



**THE ROLE OF SOCIAL SECURITY IN PROTECTION OF THE HEALTH OF
UNORGANIZED SECTORS IN INDIA: ISSUES, CHALLENGES, AND REFORMS**

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ABSTRACT

Social security means a person's overall safety within the home, at work, and in society. Social security is a mechanism that meets basic needs as well as life contingencies to ensure an acceptable standard of living. Since independence, social security has always been a key focus area of several plans and policies of the government of India. With a steady rise in the population and a rapidly evolving socioeconomic situation, healthcare problems are also included in the social security schemes over the years. However, only 6% of the working population has access to social security benefits, while 94% have little or zero access to social security benefits. It is also noted that social security problems for workers in the unorganized or informal sector are more chronic than those in the formal sectors. This paper aims to raise several key issues regarding social security in a fundamentally changing Indian context. This paper critically reviews and analyses existing social security regulations in India and evaluates how they compare with systems in developed countries. The paper makes an empirical study of India's social security schemes in general and healthcare schemes for the unorganized sector in particular. The study exposes significant issues in the country's social security laws and programs, insofar as they extend to unorganized workers. The paper concludes with recommendations on possible methods to address the shortcomings.

KEYWORDS: Social Security; Healthcare; Informal Sector; Unorganized employees; India.

INTRODUCTION

Social security is a fundamental right of the citizen, guaranteed by law to all human beings who live on their labor, and who are unable to work for their control temporarily or permanently. During the French Revolution, the first signs of social security were when a Declaration of the Rights of Man was declared. It served as a preamble to the 1793 French Constitution, which stated inter-alia; it is a sacred duty for public assistance. According to Article 22 of the Universal Declaration of Human Rights^[1], every member of society has a right to social security. A big step in this direction is the International Labor Office (ILO) statement on fundamental values and freedoms at work. The development has to bring about an improvement in people's living conditions. Therefore it should ensure that basic human needs are met at all. The Constitution of India guarantees all its people, including the right to life, freedom, housing, food, education, water, job, and livelihood. Decent, dignified, and safe work is a prerequisite for genuine social security that can only be achieved if workers' rights are recognized and employment regulated.

Social security issues of unorganized sectors are of paramount importance, and such labor is far more

vulnerable to exploitation than in any organized sector. The word 'unorganized labor' was described as workers who were unable to pursue their common interests because of certain constraints. These limitations included the casual nature of work, ignorance, illiteracy, small, and scattered size of establishments, etc.^[2] Unorganized employees make up about 93% of the total workforce, and their population in India has risen steadily over the years. It is argued that while India had a long history of informal social security and social protection schemes targeted primarily at the more marginalized sections of society, the same decline was steady and unavoidable with time. The social security measures initiated by the Central and State governments in India in the country during the past point to the fact that the social security needs are far more than what the agencies above might finance. This underlines the need to raise efforts several times, and also in a way, targets the most deserving sections of those employees. It is generally known that India's unorganized workers' primary security needs are food security, nutritional security, health protection, housing security, job security, income security, life and injury security, and security of old age.

In this context, this paper aims to assess the social security problems critically in India. Section 1 provides an overview of India's existing social security system, covering work accident insurance, healthcare, disability and death insurance, and unemployment that apply to the unorganized sectors. Section 2 explains in detail healthcare schemes for unorganized sectors and India's healthcare financing system. Section 3 describes how the Indian social security framework is lagging behind its developed counterpart. That is to say, emerging economies followed by a summary of issues and challenges found during critical analysis and comparative study of social security in India in Section 4. The final section concludes with specific reform concepts designed to turn the existing system into a framework more suited for addressing the social security challenges in India.

1. The Social Security System in India: An Overview

In philosophical words, the notion of social security is very complicated and accessible. The term "social security" has no widely accepted meaning because it has evolved over the years, and is different from country to country, and can be interpreted in many ways. Social protection as a concept is fluid, not static, and will continue to evolve over time.^[3] Simply put, social security means giving people protection from socioeconomic threats. Social security is used as a standard way of preventing vulnerability and disadvantage.^[4] Social security in developing countries

should be viewed from a broader perspective and "essentially as a goal to be achieved by public means, rather than as a narrowly defined collection of concrete strategies."^[5] One of the core goals of social security programs is the war against low income or poverty.^[6]

In Third World Countries, the emergence of social security schemes can be traced back to centuries during the colonial period. The British ruler started social security schemes for the colonial populations. Traditionally in India, a traditional family structure used to be an essential tool for providing social security to family members. However, rapid globalization and urbanization have led to the emergence of a nuclear family. Since the 20th century, it has been felt that social security structures need to be institutionalized and controlled. The first social security scheme introduced in India was the "Employers Liability Scheme" in 1929. After that, "Employees State Insurance Scheme 1948" was introduced by the government to include social security benefits such as maternity benefits, sickness benefits, employment benefits, and disability benefits.^[7] In India, a wide range of social security^[8] measures are available to different sections of the population, but, unlike the developed countries and elsewhere, they are poorly structured and institutionalized, despite clear constitutional mandates. Many elements of the social security system are a minimal reflection of India's current economic needs and priorities and explained in detail in the following sections.

