Employee State Insurance Scheme:

Is it for Workers?

Contents

Background

Employees' State Insurance Scheme (ESIS) is an integrated social security scheme based on the principle of "pooling of risks and resources", mandated to provide protection to workers and their dependents in the organized sector in contingencies such as sickness, maternity and death or disablement due to employment injury or occupational disease. The scheme provides full medical facilities to insured persons and their dependents and cash compensation for any loss of wages or earning capacity of insured persons. The scheme is operated by Employees State Insurance Corporation (ESIC) established under the Employees' State Insurance Act, 1948 (the Act) under administrative control of Ministry of Labour and Employment, Government of India. The Act was amended in May, 2010 to provide for the establishment of medical colleges, nursing colleges and training institutes.

ESIS was initially introduced in February 1952 in two areas i.e. Delhi and Kanpur and is currently implemented in the entire country (except Manipur, Sikkim, Arunachal Pradesh and Mizoram) covering shops, hotels, restaurants, cinemas, motor transport undertakings, newspaper establishments, educational and medical institutions employing 20 or more persons (coverage based on salary). Twenty-one states have reduced the threshold of coverage to 10 persons.

ESIS is a self-financing health insurance scheme in which contributions are raised from covered employees (1.75%) and their employers (4.75%) as a fixed percentage of wages. The ceiling on monthly wages for coverage is INR 15000 with effect from 1 May 2010. Thus, employee comes out of the social security net of ESIC on crossing the wage ceiling limits. ***At present ESI covers only about four per cent of the total work force and 67 per cent of organized workforce in the country.***

Benefits provided under the Scheme

Broadly, the benefits provided by the ESIS to insured persons and their dependants are given in Table below-

Sl. No.	Benefit	Description
1.	Medical Benefit	Medical care for self and dependents through a network of panel clinics, ESI dispensaries and hospitals.
2.	Sickness Benefit	Sickness Benefit is payable in cash, in the event of any sickness resulting in loss of wages due to absence from work which is duly certified by an authorized medical officer/practitioner.
3.	Maternity Benefit	Maternity Benefit is payable to insured women in case of confinement or miscarriage or sickness related thereto.

4.	Disablement Benefit	Disablement Benefit is payable to insured employees, suffering from physical disablement due to employment injury or occupational diseases.
5.	Dependent's Benefit	Periodical payment to dependants of employee in case of death of employee due to employment injury.
6.	Funeral expenses	Recoupment of funeral expenses on death of employee.
7.	Rehabilitation Allowance	Payment of 50 per cent of average daily wages for maximum of 12 months, in case of loss of job due to closure of the establishment, under Rajiv Gandhi Shramik Kalyan Yojna (RGSKY).

Table – Benefits of ESIS

ESIC provides health and medical care through a network of dispensaries, panel and hospitals. It also has tie up with other hospitals for super speciality treatments. Currently, there are 22,600 beds in ESIC hospitals. Between 2010 and 2013, eight medical colleges were established.

CAG Audits - Revelation of Ground Realities

To ascertain the functioning of ESIC, regular audits have been undertaken by CAG, in addition to internal audits carried out by its own audit wing/ private audit firm hired by them. The last audit by CAG was done in 2015 for the period from 2008-09 to 2012-13. Previously CAG had conducted audit in 2005 for the period 1999-2000 to 2003-2004 (General Report No 2 of 2006) and in 1994 for the period 1989-90 to 1993-94 (General Report Number 11 of 1995). The CAG Audits provide a deep insight in the working of the scheme and high handedness of the officials.

Shortcomings highlighted in the Audit

Income and Expenditure – Almost 84% of the income of ESIC was received as contribution from employees and employers. Other income source was from Interest on investments.

As per expenditure records, it was found that Medical Benefit contributed towards 54 to 64 per cent of Expenditure. Similarly, Cash Benefits were 11 to 18 per cent of the outgo. These two components which were for direct service to IPs contributed to approximately 80 per cent of its expenditure. In addition, Administrative expenditure for running of the scheme was 12 to 20 per cent of total expenditure. Although, this expense is definitely high, it is within statutory limit of 15 per cent of total revenue as defined under Rule 31 of ESI (Central) Rules, 1950 under Section 28A of the Act.

