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HEADQUARTERS' OFFICE

EMPLOYEES' STATE INSURANCE CORPORATION
(ISO 9001-2000 Certified)
PANCHDEEP BHAWAN, C.I.G. ROAD: NEW DELHI

RECOMMENDATIONS OF THE SUB-COMMITTEE ON MEDICAL SERVICES & MEDICAL EDUCATION

MEDICAL SERVICES

ESI Corporation had constituted a committee under the Chairmanship of D.G. ESIC. The term of reference of the committee was to suggest measures for improvement of medical services. Committee conducted one meeting and suggested some broad guidelines for making the improvement. Before the formal meeting of Sub-committee, DG ESIC had obtained suggestions from ESIC medical officers, Directors of the state ESI scheme, Deans of ESIC, and constituted eight groups having doctors, administrators, state directors, and state. Each group was given specific issues. The report submitted by these eight groups was discussed in details by ESIC HQ officers in the multiple sessions Chaired by DG. Union Secretary Labor also conducted preliminary discussions with Railways & Defence on medical services run by them. Union Secretary Labour also was kind enough to conduct a Video conference on issue of Role of Mentoring by ME Institutions and online consultations as well as development of center of excellence. The subcommittee on MS & ME discussed all related issues based on the agenda. It has already held three meetings. The final recommendations of subcommittee duly taking into account deliberations and recommendations made in various meetings are as under:

I. PRIMARY MEDICAL CARE

Primary medical care is largely provided by State ESI Scheme through a vast network of Dispensaries (1350) and almost equal number of IMPs (Insurance Medical Practitioners). This is the first point of contact of beneficiaries for availing medical services.

1. Insurance Medical practitioner (IMP)

IMP system is in place since long. The Beneficiaries were getting reasonably good services especially in the areas where the dispensary services were not available. IMPs were very useful in starting the services in newly implemented areas. But due to low payment to IMPs, non-availability of guidelines pertaining to services required to be rendered by them and lack of monitoring mechanism the service of IMP deteriorated. In order to make improvement in the IMP system the committee recommends as under:

i. The 1st priority would be for construction of dispensary on Land to be provided by the States, construction costs for which would be borne by ESIC. The IMPs would be employed as per prescribed criteria a temporary measure if norms do not permit the opening of dispensary or it cannot be set up by the State Govt. /ESIC.

ii. Operational manual for guidance of IMPs should be finalized within the next 3 months i.e by 31.8.2014, which would inter-alia include prescribed criteria for enrolment, infrastructure, record to be maintained etc.

iii. Mobile No. of IPs attached to IMP to be seeded in a time bound manner. Mobile no should be mandatory in registration field. The telephone no. in respect of existing IPs may be taken from the employer **(Action: ICT division HQ – 9 months)**

iv. Each IMP should be allowed to enrol up to 2000 IP with a package remuneration of Rs.300/- per IP family per annum which will

include providing of primary health services to IP family, investigation facilities of Urine (albumin & sugar) Haemoglobin and Blood Sugar. This amount includes average Rs.25/- per IP family for conducting investigations as mentioned above and appropriate amount for engaging a support staff. He will also supply specified medicines to IPs and family members which will be collected by IMP from the nearest ESIS Dispensary. The list of specified medicine will be provided to Director, ESIS. The IMP should display board showing the facility of investigations and medicines available for IPs.

v. IMP to maintain following record:

- Basic case record of beneficiaries in a register.
- Stock register showing receiving and consumption of specified medicine.

IMP to send monthly statement in r/o treated beneficiaries and stock position of specified medicine to SSMC/SMC & DIMS. Initially the report may be sent as hard copy and over a period of time the statement may be sent through email.

vi. Minimum infrastructural requirements as specified in the Operational Manual for IMPs. ESIC will develop such guidelines.

vii. ESIC should have a robust Public Grievance Redressal system, duly utilizing SMS, Call Centre and IT technologies. IMP should be duly covered under this. Mobile no. of all IPs should be collected. These should be uniform toll free no. throughout India and it should be given due publicity. **(Action – ICT Division and Medical Division in 9 months)**

viii. IMP shall make alternative arrangement whenever he goes on leave.

ix. A Standard Contract may be signed between ESIC and IMPs. **(Action – Medical Division - within 3 months including legal vetting of the contract)** IP may get registered with IMP of his choice. IP should have the option to change the IMP in case of change of residence or Services of existing IMP is not satisfactory.

x. **Criteria to enrol IMP:**

a. Maximum age limit should be 50 yrs. Relaxable up to 65 yrs. for ESIC/Govt. retired doctors.

b. Tenure for all should be up to 70 yrs of age, subject to medical fitness.

c. Contract period of IMP should be for one year renewable every year for a maximum period of three years. In exceptional cases this may be extended to five years. Regular dispensary should be set up within maximum period of five years.

d. It will be a compulsory requirement for the IMP to have computer system with internet facility to verify the eligibility of the IP/beneficiary and for other online transactions concerning their work. For this purpose an additional amount of Rs.10,000/- per year will also be provided.

e. If the IMP is continuing for more than 3 years, then the Local Committee will review the entire system in the area and make its recommendations for further action to the higher level Institutional body being set up for interaction with State Government.

f. **Local Committee:** The local Committee constituted under Regulation 10 A of the ESI (General) Regulation would monitor functioning of IMPs as under:

- Surprise inspection of IMPs to check
  - whether records are being maintained properly
  - whether medicines are being dispensed in accordance with the prescribed norms/instructions
- Annually review performance of the IMPs and the report of the same shall be submitted to State Executive Committee.
- **Operational Manual/guideline shall clearly define**
  - Terms of Reference of Local Committee
  - template of the check list for the guidance of the Local Committees for their inspections
  - communication channels for sending recommendations of Local Committee to State

Executive Committee, which in turn shall be required to communicate the report to National Committee,

2. Dispensaries

Most of the ESIS dispensaries are housed in rented building. Some of these buildings are in a bad shape and are not suitable for providing quality care services as well as installation of Computer hardware. State govt. is not able to give the desired priority to ESI, therefore services are generally poor. The committee after a detailed deliberation recommends following measures for making improvement:-

a) Dispensary timings

- Heavy dispensary with average daily attendance of 200 patients per day, should maintain uniform timings of 7.30 AM to 7.30 PM except for closing of registration counter half an hour before the closing timings. The same should be displayed in the registration area.
- Dispensary working in single shift: Timings should be such that IPs working in both morning and evening shifts can avail of services.

b) Refresher training

Latest instructions issued from ESIC HQ and D(M)D for the doctors should be uploaded at one place on ESIC website.

c) Lab Investigations

Heavy dispensary should have facility for carrying out minimum and essential investigations namely blood sugar, urine analysis, CBCT, & ECG. (It is understood that no additional staff would be required for operating ECG machine. However, a Lab Technician or lab Assistant would be required for other tests). A semi automatic Analyzer should be installed. Expenditure would be borne by ESIC/ESIS as per prevailing arrangement. This would help in reducing available patient load in hospitals. The ESIS should also follow the same system. (Patients from other light dispensary may also come to nearby heavy dispensary for investigations.)

d) Availability and Distribution of Drugs

State should ensure availability of drugs in the dispensary. ESIC R.C. provides the entire range of requirement at competitive rates. Further the committee recommends as under:

- Patient discharged from the hospital may be given medicine for the period prescribed or maximum for one month whichever is shorter.
- Patient attending ESIC Hospital OPD should be given medicine for a maximum period of one month.
- Patients suffering from chronic ailments should get medicine from dispensary for one month at a time unless there is specific reason for not doing so.
- The system of empanelled Chemist is working reasonably well in ESIC Delhi and ESIC outside Delhi.
- ESIC Hospitals and dispensaries maintain re-order level and indent medicine from Central Store on monthly basis as well as supplementary indent is also received whenever required.
- ESIC Delhi is engaging local chemist on the basis of discount offered for branded and generic medicine, for the medicines which are not supplied by Central Store.
- The ESIS system should follow the same system for dispensing of medicine, as mentioned above.
- In ESIC Delhi, the IMO In-charge of dispensary is empowered to reimburse the bill up to Rs.10,000/- per case. Delegation of Power of ESIS dispensary In-charge for / reimbursement of medical bill could be upto Rs.1000/- per case subject to a maximum Rs.10000/-. per month.

e) Infra-structure:

All dispensary buildings in terms of infrastructure provision, requirement of major repairs/shifting/ merging of light dispensaries and splitting of heavy dispensaries will be surveyed, and based on this

survey, persons /agencies (State/ Central Government) will be identified for repair and maintenance of buildings. (**Action- by SMC and Regional Director in three months**). This person/agency will be responsible for preparing estimates, calling tenders and finalizing the vendor/agency to execute the work (**six months**). The person/agency will oversee execution of the construction and repair of dispensaries and associated infrastructure by the vender/agency (**to be executed within one year**).

- Each dispensary should have provision of: toilet, drinking water, power back up, adequate furniture, IT hardware, telephone and optimum accessibility of dispensary premises.
- A Standard rent agreement for hiring of dispensary buildings needs to be developed for uniform implementation in all the states. (**Action - by Medical Division in 3 months including legal vetting)**
- New Dispensary to be opened on the basis of IP population as per existing yardsticks and subsequently criteria should be OPD attendance, to be reviewed annually. If man power is in excess, people with longest duration will be moved first.
- It is highly desirable that new dispensary is started only after manpower and equipments as per norms are in place.
- Heavy dispensaries having minimum specified attendance, should preferably be in own buildings of ESI Corporation. Policy in this regard may be developed.
- All Hospitals and heavy dispensaries should have token vending machines.
- Each dispensary should have proper sign boards in local languages.
- All hospitals and heavy dispensaries should have a separate registration counter for senior citizens as per GOI instructions, which may require additional man power.
- Retired GDMOs to be engaged on part time basis. In case of Delhi, D(M)D will make a review and submit the proposal to HQrs office for approval. Specific guidelines may be developed. To address shortage of medical and paramedical staff, State Governments should be advised

for proper manpower planning, recruitments as per the ESI norms as far as possible.

- The matter of repair of rented building at the cost of ESIC should be submitted to the Corporation for consideration.

EXECUTIVE COMMITTEE

The Executive Committee for monitoring of ESIS:

1. Principal Secretary/ Secretary Labour/Health - Chairman
2. Officers from other State Departments (PWD, Finance etc.) to be co-opted by Chairman - Member
3. State Health Commissioner/Director Health Services - Member
4. ESI Corporation Members belonging to that State - Member
5. MS of ESIS Hospital to be nominated District wise by DIMS on rotational basis - Member
6. Two Employer Representatives to be nominated by the Chairman Regional Board from amongst employers' Representative included in the Regional Board - Member
7. Two Employee Representatives, to be nominated by the Chairman Regional Board from amongst employees' Representative included in the Regional Board Member
8. Regional Director of ESIC of State. - Member
9. SSMC/SMCs - Member
10. DIMS/Administrative Head of State Directorate - Member Secretary

For IT purposes following officers will also attend the Meeting:

1. State IT Nodal Officer nominated by DIMS
2. WIPRO Representative
3. Any member co-opted by the Chairman

Terms of References

- Monitor performance of all ESIS hospitals and dispensaries in the State.

- addressing the recruitment issues related to ESIS Hospitals and Dispensaries.

- Monitoring of the functioning of IMPs. through periodic review of the reports of the Local Committees as well as independent inspections carried out by this Committee or its members.

- Monitoring of infrastructural issues and execution of repair work; i.e. monitoring the timely survey of all the ESIC building and getting proposals for repair, reviewing of rented premises of ESIS dispensaries.

- Monitoring of SST bills

- Implementation & Monitoring of IT Roll-out under Panchdeep, in the State, including power back-up.

- Monitoring of training of ESIS officials.

- Monitoring of grievances concerning ESIS - There should be a 24x7 telephone line for Grievances redressal *along with robust on-line monitoring system of public grievances.*

- Detailed operations manual/guidelines for the guidance of the members of this Committee to include
    - reporting formats for monitoring of grievances concerning ESIS
    - automatic reminders to Executive Committee Chairman if meetings are not held
    - Returns/proposals to be sent to respective National level Committees for further action

- The proposed national level committees are as under:
    i. National level Committee of Construction
    ii. National level Committee of Grievances
    iii. National level Committee of Training
    iv. National level Committee of IT
    v. ***The working group constituted for review of MoU between ESIC and State Governments shall also function as National level Committee for resolving all issues between ESIC & State Governments.***

Recommendations of National Committees should be placed before the Standing Committee, which is a Permanent Advisory Committee.

3. MOU with States

ESIC should function in synchronization with State Govts. involving regular and better dialogue, so that a good relationship may be established.

The medical services to ESI beneficiaries are provided by the respective state govt. as per the ESI act. For execution of the provision of Act. an MoU is executed between the state and the ESIC.

- The MoU needs to be revised to make both the parties accountable for providing required services to the beneficiaries.
- The Committee constituted earlier for this purpose under the Chairmanship of DG ESIC should finalise its recommendations, and the same should also be incorporated in the operating manuals/ guidelines being prepared.

4. Increase in coverage of the target population to provide benefits including medical care services to more beneficiaries
    a. ESIC may undertake pan-India survey to identify Notifiable areas / establishments in a time bound manner.
    b. Notification by State Governments and provision of medical care services may be facilitated as a follow up action, through Institutional mechanism, in a given time frame.

II. SECONDARY MEDICAL CARE

Secondary care is largely provided through a vast network of ESI Hospitals all over the country. There are 151 hospitals of various bed capacity having about 19000 beds. Out of these 36 hospitals are directly run by ESIC while rest are managed by the respective state Govt. Corporation run hospitals are largely over crowded while state run hospitals are under-utilized mainly due to deficient services. In order to improve the services the committee recommended as under:

Operational Manual to be prepared for each Stakeholder i.e. IPs, States, Doctors. (**Action – Medical Division in consultation with PR division: 3 months)**

- Flyers for IPs (in English, Hindi, Local language) to be placed in all ESIC/ESIS hospitals and dispensaries having information regarding their rights.(**Action – PR Division within 3 months)**
- Procedure for referral from dispensary should be included in these operational Manuals.
- Institutional mechanism for interaction with States through ESIC and State level committees.
- Need for documentation of mentoring practises for reference should be an integral part of the recommendations.
- Draft Operational Manuals prepared should be uploaded on the ESIC website for a period of two weeks for review and comments by stakeholders, before finalization.

1. Referral from Dispensary

'Kahin Bhi Kabhi Bhi' should be restricted for emergency situation. Routinely the I.P. should have a parent dispensary for himself and his

family. IP may choose separate dispensary for his family. It is highly desirable that patients go to hospital only after referral from dispensary with the proforma as specified currently, duly filled in. As far as possible Dhanwantri module should be utilised for referral.