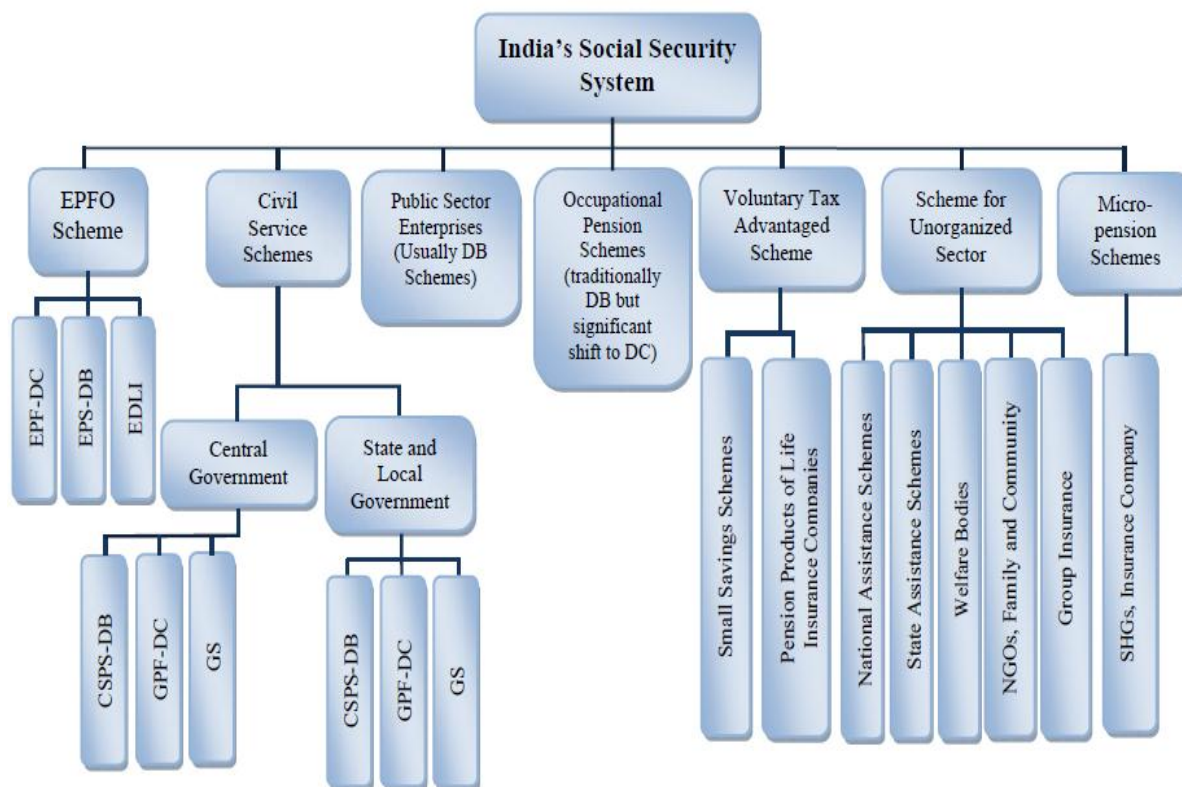


Figure 1: India's Social Security System (Source: Asher and Bali, 2010)

1.1 Social Security – The global scenario

In 1952, the ILO adopted Convention No-102, "Social Security (Minimum Standard)," which specified nine essential components of social security as medical insurance, sickness benefits, unemployment benefits, old-age benefits, family benefits, maternity benefits, disability benefits, and survivor benefits. In addition to nine components of social security, the ILO has added to the concept of social security "general defense against poverty and social exclusion." Social security has a positive effect on social well-being, development, prosperity, reduction of infant mortality and maternal mortality, and a decent minimum standard of living for individuals. Higher public spending on social services has a positive impact on poverty alleviation and better health and education outcomes.^[9]

As the unorganized workers earn social security benefits, this will tend to increase development and reduce poverty and social inequality. Since these workers make a significant contribution to a country's growth, and if they are continuously outside the realm of social protection, then they cannot make full use of their potential. It is crucial here to understand the role of social security. Only when workers are protected by economic and social security that workers can work with great zeal and make full use of their potential. This will contribute to economic growth and contribute to the improvement of society as a whole. Adequate social security policies would lead to improved human development, which in turn would lead to more significant social-economic growth.^[10] Investing in social security will be a "win-win" policy in which it serves as a short-term macroeconomic stabilizer and increases human resources and long-term growth. Comprehensive regulations on social security serve as "automatic stabilizers" in socioeconomic growth.^[11] The 2010 Millennium Development Goals acknowledged that social security could probably eliminate poverty and that "absolute social floor" would exist for everyone.