Table: Income and Expenditure

(INR ***in crore)***

	2008-09	2009-10	2010-11	2011-12	2012-13
Income	4452.45	5085.17	6980.62	8393.55	10138.63
Expenditure	2068.83	2711.82	3327.60	4261.70	6621.16
Excess of Income Over Expenditure	2383.62	2373.35	3653.02	4131.85	3517.47
Transfer to capital construction reserve fund (CCRF)	-	5000.00	-	-	3000.00
Accumulated surplus	**13481.40**	**10854.75**	**14507.77**	**18639.62**	**19157.09**

This brings to question the reality of the situation. A scheme like ESIC was created to provide social security for IPs, however as seen from its income and expenditure figures, its collections were consistently and significantly higher than its level of expenditure on services, with the result that it has been accumulating surplus over the years. In addition to the surplus, during 2009-10 and 2012-13 ESIC transferred INR 5000 crore and INR 3000 crore respectively from 'Surplus' to 'Capital Construction Reserve Fund' (CRRF*).* ***Yet the accumulated surplus increased from 13481.40 crore in 2008-09 to 19157.09 crore in 2012-13.*** Spending less on providing core services (medical benefits and cash benefits) for which ESIC was created and using accumulated surplus for medical education (construction of medical colleges) is a very serious issue of concern.

This money should be more than enough to provide world class health services to the workers who have actually paid this money. It seems that rather than providing quality health service, ESIC is more concerned with venturing into other areas. There have been consistent reports of privatization of ESIC services or using this surplus for providing social security for the unorganized workers, however, this is workers money and should be used only for the welfare of the IPs and just because there is a surplus should not be a reason for the government to use it for social security for other segment of workers who are not covered.

In addition to the surplus, ESIC has investments of INR 31,638.58 crore as of March 2013 and interest on such investments contributed to 14 to 22 per cent of income.

During the audit in 2004, ESIC had stated that the lack of increase in expenditure is due to avoiding of wasteful / infructuous expenditure and economizing the expenditure without sacrificing the benefits. However, as noticed not only in the last Audit, but in the current Audit as well, ESIC has become an expert in wasteful expenses. Delayed projects, expired medicines, defunct / unused expenses, shortage of manpower, high referrals to private players etc. all point to wasteful expenses.

Arrears of Contributions - All employers of covered establishments are required to deposit both employees' and employer's contribution. In case employer fails to do so, ESIC can take recovery action to recover the arrears with interest.

As of March 2013, an amount of INR 1655.42 crore was marked as arrears. Out of this INR 1001.82 crore was classified as not recoverable[1], INR 124.32 crore as dues from sick industries and INR 529.28 crore as pending for recovery with Recovery Officers.

A significant portion of total arrears was classified as 'not recoverable arrears' indicating weaknesses in recovery mechanism. Total arrears were about 20 to 34 per cent of annual contributions during 2008-09 to 2012-13. **The amount of outstanding arrears increased by about 30 per cent from 2008-09 to 2012-13**.

The faulty recovery mechanism was highlighted in the previous audit as well when the arrears of contribution amounted to INR 918.47 crore as on 31 March 2004 from 1,03,636 defaulting establishments.

This clearly indicates lack of an effective system to monitor and recover the outstanding contributions or a deliberate attempt to shield the erring employers? Imagine the surplus with the corporation if the recovery mechanism could be strengthened and amount recovered with penalties.

Budget

The Act provides that the ESIC shall frame a budget, showing probable receipts and expenditure and submit a copy for the approval of the Central Government (Section 32). The details of budget estimates and actual expenditure of ESIC and its Excess (+) or Saving (-) during 2008-2009 to 2012- 2013 are given in Table below

Table - Budgeted vis-a-vis Actual Expenditure during last five years (**INR in** crore)

Year	**Budget Estimates (BE)**	**Actual expenditure**	**Excess(+)/ Saving(- *per cent w.r.t. B.E.***	
			Amount	***per cent***
2001-2002	1287.39	1104.12	-183.27	-14.23
2002-2003	1401.02	1118.32	-282.7	-20.17
2003-2004	1498.2	1170.48	-327.72	-21.87
2004-2005	1484.07	1258.2	-225.87	-15.21
2005-2006	1644.91	1278.96	-365.95	-22.25

[1] Amendment in June 2010 prescribed a time period of five years for determination of contributions.

