.

Even as these matters are sorted out, can we try to get all and any gig worker being onboarded by a platform player enrolled into PMJJBY? We are talking of Rs 330-400 per annum here as against a gig-worker's wages for a month of work of Rs 8000-10000 at the lower end. Further, if she has such an account, can any pending payment be paid as soon as money starts to flow into her bank account to keep this insurance active year on year? I imagine, this may not be too difficult as e-commerce/platform/ jobtech companies already have a link with the payroll bank, each gig-worker has a bank account and e-kyc. So why is this not happening?

My conversations with bankers, insurance companies and some platform players suggest that aside from the poor economics for banks and insurers, the primary reason appears to be a lack of awareness about the scheme. There is practically no marketing about the scheme and its benefits (the Government does periodically put out some messaging but banks / insurance companies have no budget/ incentive to market. Further, we all know that financial products have to be 'sold'. Typical insurance and mutual fund markets have grown because of systematic selling with hefty commissions for the selling organization/ agent.

The current PMJJBY has no provision for selling expenses. Finally, companies do not see any no imperative (the gig-worker wants money in hand, employer does not think its worthwhile bothering because of the churn which is anywhere from 50% - 150 % per annum), no compulsory mandate (as the gig-worker has to pay, even employers who wish to enable this scheme have provided this as an opt-in option). If there was a mandate, or even a focus by platform players, this could perhaps be provided as an opt-out option and then we may see much higher enrolment?

There does not appear to be any Government scheme for insurance against loss of wages in the event of an illness that does not lead to disability or unemployment. Micro insurer, Sewa Insurance has a scheme which provides up to 15 days of wage loss coverage with a payout of 200 rupees a day for a small premium and is a great start in this direction. Yet for such efforts to be universalized, a lot more work will need to be done and will likely require contribution/ backstopping by Government leading to further budgetary questions.

A Health and Maternity Cover is perhaps best addressed through ESIC which has a robust network of hospitals and clinics in the larger industrial areas where gig workers typically work. However, the 4% of wage contribution required to be paid by the employer under the ESIC Act is a dampener in a situation where a gig-worker does not have regular employment. It is worth considering if this residual (contribution for days not worked) cost can be borne by the Government. The Government is already bearing the cost of the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) which is administered by the National Health Authority. A number of states have expanded coverage of their own accord. However, AB-PMJAY appears to be provided to a predetermined list and while many eligible people are not covered, there are also a large number of people who are not proposed to be covered. Does it make sense for the Government to extend this scheme to all unorganized sector / gig workers, with some contribution coming from employers to the extent of days worked.

For Pensions, the Government has launched Atal Pension Yojana (APY) and Pradhan Mantri Shram Yogi Maan-Dhan Yojana (PM-SYM). APY was launched in 2015 for every Indian Citizen. Under this scheme, any Indian in the age group of 18-40 can enroll in this scheme and opt for a pension of Rs 1000-5000 per month. Based on the amount of pension so opted for and age at the time of entry into the scheme, a monthly / quarterly or annual premium is determined. Under PM-SYM beneficiaries are entitled to receive minimum monthly assured pension of Rs.3000/- after attaining the age of 60 years. The workers in the age group of 18-40 years whose monthly income is below Rs.15000/- can join the PM-SYM scheme. This is also a voluntary and contributory pension schemes and monthly contribution ranges from

Rs.55 to Rs.200 depending upon the entry age of the beneficiary. Under this scheme, in the initial year(s) 50% monthly contribution is payable by the beneficiary and equal matching contribution is paid by the Central Government.

In both APY and PM-SYM, the Government of India guarantees the pension amount. APY is administered by PFRDA and operated by LIC, UTI and SBI while PM-SYM is administered by Ministry of Labour. It would seem to be a no-brainer for a gig-worker to enroll in one of these schemes but the enrolments are similarly low as for PMJJBY. The reasons also seem to be similar. A value for money in hand for the gig-worker over any future pension, lack of marketing and selling to help her understand the need because of a lack of marketing/selling budgets and the lack of a compulsory mandate. With inflation, there is perhaps a need to raise the monthly income bar to about Rs 25000 and age bar to 50 years to cover those who have worked the last 30 years without any safety nets. The Government's contribution/guarantee can be limited to an upper limit in order to manage budgets. There may also be widows, old age pension schemes which will not be required if an APY, PM-SYM like scheme is adopted in wholesome measure.