SOPs may be worked out for referral for secondary medical care, wherever tie-up for the same is allowed under existing decisions of the ESIC.

2. Continuing Medical Education (CME)

- Dispensary doctors to be trained in family medicine by posting them in hospital for 15 days on rotational basis, covering all important specialities.
- CME programmes for doctors to be held in ESIC Hospitals once in a month. It should be mandatory for dispensary (attached or within 25 kms.) doctors to attend minimum three CME programme in a year. Other dispensary doctors are also welcome to attend.
- Doctors to attend two conferences in two years. One conference should be with the fees, TA/DA. The other conference should be without TA/DA, but, course fee and leave may be provided.

3. Mentoring

Each of the ESIC-PGIMSRs should take lead in identifying some specialties for the purpose of mentoring. Once the SOPs are framed, the identified mentor institutions shall provide mentoring to other ESI hospitals in respective specialties. It was noted that no extra manpower/infrastructure shall be provided for this activity.

It was decided for mentoring (all the ESIC/ESIS hospitals) in each discipline would be formally notified - both lead as well as supporting institutions. Headquarter will create email sub-group for effective communication for each discipline. They will have the following charter.

i. Prepare the standard protocol of surgeries/standard treatment protocol /clinical pathways/common specifications banks and any other standard operating processes as may be required for that discipline. SOP would be developed and would be circulated by the HQ to all others ESIS and ESIC hospitals. An interactive website may be developed for sharing the technical knowledge between different ESI Hospitals.

ii. They would take up multi-centre research.

iii. They would conduct at least 2 CMEs per department per year for specialists of the concerned hospitals.

iv. They would be the reference point for taking stock of the facilities in the ESIC/ESIS hospitals in that discipline and would contribute towards effective development of that discipline.

v. They may also initiate an ESIC Journal in the relevant discipline.

vi. Support from the Headquarter will be provided for interactive website/demonstration/live telecast /tele-conference/dash-board, etc.

vii. Draw up an implementation plan to increase use of telemedicine and tele-conferencing.

viii. Improvement in network connectivity and using live demonstrations of some special procedures/surgeries as part of preferential training.

To begin with following specialties are selected hospital wise for mentoring other ESI hospitals.

PGIMSR-Basaidarapur: Orthopedics, Obstetrics & Gynecology, Dermatology, Anesthesia and Pulmonary Medicine.

PGIMSR-Rajajinagar: Pediatrics, Surgery, Microbiology, Medicine and Radio-diagnosis.

PGIMSR- K.K. Nagar: Biochemistry and Pathology.

PGIMSR-Joka: Shall provide support in Obstetrics & Gynecology to Basaidarapur.

PGIMSR-Andheri: Laparoscopic surgery, they will provide support to Rajajinagar in Neonatology and to Basaidarapur in Obstetrics & Gynecology.

PGIMSR-Rajajinagar: shall provide support in Pediatric surgery to ESIC Super Specialty hospital Sanath nagar.

4. <u>Shortage of Manpower</u>

- Annual recruitment Calendar: The Committee recommended that each authority (MS, SMC, RD) would send vacancy position to HQ office, once in a year on a decided month every year, and if required hiring of professional recruitment agencies can be explored by the Corporation.
- An average of last three years' work load of IPD in a hospital should be considered for the assessment of staff requirement. If the average of bed occupancy of last three years is 80% and above and the bed occupancy of the previous year more than 85% remedial measures should be taken to enhance the bed strength and staff, depending upon the availability of ready built space, with an aim to bring down the bed occupancy below 70%. However, the first attempt should be to have full strength of sanctioned staff of original bed strength.
- Whenever a post of specialists falls vacant or is likely to fall vacant within six months should be advertised. If regular specialist is not available even after advertising the post twice, full time contractual specialist may be engaged: failing which part time contractual specialist may be engaged. (There will be no need for giving extension in service to retiring specialists, as the above procedure provide for filling up of vacant specialist posts in an orderly manner).
- The process of filling up the post on regular basis and engaging a contractual specialist on full time/ part time basis would go concurrently. (The regular specialists are recruited by the Hqrs. whereas MSs are authorized to recruit contractual specialists).
- Senior Residents may be engaged as per provisions of the Central Residency Scheme or ESIC Residency Scheme. Their engagement beyond the period specified under Central Residency Scheme/ ESIC

Residency Scheme can be done on annual contract basis, outside the Central Residency Scheme/ ESIC Residency Scheme.

- If the Senior Residents are not available as mentioned above, the candidates eligible for Senior Residents can be engaged for 39 days extendable by another 39 days to tide over the immediate requirement.
- The institutions running MBBS courses have–practically no role for GDMOs. As such, GDMOs in such institutions should be moved out to other institutions in an orderly manner.
- Where the new facility like infertility clinic, dialysis unit, Nursery, ICU, ICCU etc. are provided, the additional staff as per norms has to be provided. Wherever special services are sanctioned for the first time, the sanction should include additional staff as well.
- Shortage of ministerial staff should be shared among RD office, SMC office, and Hospital equally. Vacancies should be filled up expeditiously.
- Wherever regular or contractual (full time/ part time) specialists/ super specialist are not available, they can be hired from private sector on market rate either on per case basis or fixed duration basis. Specific guidelines of engagement on market rate may be developed.
- It is felt that if the recruitment process is done, as per schedule, there may not be shortage of GDMO.
- The provision of Tele-radiologist and technician may be considered based on cost effectiveness.
- With a view to improve hospital administration, it may be examined if ESIC doctors and Revenue officers could be given opportunities to specialize in hospital administration. Doctors specialized in Hospital Administration may be optimally utilised. A separate Cadre of Hospital Administrator (doctors and revenue officers) needs to be created.

5. Telemedicine

A channel like system on the web for each specialty with fix time of telecast may be developed and should be telecast to all ESI Hospitals for upgrading their knowledge and skills. A dash board should be created for interactive sessions. **(Action – System Division in 3 months)**

5. Streamlining procedure for procurement of equipment

- A specification bank for common equipments to be framed and circulated. (**Action – Medical Division in 3 months**)
- A standard tender document for procurement of equipment should also be finalized. **(Action – Medical Division in 3 months)**
- Major equipments to be purchased with 5 yrs CMC. Equipment maintenance register should be maintained at the department level.
- The rate contract for Prosthesis and Aids is prepared by Central Stores, Director (Med.) Delhi. The specifications and rates can be shared with other ESIC/ESIS hospitals. **(Action – Director (Medical) Delhi)**
- Feasibility of finalizing rate contract for high cost generic drugs, anti-cancer drugs etc. may be worked out. **(Action – Medical Division in 3 months)**

6. Infrastructure at hospitals

- CCTV system to be installed in entrances, exits, parking area, emergency department and other vantage points. This will contribute in increasing efficiency of staff and for monitoring safety of crucial hospital areas etc.
- Good signage system should be there. Public address system to be optional and need based.

7. Redressal of staff grievances

To redress the grievances of ESI employees a senior administrative officer (in addition to his administrative responsibility) is designated as grievance officer by the Medical Superintendent in every ESIC hospital. Similarly the grievance officer may be designated in ESIS hospitals also, if not in place.

Regular meetings of Administration with the different category of Staff of hospital is an essential requirement. The ESIC hospitals may continue to adhere to the existing practice of grievance redressal while the other ESI hospitals should strive to put appropriate mechanisms in place.

