MONOGRAPH ON THE ORGANISATION OF MEDICAL CARE
WITHIN THE FRAMEWORK OF SOCIAL SECURITY
IN INDIA

R.V. RAJAN

Formerly Director-General,
Employees' State Insurance Corporation, India

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This series of monographs, which was prepared in connection with a study of the organisation of medical care within the framework of social security, undertaken by the International Labour Office, with the assistance of external collaborators, covers the following countries:

- Belgium (Soc. Sec. 1968/D.5)
- Canada (Soc. Sec. 1968/D.8)
- Ecuador (Soc. Sec. 1968/D.6)
- Federal Republic of Germany (Soc. Sec. 1968/D.7)
- India (Soc. Sec. 1968/D.1)
- Poland (Soc. Sec. 1968/D.2)
- Tunisia (Soc. Sec. 1968/D.4)
- United Kingdom (Soc. Sec. 1968/D.3)
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1. Spread over 1,200,000 square miles, India is a federation of 17 states with wide variations in climate and terrain - it has some of the highest peaks, largest plains, longest rivers and driest and wettest regions in the world. According to the census of 1961, India had a population of 440 million; it is estimated that it had risen to 949 million by 1966, and will further increase to 560 million in 1971 and to 630 million in 1976. The census indicated that nearly 360 million people lived in about 570,000 villages, out of which 350,000 had a population under 500. There were only seven towns with 1 million citizens or more, 100 with a population ranging from 100,000 to 1 million and 2,500 with a population between 5,000 and 100,000.

A. Methods by which Members of the Population May Obtain
(a) Medical Care In Case of a Morbid Condition or of Maternity and
(b) Other Personal Health Services

2. Under the Constitution of India which defines the respective spheres of the central and state governments, the item "public health and sanitation, hospitals and dispensaries" is a "state" subject. However, effective co-ordination, direction and guidance are afforded by the Central Government through the National Development Council (with the Prime Minister, Ministers of the Central Government and Chief Ministers of states), the Central Council of Health (headed by the Union Health Minister), the Planning Commission (the Prime Minister is the Chairman) and frequent meetings of Ministers and officials of the central and state governments. As national health is a national problem (communicable diseases do not respect state boundaries) schemes of importance all over the country have necessarily to be sponsored, encouraged and subsidised by the Central Government for effective implementation by state governments.

3. In examining the nature of medical care available to sectors of the community, it will be relevant to study the occupation pattern of the population; the volume of medical care provided depends often on the job of the bread-winner. The census report of 1961 gives figures of the number of persons in certain occupations. On certain assumptions regarding the size of the family in each category, approximate figures of the number of persons (men, women and children) supported by each major occupation will be deduced. Except for a slight increase in the percentage of those engaged in industry, the pattern of distribution amongst occupations in 1961 may be regarded, by and large, as applicable in 1966. Agriculture provided employment to about 131 million (about one-fourth being landless labourers) and food to them and about 154 million dependants, or a total of 285 million. Household (cottage) industry, also mostly in rural areas or small towns, sustained about 25 million. Industries supported about an equal number. Trade and commerce maintained 23 million (most of them self-employed in shops). Transport, storage and communications supported about 10 million (about 5.5 million in railways). Mining, quarrying, livestock, forestry, fishing, building,
plantations, orchards and allied activities maintained about 14 million (about 2 million in organised plantations). "Other services" of various types supported nearly 52 million (including 14 under Central Government, 19 in state governments, 14 in quasi-government and local bodies, 5 in public sector projects). "Construction" accounted for about 6 million. While the estimates may be conjectural, they will be of some advantage in endeavouring to assess the volume and quality of medical care available to citizens. A proposal for a health service scheme to benefit 1.2 million students and 70,000 teachers in universities is under examination.

4. There is no National Health Service in India; nor is the development of a medical programme on such lines a practical proposition in the near future if it has to be financed by the State. The per capita income in 1960-61 was only Rs.326; it was planned to raise it to Rs.385 in 1965-66. The per capita expenditure on medical care incurred by the central and state governments during 1960-61 was only Rs.2.19. Even assuming that the insuperable problems posed by the acute shortage of medical and para-medical personnel, equipment and of buildings for hospitals and dispensaries can be overcome, the financial resources of the central and state governments will not yet permit a free National Health Service. It may be stated that the budget of the Central Government envisages an expenditure on revenue account during 1966-67 of about Rs.34,000, million under various heads (including Health).

5. Every citizen of India, irrespective of his income or status or occupation, is eligible to avail free of cost of such medical facilities as may be made available by government or local bodies. Administratively, India consists of 17 states subdivided into about 330 districts, each of which is subdivided into taluqs. Excluding arrangements made for their employees by the central or state governments or by the management of mines or plantations, or by social insurance for industrial workers, the vast majority of the population (which lives mostly in villages or small towns) has to rely on the inadequate amenities that may be available. There are of course large and well-equipped hospitals, with all specialities under experts of skill, in the capitals of states or in very large towns, fairly well-manned hospitals in larger districts, and somewhat inadequately staffed and equipped hospitals in smaller districts and taluqs. Even though a great deal has been done by the Government of India and state governments since August 1947, when India became independent, in view of the severe shortage of medical and para-medical personnel and the inevitable time-lag in implementing schemes for training, the position is as indicated in the table on page 3.

6. The shortage of medical and para-medical personnel has been aggravated even more by maldistribution - while over 80 per cent. of the population lives in villages, over 65 per cent. of such technical personnel live in urban areas. As elsewhere in the world, medical personnel tend to concentrate in "centres of wealth".

7. One has only to think of the large number of persons afflicted with major ailments to realise the current inadequacy of resources - human and financial. It may be mentioned that, in common with developing countries in South-East Asia, India's health problems are under- and mal-nutrition (the average intake is less than 1,800 calories against the requirements of 3,000), high maternal and infantile morality (38 babies are born every minute - 2,300 every hour and over 20 million a year while infantile mortality is about 100 per 1,000 live births), high incidence of communicable diseases.
<table>
<thead>
<tr>
<th></th>
<th>1950-51</th>
<th>1965-66</th>
<th>Ratio to population in 1965-66</th>
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<tbody>
<tr>
<td>Hospitals and Dispensaries:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Institutions</td>
<td>8,600</td>
<td>14,600</td>
<td>0.003</td>
</tr>
<tr>
<td>Beds</td>
<td>113,000</td>
<td>240,100</td>
<td>2.063</td>
</tr>
<tr>
<td>Primary Health Units</td>
<td>-</td>
<td>5,000</td>
<td>-</td>
</tr>
<tr>
<td>Medical Colleges</td>
<td>30</td>
<td>87</td>
<td>5.70 million</td>
</tr>
<tr>
<td>Dental Colleges</td>
<td>4</td>
<td>13</td>
<td>38.8 million</td>
</tr>
<tr>
<td>Doctors (in active practice)</td>
<td>56,000</td>
<td>86,000</td>
<td>5,700</td>
</tr>
<tr>
<td>Nurses (in active practice)</td>
<td>15,000</td>
<td>45,000</td>
<td>11,000</td>
</tr>
<tr>
<td>Auxiliary nurse-midwives and midwives</td>
<td>8,000</td>
<td>36,000</td>
<td>13,700</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>-</td>
<td>48,000</td>
<td>10,300</td>
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(e.g. malaria, filariasis, tuberculosis, leprosy, smallpox, cholera, trachoma, venereal diseases, yaws, plague, virus diseases, live influenza, adeno-viruses, poliomyelitis, infective hepatitis, epidemic encephalitis) combined with inadequate sanitation, shortages of all types of technical personnel in the health field and practically non-existent public health services except in a few urban centres. It may be mentioned in passing that there are over 1.5 million cases of open tuberculosis, 1.0 million mental cases, 2.0 million mental defectives and epileptics, 2.0 million leprosy cases, 9.0 million goitre cases, 1.0 million cases of total blindness and 2.0 million cases of partial blindness showing ocular morbidity (excluding cataract), while up to 5 per cent. in some areas may well be subject to syphilis, an equal number to yaws (a non-venereal infection) in some endemic areas, and a high percentage (varying from 35 per cent. to 75 per cent.) to trachoma in the north and western states in India.

8. For outdoor treatment, there are dispensaries scattered over the country. The towns are fairly well served by local civic authorities. To serve rural areas, there are about 5,000 primary health centres with requisite staff, equipment and mobile vans - each of them is meant to serve about 40,000 persons. There are subcentres or referral hospitals in taluqs (district) headquarters or cities. Nor can it be said that medicaments are always available; very often the patient has to buy them on his own. It was estimated that in 1956 a householder spent about 2.3 per cent. of his income on medical care of his family. It is not astonishing that many villages rely on local practitioners of simpler indigenous systems of medicine (Ayurvedic or Unani) or homoeopathy.
9. Employees of the central (including the railway and posts and telegraphs) or of state governments and their dependants are entitled to free full medical care - outdoor, specialist and indoor (including pharmaceutical supplies). It may be stated that the arrangements made are generally adequate and satisfactory. Where treatment cannot be given in government institutions, reimbursement or expenditure is made. Workers in plantations (about 1.1 million) and their families (a total of about 2 million) are entitled by law to get free full medical care at the expense of their employers - the system is working fairly, but not very, satisfactorily. Large plantations have hospitals and dispensaries - smaller ones pool resources. There are about 2,500 plantations. The emphasis is on the curative, rather than on the preventive, side. Workers in coal and mica mines and their dependants (about 3 million persons) get full medical care free from welfare funds administered by Government; the revenues accrue from cess/duty levied on production/exports. The arrangements are generally satisfactory. The funds have hospitals and dispensaries at convenient centres besides arrangements elsewhere with public hospitals and dispensaries.

10. The only compulsory scheme of social insurance is administered by the Employees' State Insurance Corporation (E.S.I.C.).

11. There is no voluntary social insurance in India for medical care except as incidental to policies against personal accidents. Under labour legislation, employees are bound to provide first-aid facilities to workers in factories. In areas not covered by social insurance (E.S.I.C.), there are collective arrangements between large employers and their workers for medical care - the working of such agreements obviously depends on good-will, trust and ability. There are no private arrangements to any extent by way of group insurance or individual insurance. A few schemes have been run here and there by doctors but have not been particularly significant or successful. The problems of combining statutory schemes and private arrangements obviously do not arise.

12. The number of contributors to the compulsory scheme of the E.S.I.C. is about 3.5 million insured workers and about 17,000 employers. The estimated number of workers in mines, posts and telegraphs, central and state governments and local bodies, plantations and government factories who get medical care is given below:

<table>
<thead>
<tr>
<th></th>
<th>Million</th>
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<tbody>
<tr>
<td>Mines</td>
<td>.59    (1964)</td>
</tr>
<tr>
<td>Posts and Telegraphs</td>
<td>.47    (1965)</td>
</tr>
<tr>
<td>Railways</td>
<td>1.13   (&quot; )</td>
</tr>
<tr>
<td>Central Government</td>
<td>2.59   (&quot; )</td>
</tr>
<tr>
<td>State Governments</td>
<td>3.59   (&quot; )</td>
</tr>
<tr>
<td>Quasi-Government</td>
<td>1.23   (&quot; )</td>
</tr>
<tr>
<td>Local Bodies</td>
<td>1.60   (&quot; )</td>
</tr>
<tr>
<td>Plantations</td>
<td>1.20   (1962)</td>
</tr>
<tr>
<td>Government Factories</td>
<td>.77    (1964)</td>
</tr>
</tbody>
</table>

Medical care is afforded to the families of the above workers.
13. The vast majority of the population (excluding those covered by the E.S.I.C., employees of the central or of state governments or in plantations or coal/mica mines or in the public sector or in very large undertakings in the private sector in centres (where the E.S.I.C. does not operate) has to depend on whatever facilities may be made available by the Government. There is no statutory eligibility for medical care and services so rendered are regarded as a part of expenditure from general revenues. Similarly, in regard to employees of the central or of state governments or in public sector undertakings or mines, such facilities are provided not because of any statutory liability on employers but because of their anxiety to be model employers.

14. The statutory enactments envisaging medical care are:

(a) Workmen's Compensation Act (1923)

This protects workers earning up to Rs.500 per month against injuries sustained during employment in railways, manufacturing industries, mines, shipping and building industry. The liability to pay compensation according to assessment of disability (or for death) rests entirely on the employer. "Occupational diseases", so declared by Government, are regarded as employment injuries. In areas covered by E.S.I.C., the Corporation assumes liability for compensation. Medical care is not the responsibility of the employer; the Workmen's Compensation Act does not provide medical care in any form.

(b) Central Maternity Act (1961)

This applies to workers in factories, mines and plantations and has been generally adopted by state governments. There is an elastic provision for extending the application to "any other establishment or class of establishments, commercial, agricultural or otherwise". The qualifying condition is service of at least 160 days in the 12 months preceding the expected confinement. Cash benefit equal to the average daily wage during the preceding three months is payable for 12 weeks. No medical care is envisaged but a medical bonus of Rs.25 is provided if prenatal, confinement or postnatal care is not provided free by the employer.

(c) Mica Mines Labour Welfare Fund Act (1946)

There is no legal entitlement to medical care; nor is the Fund bound to provide such facilities. Section 3(2) of the Act merely stipulates that the Fund "may be utilised to defray the cost of measures for the benefit of labour employed in the mica mining industry directed towards:

(i) the improvement of public health and sanitation, the prevention of disease, and the provision and improvement of medical facilities;

(ii) the provision and improvement of water supplies and facilities for washing".

This cannot, therefore, really be treated as a statutory scheme requiring the provision of medical care.
(d) **Coal Mines Labour Welfare Fund Act (1947)**

The preamble to the Act refers to the promotion of welfare of labour in coal mines. Section 5 permits the Central Government to pay grants-in-aid to colliery owners who maintain satisfactory dispensary (out-door) services. As in the Mica Act, workers are not legally entitled to get medical care from the Fund; nor are employers statutorily required to provide such facilities. Subsection (4) of section 5 states that moneys in the Fund "may be utilised to defray:

(a) the cost of measures for the benefit of labour employed in the coal-mining industry, directed towards:

(i) the improvement of public health and sanitation, the prevention of disease, the provision of medical facilities, including the provision and maintenance of dispensary services in collieries the owners of which do not receive grants-in-aid".

(e) **Plantations Labour Act (1951)**

Workers in plantations are entitled, at the expense of the employer, to medical, health, housing, leave and maternity benefits; they are not covered by the E.S.I.C.'s activities. Plantations are dispersed in various states with Assam, Mysore, Madras, West Bengal and Kerala having 2,300 out of 2,500 in the country; even inside a state, plantations of varying sizes are spread over large areas. The fact that there have been spirited representations from workers in some states that plantation workers should be covered by the E.S.I.C. may be a pointer to inadequate facilities.

(f) **Employees' State Insurance Act (1948)**

This is the only real measure of social security in India providing medical care. The Workmen's Compensation Act and the Maternity Act place the liability on the employer while the Mica and Coal Mines Welfare Funds derive revenues from cess or duty; there is no statutory entitlement or liability to get free medical care. They can at best be regarded as measures of relief permissible under the Statute.
B. Provisions of the Employees' State Insurance Scheme
Concerning Medical Care

Scope

15. The Employees' State Insurance Act applies to all workers in "power" - using non-seasonal factories (excluding mines and railway running sheds) in which 20 or more persons work on a monthly remuneration of Rs. 400 or less. Under a recent amendment to the Act, the wage ceiling has been raised to Rs.500. The E.S.I.C. serves 3.5 million insured persons to whom it affords five benefits - four in cash and one in kind; the cash benefits are against sickness, disability (due to employment injury, including an occupational disease), maternity, and death (due to employment injury including an occupational disease). The benefit in kind is medical care which is extended to members of families of the insured. About 12.60 million persons (including the workers) get medical benefit.