2.Social Security top-ups in Drops / Sachets

Life and Disability Cover Top-Up

Can insurance companies design and administer an additional cover depending on the occupational hazard of the work (eg for riders/ drivers) which can be paid for by the employers on a daily/ weekly basis as a tiny drop and provides a top up on PMJJBY payouts in case of death/ disability. For example, a basic protection cover that may be a premium of Rs 10-20 a day and a graded pay out up to 10 lakhs based on typical days worked, age, occupation etc.

This may be targeted to give the family which has lost a bread winner earning Rs 8000-20000 a month equivalent to two thirds of such monthly income. The costing here will have to take into account marketing and selling costs for such top ups to be bought. This may be seen as 'good for business' by ecommerce/ platform companies and/ or perhaps could be funded out of CSR budgets of corporates up to a limit. As the gig-worker acquires more responsibility she may wish to add her mite to this cover.

Pension/ Annuity

NPS is already designed to take periodic contributions. So all we need is a 'drop' that can be contributed by employers based on number of days of work. The aim would be to provide a top up to the gig-worker based on actual days worked and can be designed for equal or step up contribution by gig-worker and employer. The tech platforms already run the payrolls; unique, portable Aadhar/ e-shram IDs are available so the investments can be portable across regions and employers.

In conclusion, we feel that products would be reasonably simple to design and tech infrastructure exists to keep operational cost low. The real task perhaps is to get employers to acknowledge and embrace their role in building social security for their gig-workers. There is a need initially for marketing/ selling budgets and some operational budgets in terms of

assisting employees in onboarding on e-Shram and enrolling for the Government benefits. Eventually, employers may find it worth their while to contribute to the top-up together with the gig-worker.

(The author would like to acknowledge inputs from the many colleagues who have kindly and thoughtfully provided inputs. The views expressed are her own)



Source: https://assets.telegraphindia.com/telegraph/2020/Aug/1596657636_shutterstock_1782291968.jpg

Annexure: Press Release by the Department of Labour (24th March 2021)

Social Security Schemes for Organised and Unorganised Sector

As per the Periodic Labour Force Survey (PLFS) carried out by the National Sample Survey Organisation of the Ministry of Statistics & Programme Implementation, in the year 2017-18, the total employment in both organized and unorganised sector in the country was around 47 crores. Out of this, around 9 crores are engaged in the organized sector and the balance of 38 crores are in the unorganized sector.

The categories of the workers have been divided into three categories i.e.

Establishments with 10 or more workers;

Establishments with 20 or more workers;

Workers engaged in unorganised sector

The ESI Act, 1948 is Social Security legislation applicable to all factories & notified establishments employing ten or more persons, which are located in ESI notified areas and as such it does not apply to the unorganised sector. Employees earning wages up to Rs 21,000 per month

(Rs 25,000/- in the case of persons with disability) are coverable under ESI Scheme and are entitled to all benefits available under ESI Act, 1948. At present the ESI Scheme stands extended to 575 districts in 35 States/ Union territories.

The total number of Insured Persons covered under ESI Scheme as on 31.03.2020 are 3.41 crore and the total beneficiaries are 13.24 crore. ESI contributions @ 4% are paid by employers, of which the employees or workers contribute to the extent of 0.75% of their wages and the employers contribute to the extent of 3.25% of their wages. Such contributions entitle them to all benefits available under the ESI Act.

The benefits of social security to the workers employed in organised sector establishments with 20 or more workers under the Employees' Provident Fund and Miscellaneous Provisions Act, 1952 are extended through following three schemes:

The Employees' Provident Funds Scheme, 1952;

The Employees' Pension Scheme, 1995;

The Employees' Deposit Linked Insurance Scheme, 1976.

The Employer and Employee both contribute @ 12% of wages towards provident fund. Out of this, 8.33% is diverted towards pension Fund. Employer also contributes to EDLI Scheme @ 0.5 % of wages. During the year 2019-20, 4.89 crores members contributed under the Scheme.

For the workers engaged in the Unorganised sector, social security benefits are being addressed through the Unorganised Workers' Social Security Act, 2008. The Act empowers the Central Government to provide Social Security benefits to unorganised sector workers by formulating suitable welfare schemes on matters relating to (i) life and disability cover, (ii) health and maternity benefits, (iii) old age protection and (iv) any other benefit as may be determined by the Central Government. The State Governments are also empowered to formulate suitable welfare schemes on the matters regarding housing, provident funds, educational schemes, skill upgradation, old age homes etc.