2008-2009	2130.71	2068.83	-61.88	-2.90
2009-2010	3399.05	2711.82	-687.23	-20.22
2010-2011	3890.71	3327.60	-563.11	-14.47
2011-2012	5079.70	4261.70	-818.00	-16.10
2012-2013	5749.63	6621.15	871.52	15.16

It can be seen that while actual expenditure was close to budget figures only in 2008-09, in other intervals savings of 14.23 per cent to 22.25 per cent were observed. The audit adds that the process of approval of budget in the Ministry revealed that the budget proposal as submitted by the ESIC is approved without exercising any oversight role.

Hence, either there is a very high safety margin built into the budget or the ESIC is unable to plan their actions properly to spend the money. Shortage of money is definitely not an excuse in this case.

Payments to states without audit certificates

As per the Act, the ESIC has an agreement with the State Governments to provide a uniform scale of medical care to IPs and expenditure on medical care is to be shared between ESIC and State Governments in a ratio of 7:1. ESIC makes provision for on account payment up to 90 per cent of its 7/8th share of expenditure and pays the balance 10 per cent subsequently on receipt of audit certificate from the concerned State Accountants General (AsG).

CAG Audit observed that during 2008-09 to 2011-12, the ESIC paid 2280.29 crore to 21 states as 90 per cent advance payment but the expenditures were not certified from the respective AsG even after a lapse of more than four years. Audit also observed that ESIC released funds to Andhra Pradesh, Gujarat, Haryana, Punjab, Rajasthan and Tamil Nadu in excess of expenditure certified by the AsG. The basis of making excess payments to States was not on records.

Maharashtra with 520 Crore, Karnataka 375 Crore, Kerala 206 Crore, UP 216 Crore, west Bengal with 189 crore and Andhra Pradesh with 197 crore were the biggest defaulters of unaudited payments.

Committee meetings

For governance, there are three bodies at national level namely (i) ESI Corporation, (ii) Standing Committee and (iii) Medical Benefit Council.

At State level also there are three bodies namely (i) Regional Board, (ii) Hospital Development Committee and (iii) Local Committee.

As per Section 20 of the Act, the Corporation, the Standing Committee and the Medical Benefit Council should hold meetings as specified in the Regulations. Number of Meetings for Regional Board and HDC were prescribed by ESIC through circulars/handbook. Comparison of prescribed and actual number of meetings of these committees held during 2008-09 to 2012-13 indicated severe shortfalls.

Audit observed that in 15 states (Assam, Chhattisgarh, Delhi, Goa, Haryana, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Rajasthan, Tamil Nadu, Uttar Pradesh and Uttarakhand) the shortfall in holding Regional Board meetings was 75 per cent or more.

Infrequent meetings by committees was not consistent with good governance practices and would have an adverse impact on implementation of the ESIS.

The same issues were highlighted in both the previous audits and the learning just doesn't seem to be there. How can the achievements and shortfalls in performance be monitored and evaluated for corrective measures in the absence of meetings? All the issues highlighted in this report can be easily tackled and resolved if only these meetings are held regularly.

Delay in re-constitution of Regional Boards

As on March, 2013 there were 24 Regional Boards. The tenure of Regional Boards is for three years. Out of these 24 Regional Boards, tenure of nine boards namely Maharashtra, Puducherry, Punjab, Assam, Uttar Pradesh, Uttarakhand, Kerala, Tamil Nadu and Delhi expired during 2004 to 2011. These were not reconstituted till July 2013. Proposal for constitution of Regional Boards of three states (Assam, Chhattisgarh and Jharkhand) was reportedly pending with the Ministry. Regional Board of Gujarat was reconstituted in 2012 with delay of 10 years after expiry of previous Regional Board tenure in 2002.

It is evident that the instances of delay in constitution of Regional Boards would lead to denial of appropriate forum to the stakeholders.

There have been numerous cases where the insured persons are waiting for a long time for their cases to come up in front of the Regional board but the apathy of ESIC is evident when these boards are not re-constituted. It is not that the board does not have ample resources, it is just plain disregard for the suffering of a worker whose money and sweat is what powers this scheme.

Surveys, Inspections and Test Inspections

ESIC does surveys, inspections and test inspections for effective coverage of the ESIS -

Surveys: The Social Security Officer (SSO) is expected to keep constant vigil over uncovered establishments in his/her area and recommend coverage.

Inspections: inspections are done for already covered establishments to ensure that all coverable employees are covered.

Test Inspections: The Regional Director/Joint Director cross-checks a sample of inspection which is called test inspection.