Even though they are related, there is a need to make a distinction between "economic security" and "social security." Economic security means human security in terms of jobs, wages, and properties, while social security includes basic needs for workers, such as food, support for the elderly, health care, childcare, housing, and child care, etc. Economic security is a means of achieving social security, and social security is a means of improving financial security.^[12] There is a reciprocal relationship between social security and economic growth examples are India's experience of such a relationship.

1.2 Socio-Economics Conditions of Unorganized sector in India.

One of the central features of the labor market scenario in India was the predominance of informal employment. While the sector contributes about half of the country's GDP^[13], more than 90% of the total workforce has been

engaged in the informal sector since the early 1980s and even before. As per National Commission for Enterprises in the Unorganized Sector (NCEUS)' estimate, unorganized or informal sector jobs make up about 86% of the Indian economy's workforce in 2004-2005 and 92% of informal employment in both the organized and unorganized sector. This national trend of informal workers recruiting about 90% of the workforce is more or less similar for most of the country's prominent states. A substantial proportion (around 65 percent) of unorganized sector workers are engaged in the agricultural sector, which in turn indicates the importance of rural segment in the informal economy.

The growth of formal employment in the country has always been lower than that of total employment, indicating more rapid growth in the informal sector. Temporary data show that the proportion of informal/unorganized employees is also on the rise within the formal sector. For example, by comparing the NSSO Employment Data for the 55th and 61st Rounds (for 1999-2000 and 2004-2005 respectively), the country is currently in a state of "informalization of the formal sector.", where the overall increase in jobs in the organized sector has been informal in nature during this time. The enhanced importance of the informal sector is correctly recognized in the government of India's recent policy papers addressing ways and means of generating jobs to support the rising mass of unemployed people. For example, a select group established by the country's apex planning agency to target 10 million job opportunities per year over the 10th Plan Cycle (2002 – 2007) explains "exclusively for generating the country's desirable high level of jobs. One has to target the unorganized market, including small and medium-sized enterprises."

It has been widely known that, compared to the formal sector, the informal sector in India suffers from low productivity syndrome. The sector's main characteristics are lower real incomes and adverse working/living conditions. In addition, the sector is characterized by excessive seasonality of employment (especially in the agricultural sector), the predominance of casual and contractual employment, atypical production organizations and labor relations, lack of social security measures and welfare legislation, the negation of social standards and workers' rights, denial of minimum wages, etc. Weak human resource base (in terms of schooling, skills, and training) and lower workforce mobilization status add to the weakness and weaken the negotiating power of informal sector employees.^[14] The sector has thus become a dynamic and low-cost labor-absorbing tool that cannot be absorbed elsewhere. In contrast, any effort to control and put it into a more efficient legal and institutional context is viewed as impairing the sector's labor-absorbing ability.

In recent times, the informal sector's unprecedented growth has adversely affected jobs and income security

for the vast majority of the population, along with a substantial reduction in the size of social welfare/security programs. Thus, a significant challenge raised by the explosive informal economy is the need to ensure adequate social security networks and welfare initiatives to provide the growing segment of unorganized sector workers with social security. Accordingly, the government in India (both at the center and state level) has been striving over the past decades to design and implement more effective measures to strengthen and expand social security in unorganized workers in the sector. In this context, the following section of the paper would attempt a brief but critical analysis of social security schemes propelled by the government until recently.

1.3 Social Security schemes for unorganized sectors

In India, a decent minimum level of social security helps the organized market, which accounts for about 7 percent of the total workforce. Social security arrangements for organized workers are predominantly preventive and are established by a legislative framework and institutional structures developed under laws such as the Employees State Insurance Act of 1948 and the Employees Provident Fund and Miscellaneous Provisions Act of 1952. The social security provisions for the poor in general and informal workers, in particular, were minimal, in comparison to this. For example, preliminary estimates indicate that some social security programs protect only less than 3 percent of informal sector employees. Nonetheless, the government and other social institutions have been implementing various social security projects to address the basic needs and contingencies of the vulnerable and informal sector workers for a long time, starting with the Community Development Plan (CDP) in the 1950s.

So far, at the national level, there are no unique and detailed schemes or legislation that deal exclusively with unorganized sector issues. The significant efforts to formulate national legislation have stagnated for a long time since two draft laws were drafted in 1980 and 1997, subsequently reviewed and recommended by the National Commission on Rural Labor (1987-91) and by some of the Parliamentary Committees and consultative forums specially constituted. Nonetheless, jobs in the unorganized sector benefit from a range of more or less uniform labor laws and social security measures. The Minimum Wages Act, 1948, for example, orders all central and state governments to annually notify the minimum wage rates for different categories of informal labor. It is widely recognized that the acts mentioned above have failed to sufficiently resolve the social security issues of informal workers or provide them with any clear welfare measures. Despite all of these acts being enforced, the informal sector employees are often inadequately covered in terms of job security, improved working conditions, and efficient systems/machinery for identifying qualified beneficiaries, dispute resolution, and so on.