8. Occupational Disease

Periodic courses for training/sensitization of doctors of Pulmonology Department, Dermatology, ENT, Ophthalmology and Medicine Department may be organized to improve their knowledge base on the subject of occupational disease.

9. Revision of norms for setting up of ESI hospitals

- The Committee desired a Cost benefit analysis (financial and Social) to be done for tie up hospital vis–a-vis own hospital. (**Action: Finance Division. Activation of billing module of Dhanwantri may be required)**
- *Norms and guidelines for creating new infrastructure (Dispensaries & Hospitals) on basis of IP population (with due weightage for geographical spread, scattered IPs etc.) to be evolved with special focus on States where present infrastructure is inadequate.*

It was felt that 50 bedded hospitals is not a viable unit based on the functional requirement and economy. Therefore it was decided not to have any more 50 bedded hospitals. Accordingly criteria for setting up of hospital of different bed strength were approved. Copy enclosed. It was noticed that due to relaxation in criteria mainly of 100 bedded hospital, ESIC had to approve nearly twenty six 100 bedded hospitals.

The criteria of distance was taken from the other recommendation of ESIC, where it was approved that in case the IP population is 25000 in a location, and there is no ESI hospital in a radius of 25 to 75 Kilometer, ESIC will directly provide the Secondary care services through a tie-up arrangement.

The IP population of 25000 is not sufficient to fully utilize the services of 100 bedded hospitals. Therefore the Secondary care services in such locations may continue to be provided through tie-up arrangement and norms be revised for opening of new hospitals. The proposed revise norms are as under:

S.N	Existing Norms	Proposed norms
1	**100 Beds-25000 IP**	**100 Beds-100000 IP**
2	150 Beds 100000 IP	150 Beds-150000 IP
3	200 Beds-150000 IP	200 Beds-200000 IP
4	250 Beds-200000 IP	250 Beds-250000 IP
5	300 Beds-2500000 IP	300 Beds-300000 IP
6	350 Beds-300000 IP	350 Beds-350000 IP
7	400 Beds-350000 IP	400 Beds-400000 IP
8	500 Beds-400000 IP	500 Beds-500000 IP
9	600 Beds-500000 IP	600 Beds-600000 IP

- **Norms:** The Committee approved the revised norms and recommended that for establishing a hospital-IP population would be taken in a radius of 50 kms and there should not be any other hospital within the radius of 100 kms.

  [Norms for establishing hospital in North East regions are different and need not be changed]

- All the ESI hospitals in the State should have bed occupancy of 60% or above.

- Architectural Plan should be prepared in such a way that 50 beds can be adjusted in the existing beds./building.

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10. VALIDATION OF QUALITY OF SERVICES

The Committee recommended that

- There may be fixing of Service Benchmarks and Timelines for better service to IPs with necessary arrangements for its monitoring. **(Action - Medical Division – 3months)**
- Third party agency may validate quality of medical care services in dispensaries and hospitals as per established benchmarks, from time to time. **(Action - Medical Division 6 months after communicating the bench mark to field officers)**

11. Other measures

- Personnel policies under AFMS for posting of doctors in difficult areas may be examined for adoption in ESIC.
- The different laboratories and Departments of hospital should be encouraged to obtain NABH/NABL, NABH Safe-i certification.
- Separate registration counter and colour coding of prescription slip for senior citizen patients should be there for easy identification for giving priority treatment.
- Every hospital of capacity 500 beds or more should have blood bank. Every hospital above 200 bed capacity should have blood storage facility attached to nearest blood bank of ESIC/Govt./Red Cross/IMA.
- Every hospital should have an ICU, as it is a medico legal requirement.
- Every hospital having labour room should have NICU of appropriate size.

- Facility of CT / MRI may be established in hospitals with 500 beds & above with minimum 70% bed occupancy. In other hospitals it may

be considered based on cost effectiveness. Various options such as own setup, PPP model, Outsourcing may be examined. It is noted that the availability of Radiologist is constraint.

- Horticulture in each hospital should be encouraged.

III. PROCUREMENT AND DISTRIBUTION OF DRUGS AND DRESSINGS

The Rate contracts for drugs and dressing are prepared by the ESIC HQ Office for all the ESIC/ESIS medical institutions. Based on the annual demand estimation of individual units, the supply orders are placed by the authorized DDOs (Direct Demanding Officers) directly to the manufacturer
It has been observed that availability of drugs and dressings is adversely affected due to non supply/delayed supply by the rate contract holder. Many a time this delay is due to the Rate Contract condition that the supplied medicine should not have crossed 1/6th of its shelf life from the date of manufacturing. It is also a common practice that the doctors prescribe medicines out of the Rate Contract/ESI drug formulary. In view of the above issue Sub-Committee recommended as under:

1. Rate Contract may be amended permitting acceptance of drugs (having total shelf life of 2yr or less) older than 1/6th to 1/4th of its shelf life from the date of manufacturing.
2. The treating doctor should be directed to follow the ESIC Rate Contract/drug formulary, except in special circumstances.
3. Separate DG ESIC rate contract of costly/ anti-cancer drugs with generic names should be prepared.
4. Protocols for local purchase of medicines should also be clearly defined. **(Action – Medical Division -3months)**

IV. SUPER-SPECIALITY SERVICES

ESI Corporation in the year 2009 (REFERENCE) decided to extend super-specialty services to its beneficiaries in a cashless and hassle-free manner through tie-up private hospitals. The Corporation also considered relaxation of criteria entitling IP for Super-specialty treatment. The entire expenditure was also to be borne by the ESI Corporation. It has been noted that the expenditure on super-specialty is rising very fast partly due to relaxation in the eligibility criteria and misuse by non-entitled persons. This need to be revisited so that the money of the IP is not siphoned out by others by taking the advantage of relaxed criteria as well as provision of deposition of contribution from the back date to enable any person to become entitled for super-specialty treatment.

The super specialties services were being provided by tie-up with private/public hospitals. It was proposed:

The SST could be provided through a mix of in-house facilities, PPP mode and 'Tie-up' with private/public hospitals, duly keeping in mind cost effectiveness and other relevant parameters. Different models may be examined in this regard.

1. Super specialty Referral Services

a) Non emergency referrals- The patient should be referred by a Specialist for SST, only after following specified clinical pathway (if feasible) or the specified guidelines in this regard.