Range of Benefits

16. While insured persons are entitled to "full" medical care (all facilities including hospitalisation), it has not been possible for the Corporation so far to extend such wide benefit to members of families (i.e. spouse, children and dependent parents). The main reason is that there are not enough regular E.S.I. hospitals for the purpose. Except at two centres (Hyderabad and Sirpur-Kagaznagar in Andhra Pradesh) in India, members of families either get "expanded" medical care (i.e. all facilities short of hospitalisation like laboratory and radiological investigations, specialists' consultation, dental care, pharmaceutical supplies, domiciliary visits, ambulance services) or where adequate resources of personnel are not available "restricted" medical care of the out-door general practitioner variety including ordinary pharmaceutical supplies. It is estimated that currently about 70 per cent. of families get "expanded" medical care. It is the declared objective of E.S.I.C. to give "full" medical care to families; the fulfilment of this objective must depend, however, on the commissioning of the several E.S.I. hospitals that have been planned. It may be mentioned that there are 16 E.S.I. hospitals and 18 E.S.I. annexes (to existing public hospitals) providing about 2,700 beds. Another 46 E.S.I. hospitals and eight annexes are in varying stages of construction to provide another 7,000 beds. The E.S.I.C. has so far sanctioned a sum of about Rs.340 million for the building of E.S.I. hospitals and dispensaries (84 dispensaries owned by the E.S.I.C. are working and an equal number is under construction). About 3,500 beds have been reserved in public hospitals for the use of insured persons. It would be premature to think of "full" medical care to families till the requisite number of fully-fledged E.S.I. hospitals can be commissioned.

17. While pharmaceutical supplies to insured persons or their families are free, ordinarily only preparations recognised by the Corporation, on the advice of the Medical Benefit Council (headed by the Director-General of Health Services and with heads of medical services of states and representatives of the medical profession, employers and employees as members), are supplied. The E.S.I.C. has prepared three lists - one for ordinary medicines, a second for special medicines which can be given by Insurance Medical Officers/ Insurance Medical Practitioners in "service"/"panel" areas, and a
third which will be supplied only on the prescription of approved specialists. The lists are compiled with care to preclude abuse of proprietary preparations based on "prejudice" (however genuine) of the doctor. There are about 1,000 specialists in the E.S.I. scheme - most of them part-time, utilisation of experts on a part-time basis makes possible the pooling of the limited resources of top specialists available in the country. Specialist care in medicine, surgery, gynaecology and obstetrics, pathology, tuberculosis, pediatrics, ear-nose-throat, eye and skin and venereal diseases is provided in hospitals or separately in diagnostic centres in larger cities. Dental care is given in the larger centres though not to an adequate extent.

18. It may be mentioned that while the E.S.I.C. accepts direct responsibility for the disbursement of cash benefits, the administration of medical benefits under the E.S.I. Act is the responsibility of state governments which make the requisite arrangements, advance the necessary funds and thereafter are reimbursed seven-eighths of the cost from the E.S.I.C. On the advice of the Medical Benefit Council, the E.S.I.C. has laid down certain yardsticks for capital construction (five general, two maternity and four T.B. beds per 1,000 insured persons), specialists and out-door care (one doctor per 750 insured persons with families).

19. While it cannot be pretended that the E.S.I.C. has been able to do a great deal for personal preventive health services (environmental hygiene is appropriately the concern of local authorities) it may be mentioned that when epidemics are threatened all doctors under the E.S.I. scheme render useful services through vaccination or inoculation, the E.S.I.C. joins in co-ordinated action with local authorities. The E.S.I.C. also immunises children through administration of triple vaccine (against tetanus, diphtheria and whooping cough). Pilot schemes for an integrated health service are being started in two centres. An aspect where the E.S.I.C. has shown real initiative relates to family planning. Apart from free supply of contraceptives, the E.S.I.C. helps in performing vasectomy or salpingectomy to sterilise an insured person or his spouse; it also gives a small allowance to cover incidental expenses.

Qualifying Conditions for Benefit and Free Period of Protection

20. There is no qualifying period for the entitlement of an insured person to medical benefit - his title commences from the very moment of his entering insurable employment. The title continues so long as the person is in insurable employment or is qualified to claim sickness, maternity or temporary disablement benefit. There is a free insurance period for medical treatment after one has been in employment for 13 weeks or more which ranges from six to nine months depending on the contribution record. For a person afflicted with a long-term disease (e.g. cancer, leprosy, cirrhosis, lung abscess, ulcerative colitis, gangrene, paraplegia), entitlement can be extended for another 12 months. Executive instructions permit enabling anyone receiving indoor treatment to continue to do so until cure or discharge, irrespective of lapse of title. Members of families become entitled to medical benefit only three months after the implementation of the E.S.I. scheme in any industrial centre - the time-lag is not based on any principle but is one of expediency to enable state governments to gear arrangements to take on the additional load in respect of families in the light of experience in the provision of medical care to workers.
Cost Sharing by the Beneficiary

21. It may be reiterated that neither the insured person nor any member of his family has to pay any portion of the cost of medical care he gets under the E.S.I. scheme.

Administration

22. The E.S.I.C. is an autonomous body created under the E.S.I. Act. The Chairman is the Union Minister for Labour, and the Vice-Chairman the Union Minister for Health. The Corporation meets about twice a year to decide questions of policy. The other members of the Corporation represent the Central Government, state governments, employers, employees, the medical profession and Parliament. There is a Standing Committee, headed by the Union Deputy Minister of Labour, which meets once a quarter and which also represents the interests mentioned. The Chief Executive Officer is the Director-General, who is appointed by the Government of India. While the Government has obviously to ensure that the social insurance scheme works with efficiency, there is ordinarily no interference in the working of the Corporation. Government have powers under the Act to supersede the E.S.I.C. if it fails to fulfil its responsibilities. The Central Government appoints the Director-General and principal officers (Medical Commissioner, Insurance Commissioner, Chief Accounts Officer and Actuary) and has its nominees on the Corporation and the Standing Committee. The budget of the E.S.I.C. has to be approved by the Central Government. The accounts of the E.S.I.C. are audited by the Comptroller and Auditor General. The Annual Report, the budget and accounts of the Corporation are in due course placed before Parliament.

Financing

23. The revenues of the E.S.I.C. are derived from the contributions of employers (at 2 1/2 per cent. of the wage roll in implemented areas and 3/4 per cent. thereof even where the E.S.I. scheme is not in force) and contributions from employees (depending on wage groups but roughly about 2.4 per cent. of wages). There is no contribution by the Central Government, nor do the state governments contribute anything directly — as stated earlier, they bear one-eighth of the cost of medical benefit; the argument presumably is that, after all, every citizen is entitled to measures of "health" (a "state" subject) from the local government. The contribution by employers and employees finances all the five benefits (medical, sickness, maternity, disablement and death). There is a transitory provision under which the employers' contribution can be raised to 5 per cent.; afterwards, the intention is that employers only in implemented areas will pay according to wage groups, roughly 4.6 per cent. of the wage roll. The budget of the Corporation for 1966-67 envisages an expenditure of Rs.112 million on medical benefits (seven-eighths the costs) against Rs.96 million on cash and other benefits. The cost of medical care is bound to show a progressive increase as the quality and quantity thereof is improved and comprehensive medical facilities are given to members of families also.

Right of Appeal

24. Though medical care may be only one of the five benefits provided by the E.S.I.C., it is obviously the king-pin of the mechanism of social insurance. Under section 75(1)(e) of the E.S.I. Act,
any dispute in regard to "the right of any person to any benefit and as to the amount and duration thereof" is referred for decision to the Employees' Insurance Court; there are several employee's insurance courts in the country. It may, however, be stated that it has not been considered necessary by any insured person or by the E.S.I.C. to refer any dispute over medical care to any employees' insurance court since 1952 when the scheme was first introduced. To begin with, there is no uncertainty regarding title as there is no qualifying condition for medical benefit; the family gets it after three months. In regard to the "amount" of medical care, for obvious reasons this cannot be defined in medical services involving human doctor-patient relationships. As far as "duration" is concerned, most workers who leave insurable employment return to their villages where the E.S.I. scheme does not function even though the title to such benefit may continue. Moreover, it is the convention that medical care is not denied to workers or families because of any quibbling over title. Any complaints over refusal of benefit are decided by mutual discussions and after rapid investigations - medical care is not withheld during such period.

25. The right of appeal as to the quality or the quantity of medical benefit would also appear inherent in section 75 of the E.S.I. Act; but the right is perhaps academic as neither the quality nor the quantity of medical care can be defined with the legal precision necessary to ensure its being successfully justifiable. Moreover, in the current context of severe shortage of medical and paramedical personnel and the meagre facilities available to the general public, it would be unrealistic for any judicial body to order a standard "quality or quantity" incapable of observance. This aspect of ensuring medicare must depend on goodwill, confidence, trust and understanding between the beneficiaries and the E.S.I.C. It may be added that there is a General Purposes Subcommittee of the E.S.I.C. which visits various centres to study the working of the E.S.I. scheme - especially the medical side. The Corporation also has an inspection team of specialists, regional boards in states and local committees in industrial centres (the last two formed on a tripartite basis) to deal with general or individual problems that arise and try to solve them to the best of their ability.
C. Application of the Employees' State Insurance Scheme - Experience and Problems

26. The E.S.I. scheme is administered not as a department of Government but through an autonomous Corporation constituted on a tripartite basis, with representation to the medical profession. The scheme is also the only statutory one in effect in all the states in India. The Corporation's experience in running medical care from 1952 (when only 120,000 workers were covered and their families did not get any medical benefit) to 1966 (when 12,600,000 men, women and children are served) in different states through various methods may be of some interest.

27. A reference to facilities for treatment through indigenous systems of medicine may be relevant. Even though medical benefits under the E.S.I. scheme are normally provided through modern medicine (the percentage of such cost may be 95 per cent.), the E.S.I.C. provides facilities for treatment by the indigenous systems wherever there is an appreciable demand for such facility from workers. In 1965, there were over 400 insurance medical officers, 450 insurance medical practitioners and five specialists under the Ayurvedic system - about 70 beds were also reserved in Ayurvedic hospitals. The other indigenous system (Unani) has not so far been in great demand; nor has homeopathy yet been recognised as a form of treatment. The examples of China and Japan, which had declared a moratorium over a period after which indigenous systems were not recognised, would suggest that in India also, the emphasis will perhaps finally be on modern medicine, as participation in international health services (e.g. W.H.O., U.N.I.C.E.F., Rockefeller and Ford Foundations, A.I.D., Colombo Plans, aid from U.S.S.R.) requires that health services in India should be based on modern medicine. The non-availability of allopathic practitioners (there was only one in 45 villages in 1957) and greater supply of Ayurvedic practitioners (one in 21 villages) and the comparatively cheaper treatment by the latter are factors to be remembered. Moreover, there is little doubt that Ayurveda is a hoary science of great value, which has stood the test of several centuries and whose lessons can usefully be applied. It would be churlish to belittle a science of such antiquity and popularity. It has been the experience that for certain types of ailments, Ayurveda provides relief to a greater extent than modern medicine. In Bombay, skilled specialists in modern medicine at times refer old chronic cases to their Ayurvedic counterparts. In the circumstances, the policy of the E.S.I.C. is to permit insured persons to choose whichever system (Ayurveda or Allopathy) they like. Indeed, these are not regarded as contradictory and change from one system to the other at any time is permissible. It is a platitude to say that the faith of the patient in his doctor or in the system of treatment is a vital factor in ensuring rapid recovery; it would be imprudent to ignore the psychological angle.

Ambulatory and Domiciliary General Practitioner Care

28. The E.S.I. Act envisages out-door (ambulatory) and domiciliary treatment ordinarily through the "service" system; there is, however, a provision enabling the use of the "panel" system - section 58(1). Under the "service" system, general practitioner care is given through regular E.S.I. dispensaries (clinics), whether in buildings owned or rented by the Corporation, manned by whole-time doctors (called insurance medical officers) who are not allowed any
private practice. Under the "panel" system, insured persons are allowed to choose any doctor (called an insurance medical practitioner) from the list of practitioners made by the state government after inspection of private clinics. Similarly, the doctor in private practice has to accept an insured person - a worker is permitted to change his doctor only once a year. The E.S.I.C. also avails itself, on payment, of dispensaries run by the larger employers. In November 1966, the following arrangements existed in 268 centres for 12.6 million beneficiaries:

(a) Dispensaries ..................... 589 (including 44 mobile and 40 employers' ones)

(b) Insurance Medical Officers ...... 1,289

(c) Insurance Medical Practitioners .. 3,929

It may be stated that the "panel" system mainly exists in the cities of Calcutta (about 2.8 million beneficiaries) and Bombay (about 2.6 million beneficiaries) and only in small pockets in a few other states. It would be academic to attempt to discuss which system should be followed by social insurance in India. It would be impossible to find another four or five thousand doctors and paramedical personnel on a whole-time salaried basis; even if this can be done, the prospects of siting land and of constructing dispensaries in huge industrial cities like Calcutta and Bombay (with a population of 6 million or more) are bleak. Obviously, the best use has to be made of all available personnel. An interesting trend is evident in Punjab where the state government is gradually changing over from the "panel" system to the "service" system; the government of Madras also propose to do so in Coimbatore, which is the only "panel" pocket in that state. The number of doctors involved in Punjab and in Madras would be small.

29. The E.S.I.S. Review Committee, formed on a tripartite basis under the chairmanship of a Union Minister, reported early in 1966, after a study lasting nearly three years, that "service" system offers better possibilities of giving satisfactory medical service to the insured persons and their families. It came to such conclusion after visiting several centres and hearing many witnesses (including local and all-India organisations) representing workers, employers and the medical profession.

30. While it cannot be pretended that the "service" system renders ideal service, qualitatively or quantitatively, it has been the experience that there are fewer grounds for complaints in the areas where it is applicable. A great advantage of the "service" system is that regular E.S.I. dispensaries can be constructed tailor-made to fit requirements. In some centres, E.S.I. dispensaries have been so designed as to enable not merely the handling of several patients with comfort but to provide for minor operations, like vasectomy, in the dispensary itself; even operations like dilation and curettage and simple hernia are performed with aseptic safety. As the larger dispensaries are manned by several doctors, requisite skilled personnel is available. Also, the necessary equipment can be purchased by the E.S.I.C.; this is beyond the means of most private practitioners. Such dispensaries also have essential para-medical personnel and can deal with most of the routine tests of urine, faeces and blood. Pharmaceutical supplies
are also more conveniently arranged through the "service" system; the dispensaries stock all the medicines needed under the Ordinary List, and most of those needed under the Specialist's List. Well-stocked central medical stores are located in larger centres to make good any deficiency rapidly. Local purchase by the Insurance Medical Officer (I.M.O.) for emergencies is always possible for any medicine in short supply. The "service" system is also better suited for specialists' consultations because of effective contacts between I.M.O.s and experts. An important point is that as I.M.O.s are under the administrative control of Government, they are better able to do whatever may be needed for personal health service of insured persons and their families; they have rendered good services especially in family planning. The maintenance of statistics is of vital importance to social insurance - the "service" system provides more reliable and full statistics than the "panel" system where practitioners find it difficult to send prompt and full returns.