ESIC also conducts surprise surveys in case of receipt of complaints from any employee or trade unions or when there is a reasonable doubt that the provisions of the Act are not being applied deliberately to a factory.

The Inspection Policy framed in 2008, prescribed target of 20 inspections and 20 surveys per month for each SSO. However, In Delhi, Assam and West Bengal, the audit observed a shortfall in Surveys conducted to be as high as 69.5%, 77.6% and 59.7% respectively.

Similarly, there were substantial shortfalls in inspections conducted ranging from 22.68 to 93.16 *per cent* (except Himachal Pradesh which had a shortfall of 3%).

Audit observed that the shortfall had a direct bearing on the recoverable amounts as the outstanding arrears from defaulters had increased by 30.62 *per cent* from INR 1267.32 crore (March 2009) to 1655.42 crore (March 2013).

It is painfully evident that the ESIC employees need to move out of their air-conditioned offices and conduct regular inspections and justify the high administrative expenses borne by ESIC.

Delays in settlement of claims of cash benefits

As per Citizen's Charter of ESIC, maximum time limit for payment of cash benefits after submission of claim under various categories is seven days for sickness benefit, 14 days for maternity benefit, one month for disablement benefit, three months for dependant benefit, one month for unemployment allowance and same day for funeral expenses. Test check of related records for settlement of claims revealed instances of delays with respect to those declared in the citizen's charter. These delays were as given below: -

Table: Delays in settlement of claims

Sl. No.	**State**	**Type of claim**	**No. of cases**	**Delays**
1.	Andhra Pradesh	RGSKY	6	Up to 3 months
2.	Assam	Maternity benefit	17	3 to 108 days
	Assam	Sickness benefit	172	1 to 220 days
	Assam	Temporary disablement cases	11	2 to 374 days
3.	Chhattisgarh	Sickness benefit	96	12 to 268 days
4.	Delhi	Disablement benefit	48	1 to 36 months
	Delhi	Funeral expenses	61	1 to 199 days
5.	Jharkhand	Dependent benefit	4	5 to 15 months
6.	Karnataka	Dependent benefit	120	1 to 10 months
	Karnataka	Permanent disablement benefit	190	5 days to 7 months
7.	West Bengal	Sickness benefit	35971	Up to 556 days
	West Bengal	Maternity benefit	61	Up to 249 days
	West Bengal	Temporary disablement Benefit	4029	Up to 363 days
		Total	**40786**	

ESIC replied (May 2014) that in some cases, the claims were settled late due to incomplete documents submitted with the claims.

Even with computerisation and appointing a consultant with huge cost implication, this issue has not been solved and claimants have to keep running from one office to the other for their claim resolutions. The claimants are not guided properly at the time of filing of claims and no updates are provided on the status of claims.

There have been many cases in which claims have been pending for long but the corporation just doesn't care. Not only delays, there are several cases of fraud in settlement of claims. The issue coupled with delays in constitution of Regional Medical Boards and Medical Appellate Tribunals result in long delays in settlement of claims.

Bed occupancy

ESIC provides medical care to its IPs through a network of ESI hospitals, ESI dispensaries and diagnostic centers.

Bed occupancy in ESI hospitals during 2012-13

Hospitals with number of beds	**Number of hospitals under different levels of bed occupancy**					
	<20 %	**20 to 40 *%***	**40 to 60 %**	**60 *to 80 %***	**Above 80 %**	**Total number of hospitals**
Less Than 100	12	15	16	10	7	60
100 to 250	6	13	14	15	10	58
250 to 500	1	3	2	5	8	19
more than 500			2		1	3
Total	19	31	34	30	26	140

Audit observed that two out of three hospitals with more than 500 beds were having bed-occupancy less than 60 *per cent.* Similarly, 6 out of 19 hospitals with 250-500 beds, 33 out of 58 hospitals with 100-250 beds and 43 out of 60 hospitals with less than 100 beds were underutilised i.e. operated with less than 60 *per cent* bed occupancy. About 35 *per cent* of the hospitals had bed occupancy levels of less than 40 *per cent*. ESIC stated (May 2014) that reason for low occupancy was shortage of manpower and the quality of health care services being rendered.

It's a vicious circle. The corporation is defending low bed occupancy to poor services and lack of manpower! What is stopping them from recruiting trained manpower? Even after establishing their own medical colleges, they are unable to provide quality services? Has all this expenditure of worker's money been a waste? It is evident that all the ills of the corporation are inter-linked and there is no serious effort to cure these ills.