If the nature of disease is such that the specialist concerned is not able to decide the procedure required, he/she would refer the patient to super specialist (if required in a tie up hospital) for specific opinion. After the opinion has been received, specific reference for SST be made as far as practicable to a different tie up hospital i.e. to a different tie up hospital and not to the same tie up hospital from where super specialist opinion was sought at the first instance.

b**) Emergency referrals**: Emergency referral implies that patient comes to an emergency of ESI Hospital outside normal working hours. In such case, emergency duty officer will assess and if required refer the patient for SST along with a detailed clinical note to be prepared as per specified guidelines. The emergency duty medical officer will submit the details of the case to the MS on the next day for review and follow up action, if any. MS may decide to send a team of doctors to the tie up hospital for verification. As far as applicable, the patient on emergency should be examined by the specialist concerned available at the emergency. Further, as far as practicable, the CMO/Senior resident available at emergency shall consult concerned Specialist/superiors over phone before making emergency referral for SST.

c) In addition to above the following parameters should also be considered:

i. The feasibility of obtaining specialists consultation online prior to SST referral may be examined. **(Action – Medical Division -3months)**

ii. The 3 specialties with the highest referral of patients for SST were reported to be Cardiology, Oncology, and Nephrology. The following ESIC-PGIMSRs and super specialties were identified as lead institutions:

1. Medical Oncology : PGIMSR Rajajinagar Hospitals.
2. Cardiology and Nephrology: PGIMSR Basaidarapur

The Deans concerned shall submit the proposal to ESIC HQ for a pilot program covering at least two States . Extra resources in terms of specialists as well as equipment would be admissible for

the pilot program subject to justification. The concerned Deans and Super specialists would finalize the SOPs and clinical pathway protocols for referral.

iii. All SST referrals to 'Tie-up' hospitals should be made after consultation with the specialists concerned, following specified clinical pathways/guidelines. The standard operating procedure (SOPs) should be developed for referring SST cases to 'Tie-up' hospitals. **(Action – Medical Division -3months)**

iv. Strengthening the specialties: specific proposal in this regard may be examined based on cost-effectiveness. If in-house experts are unable to handle the referral work, consulting experts can be hired on retainer ship basis.

v. Cashless SST should be provided to only to that IPs who has been referred to 'Tie-up' hospitals following SOPs. Patients going to tie-up hospitals in emergencies, without being referred as such by the ESI system, may be provided SST services on reimbursement basis. This is as per the prevailing practice in Armed Forces Medical Services and Railways Medical Services.

vi. The MoU for 'Tie-up' with private hospitals should be re-examined. **(Action – Medical Division -3months)**

vii. All such emergency referrals should be discussed by MS in a monthly meeting of specialists. It shall be mandatory for the tie up hospital to send a report to the MS concerned on the same day or the very next working day on receipt of referral giving details of the case and giving their specific opinion about the treatment to be given.

viii. Patients for Super Specialty Treatment are referred for a particular procedure. Sometimes, the tie-up hospitals undertake several other procedures that may or may not be related to referred procedure for which the patient was referred. In case where additional procedures are required it would be essential that the additional procedure is duly approved by the ESI hospital concerned. With a view to ensure this, tie-up bills should be paid only for those procedures that are referred

by the ESI hospital concerned either initially or by way of additional approved procedure subsequently.

ix. With a view to prevent too many referrals and /or those referrals being made to a particular hospital, all the referrals made in a month should be reviewed in a meeting to be chaired by MS and attended to by all the Specialist doctors concerned. Among other issues, the two important issues to be discussed in this committee should be :-

a) The necessity of referral.

b) Prescribed procedure was followed or not.

c) Whether too many patients were selected to be referred to a particular hospital and whether it required monitoring.

2. Revision of the eligibility criteria to prevent misuse:

a) Present criteria (151st meeting of ESI held on 10.12.2010).

1. Eligibility for IP : Minimum 3 months employment and 39 days contribution
2. Eligibility for family: Minimum 6 months employment and 78 days contribution

(Clarification issued on 29.7.2011)

i) above eligibility criteria not applied to old IPs when they re-join insurable employment.

ii) Superseded all eligibility criteria issued earlier.

b) Criteria prevailing before December, 2010.

If IP not eligible for SB in the current benefit period at least he should have been eligible for SB in the previous benefit period. (Mandatory 78 days contribution reckoned if paid in one of the last two CPs).

OR

Continuous employment for last two years with 156 days contribution altogether but eligible for SB in one of the four corresponding benefit periods and for Medical benefit in the current benefit period. (Out of the min 156 days contributions in 4CPs, the IP should have contributed 78 days in one of the four CPs and continuing in employment).

c) Proposed eligibility for availing SST

After introducing IT enabled registration of employers/employees it has been observed that large number of employees is being registered every month. The registration details for the year 2012-13 are as below:

No. of IPs as on 31.03.2012	171Lakh
No. of IPs as on 31.03.2013	185Lakh
Increase in no of IPs during 2012-13	14Lakh
No of IPs registered during 2012-13	129.60Lakh

From the above data it is indicated that out of 129.60 Lakh newly registered IPs, actual increase is only 14 Lakh while 115 lakh registered IPs are either not genuine nor are entitled for any medical benefit.

Eligibility for SST is verified from the system. The system calculates the eligibility as per the instructions issued in Dec 2010, i.e. 90 days of service from date of appointment and 39 days of contribution. The online registration facility enables the employer to register an employee indicating backdated appointment and also can file the contribution for the back period. This enables any employee to avail SST even from the very next day of registration, which is a potential reason for misuse.

Recommendations

i. The Committee recommended that the authority of approval for the employers' code for newly registered employer should be vested with the ESIC Regional Director rather than the employer himself,. **(Action – Revenue & ICT Division in 3 months)**

ii. The eligibility be from the date of registration on IP portal. The matter of revising the SST eligibility criteria should be submitted to the Corporation for consideration.

iii. The Committee noted that the limit of 10 days for registration is being violated. The accountability for registration of the employees within the specified time should be on Employers.

3. Establishment of SST cell for faster bill clearance

For expeditious processing of SST bills, the feasibility of bill clearing agency may be examined if found suitable, be implemented. Software being used by CGHS/UTIITSL may also be examined. However in the meantime necessary dedicated staff should be provided for the purpose. **(Action – Medical Division -10 months)**

4. Package Rates

CGHS package rates and other terms and conditions should be followed. There is no need to develop or maintain separate ESIC package rates.

5. Chemotherapy to be given in ESI hospital itself

To begin with one Medical Oncologist may be sanctioned for the all hospitals having bed strength of 300 beds and more.

As far as Chemotherapy drugs are concerned, the anti cancer drugs available in Indian Pharmacopeia, British Pharmacopeia and US Pharmacopeia, should only be reimbursed. The drugs which are not available in any of the standard Pharmacopeia will not be reimbursed. This should be duly incorporated in the MoU with the tie up hospital as well as the MoU with the States.

As far as possible, anti cancer medicine should be issued by the referring ESI Hospital. In due course, it should be made mandatory.

Also, rate contract for anti-cancer drugs should be finalized in order to use generic drugs only, if the RC for the same does not exist.

6. Prevention of unnecessary referrals from dispensary medical officers to tie up centre.

Referral from dispensary to tie up hospital for secondary /SST (wherever such referral is admissible), the dispensary in-charge should send a copy of the referral to SMC Office so as to reach SMC Office within 48 hours. It is preferable, if it is sent electronically. The tie up hospital should invariably send a scanned copy of the referral along with diagnosis and treatment

required to SMC, on line within 24 hours on receipt of referral from the dispensary concerned.

7. Audit of Referrals and bills

The monthly meeting for review of SST expenditure should be preceded by monthly audit of referrals made from the hospitals, i.e. ESIC & ESIS. All concerned MSs should submit a report in r/o number of referrals for super-specialty & hospital wise as per the performa in the Operational Manual. The audit report should be prepared by at least two doctors nominated by the SMC for the purpose. Vigilance Medical Officer should conduct random checking of referrals made by both ESIC /ESIS hospital. Further, the audit report in respect of referrals as well as minutes of the monthly meeting in this regard should be submitted for consideration of the ensuing meeting of the State Executive Committee. The feasibility of making referrals on line mandatorily should be examined. Reporting formats to be prepared Hospital wise and super-specialty wise.

Exceptionally high SST references from any employer or hospital should be monitored through **exception report**.