The government and other social institutions have launched various social security programs over the past five decades, starting with the Community Development Program (CDP) in the 1950s to meet the basic needs of the poor and informal sector workers for subsistence and contingency. These initiatives can be divided into three groups, for example: (i) Social Assistance Programs; (ii) Social Insurance Schemes; and (iii) Welfare Funds. A brief analysis of these programs is subsequently attempted to gain insights that strengthen social security in the healthcare sector.

1.3.1 Social Assistance Programs

Social Assistance programs include a range of initiatives such as programs for food distribution, income support services, and cash transfer programs. The food-based social safety net is intended to guarantee livelihoods and sufficient consumption, alleviate poverty, and boost the nutritional status of the poor and disadvantaged parts of the population. Three types of initiatives may be listed in the category, such as self-targeted bodily employment programs (Sampoorna Gram Swarozgar Yojana; Food for Job Programs; and Employment Guarantee Schemes); welfare services for particularly vulnerable groups (age and elderly, pregnant and lactating mothers, etc.); and primary education and nutrition programs. The Mid Day Meal Scheme (MDMS) and the Integrated Child Care Development Scheme (ICDS) are the other two main food security programs. One of the excellent alternatives to food security provision is the Community Grain Bank Scheme, which was launched in 13 select states in the late 1990s. Data available indicate that food bank schemes have been beneficial at the local level in improving food security for vulnerable groups in remote and difficult areas.^[15]

Fundamentally, income transfer programs in India include labor-based public works and development programs (or workfare programs) to encourage rural and urban living. The first such scheme in the form of the Rural Works Program was introduced in the early 1960s primarily because of the realization that development alone could not take care of poverty. After this, several wage employment programs such as Food for Work Program (FFW-1977), Jawahar Rozgar Yojana (JRY), Sampoorna Gram Swarozgar Yojana ((SGRY), Jawahar Gram Samridhi Yojana (JGSY), Employment Assurance Scheme (EAS), Pradhan Mantri Gram Sadak Yojana (JGSY), Food for Work Program for the Calamity Hit States (FFW-2002) and so on were initiated from time to time. The evidence available indicates that overall workfare programs are successful in reducing rural folk poverty rates by providing rural poor with certain minimum levels of jobs in unskilled manual work during slack seasons or natural calamity situations such as drought or famine. Among the social security cash transfer programs which are equally applicable to workers in the National Social Assistance Program for Agricultural Workers (NSAP) are prominent.

1.3.2 Social Insurance Schemes

Another major category of social protection for unorganized sector labor in India is social insurance schemes, which are intended to improve poor people's and household's ability to avoid sudden shocks or losses caused by social and other contingencies. The two major generic schemes under this are the Janshree Bima Yojana (JBY), 2000, and the Universal Health Insurance Schemes (UHIS), 2004. Whereas the former offers compensation for life insurance for people between the ages of 18-60, living below or marginally above the rural poverty line, the latter provides health services for vulnerable people and families. In the case of health and maternity benefits, the idea was to negotiate with an insurance agent on the type and scope of benefits that would be available. Still, the presumption was that minimum benefits would be Rs.15, 000 for hospitalization, Rs.1, 000 for maternity benefit per delivery, Rs.25, 000 as compensation for personal injuries in the event of death, and sickness compensation for registration.

The Pradhan Mantri Jeevan Jyoti Bima Yojana is another universal scheme introduced by the central government on June 1, 2015, which is relevant for unorganized sector workers for death or disability due to accident. In 2010-11, under the Indira Gandhi Matritva Sahayog Yojana (IGMSY), the government launched a pilot-based maternity benefit scheme in 53 districts. Pregnant and lactating mothers receive an Rs. Four thousand grants (increased as of July 2013 to Rs. 6000) as a cash reward for better health and nutrition.

1.3.3 Welfare Funds

Welfare funds represent a slightly different mode and innovative way of providing the workers with social security in specific employment categories. The various welfare funds, which currently cover different informal occupations in India, provide employees with various forms of welfare facilities such as health care, accommodation, child education, drinking water, etc. At the central government level, however, there are currently no separate welfare funds that provide all employees in the informal sector with certain social security levels. The impressive performance of welfare funds in the Southern States has been widely discussed in the literature over the last few decades.^[16] Given the fact that many of the older welfare funds operating at the state level are currently facing significant bottlenecks and administrative challenges, despite their impressive track record, it is desirable to investigate the model's replicability at the national level, while implementing more effective social security measures for informal labor.

From the above discussion, it can be concluded that, given their impressive share of the country's workforce, unorganized labor generally lacks comprehensive and efficient legislation and welfare schemes that guarantee a certain minimum standard of social security. The

following section discusses some of the government's recent initiatives (both promotional and protective) to improve the social security standards of unorganized labor in the country in the healthcare sector. It is reported that about 85 million people were covered by health insurance or around 20 percent of India's labor force.

