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Short Communication

Assessing community-driven healthcare schemes: evidence from villages of Leng, Lungdai and Nisapui in Mizoram, India

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ABSTRACT

This study examines the functioning, governance, and impact of community-based health care schemes in three villages of Mizoram: Leng, Nisapui, and Lungdai. Employing qualitative methods, primary data were collected through structured personal interviews and focus group discussions with Village Council members, scheme beneficiaries, and other local stakeholders. The research highlights the unique features of each scheme, including financial management, enrolment criteria, claim procedures, record-keeping practices, and civil society participation. Findings reveal that while all three schemes provide crucial financial support for hospitalization and enhance access to health services in rural areas, differences exist in governance structures, initial funding, external audits, and reimbursement procedures. Beneficiaries report that the schemes are largely beneficial and fair, though improvements are needed in technological adoption, financial literacy, and medical verification. The study underscores the importance of local self-governance, community participation, and collective responsibility in sustaining grassroots health protection mechanisms, and offers recommendations for enhancing efficiency, transparency, and scalability of such schemes across rural Mizoram.

Keywords: Village council, Rural health, Health security schemes, Local self-governance, Health financing, Beneficiary perception, Grassroots health initiatives

INTRODUCTION

Community-based health protection mechanisms play a crucial role in strengthening local governance and reducing the financial burden associated with hospitalization, particularly in regions where formal health insurance coverage remains limited or uneven. In Mizoram, the villages of Leng, Lungdai, and Nisapui stand out as unique and pioneering examples. These three settlements have established Village-level Health Security Schemes that are designed, managed, self-financed, and implemented under the authority of their respective Village Councils. To date, no other village in Mizoram—or even across India—has a similar Village Council–run health care scheme, making these cases exceptional within the national context of local self-governance and decentralized health protection.

These village-level health security initiatives operate with their own rules, regulations, and benefit structures, demonstrating how localized policy innovations can respond to community-specific health care needs. By providing financial protection against hospitalization expenses, these schemes help reduce the economic vulnerability of rural households who often rely on out-of-pocket expenditures for medical treatment. Understanding how these schemes function, how they differ from one another, and how they complement state and national health programs is therefore critical for assessing their relevance and replicability. This paper examines the rules, regulations, operational mechanisms, and comparative features of the Health Security Schemes in Leng, Lungdai, and Nisapui. Through this analysis, the study aims to highlight the significance of community-driven health care security policies and their potential contribution to

improving access, affordability, and financial risk protection in rural health systems.

In these local level health security schemes, the civil society organisations in Mizoram like Young Mizo Association (YMA), Mizo Upa Pawl (MUP), Mizo Zirlai Pawl (MZP), Mizo Hmeichhe Insuihkhawm Pawl (MHIP) and, Self-Help Group (SHG) are involving for the smooth implementation of the schemes.[1-5] The enrolments are done based the ration card for the schemes of these three villages, and all big decisions are taken in the Gram Sabha by the villagers.[6] The funds in Lungdai and Nisapui health security schemes are heavily depending on the fund of MNREGS while Leng Village is depending on the contribution of the villagers.[7]

The background section provides a detailed discussion of the profiles of the three villages chosen for the study, focusing on their demographic details, socio-economic conditions, levels of literacy, governance systems, and geographical features in order to provide a necessary background understanding for analyzing the implementation and functioning of the local health care systems.

Firstly, Leng is a medium-sized award-winning village situated in the East Lungdar Rural Development Block of Serchhip district in the state of Mizoram. The village is well-known for its community-governed local institutions and has won three National Panchayat Awards for its exemplary performance. The village is situated in the eastern part of the district, near the Myanmar border, and the region is known for its ecologically rich topography, with forested hills and rural landscapes. According to the 2011 Census, Leng comprises 170 households with a total population of 746 persons, including 358 males and 388 females, indicating a favorable female-to-male ratio. One of the most notable features of the village is its exceptionally high literacy rate of 95.47 per cent, with male literacy recorded at 98.07 per cent and female literacy at 93.01 per cent. This high level of educational attainment has significantly contributed to informed community participation in local governance and development initiatives. The administrative setup of the village is organized through a Village Council, which is a pivotal institution in decision-making, implementation of development programs, and management of community-based institutions. Leng is a part of the East Lungdar RD Block, which is being developed under the Vibrant Village Programme, focusing on the development of infrastructure and livelihoods in strategically located border villages. In terms of economic and cultural development, Leng is recognized for its focus on eco-tourism, traditional farming, and the rearing of gayal (mithun), which is of cultural as well as economic significance to the community. The natural environment of the village and the community-based management of resources have helped in the sustainable livelihood activities of the villagers, maintaining ecological balance.[8]