Availability of beds

The ESIC also projects requirement of beds based on ratio of one bed for 250 IPs in its Financial Estimates and Performance Budget every year

Shortage of Beds

As on	31 March 2009	31 March 2010	31 March 2011	31 March 2012	31 March 2013
No. of IP Covered (in lakh)	129.38	143.00	155.30	171.01	185.82
No. of beds required as per norms (1 bed per 250 IPs)	51752	57200	62120	68404	74328
No. of beds available	23088	22030	22335	22823	22600
Shortage of beds	28664	35170	39785	45581	51728
Per cent shortage of beds	55.39	61.49	64.05	66.63	69.59
No. of IP per Bed as per availability	560	649	695	749	822

From above, it may be seen that while the number of IPs increased by 56.44 lakh (44 *per cent*), the number of beds actually decreased by 488 (2.11 *per cent*) from 2008-09 to 2012-13. Further, although the capital expenditure on construction of hospitals, dispensaries, medical/ para-medical/nursing college, etc. had increased from INR 213.80 crore to INR 1671.44 crore (7.82 times*)* during 2008-09 to 2012-13, shortage of beds against the requirement increased from 55.39 *per cent* in 2008-09 to approximately 70 *per cent* in 2012-13.

ESIC responded to the audit by stating that the above calculation was not based on factual norms. The demand for new hospitals was promptly considered and approved depending on the hospitals' qualifying the eligibility criteria for opening of new hospital and actual workload. Further, many new hospitals were approved and were at various stages of completion.

The corporation seem to be defending its inefficient functioning by concocting lies. If the reasoning was correct, then the high number of construction projects delayed for a long time would have been properly addressed.

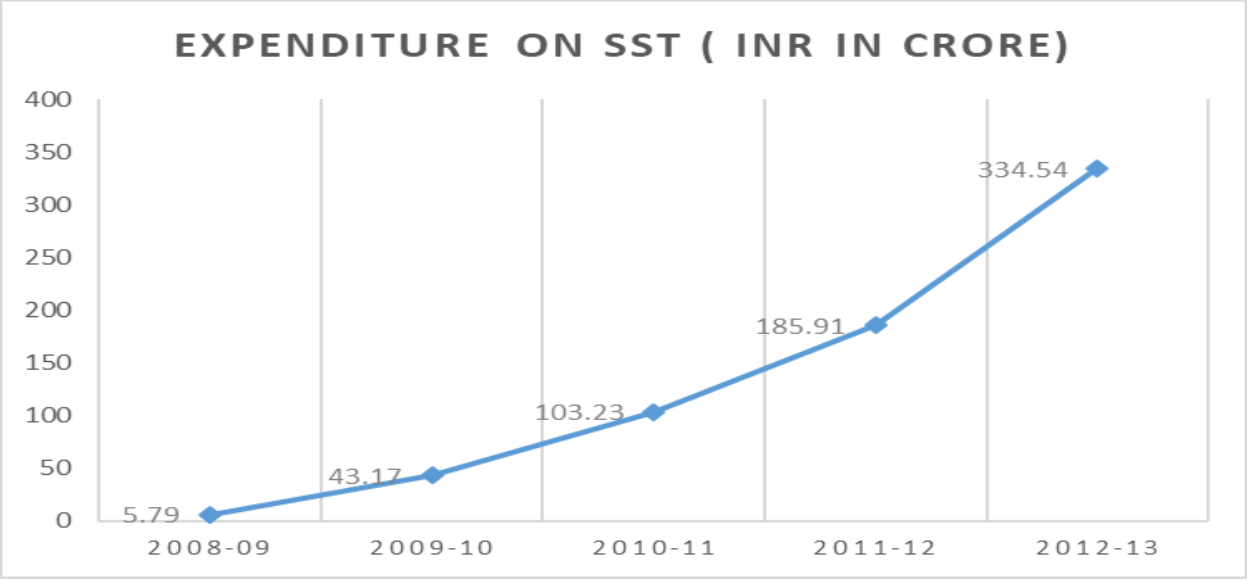
Multiple admissions per bed in ESI hospitals - Scrutiny of occupancy register of various wards of ESI hospital at Noida, Uttar Pradesh for year 2012- 13 revealed that as number of beds were not sufficient to cater to the requirement of IPs, there were multiple admissions on one bed resulting in bed occupancy of more than 100 *per cent* during 2012-13. In Female

Medicine ward, the occupancy was almost 160%. Similarly, in ESI hospital Okhla, Delhi during 2012-13, bed occupancy in various wards ranged between 61 to 205 *per cent*. In maternity ward, audit observed multiple cases of fresh delivery on a single bed posing health hazard to the infant and the mother.