31. As stated already, the administration of medical benefits under the E.S.I. is the responsibility of state governments. In the "service" areas, I.M.O.s and those senior to them concerned with the E.S.I. scheme (except for "honoraria" - i.e. specialists from outside government service appointed on an honorarium) are borne on the cadres of the medical/health departments of state governments. While the Corporation reimburses state governments seven-eighths of the costs for providing medical facilities, it has no direct control over the personnel employed in states. The complaint has been made, with some justification, that inexperienced and raw hands are posted to the E.S.I. dispensaries. Service in the E.S.I. is not popular for a variety of reasons - e.g. unpleasantness at times in dealing with vociferous industrial workers, especially in regard to certification, the volume of paper work involved, working in some smaller towns with poor amenities, lack of touch with regular surgical and medical experience and infrequent contact with top specialists. Indeed, in some areas posting to the E.S.I. is regarded as a punishment and young doctors insist that they should not be kept in such work for more than two years. It has also to be remembered that the department of medicine and health in state governments is concerned with medical and health problems for the entire population - the E.S.I. scheme currently covers only 12.6 million out of a total population of 460 million. While the E.S.I.C. collects contributions from employers and employees and is clearly answerable for adequate medical care to its beneficiaries, it has to depend on state governments who, despite the best of intentions, have their own problems. It is true that close and constant contacts are maintained at all levels between the E.S.I.C. and state governments. There is also little doubt that state governments are doing all they can in the current context of the shortage of medical and para-medical personnel; they realise that capital construction of hospitals and dispensaries by the E.S.I.C. relieves the congestion on inadequate resources while the payment of seven-eighths of the cost of the covered industrial population is an appreciable relief to their financial commitments.

32. The question of the E.S.I.C. assuming direct responsibility for medical care, even as it does for cash benefits was also considered by the E.S.I.S. Review Committee, which felt that "it would not be expedient to make any radical change in this regard at present" and preferred continuance of the status quo. The main grounds were that the E.S.I.C. will have to build up "a huge organisation", that conditions vary in different parts of the country, that as scales of pay of the E.S.I.C. (the same as the Central
Government) are higher than those of state governments the latter will face shortages, that the extension of the scheme needs full cooperation of state governments, that as "health" is a state subject local governments already have extensive medical services which could with adjustments be deployed for the E.S.I., that state governments can site lands for and build E.S.I. hospitals and dispensaries quicker, and that a multiplicity of schemes would militate against a planned approach to a national health service. The arguments for the E.S.I.C. taking over the administration of medical benefits are even stronger. After all, the E.S.I.C. is under a quasi-contractual obligation to give medical benefits to insured persons who really are policy-holders; it is not proper that it should depend entirely on state governments over whom it has really no control. On "health" matters, influence and prestige rather than legal powers conferred by the constitution enable even the Union Government to exercise leadership. In a democratic system of government, state governments who are subject to the strain and stress of political pressures are apt to equate medical facilities under the E.S.I. with the most inadequate medical facilities available to the non-E.S.I. general public who constitute over 95 per cent. of the population. Dual control connotes dilution of responsibility; apart from some delays, the insured person (policy-holder) finds it embarrassing to find his representations on medical care dealt with by a state government while he and his employer pay to the E.S.I.C.

33. The main argument in favour of the E.S.I.C. taking over medical care is the undoubtedly wide disparity in the quality and quantity of medical care given in different states. The per capita cost per insured person (including his family) shows startling variations, which cannot fully be explained on the bland ground of higher morbidity - on the cash side, the sickness benefit (based on medical certificates) per insured person also varies widely. An all-India scheme of social insurance must clearly have uniform standards. It is unfair that while insured persons pay the same rate of contributions throughout the country, the facilities available should show wide variations. The E.S.I.S. Review Committee was headed by a Union Minister and had three Ministers from larger states. Its conclusion itself would appear somewhat "apologetic"; the term "expedient" suggests diffidence in taking a bold decision.

34. There is no reason whatsoever why the E.S.I.C. should not look after medical care directly. It is pessimistic to apprehend that state governments would then sabotage the working of the scheme - after all, states are an integral part of the Federation of India and insured persons and members of their families are also citizens of states. It seems unjust to insured persons to suggest that because the E.S.I.C. can pay higher salaries and attract better quality medical personnel, state governments should continue to give medical benefits of poorer quality. There is a quid pro quo in insurance and insured persons can legitimately demur over the vicarious punishment inflicted on them through poorer medical services. It would, of course, be absurd to think that the E.S.I.C. can take over direct liability for the medical care of 12.6 million persons in various states immediately. It has done so in Delhi (which is a Union territory) since 1962 and serves about 100,000 workers and their families, or about 400,000 men, women and children. The E.S.I.C. has effected appreciable improvements in four years - families get "expanded" instead of the "restricted" medical care available previously; more E.S.I. dispensaries have been started; more beds have been reserved in hospitals; diagnostic facilities have been
enlarged; the construction of an E.S.I. general and and E.S.I. T.B. hospital has been sanctioned at a cost of Rs.25 million. The E.S.I. scheme was introduced in Delhi in February 1952 - medical care was run by the Delhi administration till 1962. As the Delhi administration dealt with about 2.5 million inhabitants and the E.S.I. beneficiaries were only a part of the public, it cannot be reasonably arraigned of nonchalance. What is suggested is that if the E.S.I.C. runs medical care directly, it can plan more effectively for adequate medical facilities all over India. While the E.S.I.C. cannot assume such liability everywhere all at once, it should certainly be possible to decide that within a period of ten years medical benefits will, like cash benefits, be administered directly by the E.S.I.C. During this period, the E.S.I.C. will take over such responsibility state by state. There is no reason at all why there should, during the intervening period or later, be any antagonism between the E.S.I.C. and state governments. Even if state governments feel that the E.S.I.C. should then pay full costs of medical care under the E.S.I. (instead of seven-eighths as at present) this could be examined. There seems to be no "constitutional" difficulty in the E.S.I.C. assuming direct responsibility.

35. The consequences of E.S.I.C. directly running medical care, especially in "service" areas, have wide implications even apart from ensuring somewhat uniform standards of medical care, better control over certification, and check on the cost of drugs and dressings. Even for the current insured population of 3.5 million, about 4,500 doctors will be needed for ambulatory and domiciliary medical care. On the current yardsticks of capital construction, E.S.I. hospitals providing 17,500 general, 7,000 maternity and 14,000 tuberculosis beds with a galaxy of specialists, doctors, nurses and para-medical personnel will be required. The E.S.I.C. will have literally thousands of doctors of varying skills and experience with very many more para-medical personnel - e.g. nurses, midwives, health visitors, laboratory technicians, pharmacists, physiotherapists, dental mechanics and hygienists, sanatarians. It can run "refresher" courses and enable proper orientation of medical personnel. It will then be an economic proposition for the E.S.I.C. to run medical colleges for graduate and post-graduate courses. Dealing with industrial workers and their families, the E.S.I.C. can provide valuable data for study of, and research in, "industrial medicine" which has so far been neglected. With delegation of powers and decentralisation of authority to the extent necessary, the work of the E.S.I.C. will not at any time be bogged.

36. In "panel" areas, medical practitioners are selected by the Allocation Committee, which inspects clinics to ensure availability of space and facilities. The "panel" doctor, insurance medical practitioner (I.M.P.) is expected to give ordinary medicines to insured persons and families; he can prescribe other special and costly medicines which are given free of cost by approved chemists to the insured person. The number of insured persons (with families) registered with any I.M.P. is limited to 750. The I.M.P. can refer cases to diagnostic centres or approved specialists or hospitals. There were 3,929 I.M.P.s on 30 November 1966.

37. There is little doubt that the working of the "panel" system is far from satisfactory. To begin with, it is well known that no practitioner of great ability likes to be an I.M.P. with the E.S.I. General practitioners with good practice amongst the middle classes fight shy of being I.M.P.s despite the handsome capitation fee.
In large cities like Bombay and Calcutta, where land is literally worth its weight in gold, space is very difficult and most expensive to get. As a result, many of the clinics are dark, dingy and cramped. The Medical Benefit Council had recommended that an I.M.P. should have in his clinic minimum space of 240 square feet. Considering that essential needs are some waiting space, a table for the doctor, a room for proper examination and a cubicle for dispensing medicine, even 240 square feet would appear grossly inadequate. Yet, many I.M.P.s in Bombay have even smaller clinics. The so-called "freedom of choice" in the "panel" system is an illusion in a country where doctors are in short supply - the nearest doctor is chosen. A change of doctor is difficult - the medical profession is well-knit. The "doctor-patient" relationship is no more strong in the panel system in India than in the "service" areas. It has also been alleged that panel doctors are more amenable to issue of certificates. The "panel" doctor prefers to prescribe costly or special medicines which the insured person gets from a chemist rather than give equally effective but ordinary medicines that the I.M.P. has to give from his stock (e.g. Irgapyrin instead of aspirin). Moreover, the insured person himself insists on more expensive medicines or injections. There is not merely increased health-consciousness but a tendency to demand costly medicines. Not all I.M.P.s attend clinics during the prescribed hours. It would be unrealistic to expect even routine tests (i.e. blood, urine, faeces) to be done by I.M.P.s most of whom do not have even proper compounders. The result is that as compared with "service" areas, a larger percentage of patients have to be referred to specialists in "panel" cities. I.M.P.s do not provide statistics in time - those received are not always realistic or full; they grudge expenditure on clerical staff which cuts into the capitation fee. Once appointed, I.M.P.s continue on the rolls unless after meticulous investigation they are found guilty of improper conduct - a very few have been so punished though several complaints have been made. The E.S.I.S. Review Committee reported "there have been cases of sizeable leakages of drugs and some cases of collusion between some doctors and approved chemists to defraud the Scheme". In a "service" area where drugs are given by dispensaries or from central medical stores, such abuses do not usually arise.

38. The real problem in the "panel" area is that the I.M.P.s, who, in Bombay, have a powerful Association, have frequently queried the elements of the capitation fee, especially the item of domiciliary visits to insured persons and families. Even when the scheme was confined only to workers in Bombay, on an average an I.M.P. paid few home visits (one a month or so per 1,000 workers); though the capitation fee was increased after extension to families, I.M.P.s do not admit any liability to visit patients in their homes. It can be said without exaggeration that domiciliary visits in panel areas are most infrequent. In "service" places, domiciliary visits are insisted upon administratively and the average number of home visits by an I.M.O. is at least 30 a month; a sliding allowance is paid for 30 visits or more a month.

39. As cramped clinics are spread all over the cities, with individualistic I.M.P.s, who are not really subject to disciplinary control, a grave disadvantage of the "panel" system has been the difficulty in giving personal health services to the beneficiaries or in being able to draw on the services of the practitioners for schemes like family planning. Obviously, most of the I.M.P.s have
no space at all or the requisite facilities even for a simple operation like vasectomy. Even distribution of contraceptives through 4,000 private practitioners poses problems. In any case, I.M.P.s have been reluctant to assume more than the bare responsibility of minimum out-door curative medical care.

40. It may be mentioned that in India, as elsewhere in the world, the medical profession is influential and effectively organised. The Indian Medical Association (the World Medical Assembly was held in India in 1962), has branches all over the country. The I.M.A. adheres to the "Principles of Social Security" adopted by the 17th World Medical Assembly in 1963 and is most zealous of the rights and privileges of I.M.P.s. Indeed, in October 1964, the I.M.P.s threatened to go on strike when a small E.S.I. dispensary was started in Bombay in a 600-bed E.S.I. hospital (built at a cost of about Rs.20 million); though freedom was given to the insured person to choose between an I.M.P. and the dispensary, I.M.P.s felt that infiltration of "service" system in a "panel" area was intolerable.

41. While state governments are doing what is possible in the circumstances to exercise control over the administration of medical care in "panel" areas, it will be appreciated that the problems to be faced whether general or in the day-to-day working are at once delicate and difficult.

42. About 100 dispensaries available with large industrial employers are utilised by the E.S.I.C. for ambulatory and domiciliary care on payment of capitation fee such as is given to I.M.P.s. It has to be said that the services rendered by such "utilisation" dispensaries have been excellent. They are well-staffed - even better than the yardsticks approved by the E.S.I.C. with doctors of experience and ability assisted by para-medical personnel. Except for some complaints here and there from insured persons and labour organisations about undue strictness in issuing medical certificates for sickness, these institutions are providing medical care of a high order. There is no doubt that employers do not get back through capitation fee the costs of running such dispensaries and treat the "loss" as part of labour welfare.

Specialist Care

43. The E.S.I. scheme provides for the following specialities wherever possible - medicine, surgery, tuberculosis, eye, ear-nose-throat, skin diseases, gynaecology, pathology, radiology, pediatrics, leprosy, orthopaedics, mental diseases, dentistry, endocrinology and anaesthesiology. Obviously, not all the specialities are available in every centre. The shoragage of specialists in India does not permit such facilities. The "brain-drain" from India has induced young doctors who go abroad for post-graduate qualifications to stay away because of better financial and other prospects. It may be mentioned that the E.S.I.C. pays the insured person a travelling allowance and a subsistence allowance (including such charges for an attendant where needed) if he has to go any distance because specialities are not locally available. There are about 1,000 specialists under the E.S.I. (most of them part-time). There is no choice on the part of the insured person in choosing a specialist; he has to go to the specialist appointed under the scheme. In other words, there is no "panel" system as far as specialists are concerned. It need hardly be added that specialists under the E.S.I. are men of
eminence and skill in their fields - some of them are part-time "honoraries" who have highly lucrative private practice. The insured person has to go to the hospital or to the diagnostic centre where part-time specialists attend on specified days during stipulated hours. It may be added that direct access to a specialist is not ordinarily permitted - the specialist will attend to a patient only on a referral by an I.M.O. (in "service" areas) or an I.M.P. (in "panel" areas); emergencies and casualties are expected. This applies naturally to the first attention - subsequent service by a specialist periodically will naturally depend on the circumstances of each case. The part-time "honorary" specialist is treated for the purpose of this study as a "service" person as he can exercise his skill only in hospitals, diagnostic centres or larger dispensaries under the E.S.I. scheme and as the beneficiary is treated free.

44. The problem of specialists also highlights the advantage of the administration of medical care directly by the E.S.I.C., which could then have in convenient centres in the country referral hospitals of a high standard and deploy the available short supply of skilled personnel to the best effect. The experience gained would also be of real use in research. Specialists working under several state governments somewhat in isolation may not be able, in spite of their best efforts, to achieve so much.

45. It has to be owned that there are not enough specialists under the E.S.I. to cope promptly with cases that arise - overcrowding in diagnostic centres is inevitable. But to a large extent this is inevitable as specialists cannot be made over-night - with the fulfilment of several plans for the expansion of postgraduate education, the E.S.I.C. may expect the position to ease of each case. It has been estimated that the country will need about 14,000 doctors of high skill - 4,500 for teaching in existing colleges, 3,900 for new medical colleges, 1,600 for postgraduate institutions and 4,000 as practising specialists. It may be mentioned that the Health and Survey Planning Committee (1961) had recommended one medical college for 5 million population to achieve a target of one doctor to 3,000 population by 1967.