Secondly, Lungdai is a medium-sized, mainly rural village situated in the Tlangnuam Rural Development Block of the Kolasib district in Mizoram. The village is located in a hilly and picturesque area around the Sakawrhmuituai hills and is famous for its pleasant and cool climate, as well as its close association with nature. The geographical environment of the village embodies the usual features of a traditional Mizo village (zokhua), where agriculture is the mainstay of the livelihood of the people. As per the 2011 Census, Lungdai has 413 households with a total population of 1,868, consisting of 959 males and 909 females. The village has 250 children in the age group of 0-6 years. One of the most remarkable aspects of Lungdai is its remarkably high literacy rate of 98.39 percent, with a mere marginal difference between the male literacy rate of 98.31 percent and the female literacy rate of 98.48 percent. In administrative terms, Lungdai is a village governed by a Village Council with a Sarpanch as the head, as per the Panchayati Raj system of governance. The village has fairly good connectivity and transport facilities, with road connectivity provided by both government and private transport services. The nearest railway station in the district is at Bairabi, which is an important transport point in the area.[9]

Thirdly, Nisapui is a small, predominantly Scheduled Tribe village located in the Tlangnuam Rural Development Block of Kolasib district (formerly part of Aizawl district), Mizoram. According to the 2011 Census, the village has a population of 822 persons, comprising 414 males and 408 females, with a favorable sex ratio of 986 females per 1,000 males. Nisapui consists of 181 households and is characterized by strong social cohesion and community participation. One of the most remarkable features of Nisapui is its exceptionally high literacy rate of 99.29 per cent, with minimal gender disparity (male literacy at 99.43 per cent and female literacy at 99.15 per cent). This high level of educational attainment reflects the village's long-standing emphasis on education and social development. Demographically, Scheduled Tribes constitute approximately 96.6 per cent of the population, underscoring the village's strong indigenous character. Economically, Nisapui is an agrarian economy. Of the 433 working class individuals listed in the census, 391 are involved in cultivation, which means that over 90 percent of the working class is dependent on cultivation for livelihood. Culturally, Nisapui has a special place in history and culture and is known as the "Cradle of Revival" because of its importance in religious and social revivals in the region. Administratively, the village is ruled by a Village Council, which is headed by five members, functioning under the structure of self-governance in the region. Geographically, Nisapui is located in a mountainous region known for its natural beauty, with the most prominent peak being the Nisapui Tlang. The region has an almost entirely Christian population, which is in line with the overall religious demography of the region.[10]

METHODS

This study is based exclusively on primary data; a qualitative research design was adopted to examine the functioning of the Village-level Health Security Schemes in Leng, Lungdai and Nisapui. Data were collected through Focus Group Interviews and structured personal interviews with key stakeholders directly involved in the administration and utilization of the schemes. In Leng, members of the Village Council were interviewed, while in Nisapui the President and Secretary of the Village Council served as primary informants. In Lungdai, an in-depth interview was conducted with the former President of the Village Council who had played a central role during the scheme's operational period. Additionally, two beneficiaries from each of the three villages were interviewed using a structured interview schedule to understand their experiences, perceptions and challenges related to the scheme.

RESULTS

Leng Health Care Scheme

The Leng Health Care Scheme, established in 2015, operates as a community-based health security mechanism entirely managed by the Village Council without any form of government assistance. The scheme is overseen by a committee constituted annually, comprising the Village Council President as Chairman, the Village Council Secretary, a Financial Secretary, a Treasurer, all Village Council members, representatives from the Young Mizo Association (YMA), the village health worker, and other vigilant citizens as deemed necessary by the Council. Although the village health worker is included as a committee member, they do not function as a government representative, and no specific training or awareness programmes are provided by the government for scheme management.