2. Social Insurance Schemes: An overview of Healthcare Insurance Schemes

The government also assists health assistance funds developed by the Ministry of Health and Family Welfare at the national level. In a few countries, State illness Assistance Funds exist in most of the states of the country. Poor patients living below the poverty line receiving care in government-approved hospitals earn grants under National Disease Assistance Funds. In India, health care is primarily funded out of pocket spending by private individuals. More than 70 percent of health spending was financed out of pocket in 2007, though just two-thirds of overall health spending was covered by private and social health insurance.^[17] Even this limited coverage does not adequately reflect the limitations of health care schemes in India. This is because the number of illnesses covered is small, and for many people, the standard of healthcare is relatively weak.

Without a proper health care program, the country cannot continue on the road of growth and prosperity for much longer. The health care system is mostly beyond the control of unorganized employees and marginalized citizens. Some starting point in this field was Rashtriya Swasthya Bima Yojana that provides cashless healthcare for workers and the vulnerable, and Ayushman Bharat recently subsumed it.

2.1 Voluntary Health Insurance Schemes

Private insurance plans pool people's liabilities against a premium that provides a benefit to third parties and organizations offering health care services. Premiums are set according to the customer's perceived risk profile and not related to the customer's income or social standing.

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

The insurance policies offered by GIC are Mediclaim Policy, Personal Accident for individuals and family, Group Accident Insurance, Jan Arogya Bima Policy, Bhavishya Arogya Policy (Insurance for senior citizens),

and Traffic Accident. Mediclaim is the leading product of the GIC. This system allows for medical costs to be reimbursed for hospitalization, home hospitalization, and medical check-up. Another scheme, i.e., the Jan Arogya Bima Policy, targets specifically people who cannot afford high costs of medical treatment. The limit coverage is fixed at Rs.5000 per annum for hospitalization or domiciliary hospitalization expenses incurred on medical or surgical treatment. All public and private insurance companies have not been beneficial in providing health insurance. The healthcare insurance is challenging to achieve in a large and highly heterogeneous country because it covers all citizens in a specific area, regardless of their income, sex, or age; an alternate option is to use community-based organizations, to target different groups.

2.2 Community-based Social Security Schemes

Various socio-religious groups and sects have addressed the social and developmental demands of society with essential follow-ups. In modern India, traditional, and contemporary forms of philanthropy coexist. Traditional philanthropy includes the idea of homeless housing, post-disaster recovery and rehabilitation, emergency relief, temples building, schools, and running soup kitchens. Community-based insurance covers any non-profit insurance scheme specifically targeted at the informal sector and is built based on an ethic of mutual assistance and the collective pooling of health risks, and the participants are involved in its management.^[18] It offers financial risk insurance to people with low incomes who usually have irregular income flows within the rural and informal sectors, and people's participation in community-based is voluntary. Nevertheless, in line with the changing times, organizations such as the Chinmaya Mission, the Swaminarayan Movement, RIDA Foundation, and Satya Sai Trust have extended their service spheres to areas such as healthcare, disabled support, rural water supply, income generation, and women empowerment. More than 7,000 non-profit organizations are required to provide healthcare services, ranging from the introduction of government policies to primary health care or specialized treatment for diseases such as leprosy and cancer.

The majority of social security schemes were initiated in the voluntary sector date from the 1990s. With the implementation of economic structural reforms in the 1990s, there is an increasing awareness of the need to expand social security to all disadvantaged groups through various approaches, including the promotion of micro-insurance schemes. A survey conducted by ILO^[19] of 54 non-profit organizations (NPOs) found that 70 percent of the 43 programs for which data were available were initiated in the early 1990s and 30% between 2000 and 2003. This suggests that the voluntary sector has only taken up the task of defending social welfare in a significant way. Several public institutions and

organizations often offer the chosen group of staff different forms of social security benefits. Among these Self Employed Women's Association (SEWA) has made significant contributions in promoting social security through the formation of women's cooperatives.

A significant number of non-governmental organizations and community-based organizations, primarily in the country's unorganized market, are active in providing a measure of protective social security for workers and their families. This provision is included in the broader package of programs that offer promotional social security, such as access to health insurance, accommodation for microfinance, and welfare services as regards compensation for health-related risks, the primary type of social insurance offered by such organizations. Of the 43 schemes reported, 34 schemes were provided for health insurance services, followed by life insurance (28), and disability (13). Health insurance schemes provided assistance for meeting illness-related expenses, including consultation, outpatient treatment hospitalization, and wage loss compensation.