Pharmaceutical Supplies

46. Pharmaceutical supplies are arranged in "service" areas through the E.S.I. dispensaries or medical stores run by the state government. For any temporary shortage, local emergency purchases are made from the market - the incidence of this to the total expenditure is fractional as adequate stocks are generally maintained. Where medicines, drugs and dressings are required during indoor treatment, the hospitals concerned give such stores free of cost to the insured person both in "panel" and in "service" areas. In "panel" areas, medicines which are not ordinary - i.e. those which the I.M.P. is expected to give free from out of his capitation fee - are prescribed for supply by chemists approved by the state government, which has a formula fixing the price. There is "free choice" to an insured person to purchase pharmaceutical goods from any chemist on the list. In practice, this choice is illusory as he goes to the chemist known to the I.M.P. or near the clinic.
In-Patient Care in Hospital

47. Indoor treatment is provided under the E.S.I. scheme either in fully-fledged E.S.I. hospitals or annexes built exclusively for the use of insured persons (and their families in due course) or in public hospitals where beds are "reserved" for the use of the beneficiaries. The rates are negotiated by the state government on behalf of the Corporation and are on an average about Rs. 8 per diem. At the end of November 1966, there were 1,974 general and 224 tuberculosis beds in E.S.I. hospitals and 207 general and 267 tuberculosis beds in E.S.I. annexes or a total of 2,672 beds. The number of beds reserved were 1,809 general and 1,519 tuberculosis. Thus, 6,000 beds were available to insured persons. Several E.S.I. hospitals and annexes are in varying stages of construction and would give another 5,500 general beds and 1,500 tuberculosis beds within the next year or two. The policy is to build hospitals through the state governments, which acquire the land, prepare plans and estimates for the approval of the E.S.I.C., undertake construction and make arrangements to get the hospitals going with requisite equipment and personnel - the E.S.I.C. provides necessary funds for the purpose.

48. An insured person can be referred by an I.M.P. directly to the hospital for emergency attention - ordinarily, it is the function of the specialists to authorise hospitalisation. While the I.M.O. or I.M.P. or the specialist is always welcome to follow up the case in hospital, and may do so occasionally, this is not the practice; after admission hospital authorities are altogether responsible for the treatment of the indoor patient. The insured person does not have to pay anything to the hospital on any account - diet is also free. No deduction is made from his cash benefit during the period of hospitalisation. Special arrangements are made to pay his sickness or disablement benefit in the hospital itself, where "social guides" are stationed. There is no choice given to the insured person to go to any hospital he prefers; he has to go to the E.S.I. hospital or annex or to the public hospital where beds are reserved. Should he go to any other hospital, the E.S.I. need not pay any amount to cover expenses or part thereof. It is a condition of benefits in the E.S.I. Act that an insured person "shall remain under medical treatment at a dispensary, hospital, clinic or other institution provided under this Act and shall carry out the instructions given by the medical officer or medical attendant thereof" - section 64(a).

Dental Care

49. Dental care is given to the extent possible to insured persons and their families; there is no free choice - the beneficiary has to go to the dental clinic or specialist provided by the scheme. There is no "panel" system for dental care, which is treated as a speciality. The E.S.I.C. has decided that well-equipped and adequately staffed dental clinics should be established in every regular E.S.I. hospital. It cannot be gainsaid that current arrangements are inadequate to ensure proper dental care of families even though they may be sufficient for insured persons.
Medical Care by Members of Professions Allied to the Medical Profession

50. As far as para-medical personnel is concerned, in "service" areas dispensaries have the required number of nurses, midwives, compounders, dressers, technicians, health visitors and the like to deal effectively with patients and to ensure that doctors are not unduly burdened by having to do work that can be done equally well by others less qualified. One of the important things to be remembered in a developing country is the imperative need to get the maximum services out of doctors, who are in short supply, additions to whose strength involves a long and extensive period of training, and to substitute, to the extent possible, para-medical personnel, who can be trained in a shorter period in larger numbers. It would be a waste of human resources to ask doctors to do a lot of clerical work, to dress minor wounds or to give simple injections. It is clearly uneconomic to use an axe to sharpen a pencil.

51. In "panel" areas, I.M.P.s are expected to (but do not really) have a compounder to dispense medicines and to have a nurse. I.M.P.s do not have large private practices and usually have only small clinics with inadequate space. Even routine tests of urine or faeces are often referred by I.M.P.s to diagnostic centres.

52. In diagnostic centres or in hospitals, whether for out-patient or in-patient treatment, para-medical personnel is provided by the E.S.I. scheme. There is no question of free choice by an insured person.

Personal Preventive Health Services

53. In regard to personal health services, one of the main complaints against the E.S.I. is that it tends to concentrate on the curative rather than the preventive side. This is inevitable as the insured persons and their families form only a small part of the population; proper environmental conditions are appropriately the concern of Government. All the same, the E.S.I.C. decided that, despite the difficulties and the cost, two pilot projects should be started in two centres (Kanpur and Delhi) for a programme of integrated preventive and curative services, intensification through home visits of maternity and child health services, intensification of preventive inoculation by giving routine tetanus toxoid to workers and their families and triple vaccine to children, closer co-operation between doctors engaged by employers, the E.S.I., Government, local bodies and voluntary organisations, and effective liaison with agencies like the National Malaria Eradication Programme and Family Planning. The intention is that, with the experience acquired in working two centres, the project will be extended to other centres with further improvements gleaned.

54. It may be stated, however, that in "service" areas a great deal of useful work is being done for personal preventive health services by I.M.O.s and ancillary staff. Apart from vaccination or inoculation (including triple vaccine), valuable services are rendered for family planning. It would be optimistic to expect appreciable results in "panel" areas where the practitioners, who work only part time and are not being fully devoted to social insurance, have neither the space nor the equipment nor the assisting staff.
55. The E.S.I. scheme ordinarily prefers to have its own arrangements for treating its beneficiaries (indoor, specialist, out-door, pharmaceutical) and is able to do so for most diseases as the number of persons involved justifies such a course. There are, however, ailments like cancer or mental diseases where the incidence is not sufficiently high to justify an E.S.I. institution. Moreover, the number of specialists or the equipment needed in such lines is limited. It is the practice in such cases to refer patients to the specialised institutions on payment at negotiated rates. The E.S.I.C. is anxious that its beneficiaries should get the benefit of the highest skill available in the country; it may be mentioned that some patients requiring neuro-surgery are at times sent about 1,500 miles at the expense of the E.S.I.C. which bears transport and subsistence charges. There are "social guides" appointed by the E.S.I.C. who are stationed in diagnostic centres and in hospitals to receive and guide patients and look after them while they are having indoor attention. The E.S.I.C. does not greatly favour using social workers from public or private agencies providing social services.

Medical Certification of Incapacity for Cash Benefits

56. All cash benefits become due only on the production of medical certificates from approved medical officers. Cash benefits are paid for sickness, disablement (temporary or permanent), maternity and death. In regard to sickness of any duration, there are three certificates issued at relevant intervals — preliminary, intermediate and final (the last one when the patient is fit to rejoin his employment), a similar procedure applies to temporary disablement. The assessment of permanent disability is made by a medical board consisting of three or more specialists — compensation is paid as a weekly "pension" except where the amount involved is very small. Maternity benefit has also to be claimed on medical certificates.

Medical Records

57. In "service" areas, a "medical record envelope" (M.R.E.) is maintained in respect of each insured person and his family, and the I.M.O. enters details of each attendance and the treatment given. An insured person is attached to the E.S.I. dispensary nearest his residence. In the event of his changing his residence, his case is transferred along with the M.R.E. to the new dispensary. It is not the practice for the M.R.E. to be sent to the specialist to whom relevant details are provided. Nor is it the practice for the M.R.E. to go to hospitals. Periodic prescriptions and advice of the specialist are placed in M.R.E. A summary of indoor treatment is also placed in the M.R.E. The procedure in "panel" areas is the same with consequential adjustments. It would, however, be unrealistic to claim that the M.R.E.s are in effect maintained in a comprehensive manner especially in "panel" areas.

Professional Secrecy within the Scheme

58. It is the policy of the E.S.I.C. to ensure professional secrecy within the scheme. Spirited attempts have been made by employers to persuade the E.S.I.C. to divulge the nature of the ailment of the insured person; the E.S.I.C. has so far resisted such endeavour. No doctor ("service" or "panel", specialist or in hospital) is permitted to communicate to anyone except officers of the E.S.I.C. (and of course the patient himself) the nature of the
disease. The E.S.I.C. is a tripartite body and representatives of labour, of All-India Organisations of the All-India Medical Association and of Government have supported the Corporation in its resolve to maintain professional secrecy.

Internal Control of Benefits

59. It has already been stated that medical benefits under the E.S.I. are administered by state governments. There is a Medical Benefit Council - under the chairmanship of the Director-General of Health Services of the Government of India, with representatives at a high level of employers, employees, central and state governments and the medical profession - which advises the E.S.I.C. on technical matters generally and also keeps an eye on the quality of medical care. The Standing Committee of the Corporation with the same interests represented also watches medical benefits as does the Corporation which has also appointed a General Purposes Subcommittee (with members from employers, employees, the medical profession and Parliament along with the Director-General and the Medical Commissioner) which visits one or two states each year, goes to several centres, meets representatives of employers, employees and the medical profession and studies the quality of medicare; its recommendations, usually adopted by the Corporation, are implemented by the state governments. The recommendations cover a wide range - from an indication of shortfalls in staff or treatment or drugs to plans for capital construction of E.S.I. hospitals and dispensaries. There is a tripartite regional board in each state headed by the state Labour Minister (the Health Minister being the Vice-Chairman) and a tripartite local committee in each centre which watches medicare. In addition, the E.S.I.C. has an inspection team consisting of three specialists (in medicine, surgery and tuberculosis) which visits states (at times by surprise) to watch the working of the E.S.I. All this is apart from frequent inspections by the Director-General and the Medical Commissioner and his senior deputy. State governments also inspect medical arrangements. The director of medical services in each state, assisted by a senior deputy and by medical inspectors, watches the quality to see how progressive improvement can be effected.

60. The inspections mentioned also apply to control over the volume and cost of benefits, the E.S.I.C. has to maintain a hawk's eye on both aspects. Abuses by beneficiaries on the medical side mainly relate to leakage of drugs in "panel" areas - several complaints have been made about I.M.P.s prescribing costly medicines to insured persons and utilising them for private patients, about chemists getting blank prescriptions filled in by them for expensive drugs or injections or about insured workers presenting prescriptions to chemists and getting in return soap or cosmetics or other stores. While it is not considered that the abuses are of any great magnitude, such cases are investigated with vigilance. In "service" areas, abuses by beneficiaries are at times the use of coercive tactics to obtain medical certificates by malingerers. Here again, though the incidence of such malpractices is not significant, appropriate action is taken.

61. It has, however, to be admitted that there is wide disparity in the various states in the quality of medical care and facilities and also in the cost of benefits, particularly in regard
to pharmaceutical supplies. Some states have been especially active in availing themselves to the maximum extent of the financial assistance of the E.S.I.C. (which provides funds for capital construction and pays seven-eighths the cost of medical care) and have made considerable headway, while a few states have been somewhat nonchalant in taking advantage of the E.S.I.C.'s helping hand. The only solution, however "radical" it may seem apparently, but only apparently (with due respect to the E.S.I.S. Review Committee), would be for the E.S.I.C. gradually to assume direct responsibility for the administration of medical benefits. Under current conditions, when state governments are zealous of their rights under the Constitution, are sensitive to criticism and are preoccupied with several problems concerning the mass of the population, it would be wishful thinking to expect the E.S.I.C. to exercise effective control over quality or cost of medical care.

62. It may be mentioned incidentally that factory inspectors check up first-aid arrangements during inspections (the Factories Act imposes on the employer liability for such facilities). In plantations where the management has statutory responsibility to provide medical care, inspection machinery also exists. Considering that the plantations vary considerably in size and are dispersed widely (many in hill areas), it is doubtful if such inspections are really effective. The managements have to be trusted to do the best possible in the circumstances. In regard to workers in mica or coal mines, the administration is under the Government of India. Disparity in quality or cost is insignificant; a concerted endeavour is being made to improve quality. There is no "panel" system in plantations or in mines; workers and families have to rely for outdoor, specialist, pharmaceutical or hospital facilities entirely on arrangements made by the management/fund.

Procedures to be Followed When Care Sought Under the E.S.I.C.

63. The problems faced in regard to identification of patients in India, as perhaps in most developing countries in South-East Asia, are delicate and difficult. Not every birth is registered with the public authorities. As the majority of the population is not Christian, baptismal certificates are also not available. Names by themselves are no safe guides; the same name is spelt differently. A photograph to establish identity is not merely expensive; it may even be unrealistic. A bald obese middle-aged man may bear no resemblance to the handsome slim youngster with wavy hair he was some years earlier. Finger prints are unsuitable - they carry a stigma of illiteracy and also an insinuation of a criminal record. Even for the literates, signatures and handwriting may vary with the passage of time. The procedure followed by the E.S.I.C. in India envisages the filling-up of a declaration form at the time of entering insurable employment; the form, which is sent to the E.S.I.C.'s local/regional office by the employer, gives details such as name, father's name, marital status, name of wife/children, address, home village and age. On the basis of the form an insurance number is assigned to the worker - the system is so devised that no worker can have more than one number and no number covers more than one worker. The number indicates the code number of the employer and the region of issue. A worker carries his insurance number with him irrespective of a change of employer or even a shift from one state to another. A duplicate identity card is issued on payment of a small fee in the event of loss. Employers usually have labour welfare
officers whose duty it is to ensure the observance of labour legisla­
tion; they keep in close touch with the workers and their organisa­
tions. It is conventionally a part of their duty to ensure that
workers get their benefits (whether under the E.S.I. scheme or the
Employee's Provident Fund scheme). Such labour officers are in close
reach with local pay offices of the Corporation. Declaration forms
are ordinarily handled by labour officers. On receipt of the decla­
ration form, an identity card is issued to the insured person giving
the more important personal details. Pending the issue of a regular
identity card, the bottom portion of the declaration form which is
perforated and detachable from the form serves as temporary authority
for medicare under the E.S.I. It will be recalled that there is no
qualifying condition for medical benefit which starts from the moment
of entry into insurable employment. The identity card with sig­
nature or thumb impression (if illiterate) is presented by the insured
person to the I.M.O. (in "service" areas) or to the I.M.P. (in "panel"
areas) who enters thereon any physical identification marks of the
beneficiary. For entitlement of members of families to medical
benefits, a separate identity card is issued giving basic details of
the insured person and listing the names and ages of the members.
Any additions or deletions thereto are reported to the local office
of the Corporation and consequential entries made in the identity
card. The main reason for the issue of separate identity cards,
one for the insured and another for the family, is that cash benefits
are available only to the former. Separate identity cards enable
the worker to claim cash benefit from a local pay office even while
members of his family receive medical care in clinics, dispensaries,
diagnostic centres or hospitals on their documents.

64. While it would be disingenuous to claim that there has
been no case of fraud or impersonation, no serious problems have
arisen out of the practice in the E.S.I.C. which has worked satis­
factorily. While there have been cases here and there of imperso­
tion in obtaining medical certificates on the basis of which cash
benefits are claimed, fraud to get medical care is almost unknown.
It does often happen, however, that a recent arrival of a member of
the family (whether by birth or coming from the village after the
worker gets living accommodation) gets medical care even though he/she
has not been included in the identity card. This is, however, not
a loss as names of such newcomers get entered in due course in identity
cards - it would be churlish to withhold medical care because of the
inevitable time-lag in observing formalities.