The scheme's financial resources are generated primarily from household enrolment fees, supplemented occasionally by voluntary donations from contractors, Members of Legislative Assembly or government officials working in the village. The enrolment criteria require households to be ration card holders in Leng, and households with multiple ration cards must pay per card. Enrolment fees are fixed at ₹1000 for general households and ₹2000 for government servants earning above ₹50,000 per month. Enrolment is normally conducted between March and April each year, after which no new members are admitted. All ration-card-holding households in the village typically enrol.

Eligibility for claims requires members to be hospitalized and to submit a discharge certificate to the Financial Secretary or Treasurer. Claims are processed without any additional medical verification or committee approval. The scheme covers 50% of the hospital bill, subject to an annual ceiling of ₹20,000 per household. For claims below ₹20,000, 50% is reimbursed, while for bills above ₹20,000, the maximum payable amount remains ₹20,000. Although this ceiling has been reviewed occasionally, it has remained unchanged since the scheme's inception. Exceptions exist in cases considered serious by the committee, where non-hospitalized patients may also receive assistance. Certain exclusions apply, including hospitalizations related to accidents involving drugs or alcohol, normal labour, and childbirth.

Documentation practices rely entirely on handwritten records and preserved hardcopies of medical papers, as no computers or Information Technology (IT) systems are used. Only WhatsApp is adopted for information dissemination. Financial shortages are rare but, when they occur, are met through external donations rather than delaying payments. Banking arrangements remain informal, with the Treasurer depositing funds in his personal bank account, as no formal bank partnership or corpus fund exists.

Transparency mechanisms include annual reports and publicly accessible record books, although there is no formal audit system. No corruption cases have been reported, and grievances are handled verbally through committee discussions, as no designated complaint box exists. Civil society involvement is evident through the participation of YMA members and other community volunteers, though church bodies are not represented. The scheme enjoys strong public awareness, disseminated through local newspapers, pamphlets, WhatsApp, the village crier, and Gram Sabha meetings. Additional benefits include a 30% discount on the village ambulance service for enrollee families. Community unity and collective responsibility are central to the scheme's functioning, with some members voluntarily refraining from claiming benefits to reserve funds for more needy households. The scheme remains unregistered with the Firms and Societies Department, reflecting its purely community-driven nature.

Lungdai Health Security Society

The Lungdai Health Security Society, established in 2017, is one of the earliest village-level health protection models in Mizoram and the only one among the three case villages to receive an initial financial contribution from the government. At its launch, the then Chief Minister Lalthanhawla sanctioned ₹10 lakhs as a corpus fund, which, combined with an equivalent contribution from the community, created a pooled reserve of ₹20 lakhs deposited as a long-term fund. Additional resources are generated through periodic contributions from households under Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS), donations from churches and civil society organizations, and enrolment payments collected from late enrollees—calculated for approximately 2,400 individuals.

Governance is carried out by a bi-yearly Health Security Committee, which includes representatives from every church having a church building, one representative each from major community organizations YMA, Mizo Upa Pawl (MUP), Mizo Zirlai Pawl (MZP), Mizo Hmeichhe Insuihkhawm Pawl (MHIP), Self-Help Group (SHG), all Village Council members, and selected prominent citizens. The committee elects its own Chairman, Secretary, Financial Secretary, and Treasurer. Unlike other schemes, no government officials are part of the committee, and no external training or capacity-building support has been provided by the state.

The scheme initially reimbursed 30% of hospitalization expenses up to an annual ceiling of ₹25,000 per beneficiary, but in 2020, reimbursement support was revised downward to 20%. Claims require production of a Health Security Card, a discharge certificate, and original inpatient bills signed and stamped by the treating doctor. Beneficiaries are eligible on an individual basis, with the ceiling of ₹20,000 applying per person within a 365-day period. Self-inflicted injuries and cosmetic or beauty-related treatments are excluded. Enrolment is open annually in July, and eligibility is extended to all ration card and job card holders, provided they contribute the same amount originally invested into the corpus fund. No dropout cases have been recorded.

Record-keeping is conducted manually. The Health Security Card is used for verification, and all claims are marked and registered in handwritten record books maintained by the Secretary and Financial Secretary. No IT tools are used. Although funding shortages occasionally arise when contributions do not match claim requirements, no unpaid claims have occurred, and funds are managed without debt. Public awareness of the scheme is high, largely due to effective dissemination through WhatsApp groups, local newspapers, and Gram Sabha discussions. Internal audits are conducted annually, and audited reports are presented during community meetings.