8. Audit of bills submitted

i. The Medical Vigilance Officer should conduct post audit of SST bills on random basis. The MoU with tie up hospital should incorporate a suitable clause, so that tie up hospital submitting wrong bills could be blacklisted.

ii. The Medical Vigilance Officer should also do random visits to tie up hospital to check patients under treatment.

iii. The feasibility of receiving bills from tie up hospitals on line with a view to integrate it with Project Panchdeep should be examined, so as to, in particular, avoid duplicate payment of bills.

It is expected that with the above measures, SST expenditure would come down significantly. With a view to facilitate monitoring each ESIC Hospital

should target to reduce SST expenditure by 15% during 2014-15 over the SST expenditure incurred in 2013-14.

V. HIGH COST TREATMENT

- The ESIC would bear the full cost of treatment, wherever CGHS package rates are available up to the limit of package rate.
- The upper limit for treatment in cases not covered under CGHS package would be Rs. 14,00,000.00 (Rupees Fourteen Lakhs) per annum per person eligible for ESI medical benefit. Any treatment costing more than this amount is expected to be the responsibility of the Health System in the country and not ESIC.
- All SST would necessarily require fulfillment of conditions for eligibility of SST for IP or eligible family members.
- In respect of children of IP, congenital diseases and genetic dis-orders would be eligible for coverage up to the ceiling mentioned earlier only in case the child is born after the IP had become eligible for SST.
- In case of malignancy and chronic renal failure, pre-existing disease will not be eligible for coverage, so as to prevent potential misuse of SST.
- Dialysis should be brought back within the definition of SST, as such cases invariably require renal transplant and lifelong treatment both before and after the renal transplant.
- In respect of organ transplant and bone marrow transplant, the payment should be restricted only to the rates applicable for related donor. This would reduce potential misuse.
- Further, in respect of organ transplant involving the malignancy, the organ transplant may be restricted to transplant of the organ having primary malignancy. This would also prevent considerable potential misuse of this facility by the tie up hospitals.

  Treatment in case of malignancy at tie up hospitals would be eligible only for surgery/Chemotherapy/Radiotherapy. Any additional treatment/procedure would require specific recommendation by Medical Board, duly constituted for the purpose by the ESI Hospital concerned.

- The cost of artificial limbs will be restricted to a ceiling of Rs.1.00 lac. (Most of non electronic limbs are available much below this amount. The cost of electronic limbs is very high. The electronic limbs can be considered under ESI Scheme only when its cost comes down significantly and below this amount). The artificial limbs costing more than this amount will be the responsibility of the Health system in the country.

VI. STRATEGIC ISSUES:

The Sub-Committee expressed concern on various strategic issues such as: expenditure incurred towards SST, commissioning of Medical/Nursing/ Paramedical institutes, taking over of new ESIS hospitals by ESIC, better administration of ESIS services. The committee recommended on the above issues as below:

1. With a view to improve financial discipline, all expenditure, including expenditure on secondary and super specialty referrals should be counted towards the amount admissible under the ceiling. This will not include expenditure on running of all ESIC Medical Colleges & associated hospital, in the State and, wherever, there is no ESIC medical college expenditure on running of ESIC Model Hospitals. It will also not include expenditure on items for which, by specific decision, the cost is to be borne fully by the ESIC. The expenditure on prosthesis, aids would also be counted towards the amount admissible under the ceiling.
2. Further, no more ESIS hospitals should be taken over by ESIC.
   All new hospitals that are under planning, construction etc., other than those that have already been commissioned by the ESIC, should be run by the State Governments.
3. To implement the above decision the expenditure Per IP ceiling may be increased, to Rs 2500/-. THE AMOUNT TO BE PAID TO STATES WOULD, HOWEVR, NOT BE LESS THAN WHAT THEY ACTUALLY GOT IN 2012-13. SUITABLE TOP UP, IF REQUIRED, WOULD BE PROVIDED TO STATES FOR FIVE YEARS STARTING FROM 2014-15. Also this ceiling may be increased by Rs.150/- per IP every year for five years starting from 2014-15.
4. Committee constituted by DG, ESIC for preparation of operational manuals on various functional areas to empower stakeholders and facilitate better administration of ESI Scheme shall also examine and give recommendations on the following issues

- Ceiling on expenditure on medical treatment to IPs / beneficiaries
- Percentage of expenditure on medical care to be committed for promotive & preventive services; and primary care services. This specific issue also may be the part of the working group for finalising the MoU with the States.

5. With a view to facilitate expeditious implementation, the States may consider setting up State ESI (Medical Benefit) Corporation as Autonomous Bodies. Enabling provision for State ESI Corporation already exists under the ESI Act. Committee desired that some norms need to be developed for reimbursing the administrative costs of State Level ESI Corporations**. (Action – Revenue Division – 3 months)**
6. States may consider having a separate cadre of medical and para medical personnel and other staff for ESI Scheme. (In some States the medical personnel are deployed on deputation from the State Health Department and the requirements of the ESIS get lower priority). Wherever it is not possible to have separate ESIS cadre, it should be ensured that doctors and other staff are deputed for a minimum period of 5 years.
7. The States should also provide man power under ESIS as per the ESIC norms. Necessary incentive scheme already exists for the purpose.

VII. DELIVERY OF SERVICES UNDER ISM/AYUSH

It has been observed that ISM/AYUSH services are not upto the satisfaction of ESI beneficiaries despite the fact that entire expenditure on AYUSH is born by ESIC outside the Ceiling limit for the first five years. There are no clear-cut guidelines for opening/discontinuation of an AYUSH unit. Improvement in Ayurveda Rate Contract is needed to ensure delivery of good quality medicine. Non attractive remuneration of contractual AYUSH Physician/staff, absence of RRs for Ayurveda Pharmacist, Siddha system and other staffis affecting the satisfactory delivery of services. There are no guidelines for establishing Indoor AYUSH unit. There is lack of awareness on AYUSH amongst ESI beneficiaries. In order to promote AYUSH, Committee recommends as under:

1. ESIS hospital/dispensary having average OPD attendance of minimum 200 patients/day during the previous six months may set up one AYUSH unit of their choice from among the 4 systems of medicines namely Ayurveda, Siddha, Unani and Homeopathy.

2. OPD attendance of minimum 200 per day of a hospital would be taken only from OPD registration under the Dhanwantari module for setting up of AYUSH Unit. (Implementation of Dhanwantari would be essential for this purpose).

3. It is envisaged that in whichever Financial Year such unit is set up, a few months time may be required to popularize and create awareness about the AYUSH unit in that hospital. It is expected that in the next Financial Year average OPD attendance of the AYUSH unit should be at least 25 patients per day. This expenditure will be treated as a part of the ESI expenditure only if this benchmark is achieved in Financial Year subsequent to Financial Year in which the said AYUSH Unit was set up. If this Bench mark is not achieved, either the unit should be closed down or the expenditure will have to be born by State Govt. outside ESI Scheme.

4. With a view to facilitate closing down of the unit in such circumstances, the AYUSH doctors and other staff for the said unit should be recruited on contractual basis for one year, renewable every year for a total period not exceeding 3 years. With a view to monitor performance of such units, this opportunity would be available to only those ESIS hospitals where Dhanwantari module with OPD registration, admission and discharge has been implemented.