On one hand, we have a case of low bed occupancy in many hospitals, on the other hand, we don't have enough beds as per requirement. To top it all, we have cases of multiple admissions on a single bed. This clearly shows that the corporation has not done any planning and not anticipated the increase of IPs in some areas and augmented the services accordingly while increasing services where they may not be needed thus resulting in a wastage of precious resources. ESIC should well remember that this is worker's money not some dole which can be squandered on their demand.

Increase in expenditure on referral cases for super speciality treatment (SST)

ESIC issued guidelines (July 2008) for referring its IPs for getting super speciality treatment by tying up with reputed government/semi government/private hospitals/institutions which provide cashless and hassle free treatment to IPs and their dependents. The services to be covered under SST were cardiology and cardiothoracic vascular surgery, neurology and neurology surgery, paediatric surgery, oncology and oncology surgery, urology and urology surgery, gastroenterology, endocrinology, burns and plastic surgery, reconstruction surgery and any treatment rendered to the patients by a super specialist. Audit observed that the expenditure on the super speciality treatment from empanelled hospitals had been consistently increasing over the years. The position of expenditure on SST in nine states test checked is shown in Graph below-



As would be seen, the expenditure on referral cases on SST had increased from INR 5.79 crore in 2008-09 to INR 334.54 crore in 2012-13 (about 57 times). Such substantial increase in referral expenditure could be because of non-availability of SST services with ESIC hospitals or lack of confidence in medical services being provided by ESIC. For example, as against sanctioned strength of 21 cardiologists and 17 neurologists, the ESIC had only two cardiologists and one neurologist across the country.

Further, although ESIC Dental College, Rohini was established in March 2010, it was observed that three ESIC hospitals at Okhla, Noida and Jhilmil were referring their patients for dental treatments to empanelled private dental clinics.

'Norms and standards of Staff and Equipment for ESI Hospital and Dispensaries', provides for CT Scan and MRI facility in a 250 or 500 bed hospital. Audit observed that the ESI hospital, Jhilmil (300 beds) and ESI hospital, Noida, (300 beds) did not have these facilities a significant number of cases were being referred with attendant expenditure. The expenditure of INR 4.32 crore could have been avoided if these hospitals had got these facilities installed. It is possible that the referral system has become a source of black-marketing to the profit of private enterprises

Non-Usage of Medical Equipment - Audit further observed that 142 medical equipment's worth INR 9.43 crore (cost of nine equipment was not available) were lying idle in various hospitals/dispensaries as on March 2013. As a result, the medical benefit/ care from these equipments could not be derived by IPs and significant expenditure incurred on these equipment was rendered unfruitful. It was also observed that 156 equipment in ESI hospital Joka, West Bengal were installed after delays ranging from 92 to 876 days.

ESIC stated (July 2004) that State Governments had been asked to reorganize the health care delivery system and run the hospitals through third party participation i.e. by inviting participation of a third party by the State Government on agreed terms and conditions.

What is the need to invite third party to provide health services? Is the state government incapable of providing quality health services to people in their states? If this is the case, then government hospitals should all be handed over to third parties. In fact, the money spent on referrals could have been used to augment the facilities being provided at ESIC centres and hospitals. Yet another example of wastage of resources and collusion with private entities.

Medicines *(Procurement and Quality)* - Data of 19 hospitals and four dispensaries test checked indicated that the expenditure on local purchase in these cases increased from INR 6.15 crore (during 2008-09) to INR 16.61 crore (during 2012-13) i.e. by 169.89 *per cent.* Large increase in quantum of medicines purchased locally bypassing the rate contract procedure led to wasted financial resources. In almost all cases of local purchases, the cost of procurement was higher than the rate contract.

ESIC replied (May 2014) that the prices increased significantly in a short span of time due to which suppliers failed to supply the medicines on the existing rates. In such cases, the local purchases were made from approved local chemist.