The scheme is known for strong civil society participation, with active support from churches, YMA, MHIP, MUP, and SHG. Financial operations are conducted through a partnership with the Lungdai Rural Bank. Unlike other villages, the Lungdai Health Security Society is officially registered under the Taxation Department, adding a level of formal recognition. Overall, the model is perceived as efficient, transparent, and suitable for adoption by other villages in Mizoram.

Nisapui Health Security Scheme

The Nisapui Health Security Scheme, established in 2020, functions as a community-based health protection mechanism fully managed by the Village Council without any government assistance. Administration is carried out by a board constituted annually, consisting of the Village Council President as Chairman, the Village Council Secretary, a Treasurer nominated from among church leaders, two government servants serving as auditors, the presidents and secretaries of YMA, MHIP, MUP and SHG, two representatives from the Presbyterian Church, one representative from other local churches, all six Village Council members, two village health workers, and one prominent citizen selected by the community. Although two health workers are included, they serve only by virtue of their designation and do not represent the government. No external training or capacity-building support is provided by the state; instead, board members are oriented during board meetings and Gram Sabha deliberations.

The primary financial resource for the scheme is derived from MGNREGS. With the consent of beneficiaries, every household contributes ₹20 per working day, deducted from MGNREGS payments only after funds are credited to the Village Council account. Households without job cards are given the option to enrol annually, although no requests for enrolment have been received so far. Because enrolment is tied to job card ownership, no formal enrolment window is maintained, and no households have withdrawn from the scheme.

Claim procedures are clearly structured: upon hospital discharge, beneficiaries submit a photocopy of their discharge certificate to the Chairman, who verifies, signs, and seals the document. It then passes to the Secretary for further verification and finally to the Treasurer, who disburses the approved amount in cash. The scheme reimburses 20% of hospitalization expenses up to an annual ceiling of ₹20,000 per household. Although the ceiling is reviewed periodically, it has remained unchanged since the scheme's inception. No exclusions exist for beneficiaries who continue paying their contributions, and no special cases of removal have been recorded.

Documentation practices are entirely manual. Hardcopies of discharge certificates and medical bills are preserved in files, and all transactions are recorded by the Treasurer in handwritten cash books. No computer-based system is used, and there are no short-term plans to introduce IT tools. However, WhatsApp groups and local newspapers are actively used to disseminate information. Regular financial operations sometimes face delays due to late crediting of MGNREGS funds to the Village Council account, resulting in postponed payouts, although no unpaid claims have occurred.

Governance and accountability mechanisms include annual internal audits conducted by two auditors and the presentation of quarterly reports during the Gram Sabha. Record books are accessible to the public, and no corruption-related issues have been reported. Complaints are received verbally either by board members or during Gram Sabha sessions, as no dedicated complaint box exists. Civil society participation is significant, with active involvement from church organizations, YMA, MHIP, MUP, and SHG. The scheme maintains a joint bank account with the Lungdai Rural Bank, although no corpus

fund has been established. Benefits also include access to the village ambulance service at a subsidized rate of ₹20 per kilometre for beneficiary families. The community has proposed creating a dedicated ambulance fund through this scheme to eventually provide free ambulance services.

The scheme is not registered under the Firms and Societies Department, reflecting its status as a locally governed, community-driven initiative. Overall, the Nisapui model enjoys strong public awareness, effective grassroots participation, and is widely considered suitable for replication in other villages.

Beneficiary perceptions analysis

The beneficiaries of the Leng, Nisapui, and Lungdai health schemes unanimously recognize the programs as highly beneficial, particularly for rural households with limited income and daily wage workers. In Leng and Nisapui, the reimbursement of 50% and 20% of hospital bills provides substantial financial relief, allowing villagers to seek medical attention without waiting for illnesses to become critical. The schemes also support ambulance services, which further enhances access to healthcare. In Lungdai, while all hospital bills cannot be fully reimbursed under the scheme, beneficiaries still appreciate the financial assistance, noting that delays may occur if the illness is not considered critical.

Contributions to the schemes are generally considered affordable and non-burdensome across all three villages. Even households that do not directly benefit from medical reimbursements recognize the communal value of their payments in supporting other villagers in need. Reimbursement timing varies between the villages: in Leng and Nisapui, payments are sometimes delayed due to temporary scarcity of funds, although unpaid claims have not occurred. In Lungdai, claim processing is slower, often taking one to two months due to the need for board deliberation. Despite these differences, beneficiaries in all villages generally find the disbursement process fair.