Life and disability cover is provided through Pradhan Mantri Jeevan Jyoti Yojana (PMJJBY) and Pradhan Mantri Surksha Bima Yojana (PMSBY). Benefits under the schemes are for Rs.2 lakh on death due to any cause & permanent disability, Rs.1.0 Lakh on partial disability and Rs.4 lakh on death due to accident to the unorganised workers at the annual premium of Rs.342/- (Rs.330/- for PMJJBY + Rs.12/- for PMSBY) depending upon their eligibility.

The eligible Unorganised Workers can avail the scheme from their respective banks at annual premium of Rs. 342/-. As on 30.12.2020, 9.70 and 21.87 crore people have been enrolled under PMJJBY and PMSBY respectively.

The health and maternity benefits are addressed through Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) which is a universal health scheme administered by the National Health Authority. The number of eligible beneficiaries under Social Economic Caste

Census (SECC) of 2011 on the basis of select deprivation and occupational criteria across rural and urban areas is 10.74 Crore families (50 crore people). The Scheme gives flexibility to States/UTs to run their own health protection scheme in alliance with AB-PMJAY. The States/UTs implementing AB-PMJAY have further expanded the coverage of the scheme to include 13.13 crore families (65 crore people).

For old age protection to unorganised sector workers including traders, shopkeepers and self-employed persons, the Government has launched two flagship schemes namely Pradhan Mantri Shram Yogi Maan-DhanYojana (PM-SYM) and National Pension Scheme for Traders, Shopkeeper and Self-Employed Persons (NPS- Traders). Under the schemes, beneficiaries are entitled to receive minimum monthly assured pension of Rs.3000/- after attaining the age of 60 years. The workers in the age group of 18-40 years whose monthly income is below Rs.15000/- can join the PM-SYM scheme and Traders, shop keepers and self-employed persons whose annual turnover is not exceeding Rs.1.5 crore can join NPS – Traders scheme.

These are voluntary and contributory pension schemes and monthly contribution ranges from Rs.55 to Rs.200 depending upon the entry age of the beneficiary. Under both the schemes, 50% monthly contribution is payable by the beneficiary and equal matching contribution is paid by the Central Government. Both the schemes are being implemented in all the States/UTs of India. The details of numbers of beneficiaries as on 28.02.2021 under PMSYM and NPS Traders, 44.90 Lakh and 43,700 respectively.

This information was given by Minister of State (I/C) for Labour & Employment Shri Santosh Kumar Gangwar in a written reply in the Rajya Sabha

102 foot marches for justice and peace in 10 days

Ramesh Sharma

March for Justice & Peace at a glance	
Number of foot marches	106
Number of states covered	12
Number of districts covered	102
Number of villages covered	3680
Number of people who walked	5000/ day x 12 days
Total distance covered	~11000 Kms
Public meetings conducted	1700
People who signed up to set up Ministry for Justice & Peace	~500,000

Ekta Parishad strongly believes that without justice, peace always remains a dream for the marginalised communities in the world. In the Indian context, where millions of people are directly or indirectly affected by structural violence, (inequality, discrimination, poverty, marginalisation etc.) any efforts to ensure justice in their lives must protect their dignity and identity, too.

We can see the massive on-ground impact of the 102 foot marches (for Justice & Peace) that Ekta Parishad has organized between International Day of Peace (21st September) to

International Day of Nonviolence (2nd October). The energy and enthusiasm of the people who walked in the 100 districts across 14 states of India reflected a deep faith in the peace-building process. Each of these 100 foot marches have hundreds of stories of people's fight for justice and peace, which carry the values of nonviolence as a core of their struggle.



In a concluding event held on 2nd October in Tilda, Chhattisgarh, the Hon'ble Governor Madam Ms. Anusuiya Uike expressed her deep gratitude towards the highly disciplined non-violent actions organised by Ekta Parishad over the last few decades. Being a tribal leader herself, she has shown her full support towards the march for justice & peace and wishes that the state take serious action towards establishing a dedicated 'Ministry for Justice & Peace' and be able to transform the lives of millions of people and rebuilding our society and nation free from hunger, poverty and violence.

Stories from the marches: State representatives and coordinators report from ground zero

Mangirani from Bishnupur, Manipur

“Karang Island is an island in the middle of the Loktak lake in the Bishnupur district of Manipur. The island covers a geographical area of 2.5 square kilometres and has a population of 3,400 people.