65. A point to remember in social insurance in developing
countries, where its introduction for a variety of reasons is not
welcomed with great enthusiasm, is that undue suspicion or distrust of
the beneficiary may well prove suicidal to its objectives. While a
foolproof system, with a variety of safeguards (e.g. periodic photo­
graphs, signatures, compulsory finger prints, a large percentage of
checks), may seem academically justified, it is exceedingly doubtful
if it is really necessary. An insured person is a policy-holder and
should not be subjected to avoidable harassment. Occasional cases
of fraud are pursued and delinquents at times prosecuted (under the
ordinary law of the land as well as under the E.S.I. Act). Effec­
tive liaison with responsible organisations of labour (at local and
high levels) is also useful. After all, labour is a partner in the
scheme contributing about 2.4 per cent. of wages to the E.S.I. Fund;
even the current employers' contribution of 2.5 per cent. of the
wage-roll is in effect a part of wages the worker would otherwise
have earned. Under the E.S.I. scheme, on an average only 1,000 workers and their families are attached to an I.M.O./P.- the yardstick is one doctor for 750 insured persons with families. Some medical men may have more and some many less. The point of identification of an insured worker or his family (based on the identity card and friendly inquiries) has not posed difficult problems.

66. There are, however, difficulties experienced in regard to continuance of eligibility for medical care. Under the E.S.I. regulations, an insured person becomes disentitled to medical care if certain qualifying conditions regarding payment of contributions in the corresponding contribution period are not fulfilled. To preclude hardship to victims of long-term ailments, the maximum permissible periods of medical care prescribed are much longer than in cases of ordinary sickness. All the same, both in regard to ordinary sickness and long-term ailments, an insured person may become disentitled to medical care. The regional/local offices of the E.S.I.C. inform the I.M.O. or I.M.P. about such disentitlement through what is known as the "exit" procedure. It has often happened that due to the time-consuming processes involved in checking and correspondence, a person declared disentitled has meanwhile become re-entitled again because of subsequent entry into insurable employment. Executive instructions exist to afford medical care on trust or on quick (even telephonic) reference to the new employer. The real trouble is about persons who become really disentitled in the middle of a spell of sickness. It has been said earlier that the E.S.I.C. has, on humanitarian grounds, agreed, irrespective of the lapse to title, to allow an insured person to get continued indoor treatment till recovery or discharge. A proposal to amend the E.S.I. regulations formally to enable an insured worker or his family to continue to get treatment once started till the spell of sickness ends, or in regard to long-term illness as long as the patient needs active treatment, is under examination.

67. Arrangements exist for the audit of accounts of expenditure on medical care in all stages. The Comptroller and Auditor-General is appointed by the President of India for a term. To enable him to be independent, he cannot be removed unless impeached by Parliament. He has an accountant-general in each state who is independent of the state government. The audit report of the Corporation (including accounts of state governments on medical care) is placed before Parliament. Cases of infructuous expenditure on medical care, because doctors in "panel" areas were paid a capitation fee even after insured persons were disentitled, have been mentioned in some audit reports in the past. The responsibility for disentitlement has naturally to be assumed by E.S.I.C. through its regional/local offices where contribution cards are kept. The I.M.O./I.M.P. has no means of knowing when any patient becomes disentitled. The procedure for frequent verification was tightened up after the audit report. The incidence of disentitled cases continuing on the live rolls of a "panel" doctor currently is very low. In "service" areas, the infructuous expenditure involved, even if disentitled persons are treated, is small as the staff employed is on a whole-time salaried basis; also the E.S.I.C. would not seriously grudge any amount spent on the relief of suffering in such cases.
Records

68. In "service" areas, there are E.S.I. dispensaries ranging from one to ten I.M.O.s depending on the size of the insured population and their concentration. Usually two is the minimum for any dispensary however small the number of workers; one of them is a lady doctor as insured persons prefer their womenfolk and children to be treated by women. In some "sparse" areas (say with 1,000 insured persons or less) it has not been possible to get a woman doctor. Among India's allopathic doctors the ratio of women to men is about 1:8. In larger dispensaries, the seniormost doctor is styled I.M.O. In-charge; he is responsible for all administrative work. One of his duties is to maintain a register of insured persons who (and whose families) are entitled to medical care in his dispensary. The regional office of the Corporation (there is one in every state) allots an insured person to the dispensary nearest his residence or, where there are two or more equi-distant, to the one preferred by him. The register is corrected from time to time - additions are made for newcomers and deletions effected for disentitlement. The register is checked with the regional office documents. While it would be incorrect to say that the register is always correct, the errors are usually on the "safe side" - even the disentitled at times figure therein. Cases of an entitled worker not being on the register are very rare.

69. The E.S.I.C. provides five benefits - four in cash (against sickness, disablement, maternity and death) and one in kind (medical). For cash benefits the most careful record is maintained for every individual insured person. Every local pay office has what is called a "benefit file" for each insured person. The file is a dossier containing all relevant documents e.g. medical certificates, "shuttle cards" determining the rate of benefit, period for which benefit was paid and the rate and total amount, reference to insured person/employer. It is essential that a benefit file maintained for cash benefits as some of them are not merely governed by qualifying conditions but their quantum and duration are specified in the E.S.I. Act (e.g. sickness benefit is payable only for a minimum period of 56 days in a continuous period of 365 days, maternity benefit is due for a period of 12 weeks). Every local office has literally tons of benefit files, which are stored in steel cabinets as they are valuable documents - once a year or so, "weeding" is done to clear space by removing files that are not "live".

70. The position in regard to maintaining a record of cash benefits is fairly simple as the cost of benefits can be assessed in terms of money. Computation of medical benefits by rule of thumb is clearly not possible as it is personal and professional. The only record of medical benefits is the "medical record envelope" with an I.M.O./I.M.P. which gives the case history of each patient. The cost of medical care for each item of medical care per insured person and his family can never be ascertained. All that is possible is to divide the total cost incurred under the scheme for medical care by the number of insured persons and deduce the cost per insured worker (and family). Accounts are not maintained separately for each item of medical care in clinics, dispensaries or hospitals. This aspect will be considered later.
D. Methods of Remunerating Members of Medical and Allied Professions and of Paying for Hospital Facilities and Pharmaceutical Products and other Medical and Surgical Supplies

Remuneration of Members of Medical and Allied Professions

71. In plantations where the medical care of workers and families is the employers' liability, both part-time and full-time doctors are employed in dispensaries and hospitals; details are not readily available. In mica and coal mines, the administration of welfare funds is the responsibility of the Government of India. The general trend is to have full-time salaried staff on scales of pay of the Central Government in dispensaries and in hospitals, except in regard to specialists where part-time employment is inescapable.

72. Under the E.S.I. scheme, "service" areas are manned entirely in dispensaries by whole-time salaried doctors, who are not allowed any private practice whatsoever. The doctors are borne on the cadre of the state medical services which operate throughout the state. Men and women are inducted into the E.S.I. from other posts in the state service—likewise, E.S.I. I.M.O.s are sent out to some other posts under the state government. As private practice is not permitted in the E.S.I., a non-practising allowance is given—the amount varies widely from state to state. Salary scales also differ considerably—in some states, the salary and allowance of an I.M.O. may not even be half that of his confrere in a better paying state. To compensate for the arduous duties in a dispensary where he has to handle industrial workers and families and work under trying conditions, an I.M.O. gets an E.S.I. allowance of Rs.100 per mensem, which is borne entirely by the E.S.I.C.

73. In "utilisation" dispensaries (i.e. facilities of employers availed of by the E.S.I.C. for outdoor medical care), payment is made to the employer as if he were an I.M.P.; a capitation fee is paid. The dispensary has to provide ordinary medicines—the E.S.I.C. bears the cost of special and expensive ones. Utilisation dispensaries give all ordinary medicines (unlike I.M.P.s and are well equipped to do most of the tests; some of them do blood or sputum cultures. Some of them have highly qualified personnel (even a specialist or two), adequate equipment and ample facilities. Promiscuous reference is not made to the diagnostic centres. Utilisation dispensaries are more economic per insured person than I.M.P.s and generally render superior services. Only large employers' facilities are used—there are only 40 such dispensaries against about 17,000 employers, 4,000 I.M.P.s and 500 regular E.S.I. dispensaries. Careful inspection is made by the E.S.I.C. before any employer's facilities are used.

74. In "panel" areas, an I.M.P. is paid a capitation fee, which currently is Rs.17.50 p. per insured person, to look after the worker and members of his family. The capitation fee was settled by the E.S.I.C. on the advice of the state governments in consultation with the medical profession. Originally, when the E.S.I. served only the workers, a panel practitioner was permitted to have a larger number of insured persons than the present ceiling of 750 insured persons and their families or about 2,200 beneficiaries. The medical profession has been pressing for some time that the capitation
fee should be increased in view of the rise in prices and costs of living. On the other hand, there has been a feeling that as I.M.P.s give very little ordinary medicines from their stocks (prescribing more expensive ones to be supplied by approved chemists at E.S.I.'s expense), do not do much treatment (even routine examinations are not done), pay next-to-no domiciliary visits and are not really "family" doctors with doctor-patient relationship (many have only cramped cubicles where clinical diagnosis is difficult), the capitation fee should be reduced. The E.S.I.C. appointed a committee under the Director-General of Health Services to examine the representations - the committee reported that there was no case for increasing the capitation fee. Earlier, the E.S.I.S. Review Committee also held that "the present capitation fee of Rs.17.50 per family unit per year is not low and does not need upward revision at this stage".

75. There is little doubt that the position in regard to the capitation fee is far from satisfactory. It was fixed on a rough-and-ready, or even "hit-and-miss" basis. There was no calculated endeavour to define the various services involved and their volume and extent or to assess the value of each one of the components. This may well have been an insuperable task. The medical profession has never taken kindly to searching inquisition and has regarded itself as indispensable to special insurance. It is obviously impossible to replace totally the "panel" by the "service" system even during the next two decades or more; especially in larger cities, such an attempt is impossible. Meanwhile, it has to be a process of adjustment between the Corporation and the medical profession.

76. In regular E.S.I. hospitals (there are so far 16 of them - many more will be commissioned in a year or two), there are whole-time, salaried, non-practising doctors borne on the cadre of the state medical services. In large hospitals (e.g. the Mahatma Gandhi Memorial Hospital in Bombay with 650 beds), all specialists are also whole-time and non-practising. This is obviously not possible in smaller E.S.I. hospitals or in all public hospitals where beds are reserved or where specialist out-door attention is provided. The system of "honoraries" prevails in such places - men of eminence in their special lines are asked to serve E.S.I. patients on a specified number of days each week during specified hours. In large cities, diagnostic centres have been started under the E.S.I.; here also, the "honoraries" give the benefit of their specialities. The remuneration paid to "honoraries" is fixed by the state government, which is in the best position to negotiate the terms. It should be mentioned that "top" persons in their specialities serve the E.S.I. for a nominal honorarium even though their private practice fetches them literally thousands of rupees each month.

77. There is no procedure in the E.S.I. of fixing remuneration based on experience or qualifications. The salaried personnel are borne on the rolls of state medical services where experience earns increments. Similarly, the highly qualified doctors have better prospects of reaching the higher rungs of the ladder. Posts in the medical services, as in all other government services, are pensionable under a non-contributory scheme and the incumbents also participate in a provident fund.
78. The case of an E.S.I. medical service becomes more important when one envisages the scope for professional, and even personal, advancement inherent in such a large service. Its potentialities for research and service would be significant.

79. Para-medical personnel in "service" areas are also government servants of the state concerned. In "panel" areas, the I.M.P.s do not deploy such personnel to any extent in their clinics. The E.S.I.C. has agreed in principle to subsidise state governments for the cost of running training courses for nurses, pharmacists and technicians; it is doing so in two states. An E.S.I. medical service which would consist of medical personnel at all levels (general practitioner, specialist, hospital) and para-medical personnel ranging from nurses to dental mechanics would again seem to be the appropriate solution for stimulating the training of para-medical personnel; the addition, through the E.S.I., of such resources would be a national asset.

Payment for Hospital Facilities

80. Where beds are "reserved" in public hospitals for E.S.I. beneficiaries, the usual method is to reserve a specified number of beds, determined on the number of insured persons in the area, and pay a certain sum per diem as reservation charges per bed occupied. The average amount paid is Rs.8 per day. The reservation charge covers all items (including diet) even though for highly costly medicines extra payment may be made by the E.S.I.C.

81. It may be mentioned that the cost per bed per day in an E.S.I. hospital a year ago was as high as Rs. 18 against Rs.8 paid for a reservation bed. Other E.S.I. hospitals showed a cost varying from Rs.12 to Rs.16. This is only to be expected. Apart from the fact that an E.S.I. bed is pooled with several others in a public hospital, the amenities provided in a regular E.S.I. hospital are far superior. In a public hospital, an insured person is merely a paying member of the public. In an E.S.I. one, he is one of the owners. There is little doubt that the higher cost of running E.S.I. hospitals is fully justified by the better quality and larger number of staff, individual attention (including special diet according to each type of case), better facilities and dedicated service. Psychologically, being an inmate of an E.S.I. hospital gives the beneficiary satisfaction. The E.S.I.C. is going "full-speed-ahead" on capital construction in the consciousness that such hospitals will be much more expensive than reservations.

Payment for Pharmaceutical Products

82. Pharmaceutical supplies for the use of insured persons and their families are provided in "service" areas through dispensaries, diagnostic centres, central medical stores or hospitals. In "panel" areas, the services of chemists become inevitable. Panel doctors are expected to give only ordinary medicines but can prescribe more costly medicines and injections from List I (ordinary) or List II (special) of the formulary of the E.S.I.C.; the prescriptions are honoured by chemists approved by the state government on behalf of the E.S.I.C. The terms and conditions of supply are settled between the state government and representatives of chemists - a pricing formula is evolved on the basis of which bills are submitted.
There are undoubtedly considerable delays in the payment of chemists' bills, which literally run into thousands in Bombay and Calcutta; each one has to be checked. The chemist gets an E.S.I.S. 2-A form for supply to an insured person. In Bombay an average chemist gets anywhere between 100-150 of these from I.M.P.s with a monthly value of Rs.4 to 5,000. Complaints about delayed payment have been bitter in one state. While the margin of profit in the pricing formula may provide a cushion for interest an account of delay in payment, undue procrastination causes hardship.