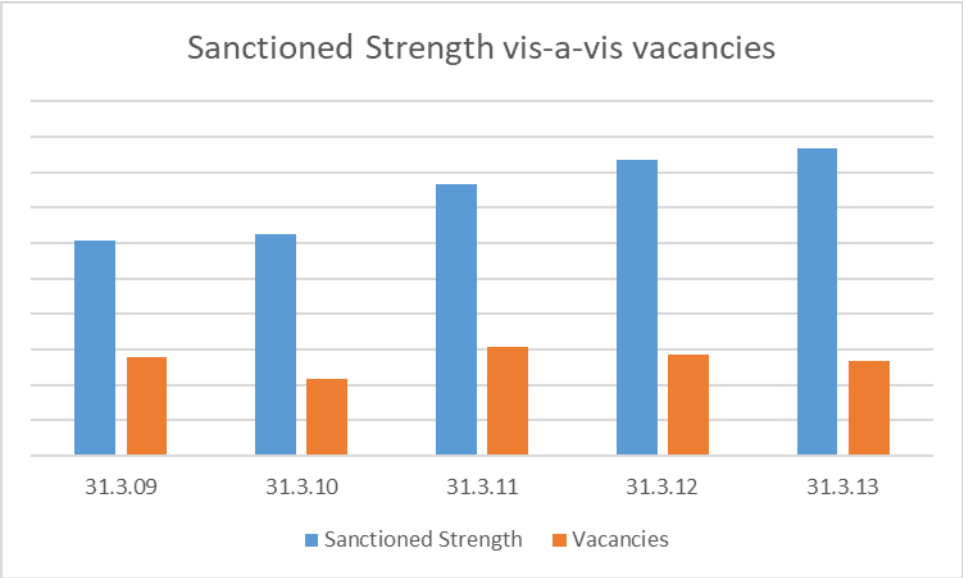
However, ESIC cannot justify that the suppliers were bound to supply the medicines in accordance with the terms of rate contract till their validity. In case of non-supply, the extra expenditure involved in procuring supplies from elsewhere was liable to be recovered from the supplier. However, no such recovery of extra expenditure was found on records, which indicates that the provisions of the rate contract were not being enforced. There would be cases where the rate contract prices were higher than the prices of Local purchases. Did the contractor return the excess money in these cases?

Audit also raised objections in the procurement process where in medicines which were close to the expiry dates were purchased. Further in several cases, the procured medicines were distributed without undertaking a sample testing at an approved lab. The test reports received from labs after a delay of 40 days to 296 days, confirmed that the medicines were of sub-standard quality. The failure of hospitals in securing compliance with the required provisions led to supply of sub-standard drugs to IPs posing serious health hazard.

The list just goes on and on. What a waste of workers' money who pay from their salaries for treatment but do not get any treatment from an organisation which is flush with funds but does not want to spend that money in procuring proper medical services. No disciplinary measures have been initiated against any erring and negligent officials.

Manpower

Analysis of the data relating to the availability of staff revealed that the services of ESIC were adversely affected with large number of vacancies (Ministerial staff, Medical staff) in all cadres throughout audit period i.e. from 2008-09 to 2012-13. Overall position of the vacancies across the ESIC vis-à-vis sanctioned strength is given in **Graph below**



Sanctioned post and men-in-position for medical posts

Post	Sanctioned	Men-in- position	Vacant (*per cent* of the sanctioned)
Specialists	824	489	335 (41)
GDMO	1859	1445	414 (22)

Medical Officers (Ayurveda, Dental, Homeopathy)	101	82	19 (19)

Source: Reply to parliamentary question 463 dated 5/08/2013

Thus, the ESIC run hospitals were facing significant shortage of doctors. The shortage of 41 per *cent* of the specialists had an adverse impact on the specialists' services of the ESIC hospitals, leading to an increase in the quantum of referral cases.

Non retention of trained PG students

ESIC decided (2009-10) to establish a Post Graduate Institute of Medical Science and Research (PGIMSR) at Rajajinagar, Bangalore in the same premises where the 500 bed model hospital was already operational.

As per conditions stipulated in bond filled by the students before admission, students after completing PG courses should serve in the ESI hospitals for a period of five years and execute a bond for INR 7.5 lakh with interest @15 *per cent* per annum in case of violation of the above terms. Audit found that only two out of ten students who became Post Graduates during 2012-13 were serving in the ESI hospitals. Thus, ESIC could not utilize the services of its PG students despite taking service bond of five years.