For most of the population living on the island, fishing is the main source



of livelihood. Over the last few years, people in Karang have been facing multiple problems regarding the settlement of their land rights on this native island. Ekta Parishad has been working towards ensuring that the fisherfolk get their due land rights.

Our successful foot march and boat march in the adjoining floating villages has helped people come together to speak up for their rights.”

Durga Panwar from Jhabua, Madhya Pradesh



“The Kalibeli area of Jhabua district in Madhya Pradesh is known as the home to the Bhil & Bhilala tribal communities. Jhabua district is also known for the historical revolt during the 18th century led by various tribal leaders, where they demanded their ‘self-ruled territory’.

Coincidentally, it’s Dilip Singh Bhuriya, former Minister of Tribal Affairs, Government of India and represents the Jhabua constituency, who is appointed as Chair for drafting the legislation for recognizing tribal autonomy over their land & resources and re-establishing their local governance systems.

However, even after more than two decades of this legislation being passed by the parliament, the tribal community is still waiting for their age-old demand for autonomy to be fulfilled.

During our foot march, too, the tribal communities reiterated this demand for the execution of tribal self-rule.”

Umesh Kumar, State Coordinator of Bihar



“Bihar has a legacy of one of the most historical and successful foot marches organized by Vinoba Bhave during the 1950s-60s called ‘Bhudan Andolan’. Even today, Bihar remains a lighthouse of people’s non-violent struggle for their rights.

Despite all these struggles, the situation of the Mushar community has remained unchanged and they are still one of the most vulnerable communities in south & north Bihar.

Walking through the villages of Bihar has always been an eye-opening experience. This foot march for justice and peace once again ignited our collective effort and enthusiasm to fight for the land & livelihood rights of the Mushar community.”

Runjhun from Tinsukiya, Assam

“Walking in the flood plains of the Tinsukia district has always been challenging. However, despite logistical challenges, our team members and community leaders saw this foot march as an opportunity to highlight the problems they’re facing.

For me, each step of the march gave me the energy and confidence to lead even more grassroots actions in the future. Nearly 70-80 women walked with me every day and enthusiastically participated in village-level meetings.



One thought which prominently emerges in our foot march is “Why should we wait for the welfare state?” when people can achieve things with their own efforts without depending on the delayed responses from the state. As a result, soon after the foot march, we organised a Shramdan Camp and built a bamboo bridge with the active support of hundreds of people who wanted easy transportation access between their villages in the flood plains.”

Chunnulal Soren, Member of National Committee of Ekta Parishad, Jharkhand

“Being a young tribal leader, I have always been motivated to do something meaningful for my community in Jharkhand. The first time I walked with 25,000 foot marchers in Janadesh in 2007, it completely transformed me and my thinking forever. I was amazed at how thousands of people were ready to stand against injustices and use all means of nonviolence to get their rights.



The success of Janadesh (2007), Jan Satyagraha (2012) and Janandolan (2018) taught me about basic discipline and dedication for nonviolent actions. Today, after leading such a march in my own Hazaribagh district, I feel motivated and confident to lead future campaigns. I wish to organise a statewide action for protecting the rights of the tribal community, especially in the mining-affected districts where they have been constantly facing displacement.”

Manglu Ram from Dhamtari, Chhattisgarh



“Nearly a 100 years ago in 1920, Mahatma Gandhi visited Chhattisgarh for the first time to support the people’s struggle called ‘Jungal Satyagraha’ against colonial Forest Legislation and restrictions in the Sihava area of Dhamtari district. After the successful nonviolent action in Sihava, the native tribal community succeeded in getting their due land & livelihood rights.

It’s a tragedy how today in the same region, tribals are fighting against a similar mindset of local officials, who denied ensuring the rights they secured after the Forest Rights Act (2006). We participated in this foot march for justice and peace, because it is an opportunity to re-cultivate the ground for bigger action. The gross denial of people’s claim over their native land is fuelling the struggle for their rights over land & forest resources. After our week-long encouraging foot march, we feel that now the ground is fully prepared for a much larger decisive action soon.”



RAJIV GANDHI
INSTITUTE FOR CONTEMPORARY STUDIES

Rajiv Gandhi Institute for Contemporary Studies

Jawahar Bhawan,
Dr Rajendra Prasad Road,
New Delhi 110 001
India

Please visit us at:

web: www.rgics.org



<https://www.facebook.com/rgics/>



<https://www.youtube.com/user/RGICSIndia>