Transparency in account-keeping is perceived positively. In Leng and Nisapui, records are disseminated during Gram Sabha meetings, fostering trust in the treasurer, although no external audits are conducted. In Lungdai, beneficiaries noted that financial records are regularly updated in the local newspaper, providing additional transparency. Awareness of the schemes is high in all three villages, facilitated through multiple channels such as WhatsApp groups, newsletters, village criers, and Gram Sabha meetings. However, in larger villages like Lungdai, some households may have slightly lower awareness levels due to the higher number of beneficiaries.

Beneficiaries generally feel that the level of reimbursement aligns reasonably with their contributions. In Leng and Nisapui, the reimbursement percentage is seen as adequate, though some suggest that increasing contributions could allow higher coverage and raise the maximum claimable amount. In Lungdai, the reimbursement rate was reduced from 50% to 20% in recent years, which some beneficiaries perceive as sufficient, while others feel it could be improved.

All three communities strongly recommend establishing similar schemes in other villages, citing their effectiveness in covering medical expenses not included in government programs. Suggested improvements include raising contributions to enable higher reimbursement percentages, increasing the maximum claimable limit, and further streamlining administrative procedures to reduce delays in claim processing. Overall, the schemes are valued for their role in promoting health security, fostering community solidarity, and enhancing access to medical care in rural Mizoram.

DISCUSSION

The present study reveals that the three local health care schemes have made meaningful contributions toward improving access to health services and reducing financial burden among beneficiaries. However, the results also indicate several operational, administrative, and service-related limitations that affect their overall effectiveness. The recommendations discussed below are derived directly from the empirical findings of the study and reflect the experiences of beneficiaries, health care providers, and implementing authorities.

Technological usage

All three village schemes rely heavily on handwritten records and minimal digital tools, using WhatsApp only for information dissemination. Implementing computer-based record management and IT tools can improve efficiency, accuracy, and transparency in claim processing, fund tracking, and reporting. Digital records would also facilitate easier retrieval of patient histories and reduce the risk of misplacement or loss of documents.[11]

Regular external audit

While internal monitoring by the Treasurer and Finance Secretary exists, an independent external audit is necessary to ensure greater financial transparency and accountability. Regular audits would strengthen public trust, detect errors or mismanagement early, and help align fund usage with scheme objectives.[12]

Higher contribution - higher percentage and maximum claim amount

Beneficiaries have suggested increasing enrolment contributions in proportion to enhanced coverage. Raising both the reimbursement percentage and the annual maximum claimable amount would provide more substantial support to households, especially those facing critical medical expenses. This approach ensures that contributions are commensurate with benefits received.[13]

Medical knowledge person checking

Currently, claims are verified by committee members without medical expertise. Involving a trained medical professional or health worker in claim verification would ensure accurate assessment of hospital bills, prevent misuse, and enhance the scheme's credibility in reimbursing appropriate medical expenses.[14]

Capacity building and financial literacy

Committee members and beneficiaries would benefit from training in financial management, health insurance concepts, and record-keeping. Capacity-building initiatives can improve governance, decision-making, and understanding of scheme operations, enabling better fund utilization and long-term sustainability.[15]

CONCLUSION

The community-based health schemes in Leng, Nisapui, and Lungdai demonstrate the vital role of local governance and collective responsibility in ensuring access to health care in rural Mizoram. Each village has developed a system tailored to its socio-economic and administrative context: Leng relies solely on enrolment fees and donations with flexible, community-driven support; Nisapui utilizes MGNREGS contributions and structured board management; and Lungdai benefits from a corpus fund initiated with government support, supplemented by household contributions and civil society involvement. Across all three villages, beneficiaries report that the schemes are highly beneficial, particularly for low-income households engaged in daily wage or jhum cultivation work, as they provide partial reimbursement of hospital bills, access to ambulance services, and financial support during medical emergencies. The schemes are perceived as transparent and fair by the community, with effective awareness programs via Gram Sabha, WhatsApp, local newspapers, and village criers. Overall, the three village health schemes stand as exemplary models of community solidarity, and with targeted improvements, they hold potential for replication in other rural areas, ensuring broader access to affordable health care for underserved populations in Mizoram.

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