Incorrect selection of places for opening of hospitals

As per ESIC norms, minimum 400000 IPs are required for establishing a 500 bed hospital. Audit observed that, the number of IPs in Gulbarga (Karnataka) and Mandi (Himachal Pradesh) were only 40700 and 207100 respectively (as on 31 March 2013). Thus, decision to establish hospitals at these two places was imprudent as these did not fulfil minimum required norms.

Several other observations related to incorrect electricity load factor, delayed construction, non-recovering of labour cess, irregular expenses on renovation of minister's office, faulty project monitoring systems etc. were noticed which resulted in severe financial losses to ESIC.

What gross mis-management of funds by the corporation! Does the corporation think that it is in the business of real estate? How long does it take for construction of hospital / dispensary? The plot would only have been procured after a survey would have been done and agreement with the state government regarding implementation of the scheme. Did it happen that as soon as an agreement happened, the factories in the areas closed or wage limit increased?

Further, when enquired about the inaccessibility of hospitals and dispensaries at some places because of their locations, ESIC says that main constraints in locating the hospitals at places accessible to the beneficiaries is that substantial land is required for construction which will not be available at affordable rates in prime locations. So they construct hospitals which are not accessible. The corporation is not willing to purchase prime land for easy access to medical facilities but it is willing to purchase prime advertising space in leading National Dailies and Television networks to promote itself. However, there are no awareness campaigns for the medical facilities and benefits provided by the corporation.

Questions that need urgent answers and redressals

1. Why is there a shortfall of Medical personnel?
2. Why are the meetings of various boards and councils not held regularly as per guidelines?
3. Why are various boards and councils lying defunct and non-functional in many areas.
4. Why aren't the arrears recovered from defaulting organizations?
5. Why is there a delay in settlement of claims?
6. Why is the condition of medical services like ambulances and medical staff poor?
7. Why are the beds in ESI hospitals not commissioned to its full capacity?
8. Why does the precious medical equipment lie idle for want of specialists or AMC contracts?
9. Why are the hospitals / dispensaries not constructed timely, after proper planning and within budget?
10. Why is there a proposal to involve private players to run ESI hospitals?
11. Why has the action plan to strengthen the Occupational health services in the country not been implemented?
12. Why do the same audit discrepancies keep reappearing?

It seems that ESIC does not want to learn any lessons. For the corporation, Audit is just an exercise which will happen routinely and some time will need to be spent with the auditors. Once the audit finishes it is back to business as usual. If this is the case, why should CAG waste public resources on auditing and Instead the CAG should simply publish the same report after just changing the audit date and save valuable tax payers money. **The corporation needs to seriously introspect its working and start improving immediately.**

Pragmatic Ways Ahead: Take Action Now!

- Amend the ESI Act to include Trade Union representatives, NGOs, social activists as members of various ESIC boards and committees to monitor implementation of services.
- Amend the definition of "Employee" in the ESI act to include "was working in an establishment" as in cases of occupational diseases (like silicosis, Asbestosis etc.), by the time they are diagnosed, the worker might have already left the employment.
- Survey new areas for implementation of scheme and work with state governments for speedy implementation.
- Appoint all Medical / Para medical staff including specialists against pending vacancies.
- Clear all pending claims urgently and ensure timely settlement
- Re-constitute regional boards, Medical benefit councils and Medical Appeal tribunals in all areas of implementation and hold regular and fruitful meetings.

- Locate hospitals / dispensaries in easily accessible locations. These facilities should be located on the ground floor as much as possible else have disabled friendly facilities.
- Build own dispensaries / hospitals and vacate hired premises.
- Improve medical care facilities and create awareness among the IPs of the region about various services available to them.
- Evaluate the services and prepare indicators of quality. Encourage staff to provide good quality services. Organize social audit through Trade Unions, NGOs, Professionals and IPs.
- On the day of registration itself, the IP should be given detailed information by ESIC officer personally and at the end of the session, a booklet giving information in local language giving information on all the benefits, their limitations, procedure to claim benefits should be given. At regular intervals, they should organize seminars for the workers to know the benefits.
- Stop harping and leaning on private players to provide health services. Develop in-house capabilities and capacities to provide quality health care facilities.
- Publish latest and accurate data about the functioning of the scheme and promote transparency.
- Focus on creating awareness about the reasons for various diseases and Occupational Health among the workers and employers.
- Last but not the least, implement properly what is decided. Schemes should be on not only paper but result in changes in ground realities and improve worker's health across the nation.

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