83. The system of supply through approved chemists would not really appear to be altogether unavoidable. It is true that there are hundreds of chemists scattered all over Bombay and Calcutta. The insured person is free to choose his own chemist from the list. As indicated earlier, leakages of medicines/injections and abuses by insured persons have not been uncommon. There does not seem to be any reason why even in "panel" areas, the E.S.I.C. (through the state governments for the present, and directly when it takes over medical care) cannot have its own retail distribution centres dispersed conveniently for the supply of pharmaceuticals. As long as an insured person does not have to go too far (say a mile or two) to get medicaments, he has no real cause for complaint. The advantage of the E.S.I. having its own distribution centres are obvious - prevention of leakage, precluding abuse by beneficiaries (the depots will not be able to give soap, powder, or toilet articles chemists usually stock!) and above all substantial economy. In Delhi where the E.S.I.C. runs medical care directly, and in "service" areas where state governments buy supplies, the rates of purchases are obviously cheaper than what the chemists can get. There are "rate contracts" with prime manufacturers, which cut out the wholesaler. Central purchase of large requirements are obviously most economic from the E.S.I.C.'s angle and most convenient from the point of view of the manufacturer also. What is even more important, purchases made by the Corporation, or through the state governments, can be specifically marked "E.S.I." to prevent percolation into the market. In some states under the "service" system, the governments have arranged with manufacturers to have each pill or tube or carton stamped "E.S.I." In Delhi, the Ministry of Health, which runs medical care for Central Government servants and their families, make such distinctive marking "C.H.S." a condition of purchase. It would be misplaced sympathy to think of hundreds of chemists who may be displaced if the E.S.I. scheme makes pharmaceutical supplies on its own. E.S.I.C.'s share of cost of medical care (i.e. seven-eighths) during 1966-67 is estimated to have been nearly Rs.112 million. It is estimated that the cost of drugs and dressings per insured person (and family) is Rs.12. For about 3.5 million workers under the scheme, this means a cost of about Rs.42.0 million. Of the 3.5 million under E.S.I., well over half are covered in the "panel" areas of Bombay and Calcutta. It may be mentioned that in greater Calcutta the state government is opening its own chemist's centre in one place. A chain of E.S.I. chemists' centres with a central depot, with free inter-telephone facilities and station vans to move supplies rapidly on call from the central depot or nearest centre to meet any shortage anywhere, would save the Corporation a great deal of money (which can be used for enlarging benefits) directly and even more indirectly by reducing, if not avoiding, abuses.
84. Consistent with the general policy of the Government of India to accelerate internal production to the maximum extent and to agree to imports only where they are inescapable because stores required for vital needs are not produced in this country or are produced in insufficient quantities, the pharmaceutical industry in India has also been developed and expanded to a substantial extent during the last decade or so. With the active collaboration of original (foreign) manufacturers, rapid strides have been made consistent with quality, safety and efficacy, both in the private and in the public sector. India's plans of industrial development envisage maximisation of production in both sectors, which work side by side in amity. Originally the British Pharmacopoeia - perhaps a legacy of history as India was a part of the British Empire till August 1947 - was in vogue; later, however, drugs recognised by the W.H.O., the United States of America and the United Soviet Socialist Republics have been added for use and production in the country. A national formulary is being worked out. The Indian Council of Medical Research with the assistance of members of the medical profession, administrators of medical services in states, and the pharmaceutical industry is playing an important role in this connection.
E. Rural Medical Services

85. The rural nature of India's population was brought out earlier; the following figures from the report of the census of 1961 emphasise this aspect further:

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>%</th>
<th>Females</th>
<th>%</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>183.6</td>
<td>41.8</td>
<td>178.8</td>
<td>40.3</td>
<td>360.4</td>
</tr>
<tr>
<td>Urban</td>
<td>42.7</td>
<td>9.7</td>
<td>34.1</td>
<td>8.2</td>
<td>78.8</td>
</tr>
<tr>
<td>Total</td>
<td>226.3</td>
<td>51.5</td>
<td>212.9</td>
<td>48.5</td>
<td>439.2</td>
</tr>
</tbody>
</table>

Thus, out of a total population of 439.2 million, 362.4 million lived in villages. The position will not be substantially different in 1966 despite a shift from rural to urban areas during the last quinquennium due to the increasing tempo of industrialisation. Even the so-called urban population may not really have characteristics associated with townfolk in view of the small size of several towns; the census of 1961 indicated the following pattern of towns:

Class 1 (population above 100,000) 107
Class 2 (population between 50,000 and 99,999) 141
Class 3 (population between 20,000 and 49,999) 515
Class 4 (population between 10,000 and 19,999) 817
Class 5 (population between 5,000 and 9,999) 844
Class 6 (population less than 5,000) 266

2,690

It will be seen that most of the towns are perhaps really only overgrown villages. A feature of a town may be that its local affairs are managed by a municipality while a village or a group of villages is looked after by a Panchayat.

86. It may be of interest to note the distribution of the rural population in inhabited areas:

<table>
<thead>
<tr>
<th></th>
<th>No. of Villages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 10,000</td>
<td>217</td>
</tr>
<tr>
<td>5,000 - 10,000</td>
<td>1,916</td>
</tr>
<tr>
<td>2,000 - 5,000</td>
<td>19,882</td>
</tr>
<tr>
<td>1,000 - 2,000</td>
<td>51,740</td>
</tr>
</tbody>
</table>
87. It will be clear that it is exceedingly difficult to provide comprehensive health services in rural areas scattered over about 1,200,000 square miles in several states, large and small; there are nearly 380,000 tiny hamlets. The implementation of public health programmes of a national character by the state governments, with assistance from the Central Government, and the growth of healthy practices, greater goodwill and better education, in regard to water supply and sanitation, eradication/control of communicable diseases, family planning, training of health personnel, arrangement of medical education and research, and deployment of the short supply of medical and para-medical personnel to the best advantage for out-door, specialist and indoor treatment is beset with almost insuperable obstacles. It is paradoxical that though rural folk produce food for the country, they are worse fed than the town people. The nutritional deficiencies are protein, malnutrition, vitamin A deficiency, thiamine deficiency, riboflavin deficiency, iodine deficiency and nutritional anaemia. The common ailments are malaria, fevers, measles, diarrhoea, dysentry, typhoid and para-typhoid, influenza, pneumonia, cholera, skin diseases, asthma, chicken pox, respiratory diseases and intestinal parasitism. The communicable diseases are:

(a) malaria, tuberculosis, trachoma, venereal diseases, yaws;
(b) gastro-intestinal disorders like dysentry, diarrhoea, cholera, typhoid;
(c) helminthic infestations like ankylostomiasis, guinea worm, other worms; and
(d) certain zonotic diseases (i.e. diseases of animals transmittable to human beings) such as bovine tuberculosis, anthrax, brucellosis, rabies, leptospirosis, plague, anthropod borne encephalitis.

88. The death rate which was 31.2 in 1931-41 came down to 27.4 in 1941-51, to 21.6 in 1956-61 and is expected to fall to 18.2 in 1961-66 and 13.9 in 1966-71. The birth rate was 41.7 in 1951-56 and 40.7 in 1956-61; it is expected to come down to 32.9 in 1966-71. The expectation of life which was 23.6 (male) and 24.0 (female) during 1891-1901 and 32.5 and 31.7 respectively during 1941-50 was 45.8 and 47.2 in 1961-66; this is estimated to rise to 51.9 and 53.2 respectively during 1966-71.

89. Medical facilities in rural areas are provided by government or local authorities (Panchayats) or by a few voluntary organisations. Only those run by the state are of any magnitude even though other agencies are rendering valuable services for outdoor medical care. There can obviously be no hospitals in small villages and for indoor treatment a journey varying on an average from seven miles
(villages over 2,000) to ten miles (tiny villages with population of 200 or less) is inevitable. There are obviously wide variations as between states not merely in providing necessary facilities for health care but in the measure of control exercised in preventing the spread of epidemics. Maldistribution of trained personnel who congregate in urban areas aggravates the problem. Highly trained doctors also have to perform routine duties which can as well be done by lesser qualified persons. The need to inculcate in children proper health habits from the earliest stage is urgent.

90. The main scheme of serving rural areas is through primary health centres (there are about 5,000 of them) which are located in community development blocks - such blocks are a part of the general plan of the Government of India to revitalise villages in all directions by bringing to the rural folk the full benefits of modern methods of agriculture, small industries, education and health. Primary health centres serve a population between 30,000 to 40,000 persons in contiguous villages. The centres have dispensaries fairly well equipped for routine tests and with six to ten emergency beds. The centres are preferably located at the headquarters of the community development block. There may be one or two sub-centres in large blocks. In some areas, there are secondary health units which are better manned and equipped. There are mobile dispensaries to cater to the needs of outlying areas - ambulances are also provided. For referral services, difficult cases are sent to the secondary units or to taluq or district hospitals.

91. There is no scheme of insurance for any class of population in India other than the E.S.I. There is no scheme of even partial insurance (with beneficiaries providing at least a part of the costs to preclude the element of charity and to preserve the sense of human dignity) in rural or other areas in the country. What is expected is that the state (either the state and/or Central Government) will provide free medical services to the entire population. This is obviously beyond the financial resources of the Union Government and state governments put together. The Director-General of the E.S.I.C. estimated in 1965 that the annual cost of "full" medical care (outdoor, diagnostic, specialist, indoor) to workers and families would be Rs.64 per insured person; the Corporation's share being Rs.56. With the subsequent rise in prices, even this estimate may be exceeded. According to the census of 1961, there were 129 million male and 59 million female workers or a total of 188 million workers for a population of about 440 million. Even assuming a cost of Rs.64 per worker the total cost for the current population of 495 million would be Rs.13,000 million. The taxable capacity of the citizens (the per capita income is under Rs.390) will not enable such a commitment in view of the various items of other expenditure on development and nation-building activities.

92. Under current conditions, villages have to rely on indigenous systems of medicine - practitioners are more easily available and methods of treatment are more economical. After all, only 2 per cent. of the villages in India have a doctor of modern medicine in private practice - while nearly 5 per cent. of villages have practitioners of indigenous medicine and 2.5 per cent. homoeopathic practitioners. It is more than likely that as modern health services come into being, with very substantial additions to medical and para-medical personnel currently in such short supply, the old
systems will disappear as they did in Japan earlier in this century. This probability is heightened by India's active participation in international health policies based on modern medicine (an Indian representative has been elected President or Vice-President of the World Health Assembly on a few occasions).

93. It is necessary, during the time-lag inevitable in acquiring the requisite number of medical and para-medical personnel, to get the best out of existing resources. One step may well be to utilise on a part-time basis the services of medical practitioners in rural areas - somewhat on the lines of the "panel" system under the E.S.I. Another would be to relieve existing medical personnel of the routine (even clerical) duties that they now perform so that they can deal with more patients. A third may be more domiciliary treatment of cases and a quicker turnover in hospitals within the limits of safety to ease the severe congestion - modern methods tend to prefer domiciliary treatment of even tuberculosis where recovery may be accelerated by "home" environment if suitable. Another way of relieving the strain on limited indoor space may be to have convalescent homes where only supervisory attention would be needed. After all, the target that can be achieved in the near future for the general population is only one bed per thousand persons. Better arrangements have to be made to avoid mixing of serious with minor cases; closer proximity of the out-patient department to the hospital proper may also help. As small villages are widely dispersed, emphasis on mobile dispensaries rather than stress on building and manning static dispensaries, may pay dividends. The mobile health units should have adequate transport to take serious cases back to the taluq/district headquarters hospitals, which should be strengthened qualitatively and quantitatively so that they serve as the base and their skill can be effectively utilised for cases in outlying areas. A mobile team of specialists would be useful. Taluq/district hospitals can render valuable services if attached to graduate and post-graduate teaching institutions.

94. The magnitude of the problem of affording medical and health services to the rural population would at first sight appear to be so huge as to evoke despair. It is felt, however, that with the reasonable expectation in the near future of substantial increase in the resources of medical and para-medical personnel (though such additions may to an appreciable extent be neutralised by an increase in population), careful planning of the broad lines of strategy to tackle the distressing position might result in reducing human suffering. It would be sheer wishful thinking to expect that "public assistance" on its own can provide medical or health care to the teeming millions. A self-balancing scheme of social insurance like the E.S.I. has obvious limitations. It is true that section 1(5) of the E.S.I. Act of 1948 envisages that its provisions may be extended to "any other establishment or class of establishments, industrial, commercial, agricultural or otherwise". While it is likely that the E.S.I. Act will be extended to smaller factories (those employing less than 20 persons) and may also, in a year or two, cover "commercial" establishments in some centres here and there, the aim of the E.S.I.C. will naturally be to reinforce medical care to ensure that members of families of those already insured get "full" medical care (including hospitalisation); this will involve capital construction of an adequate number of E.S.I. hospitals according to the yardstick prescribed (i.e. five general, two maternity and four tuberculosis beds per 1,000 workers). The E.S.I.C. decided that the
The E.S.I. Act should be extended to other sectors of the population only after "full" medical care is given to members of families. It is probable that the E.S.I. will cover all larger commercial establishments within the next few years - this is not difficult as they are easily located in centres where industrial workers are already covered. It should also be possible for the E.S.I.C. to afford protection later to small establishments and in due course even to self-employed shopkeepers, who can be located as they have to obtain licences from local authorities. Agriculture would seem beyond the capacity of the E.S.I. for some years to come. If the E.S.I. Act is extended to agricultural establishments, it cannot be worked for obvious reasons - e.g. the pitiful per capita holding of land and poor income, the large number of agricultural labourers who change employers, the dependence of agriculture on nature's bounty (a poor monsoon means untold misery and unemployment), the difficulties inherent in the location of beneficiaries and fixing responsibility for payment of contributions, and the exorbitant administrative expenditure if cash benefits are paid to millions of beneficiaries scattered in hundreds of thousands of small villages. It is not feasible to provide to agriculturists, who form over 80 per cent. of the population, the comprehensive benefits given by the E.S.I.C. on a self-balancing basis to industrial workers.

95. What is essential, however, is that the health of the rural population should be protected. As this is not possible under "public assistance" or under "social insurance", ways and means must be found to solve the problem. One way may well be that a health insurance scheme should be devised, at least for those who own land, which would cover a fair portion of the expenditure involved. If the E.S.I. scheme roughly collects 5 per cent. of the wage-roll for a self-supporting scheme, providing cash and medical benefits, a simpler scheme can be devised after careful investigation which would afford only medical cover. The census of 1961 indicated 66.4 million men and 33.1 million women who owned land - however small the holding - and 17.3 million men and 14.2 million women agricultural labourers. Earlier, it was estimated that including dependants, about 285 million persons are sustained by agriculture. The landless may in the first instance be ignored. It would be quixotic to attempt the impossible - in the light of experience and developments, the delicate problems involving their coverage may subsequently be examined. All individuals owning land pay revenue to the Government; they can, therefore, be located without serious difficulty by local revenue authorities. While fully conscious of the difficulties in adding to fiscal imposts (any scheme of health insurance has to be compulsory), it would appear that some plan on the lines of health insurance (subsidised appreciably by the state as it cannot be self-supporting) should be investigated to utilise the increase anticipated in the number of medical personnel in the near future. It has to be remembered that, despite the desire to provide free medical and health services to the population, the vast majority of citizens, especially in rural areas, have to spend anything between 3 per cent. and 5 per cent. of their meagre income on medical treatment. If the state is able to pool such amounts now spent sporadically by individuals, a great deal can be done. While the suggestion made may seem didactic and even impractical, it may be worth examination.
F. Relations between Statutory Social Insurance Schemes and Public Health Authorities, including Planning and Co-ordination of Services

96. The Planning Commission, headed by the Prime Minister, takes stock of the resources of the central and state governments and, in consultation with the National Development Council (chief ministers of states are members), formulates schemes for a progressive improvement in living conditions. The first Five-Year Plan covered the period from 1951-56, the second from 1956-61 and the third from 1961-66; the fourth Plan for 1966-71 is in the final stages of formulation. The funds provided for health in the various plans were:

- first Plan: Rs. 1,400 million
- second Plan: Rs. 2,250 million
- third Plan: Rs. 3,420 million
- fourth Plan (estimated): Rs. 11,000 million

97. The importance of family planning has been recognised by the Government of India and the state governments. The estimated provision under this head during the fourth Plan is Rs.2,300 million. The explosion of population is a real problem in India, as it is in developing countries in South-East Asia, as all programmes for increasing production, agricultural or industrial, to raise standards would be stultified if the growth rate is not checked. Family planning has been made a department of the Government of India; a concerted endeavour will be made by the Central Government and state governments to reduce births.

98. The changing economy of India during the quickened tempo of industrial development means that, despite continued reliance on agriculture, there is a great deal of migration from rural areas to towns. Such transfer creates social, economic and health problems. Changes taking place in such redistribution of population provoke grave problems. The large migration to urban areas is made in the hope that the prospects of gainful employment are greater in such centres. Urban problems of health have, therefore, become very much more exaggerated because there is no control over migration and effective steps cannot be taken for improving the housing and living conditions of this migrant population.

99. It has already been indicated that the Government of India is endeavouring, with the active assistance of state governments, to enlarge facilities for graduate and post-graduate education. A suggestion once considered was the possibility of reducing the duration of the medical graduate course from five to four years - it was decided that shortening the duration would not be consistent with efficiency.