5. The data available under the Dhanwantari module would be used to assess fulfilment of the benchmark.

6. The proposal for opening the first AYUSH unit and subsequent ones would require the approval of ESIC Hqrs. And should fulfill following minimum criteria:

    - Opening of second AYUSH unit in a different stream of AYUSH, the minimum AYUSH OPD attendance should be 40 patients per day in already functioning unit.

    - The minimum AYUSH OPD attendance in one system should be 60 patients per day to be eligible for setting up of second AYUSH unit in the same system.

    - Similar approach would be followed for opening AYUSH units in other systems or setting up of more AYUSH units in the same system. Norms would be developed for this purpose subsequently.

    - The 5 year period for reimbursement of full cost by EISC, hospital- wise, will commence from the first April of the year subsequent to the year in which the first AYUSH unit was started.

7. All attempts should be made for promoting AYUSH system at the hospital level wherever there is adequate demand.

8. Later on, depending on patients load, the Centre of Excellence concept may be considered in AYUSH system also and norms/guidelines may be developed.
9. Herbal Park shall be part of Centre of Excellence and should be established in all ESI hospitals.
10. ESIC should develop the staff norms for different AYUSH units.
11. To ensure quality drugs, Annual Turnover for participating pharmaceutical units should be enhanced from existing 1 Crore to 5 Crore in the Ayurveda Rate Contract which would be placed before the Corporation for approval as a separate agenda item.
12. Wherever AYUSH unit already exists or these are proposed to be opened as per norms mentioned earlier, it should be supported by appropriate awareness creation activities.
13. Framing of RR for Ayurvedic pharmacist, Siddha and Unani Physicians, Ksharsutra and Panchkarma experts needs to be taken up at the earliest so that all the posts could be filled up on regular/contractual basis.

VIII. Periodic health check-ups of ESI beneficiaries

Based on decision taken by ESI Corporation during its 161st Meeting, a Sub-Committee on 'Medical Services and Medical Education ' was constituted with one of its Terms of Reference being - **to examine the feasibility of putting into place a mechanism for periodic health check up of IPs, after a certain age, to minimize need for SST later.**

In this regard, it is proposed to conduct a pilot study on periodic health check-ups of IPs to find out its feasibility and efficacy for further implementation throughout India. To begin with, the study may be carried out involving ESI beneficiaries above the age of 50 years at ESIC Hospital Joka (Kolkata), KK Nagar (Chennai) and Peenya (Bengaluru). For this propose, a dedicated team may be set up in these hospitals, from amongst the existing staff consisting of one medical officer, nursing staff and nursing orderly. For the first month, the team may be made functional for 2 working days in a week and in subsequent two months- 3 days in a week. A total of 70 (30 IP family) beneficiaries may be screened per day. With this exercise, a data base of around 3000 beneficiaries will be created. Health data of these ESI beneficiaries may be recorded in a specified Performa.

The beneficiaries for this pilot study may be called as per following method:

Concerned SRO office may be involved which will identify employer units having an IP base of more than 40 IPs and will ask the employer/ HR Manager to refer a defined number of employees and their family members (both above the age of 50 yrs) to the designated ESIC hospital for preventive health check-ups, as per pre-informed schedule.

The data, so generated through the pilot study, will be further analyzed to find out the feasibility, benefits, efficacy and cost-effectiveness of scaling up the periodic health checkup program to all ESI Beneficiaries above a certain age.

IX. IMPLEMENTATION OF DHANWANTRI MODULE

The process of implementation of Dhanwantari Project started in 2010 but due to various reasons it could not be fully implemented till date. Some of the reasons for non-implementation are: Inadequate infrastructure(ESIC/ESIS), poor performance of System Integrator, inadequate administrative control by stake holders (SMC/Director/MS /Dean), non-effective Change Management. For better implementation of Dhanwantari module the committee proposed the following measures:

1. A joint team of representative of SSMC, Wipro, and DIMS should visit each dispensary wherever IT installation is yet to take place. They should assess whether the existing accommodation in the building is adequate for installation of the IT infrastructure, including space for keeping DG set, diesel etc., depending upon the power shortages in that area. If so, they may negotiate increase in rent with landlord and make a recommendation in this regard to the SSMC. The Committee consisting of SSMC, DIMS and representative of the RD will finally approve any increase in rent. The upper ceiling of increasing of rent will be 15% of existing rent.

   Wherever it is felt that infrastructure at the existing dispensary premises is inadequate for installation of IT hardware, the committee shall recommend shifting of the dispensary. Final, decision of shifting the dispensary and invite fresh tender for the new premises is to be taken by committee headed by SSMC, at the state level.

   The same process should be followed in dispensaries wherever IT hardware is installed but not functional for lack of adequate space or power.

   Till a permanent solution is achieved, necessary action should be taken so that at least registration is done online and certificates are issued online.

2. System Integrator should ensure that all the host-PCs/Stand-alone PCs are functioning all the time. If any such Host PC / Stand-alone PC is not functioning, it should be considered as hardware problem and should be followed up and reasons found out.

   Based on online monitoring of Router and Host PC at the dispensaries and information coming from ticketing system on host PCs being down, SSMC and DIMS should be informed on a daily basis about equipments not getting switched-on. This data may also be part of SLA dashboard and to be reviewed with the System Integrator (Wipro) on a regular basis.

   The System Integrator should do prescribed preventive maintenance and replacement of equipment as per the contract. The record of such replacement and Preventive Maintenance should be maintained physically at the Dispensary/Hospital level. In addition, it should be made available in the system (as reports/exceptions in a dashboard) to be made available to SSMC/DIMS, etc., on monthly basis. Necessary reporting system should, if required, be developed, so that it is a part of the overall system.

3. A small IT Cell under the control of SSMC should be created in each State for expeditious implementation of Dhanwantri. It will be a two member cell; one person looking after "applications "and the second person looking after the rest of the issues. They may be hired from the market through NISG under MoU between ESIC and NISG. They will work under the overall supervision and control of the PMU at ESIC.

   It is noticed that there are no regular or even no meetings of State Level Coordination Committee {State Implementation Committee (SIC) are being held for IT roll out. This is the right forum to raise and resolve issues concerning support from the State Governments and

co-ordination with ESIC. In order to make this forum effective, the following steps are suggested:

a. Frequent visit by SMCs/SNO(IT)s to hospitals and dispensaries
b. Invite the SI to the SIC meeting and discuss about quick disposal of complaint tickets & replacement of faulty equipments, training, etc.
c. Escalation by the Member Secretary to ESIC authorities at Hqrs office for proper intervention in case meetings is not being held.
d. Requesting concerned Government to delegate adequate financial powers to State ESIS Heads (MS/IMO I/c / Director) for procurement of paper and consumables, etc
e. It is also important that the Principal Secretary, Labour/Health chairs the meeting at least once in 3 months.

Regional Connect Meeting needs to be held every month with the active participation of the SMC/RD/MS/ State Director/SI.

Wherever felt necessary by DIMS, the consumables for implementation of Dhanwantari, will be procured (for both hospitals and dispensaries) utilizing the funds of HDC under " Improvement Head". ESIC Hqrs. may develop guidelines for financial limits for this purpose.

Every State/UT DIMS/Directorate Office should have one State Nodal Officer in Dhanwantri and one Nodal Officer in each location (Dispensary & Hospital in the State/UT), if the same is not already in place.

It is further suggested that the ESIS Directors/ State Nodal officers of those states where Dhanwantri Module has not been successfully implemented should be invited to visit other states which have successfully implemented the same such as Gujarat, Goa, and Delhi.