3. Evaluation of existing social security schemes in India

To evaluate India's current social security structure, first, the compliance with the requirements recommended in the ILO Convention on Social Security (Minimum Standards), 1952, and subsequent conventions is reviewed. Whether or not India has ratified them is not considered because the goal is not to examine whether India fulfills its Treaty obligations or not. The aim is to see where India is complying with minimum social security standards approved by the community of nations. As these conventions address only minimum requirements, as expressly specified in the ILO Convention's title, the key features of our schemes are contrasted with those of systems in selected developed countries for a more comprehensive evaluation. The comparison has been restricted to a subset of Asian developed countries and limited to healthcare schemes. This section also examines the social security schemes in India in terms of the healthcare expenditure as a percentage of GDP compared with the selected developed countries.

3.1 Health Care Expenditure as a percentage of GDP

Healthcare spending is an essential part of the social security scheme as a percentage of GDP India performs far below than developed countries. For 5% of healthcare spending as a proportion of GDP, the share of government accounts for India is less than 1 percent. On the contrary, the developed countries have a much more robust and equal share of government expenditure on health care that represents the strong healthcare policies in those countries.

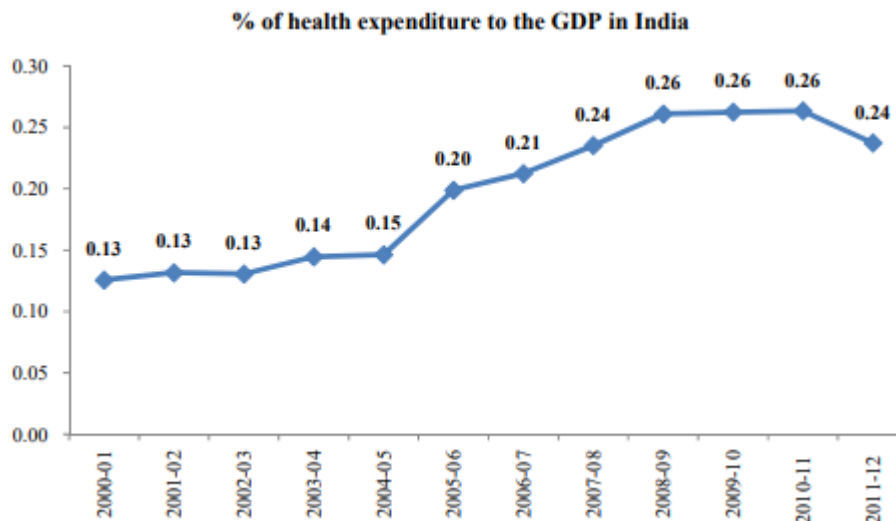


Figure 2: Percentage of Health Expenditure to the GDP of India (Source: OECD, 2012)

Figure 2 reveals the increasing trend of the percentage share of public health expenditure on the country's GDP. The percentage share of public health spending accounted for about 0.13 percent of the country's GDP during 2000-01. Later, the percentage share rose

marginally and shared 0.26 percent of the country's GDP in 2008-09, staying in the same position until 2010-11. The percentage share is forecast to be around 0.24 percent during the year 2011-12.

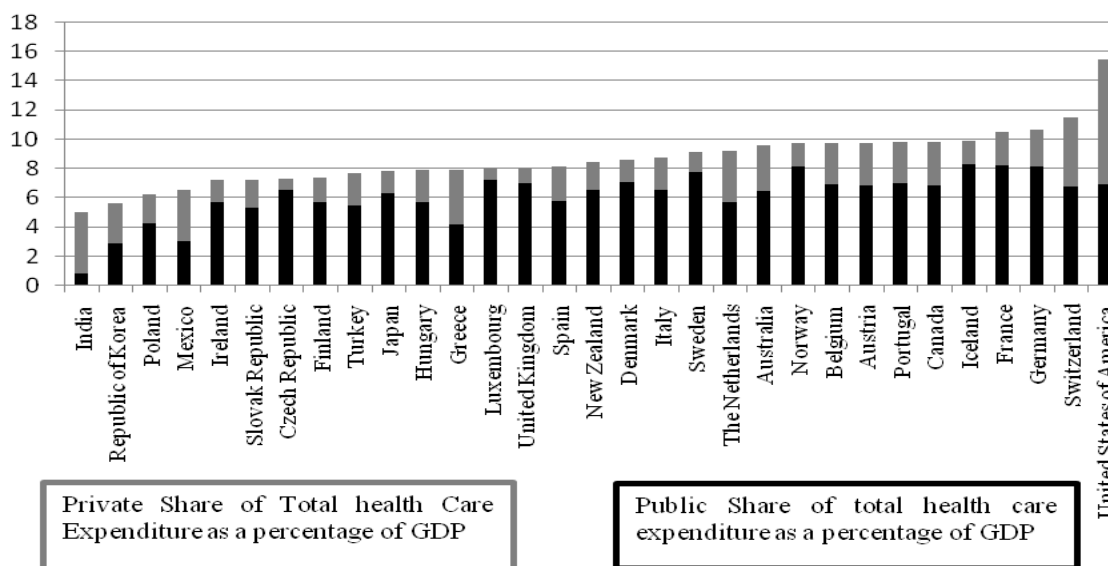


Figure 3: Healthcare expenditure as % of GDP (Source: AARP International, 2014)