100. Even though the E.S.I.C. is autonomous, it commands by its constitution the confidence and co-operation of state governments and public health authorities. The Vice-Chairman is the Union Minister for Health while the vice-chairmen of regional boards are health ministers of the state governments. The Medical Benefit Council is headed by the Director-General of Health Services (Ministry of Health, Government of India). Apart from representatives of workers, employers and the medical profession, the majority
of the members are directors of medical services of states who, as heads of departments in their states, exercise administrative control over all institutions run by local bodies and have considerable influence even over voluntary organisations which have hospitals or dispensaries. Some idea of the roles played by state governments, local bodies and voluntary organisations may be had from the following figures of some of the medical and para-medical personnel during 1960.

<table>
<thead>
<tr>
<th></th>
<th>State Govts.</th>
<th>Local Bodies</th>
<th>Voluntary Organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical officers</td>
<td>9,901</td>
<td>1,714</td>
<td>1,433</td>
</tr>
<tr>
<td>Pharmacists and compounders</td>
<td>7,992</td>
<td>1,683</td>
<td>396</td>
</tr>
<tr>
<td>Nurses</td>
<td>7,641</td>
<td>259</td>
<td>1,457</td>
</tr>
<tr>
<td>Public health assistant (or sanitary inspector)</td>
<td>9,057</td>
<td>1,512</td>
<td>11</td>
</tr>
<tr>
<td>Health visitors</td>
<td>1,908</td>
<td>234</td>
<td>20</td>
</tr>
<tr>
<td>Midwives</td>
<td>7,260</td>
<td>1,916</td>
<td>522</td>
</tr>
<tr>
<td>Dais</td>
<td>2,343</td>
<td>166</td>
<td>110</td>
</tr>
</tbody>
</table>

101. Not having an adequate number of dispensaries or hospitals of its own, the E.S.I.C. has to rely a great deal on facilities available with state governments, local bodies or even with voluntary organisations. It may be mentioned that missionary (e.g. Christian, Ramakrishna and Muslim) agencies are rendering useful services - it is not the usual practice to insist that only patients who belong to the religion concerned will be treated by such institutions; as a matter of fact, such a restriction would be of dubious legal propriety. By and large the E.S.I.C. relies almost entirely on the services available through state governments for indoor care. About 3,400 beds have been reserved in public hospitals. In smaller industrial areas, where the size of the insured population does not justify a fully-fledged E.S.I. hospital, the E.S.I. annexes are built in the premises of the public hospital. The services of the personnel, medical and para-medical and the equipment available in the hospitals adjacent to which annexes are built are at the disposal of the E.S.I. scheme - the proportionate cost to the E.S.I. is worked out. It is obviously uneconomic to build regular E.S.I. hospitals in smaller centres - even apart from the financial angle, it would be imprudent in the context of shortage of personnel for the E.S.I. to set up its own arrangements. The smallest hospital built by the E.S.I. would provide at least 50 beds (general and maternity) for an insured person strength of about 7,000. It is also not considered advisable to have huge multi-storeyed hospitals if such a course can be avoided. While it is appreciated that a large modern hospital would be "a centre
in which medical practitioners could find professional and intellec­tual aid"), experience has confirmed the view of an expert com­mittee of the World Health Organization that "no general hospital should have more than approximately 600 beds". The E.S.I.C. prefers a hospital with between 400-500 beds, where the industrial con­centration justifies such a size. The tendency to have an E.S.I. hospital in the heart of the city is discouraged for financial and administrative reasons. With requisite ambulance services, it is clearly an advantage for a hospital to be on the outskirts of a large town. Where distances are not large, a multiplicity of hospitals is not favoured. The plans and estimates for hospitals are designed by the state governments and examined and approved by the E.S.I.C. - there is very little delay as the E.S.I.C. generally abides by the advice of state governments, who know local conditions and local costs. It would be quixotic, considering the size of India with wide variations of climate and soil conditions, for the E.S.I.C. to embark on a "master plan" for capital construction though academically such a plan is of great fascination to the armchair critic. The maximum and minimum temperature varied on 11 January 1967 from 34° and 20° centigrade respectively in Bombay to 18° and -2° respectively in New Delhi ("Statesman" dated 12 January 1967). Starling differences in soil conditions are inevitable in a country running 2,000 miles from north to south and 1,700 miles from east to west. There is effective co-ordination of engineering and technological skill available with the state governments. The E.S.I.C. has avoided the temptation to have its own civil engineering unit. The largest E.S.I. hospital sanctioned will be in Delhi to provide 700 general beds in a multi-storeyed building and 300 beds for tuberculosis in the same compound. It is the practice, where possible, to have an independent block for indoor treatment of tuberculosis within the same large area of land. Medical experience has confirmed that it is no longer necessary to keep those afflicted with this disease in a far-away place, well out of the limits of ordinary habitation. The E.S.I. has a 650-bed hospital in Bombay. It will have a few hospitals with between 400-500 beds, a fair number with between 150 and 400 and many more of smaller size. The planning of these hospitals (in which the E.S.I.C.'s investment is over Rs.300 million) is testimony to the effective utilisation of technological skill in the states.

102. Once an E.S.I. patient gets into bed in a hospital, whether in an E.S.I. or in a "reserved" bed, all the facilities available in the state are extended to him. A specialist in an E.S.I. hospital may want a difficult case referred for "second opinion" by a colleague working outside the scheme - an E.S.I. or a public hospital may not have facilities available elsewhere. In regard to cancer, the incidence of the disease would not justify a regular E.S.I. hospital - in any case the limited facilities available for treatment cannot be dissipated by dispersal; the E.S.I.C. has not merely made arrangements with public hospitals but also sends its patients to a "private" hospital in Bombay. Difficult cases of neuro-surgery are transported 1,500 miles from the north-east to south-east of India, where a good hospital, adequately manned and equipped, exists. Cases of this type can be multiplied. The E.S.I.C. provides at its sole cost prosthetic appliances to insured persons who lose limbs - whether due to employment injury or other­wise. It uses the services of the army centre in Poona for the
purpose. The E.S.I.C. is also trying to arrange prosthesis through two or three other agencies. An E.S.I.C. study group is in the final stage of its examination of the problems of rehabilitation of workers (including rehabilitation subsequent to effective treatment for tuberculosis) with particular reference to the utilisation of existing facilities available with governments, quasi-governments, public or voluntary agencies. The E.S.I.C. has no objection to providing the funds that may be needed, although naturally the amount thereof will have to be determined on examination.

103. While E.S.I. patients are given beds in public hospitals - as a matter of right where beds are reserved and even ordinarily otherwise though after some waiting as citizens of the state - the E.S.I. hospitals are not open to the general public even if the state government or the local body or the individual is prepared to pay the costs. The only exceptions are in regard to "casualty" or "emergency" cases. The E.S.I.C. runs medical care and is, therefore, bound by larger considerations of relief of suffering. No E.S.I. hospital will, for example, refuse to treat free of cost somebody run over by a car or who has had an accident nearby or who needs urgent surgical attention. Otherwise, E.S.I. hospitals and dispensaries are not open to the general public. There has been considerable criticism about such reluctance by the E.S.I.C. At times, it has created embarrassing problems. The E.S.I. Act covers only those drawing not more than a specified amount, recently fixed at Rs.500 a month. While a worker within such a wage ceiling is able to get medical care, his colleague who draws a few rupees more is deprived of such advantages and has to depend on the inadequate and unsatisfactory care afforded to the population by the state. An even more anomalous position arises in centres where the population is almost entirely industrial - e.g. the steel projects - and there is no one living there who is not a worker in the industry or who performs services for workers (e.g. grocers, hairdressers, tailors). In large industries, the managements, whether in the public or private sector, are prepared to build hospitals even before the E.S.I. is extended to that centre, if the E.S.I. will treat employees drawing more than the current ceiling.

104. This aspect has been mentioned as it raises very interesting issues. Under the E.S.I. Act, funds derived from employers and employees can be expended only for the benefit of workers covered by the scheme. Viewed legalistically, allowing even one bed in a 500-bed E.S.I. hospital for the use of a non-insured person, even on payment of cost, may be of dubious propriety. On the other hand, it would be a waste of resources, of personnel and an impossibility, administratively and financially, to have, say a 500-bed hospital for E.S.I. beneficiaries and a five or ten-bed hospital for others who are more highly paid. Moreover, it would be imprudent for different agencies in developing countries to work in watertight compartments. Co-ordinated plans on a national basis would preclude duplication and make possible the maximum utilisation of the resources - human, material and financial. The E.S.I.C. has been considering this problem for some time on the observation of the Estimates Committee of the Parliament (1959-60) that "while giving priority to the workers, the question of throwing open surplus beds in a hospital to the general public may be examined. The state governments may, however, be asked to make a bigger contribution when the general public is also allowed access to the hospitals of
the Corporation. This is particularly important from the point of view of making available specialists' services to all living in a particular area. The E.S.I.S. Review Committee, which reported in 1966, felt that "so long as the surplus beds are paid for by the state governments, there should be no difficulty in entering into such an arrangement. It should, however, be ensured that the beds are made available to the general public only if they are surplus". The proviso would rule out any possibility of E.S.I. hospitals being used by the public as the number of beds in E.S.I. hospitals is far short of requirements. The Corporation which discussed the E.S.I.S. Review Committee's report endorsed the view. The Corporation has for obvious reasons rejected the suggestion to build hospitals with bed strength in excess of its requirements to cater to the public, e.g. to build a 500-bed one when only 300 beds are needed for its insured persons. The funds of E.S.I.C. are not, after all, inexhaustible. Indeed, the stage has been reached when the Corporation has invested almost all its surpluses in E.S.I. hospitals and dispensaries. Further sums for capital construction can only be had if the current employer's contribution is raised beyond 2 1/2 per cent. of the wage roll.

105. On the diagnostic side, there is close co-ordination between the E.S.I.C. and public health authorities. Most of the specialists (951 out of 975) are part-time specialists employed by the state governments. The number of specialists in various lines available in the country is limited and the best use has to be made of their skill.

106. In regard to out-door care in "service" areas, the E.S.I.C. prefers to have its own arrangements through E.S.I. dispensaries. Very little use is made of the facilities available with, or offered by, public authorities. It has been suggested that municipal dispensaries run by local bodies in towns may be used and that special arrangements may be made for insured persons through separate hours or counters. The E.S.I.C. has not favoured such a course as beneficiaries under the E.S.I. are entitled to higher standards of medical care than the rest of the public and mixing up insured persons with members of the general public would provoke delicate problems.

107. Close contacts at all levels are, of course, maintained between the E.S.I. personnel and the public health authorities, who appreciate that separate arrangements by the E.S.I. ease the strain on their finances and space. Particularly in time of epidemics, such liaison is essential. Even though "health" is a state subject, the E.S.I.C. co-operates actively in measures relating to vaccination or inoculation. Apart from I.M.O.'s getting vaccine from public health authorities and using them to the best advantage for the benefit of insured persons and members of their families, and conducting propaganda amongst patients for the observance of prophylactic methods, the E.S.I.C., with its contacts with labour organisations, actively assists local authorities in visits to residential areas of industrial workers. The Planning Commission which makes an over-all assessment of the resources of each state government (grants-in-aid by the Centre to the state to an appropriate extent is an inescapable corollary) has discussions with each state government on each subject. When the budget for "health" of
each state government is reviewed by the Planning Commission, a representative of the Corporation joins in the discussions. The Director-General and the Medical Commissioner are members of several bodies set up by the Central Government ranging from the Central Council of Health to small subcommittees on particular subjects. The Medical Commissioner is on the committee of a public sector project to establish lines of manufacture of pharmaceuticals. Dealing as it does with 3.5 million workers and members of their families the E.S.I.C. is one of the largest consumers of drugs and medicines - its advice on their results and manufacture is appreciated. A quasi-official society on industrial medicine has the Medical Commissioner as an active member. The growing importance of industrial medicine is being realised. Thinking on the subject will doubtless lead to results. The E.S.I.C. is perhaps the only agency in India which can really provide the requisite data for post-graduate studies in the subject.

108. The E.S.I.C. is in a position of vantage in regard to maintenance of cordial relations with public health authorities, in arranging the co-ordination of services and in assisting in planning. The medical benefit in its social insurance scheme is administered by state governments, which are not merely agents but are partners in the project. Even if the E.S.I.C. were to administer medical care directly, the position of vantage would not be seriously affected as the Corporation is a statutory body, created by an Act of Parliament, with the Union Labour Minister and the Union Health Minister as Chairman and Vice-Chairman respectively, representatives of the Central Government (including the Director-General of the Health Services) and state governments and of employers, employees and Parliament. The Director-General is appointed by the Central Government - the decision on the choice of incumbent is taken at the cabinet level. Principal officers are also appointed by the Government of India - the Medical Commissioner is a very senior officer in the All-India Central Health Service. It is not every social insurance carrier which can have the influence and the prestige which the E.S.I.C. is able to wield in its relations with public health authorities.
G. Attitudes of Parties Interested in the Scheme

Persons Protected

109. In the early days of working of the statutory scheme of social insurance the scheme was far from popular. It was said that its compulsory nature appeared somewhat repugnant to democratic concepts. As the vast majority of the beneficiaries (industrial workers) were not particularly educated, they saw no reason why they should have to pay about 2.4 per cent. of their wage roll for the five benefits under the scheme. The employers were far from happy about having to pay 1 1/4 per cent. of the wage roll for the introduction of the scheme and bitterly complained that such contribution would add to the cost of production and raise prices. The facilities available in the beginning were also poor; when the scheme was inaugurated in February 1952 in Kanpur and Delhi by the then Prime Minister (the late Pandit Jawaharlal Nehru) only out-door general practitioner care was given to insured persons. It was only some time later that "full" medical care (including hospitalisation) was provided to insured persons. A few years later, members of families were given "restricted" medical care here and there. It was only in 1960 that "expanded" medical care was afforded to families. Even today, "full" medical care to families is possible only in two centres. It is difficult at the best of times to sell any scheme of insurance; private companies dealing with other risks have to engage a multitude of agents to canvass business. A compulsory scheme provokes resentment by its very nature. But as the years rolled by and there was a progressive improvement in the quality and quantity of medical care which was also extended to families, the attitude of the workers began to change - imperceptibly at first and distinctly later. Today, it can be said without any exaggeration or a false sense of smug complacency that the E.S.I. scheme is appreciated by the workers covered in spite of shortcomings in medical care. The beneficiaries see the E.S.I. hospitals and dispensaries going up almost month by month in various centres; they are aware that the E.S.I.C. is doing all it possibly can to improve medical arrangements. The cash benefits provided on the basis of medical certificates are of real relief. Where in 1954 or 1955 the E.S.I.C. met with resistance in implementing the E.S.I. Act (its provisions are brought into force by a notification by the Central Government centre by centre), its problem now is how to meet the demands from workers in non-covered areas, who are pressing for the early introduction of social insurance. Indeed, threats of a strike were given in one or two centres to accelerate the introduction of the E.S.I. Act.