Large welfare states, including Europe's social democracies, spend more than 25 percent of their GDP on social security, one-third of which is spent on health care. The global average is 8.39% of GDP (2.67% for healthcare) and ranges from 4.05% (0.95% for healthcare) in India to 12-13% in South Africa, Brazil and Russia (3-4% for healthcare) and 29.40% (6.8% for healthcare) in Sweden^[20] as illustrated in Figure 3. Thus, one may argue that the Indian government is not as responsible as the developed countries' governments in providing health facilities to retired people and older people.

3.2 ILO Conventions and healthcare benefits available in India

ILO Convention 102 required the provision of medical insurance to a proportion of workers, the economically active population, residents, or workers in industrial workplaces, as mentioned above, for the benefits of old age. ILO Convention 130 increased the coverage level to include the coverage of all workers or 75% of the economically active population or 75% of all citizens. Convention 130 also added dental care and medical rehabilitation to those mentioned in Convention 102. Countries are also required to provide preventive care and general practitioner treatment, including home visits,

specialist care, critical prescription supplies, hospitalization, dental care, and medical rehabilitation.

Medical care provided by the ESIC in India meets the requirement concerning the scope of medical care, except for the general practitioner's home visit. But even for non-seasonal factories and categories of services to which it was extended, the ESIC does not have a complete cover. This does not protect businesses with less than ten workers and does not include coverage in geographical areas not protected by the extension. The medical care given by the RSBY is well below the requirement, as the only hospitalization costs up to Rs 30,000 are covered, and outpatient treatment is not received. Also, the RSBY services are only eligible for informal categories. India also has a universal health care program that includes primary health centers in rural areas and hospitals in urban centers, required to offer practically free services. But these centers and hospitals are overcrowded, frequently short of medical equipment, and in a position without the full complement of physicians and other medical staff, and it cannot be assumed that they have guaranteed care to the population. There, India also falls short of ILO standards.

3.3 ILO Healthcare benefit in comparator countries

In Japan, National health insurance covers all residents up to the age of 75 who are not covered by employees' health insurance. The health insurance system for workers is operated by an employer health insurance provider or by alliances of companies employing five or more people in industry and commerce. Self-employed persons are excluded, but the voluntary cover is provided for firms with fewer than five employees and agricultural, forestry, or fishery workers. For national health insurance, the average annual contribution was 84,265 yen for each covered individual and 143,362 yen for each household in 2012, and the employer had no participation. The self-employed contribute similarly to the national insurance scheme. Public health benefits and health care for employers cover all forms of medical expenses, including surgery and hospitalization. Still, the patient will pay some of the costs, ranging from 10 to 30%, depending on the income and age group.

In China, Health insurance has two elements-government insurance and an individual plan for health savings. All workers in urban areas, whether in public agencies, businesses, social organizations, or non-profit organizations, are protected. No donation is to be made by the insured to the social insurance pooling scheme, but usually, 2 percent of gross earnings are to be paid to the individual account. The employer spends about 6 percent of total payroll, 70 percent of which is for the pooling fund, and 30% for the insured's actual account. The government pays administrative expenses. Registered employees receive medical care on a fee for service basis at approved institutions. The individual account charges up to 10% of the local average annual income for the insurance benefits. The pooling fund costs

more than 10%, but up to 600% of the local average annual wage. Separate medical insurance is provided for rural and non-salaried urban jobs.

In South Korea, The medical and long-term care services include all Korean residents and workers. A Medical Assistance plan serves low-income residents. The covered persons pay 3% of the total monthly earnings for medical insurance and 0.19% for long-term care. Employers also pay 3% of the monthly wage for medical insurance, and 0.19% for long-term care. Health diagnosis, surgery, hospitalization, and medications are included in the benefits. Such services are delivered under the supervision of the National Health Insurance Service (NIS) by physicians, clinics, and pharmacists. The insured person pays 20 percent for hospitalization and 30 percent for outpatient care 60 percent. Long-term benefits include home care and community care programs in approved nursing homes.

In Malaysia, there is no independent workplace healthcare benefit plan, and the assumption is that the company must pay for it. However, workers are entitled to withdraw money from Account 2 to pay for serious illness if the employer fails to cover the expenses. Fifty-five diseases were classified as necessary by the EPF Committee. It should be noted here that the Ministry of Health offers some cost-sharing by the recipients of public health care services.

Within the community of developed and developing Asian countries discussed above, no common trend emerges in the medical insurance benefits systems. The China and Japan systems, however, have some features that India might benefit from. Each of these countries has broad coverage: in China, the services cover each salaried and non-salaried urban and rural workers; in Japan, workers in both the formal and informal sectors fall under their remit. Also, in China, it is the central and local governments that make a reciprocal contribution instead of the employers, for rural and non-salaried jobs. In Japan, the government and employers make fair contributions to the formal sector. In the informal sector, only small contributions must be made by the workers.

4. Issues and challenges for social security schemes in India

Despite India's wide range of social security schemes, its overall effect has fallen short due to beneficiary selection methods, weak distribution mechanisms, and imperfect accountability. While many programs were unsuccessful in finding all the poor or even reaching all the listed beneficiaries, there were also widespread leaks and corruption. The government is now trying to answer these issues in various ways.

- Beneficiary selection through a participatory group process and, for the first time, a Socioeconomic and Caste Census, conducted in 2011 (SECC 2011), randomizing households based on their socioeconomic status under the Sabha gram.

- Enhanced distribution systems with equipment and proper workforce
- Improved monitoring, transparency, and accountability through wall painting, Jan Sunwai or gram sabha public hearings, and social audits.
- A whopping 95% of households believe the government has failed to raise poverty
- Overall, about 18 percent of informal households in the workforce claim that the government has effectively provided health services.

These methods have been successful in different programs, such as MGNREGS and certain villages or states. Some of which are documented in various sections of this paper. However, while encouraging, the methods have still not been applied to a sufficiently large scale. In section 1 of this study, the leading social security initiatives were discussed. This includes promotional measures like NRLM-Ajeevika, mid-day meals, and conditional cash transfers like JSY. There are various challenges to implement social security schemes in India.

First, Convergence of Social Security schemes - Although there is a multiplicity of social welfare schemes administered by various central and state government agencies, there is ambiguity on the beneficiaries' level as to what precisely they are entitled. This includes the issue of duplication of effort, record keeping, and there is also the risk of double or multiple benefits coming to the same individual by bribery under different schemes. The existence of many schemes for the same common purpose makes a strong argument for rationalizing the entire system, resulting in the integration of all programs and benefits under one umbrella. Furthermore, it is found that while there is potentially a lot of room to expand social security coverage to several areas mentioned above, a robust all-inclusive program would take enormous resources.

Second, Implementation issues - The introduction of the universal social security system for all need a robust administrative mechanism. The scheme's merits apart, the scheme can't take off, sometimes due to lack of interest in critical implementers. All states did not uniformly implement many of the central government schemes where the state government was required to commit some resources. The main challenge faced in the past is finding the beneficiaries, their registration and getting them aware of participating in the scheme

Third, the delivery mechanism of social security schemes - The existing processes relating to the provision of several social security benefits to both organized and unorganized workers found to be complicated. Research available on numerous such programs, including the Planning Commission of India's assessment reports of the programs, almost uniformly points out the implementation gap in most social security schemes. The shortfall includes lack of delivery infrastructure at the

level of state governments, shortage of organizational capabilities in delivery agencies, misidentification of the program beneficiaries, and lack of people's awareness regarding details of schemes as well as their entitlements.

CONCLUSION

From the discussion in the paper, based on a critical analysis of current social security initiatives in India, it is evident that the past decade has witnessed an unparalleled revival in India's social security scenario. This is due to increased government recognition, in an era of globalization of economies, appropriating the adverse labor market implications of the growing informal sector. While needing more clarification and strict implementation, many of these policies and programs encourage more educated national and international discussions. A positive feature of these new policies is the government's evident efforts to develop and enforce right-based social security programs, along with supporting governance mechanisms that seek greater involvement from all other stakeholders, including the intended beneficiaries themselves.

From the empirical study of India's unorganized sectors, it is observed that their socioeconomic status is fragile. In any economy, the social security system is primarily designed to protect poor and needy people from economic deprivation. The study found that in developed countries, social security is quite broad in terms of its contribution to meet the needs of their unorganized sectors. Yet in India's case, the absence of such an extensive social security system has significant consequences for the well-being of the vulnerable people who, for reasons beyond their control, are unable to meet their needs. Lastly, measures are required to fix the issues observed in India's social security system, which is suggested in the next section.

Recommendations

The country's social security program is robust, but there is a range of shortcomings and weaknesses, primarily concerning the unorganized field. It is suggested that social security reforms in India be organized to address the issues and challenges faced. First, splitting social security requirements into two groups. The first group with minimum social security floor that includes the necessary components of social security at its minimum level. The second group with security needs that can be added or built later on in line with convenience and affordability. Second, both state and central schemes should be merged into one scheme or fewer schemes, bearing in mind regulatory limitations. The life insurance firms can offer life insurance and pension benefits, and non-life insurance firms should provide health coverage. *Third*, the minimum level of social security should be a central issue and should be compulsory for all eligible persons throughout the country through a single point interface between the workers and social security service providers. *Lastly*, build correct distribution networks and develop adequate social security delivery systems

capable of reaching all expected beneficiaries while preventing benefit leakage, and favoritism and rent-seeking from scheme managers.

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