110. There are very few complaints in respect of cash benefits - this is to be expected because cash benefits are mainly governed by the rule of thumb and depend on arithmetical calculations of rates of benefit based on factual data about qualifying conditions. There is the demand that the terms of benefit are too austere and should be liberalised by easing the qualifying conditions, increasing the rate of benefits and extending their duration. The "waiting period" of two days for sickness benefit (one of the lowest in democratic countries) is also very unpopular - though the majority of the members of the E.S.I.C. Review Committee favoured its retention, the members representing labour pressed in a Minute of Dissent for its abolition. The exemption limit for payment of contributions by an
employee (Rs.1 per diem in the E.S.I. Act and Rs.2 per diem recom-
mended by the E.S.I.S. Review Committee) is considered too low -
Rs.3 is suggested by workers. The demand for a "no claim bonus"
(for not drawing sickness benefit) is also pressed even though this
would be objectionable from many points of view, including the
interests of the insured person himself. While there is a general
feeling among workers that the E.S.I. scheme is a great boon as it
not merely gives them medical care and cash benefits but also
ensures their continuity in employment during sickness (under section
73(1) of the E.S.I. Act "no employer shall dismiss, discharge or
reduce or otherwise punish an employee during the period the employee
is ... under medical treatment for sickness ... or confinement" while
under subsection (2) "No notice of dismissal or discharge or reduc-
tion given to an employee during the period specified in subsection
(1) shall be valid or operative"), there is naturally a desire for
an enlargement of benefits.

111. It is inevitable that there should be complaints about
medical care. While every complaint is carefully looked into by
the I.M.O. in charge, the Administrative Medical Officer (a deputy
director of medical services in each state in charge of E.S.I.),
local committees, regional boards and the state government and
E.S.I.C., it must be realised that 12.6 men, women and children
receive medical attention; the number and nature of complaints
should be judged in this context - the percentage is small. In
Delhi, where the E.S.I.C. directly administers medical benefit to
about 400,000 persons, on an average 20 complaints a month are
received. Every representation receives individual consideration.
Workers realise that, as compared with the rest of the population
(they have brothers and sisters, cousins and nephews outside the
E.S.I.), they are very much better off and save an appreciable sum
of money (a certain percentage of their income on medical expenses).
The attitude to the E.S.I. scheme, one of great satisfaction and
relief, is not affected by the admittedly inadequate facilities for
"full" medical care to families.

Employers

112. While employers were also initially against social
insurance, it can now be said that they are reconciled to it. They
are aware that the E.S.I.C. has taken over the liability for work-
men's compensation to cover which they previously had to insure with
private companies at premia varying from 1/2 to 1 1/2 per cent. of
the wage roll, depending on the size of the factory and conditions
of work. They now pay the E.S.I.C. 2 1/2 per cent. to be covered
against such risks besides other cash benefits and medical care for
their workers. Larger and medium-sized undertakings which ran their
own dispensaries and had arrangements with hospitals for indoor care
have generally discontinued such facilities and saved money. The
main complaint of employers is that the E.S.I. has increased
absenteeism; their special resentment is against large-scale absences
during festivals and harvests when I.M.O.s/I.M.P.s are alleged
liberally to issue certificates for sickness feigned or apocryphal.
The E.S.I.S. Review Committee which investigated this persistent
allegation came to the conclusion that "there is no evidence before
us to show that absenteeism in industry has shown a significant in-
crease after the introduction of the E.S.I. scheme or that there has
been malingering on a large scale". It may be said that the larger employers, who are generally progressively minded, like the scheme, which is a useful stimulant to productivity. Small employers, especially the marginal cases, employing between 20 and 30 persons, feel aggrieved as they have to pay contributions and to collect them from employers - but then workers in such concerns are most in need of social security.

Members of the Medical and Allied Professions

113. The attitude of the medical profession to the statutory social insurance scheme is one of unfriendly tolerance - of bearing the inescapable. It is displeased that it is not more closely represented in the administration of the E.S.I.C. - there are only two members on the Corporation and one on the Standing Committee (out of 36 members in the former, 26 represent the central or state governments, and out of 13 members in the latter, seven represent the central and state governments). It is dissatisfied with the capitation fee of Rs.17.50 a year per insured person and family and wants an increase, even though studies made by the E.S.I.S. Review Committee and the Director-General of Health Services afford no justification for a rise. It is sensitive to action against any member in the "panel" area who is arraigned of irregular attendance or of improprieties. It is bitterly against the "service" system even though the E.S.I.S. Review Committee and the Corporation consider it better fitted to render medical services to the beneficiaries. As elsewhere in the world, the medical profession in India is well organised and may even be regarded technically as a strong trade union. That the E.S.I.C. has been able so far to keep the medical profession participating in its scheme is due to the tactful contacts with its leaders. The medical profession is not very enthusiastic about social insurance and would prefer a policy of laissez-faire, leaving the population to negotiate arrangements individually with practitioners.

Central Government

114. The attitude of the Central Government to the E.S.I.C. is, of course, one of support and sympathy. The Government of India is a firm believer in social insurance. The leadership and the guidance given by union labour and health ministers have been responsible to a large extent for the progressive improvement in the E.S.I.C.'s performance. State governments do their best, but have obvious difficulties as they are responsible for the health of the entire population of whom E.S.I. beneficiaries are only a fraction. In earlier years, some of them even thought that special facilities to industrial workers savoured of invidious discrimination. During the last quinquennium, however, their attitude has changed, with the awareness that by paying one-eighth of the cost they are able to divert funds released for the rest of the population, while capital construction and arrangements for medical care made by the E.S.I.C. ease the strain on the limited resources available.

General Public

115. It is interesting to study the reactions of the general public to statutory social insurance covering only a part of the population. It has been indicated earlier that the vast majority of people in the country get poor medical care - qualitatively and
quantitatively; the services in rural areas particularly are extremely poor. Industrial workers came from rural areas and go back to rural areas when they give up work. Even during the long period of his employment in industries in urban areas, the worker goes home once a year or more for social purposes. There is no stable labour force of any size yet in India living permanently in towns. There is, therefore, close and frequent touch between an insured person and residents of the village he comes from. It is not every worker who can get living accommodation for his family in the centre where he works. Members of families of insured persons in rural areas do not get medical care under the E.S.I., which does not function in outlying tracts; they are just a part of the general public. While the average size of a family in India may be taken as five (the husband, the wife and three children), statistical studies indicate that the average size of the family of an insured person served by the E.S.I. is only 3.88 (including the insured person himself). The worker going home tells his relations and friends of the facilities he gets for medical care under social insurance. It is only to be expected that the reactions of rural folk are varied. There is some resentment that while those who produce food for the country have literally to scrounge for whatever poor amenities may be available, those who live in towns and are engaged in industry get comparatively excellent medical facilities - the resentment is against government and not against the E.S.I.C. The villager is not convinced by the arguments adduced for his not being given proper care i.e. dispersal of population in small villages, shortage of medical or para-medical personnel or lack of funds. By and large, social insurance as a concept is already "sold" in villages whose residents would be quite prepared to pay a small contribution for such protection. The attitude of inhabitants in towns, who are not covered by the E.S.I., is also one of resentment. They have to buy medicines (at times even ordinary ones) prescribed in municipal or government dispensaries. They have to wait in a long queue to be seen by specialists in short supply (while the E.S.I. beneficiary gets attention on specified days) and are often given an appointment some days later; or they have to go to the private clinics of specialists and pay fees well beyond their capacity. Space in a hospital, except emergencies or casualties, also means a long wait for the general public while the E.S.I. beneficiary can get indoor accommodation (in an E.S.I. hospital or public hospital where beds are reserved) immediately. Non-E.S.I. residents in towns belong to professions or trades or run their shops and services. Domestic servants form a class by themselves. The majority of the general public in towns (i.e. other than E.S.I. persons or employees of the central or state governments or civic bodies) would be more than willing to pay premium for medical care under social insurance, even if they are self-employed, provided the scheme covers such facilities only and is not a composite one with high premium like the E.S.I., providing cash benefits for various contingencies.
H. Special Problems

Maldistribution of Members of the Medical and Allied Professions and of Medical Facilities

116. The maldistribution of medical and para-medical personnel among the states in India and between urban and rural areas has been mentioned earlier. The Institute of Applied Manpower Research in its I.A.M.R. working paper No. 6/1965 - Part I, estimated the number of medical practitioners of allopathic medicine as follows:

- Number of doctors at the end of 1964: 108,737
- Number of men doctors: 96,308
- Number of women doctors: 12,429
- Number of graduates (M.B.B.S.): 57,571
- Number of licentiates: 51,166
- Number practising medicine (including 5,600 specialists): 84,000
- Number of teachers: 8,600
- Administrators and executives: 4,000
- In other activities: 3,400
- Total number of active doctors: 100,000
- Number of active doctors in private practice: 54,000
- Number in public sector establishments: 40,000
- Number in organised establishments of private sector: 6,000

117. A feature that deserves notice is that women form less than 15 per cent. of the medical personnel. At the end of 1964, there were 227 doctors for every million of population - 201 men and 26 women. This is of special relevance in India where many men like their women and children to be examined and treated by women doctors. Even apart from some prejudice against examination of women by men doctors (this does not exist at all among the educated classes, is dying out fast in urban areas and even in rural areas) there is a feeling that women have a better "touch". Even though a large number of women graduates are being turned out each year at an increasing rate, they do not like serving in rural areas.

118. The maldistribution of personnel even in urban areas is pronounced - while doctors are readily available in large cities like Calcutta, Bombay, Madras or Delhi, the smaller towns do not attract an adequate number. In the working of the E.S.I. scheme, state governments find it difficult to retain I.M.O.s in "sparse" areas.
(i.e. centres with less than 1,000 insured persons) for any length of time and transfers have to be frequent. Some candidates who turn up for interview often make it clear that they will not serve in any place other than a class I town - with a population of over 100,000; a few even specify only very large cities. During the process of adding to the inadequate number of medical and para-medical personnel through schemes under implementation for training, it is clearly a "seller's market" as far as medical skill is concerned. If there is unemployment in the medical field, it is only in larger urban areas where doctors can be found in sufficient numbers. A study made showed the following pattern of distribution of doctors in India.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>57,302</td>
<td>7,471</td>
<td>64,773</td>
</tr>
<tr>
<td>Rural</td>
<td>30,456</td>
<td>1,082</td>
<td>31,538</td>
</tr>
<tr>
<td>Total</td>
<td>87,758</td>
<td>8,553</td>
<td>96,311</td>
</tr>
</tbody>
</table>

119. In a democratic set-up as in India, the use of compulsion to force men and women to villages is somewhat repugnant. An endeavour is being made by providing, to the extent possible, facilities for housing and an appropriate non-practising allowance.

120. It may be stated that as far as the statutory scheme is concerned, the maldistribution presents no grave problems. The "panel" system of utilising private medical practitioners is in force mainly in the large cities of Bombay and Calcutta. Elsewhere, the "service" system means that I.M.O.s are government servants, subject to transfer anywhere in the state. The only snag is that personnel in "sparse" areas cannot be retained very long. By the very nature of the scheme, it is in force mainly in towns, large and small, where industries are located. The sparse areas serve only a small number.

Lack of Medical and Allied Personnel and of Medical Facilities

121. The scheme is not able to get all the personnel, medical or allied, that it needs. While "panel" doctors are available in adequate numbers in large cities and there is keen competition to become an I.M.P. under the E.S.I., the scheme cannot get enough men and women in "service" centres to come up to the yardstick of one doctor to 750 insured persons - the shortage is also reflected in ancillary personnel. This cannot be helped. It can only be hoped that the position will ease year by year. In any case, where the general population on the whole gets one doctor per 5,700 persons in 1965-66 (in rural areas only one doctor for about 30,000 inhabitants), the E.S.I. provides on an average one doctor per 1,000 insured persons and family or per 3,800 persons.
Lack of Means of Communication

122. The scheme itself is not seriously affected by lack of communications. Located in industrial centres, in urban areas, transport by road and rail within the town or two towns for specialities if necessary is available; the centres are also served by telephones - every E.S.I. dispensary/hospital has telephones. In regard to the general population, however, lack of communications is a serious bottleneck for medical care. Many villages are not connected even by telegraph - telephones are not common in rural areas. For a country spread over 1,200,000 square miles there were in 1961 only about 365,000 miles of railways, about 150,000 miles of surfaced and 300,000 miles of unsurfaced roads and 150,000 miles of national highways. The number of buses is not adequate - taxis are not stationed in rural areas, are difficult to get in small towns and inadequate, except in large cities.

I. Statistical Data

123. Though detailed figures in respect of all aspects of the social insurance scheme are not available, the information in the following annex may be of some interest.
ANNEX

A. NUMBER AND INCIDENCE OF CONSULTATIONS (1966-67)

<table>
<thead>
<tr>
<th>Description</th>
<th>Insured Persons</th>
<th>Families</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Per I.P.</td>
<td>No.</td>
</tr>
<tr>
<td>First</td>
<td>8,579,000</td>
<td>3.63</td>
<td>7,160,000</td>
</tr>
<tr>
<td>Subsequent</td>
<td>19,724,000</td>
<td>8.34</td>
<td>13,342,000</td>
</tr>
<tr>
<td></td>
<td>28,303,000</td>
<td>11.97</td>
<td>21,502,000</td>
</tr>
</tbody>
</table>

B. ANNUAL COST BY TYPE OF MEDICAL BENEFIT (1966-67)

<table>
<thead>
<tr>
<th>Type</th>
<th>Cost per I.P.</th>
<th>Percentage of Wages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient care</td>
<td>16.28</td>
<td>1.08</td>
</tr>
<tr>
<td>Medicine</td>
<td>12.15</td>
<td>0.80</td>
</tr>
<tr>
<td>Hospitalisation</td>
<td>5.08</td>
<td>0.34</td>
</tr>
<tr>
<td>Specialist Services</td>
<td>0.39</td>
<td>0.03</td>
</tr>
<tr>
<td>Administrative Cost</td>
<td>1.38</td>
<td>0.09</td>
</tr>
<tr>
<td>Contingencies</td>
<td>0.03</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>35.31</td>
<td>2.34</td>
</tr>
</tbody>
</table>

C. NUMBER OF DOCTORS ON 30 NOVEMBER 1966

(i) Doctors under "Panel" system .......... 4,029
    Insured persons on "Panel" ............ 1.98 million
(ii) Doctors under "Service" system ........ 1,189
    Insured persons under "Service" ....... 1.45 million
    Total number of doctor-hours per week .... 52,533
    Doctor-hours per week per 1,000 I.P.'s .... 36

1 Assumed as Rs.1,510.
D. PLANNED EXPENDITURE

The expenditure per annum per insured person incurred by the Corporation in coming years (i.e. seven-eighths of costs) is likely to be as under:

Insured Persons Only

Insured persons ("full" medical care) ....... Rs.16

Families Only

(i) "restricted" medical care .............. Rs.24
(ii) "expanded" medical care .............. Rs.32
(iii) "full" medical care .................. Rs.40

Insured Persons and Families

"Full" medical care ....................... Rs.56

E. CORPORATION'S SHARE OF EXPENDITURE (i.e. seven-eighths)

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1962-63</td>
<td>Rs.47.2 million</td>
</tr>
<tr>
<td>1963-64</td>
<td>Rs.54.8 million</td>
</tr>
<tr>
<td>1964-65</td>
<td>Rs.73.2 million</td>
</tr>
<tr>
<td>1965-66</td>
<td>Rs.95.9 million</td>
</tr>
<tr>
<td>1966-67</td>
<td>Rs.111.7 million</td>
</tr>
</tbody>
</table>

F. INSURED PERSONS ON 31 MARCH EACH YEAR

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>1.71 million</td>
</tr>
<tr>
<td>1963</td>
<td>2.34 million</td>
</tr>
<tr>
<td>1964</td>
<td>2.67 million</td>
</tr>
<tr>
<td>1965</td>
<td>2.97 million</td>
</tr>
<tr>
<td>1966</td>
<td>3.41 million</td>
</tr>
</tbody>
</table>