Capturing of IP data for a particular home dispensary is to be made mandatory. It is highly desirable that barring emergency situation all patients should avail treatment /medicines etc. from home dispensary. However, this may require some more persuasion before implementation. Therefore, to begin with patient can get repeat medicines only from home dispensary. To facilitate this, patient may be given a choice to choose one dispensary for self and another for the family anywhere in the country.

Some other proactive measures may be taken by the Location Head for better adoption as following:

i. Forwarding all IT infra/Application issues to IT helpdesk.
ii. Internal monitoring on daily/weekly/monthly basis on the usage of application in relation to actual work done.
iii. Implementing orders on mandatory usage of application & corrective action plan for non-adoption of application.
iv. Mandatory capturing of all patients' clinical data, etc. in OPD; admissions, discharges, etc. in IPD application for statistical purpose.
v. Creation of frequently used packs, profiles by department staff under the guidance of HOD's.
vi. Suggesting value added changes in application through the SPOC/

4. The Centralised Dhanwantri Master data management team at Hqrs. Office needs to be strengthened by adding additional manpower such as one pharmacist and one doctor to facilitate timely updation of newer medical master data, requested from all the locations, pan-India.

5. Implementation of Dhanwantari at Hospital and dispensary level should be monitored. Good performance should be recognized both at individual and institutional level**.**

Incentive should be provided to both the Government as well as staff working at ESIS hospitals / dispensaries. A scheme of incentive based on

system generated data on adoption of Dhanwantri modules by Doctors / Para Medical Staff may be examined for implementation for improving adoption. The quantum of incentive needs to be worked out by System automatically on the basis of benchmarks decided by ESIC. Doctors/para medical staff whose performance is not satisfactory should be informed about their performance through automated e-mails. A specific proposal in this regard to be formulated by ESIC **(Action . ICT/Med Div in 3 Months)**

Monthly change management / soft skill sessions should be held on attitude development particularly to that section of staff where maximum resistance is observed.

6. Performance parameters should be monitored through SLA dashboard. Quarterly payment to System Integrator to be linked to deliverables specified from time to time. One SPOC to be identified by ESIC for each module of Panchdeep. Also one SPOC each from ESIC, PMU & WIPRO to be identified and made responsible to address various issues related to Panchdeep like:-
   i. Change request
   ii. AMC with WIPRO
   iii. Complaint disposal
   iv. Surprise Inspection and statement from WIPRO
   v. Review and coordination with WIPRO

   A phased programme of adoption of different modules under Dhanwantari should be adopted. It may be different for different hospitals and Dispensaries depending upon the current level of adoption of Dhanwantari in different hospitals / dispensaries.

7. Report on usage of Dhanwantri by different units should be available in Dhanwantri module for State Directorate / IMO I/cs, etc. for taking effective steps in increasing the usage and adoption and reporting to State Executive Committee.

8. In order to avoid misuse of Medical benefits by I.P. & their families due to generation of TIC directly by the Employer, the entire issue of TIC needs to be re-examined de novo and simultaneously ICT Div to also launch a campaign for clearing the backlog of Pehchan Cards in specific time plan.

9. A separate provision to be made in Insurance Module of Project Panchdeep for identifying the contract workers in the concerned establishment which can be validated from the return of the respective manpower supplier who is registered with ESIC establishment. The said provision will enable validation of contract employees supplied by man power supplier across principal employer.

10. Complaint matrix need to be examined on periodical basis by PMU for analysis and further corrective action. Similarly other reports on various modules to be examined by PMU on periodical basis.

Any other reports as required by ESIC on modules would also be taken up by PMU On periodical basis PMU will report to ESIC on performance of the project and also for corrective actions.

X. REVIEW OF FUNCTIONING OF HDC (HOSPITAL DEVELOPMENT COMMITTEE)

The functioning of HDC was reviewed to make it more effective. The committee presently has 9 members apart from local members(s) from ESIC/Regional Board. Out of the 9 members, two members each, representing Employers and Employees are to be nominated by the State Government, but it has been observed that no nomination has been made by the State Govt. in many of the States, thereby denying representation from two significant stake holders in Hospital Development Committees. Also there is no representation from the office of SMCs in the present composition.

It has also been observed that HDCs functioning in the Model Hospitals had administrative difficulties in handling HDC- Improvement Fund for State run ESI Dispensaries. The HDC improvement fund is part of On-Account Payment which is monitored by SMC and booked by the accounts of the Regional Offices. The Model Hospitals have no provision to operate the head of expenditure, therefore the improvement of State run dispensaries was not taken up by such HDCs.

It is felt that the HDCs have adequate financial powers. Purchase of equipment etc sanctioned by the HDC is required to be made by the MS of the hospital who is the Chairman of HDC. MS, ESIS hospital are not delegated with adequate financial powers, accordingly the proposals are referred to Director/State Govt. and the procurements are getting delayed in this process and the very purpose of HDC is defeated. The issue of shortage of staff has also been raised by field functionaries.

It has been learnt that in many hospitals/ dispensaries no specific norms have been followed for deployment of maintenance staff for ARM work and in some locations the deployment is way beyond the norms.

It is observed from the feedback that maintenance of Staff Quarters situated in the compound of ESI Hospitals/Dispensaries are not clearly defined in the functions assigned to HDC.

In view of above the Sub-Committee recommends the following for better functioning of HDCs:

1. Two representatives each, representing Employers and Employees to be nominated by DIMS of concerned State provisionally, for a period of six months at a time, till the nomination from State Govt. is received.
2. A representative from the office of SMC.
3. Two representatives each, representing Employers and Employees to be nominated by DIMS of concerned State provisionally, for a period of six months at a time, till the nomination from State Govt. is received.
4. Representative of State Labour Department may be replaced with representative from DIMS.
5. Constituting a separate subcommittee of the HDC, comprising the following members to look into the issues of attached State run ESI dispensaries regarding improvement activities and expenditure would be met and booked by SMCs:-

DIMS/JDIMS	Member
Dy. MS of Hospital	Convener
Representative of SSMC/SMC	Member
Dispensary in-charges concerned	Member

6. The SMCs may allocate the budget allotted by Hqrs Office for ARM of the Hospitals & Dispensaries proportionately, among the HDCs in the state depending upon the size of the hospitals, number of attached

dispensaries, staff quarters, etc, to ensure equitable distribution of budget.

7. State Govt. shall delegate concomitant power to their MSs of the respective hospitals. Procurements, etc as sanctioned by HDC, shall be made by the MS, following applicable procedures of GFR/Financial Rules.
8. Hospital having bed occupancy of 50% or more based on statistical data of 2012-13 may be provided with one time improvement fund for procurement of medical instruments and equipments as non sharable expenditure up to the amount of Rs. 10.00 lac for the year 2014-15 (extendable up to September, 2015)To draw this fund, the eligibility criteria are that the hospital should have adopted the Dhanwantri module with online registration, admission and discharges which shall be certified by DMC (Sys.), Hqrs, New Delhi.
9. Similarly in respect of ESI Dispensaries, it is recommended to grant initially Rs. 10,000 per Dispensary for procurement of instrument and equipment where average attendance in each Dispensary is 30 patients per day in the first year i.e. 2014-15 (within March, 2015). For the 2nd year, the grant is linked to online implementation of Dhanwantari Module by the State Government and where Dispensaries are having average attendance of 45 patients per day. In the 3rd year, if the average attendance of the dispensary is increased to 60 patients per day with online implementation of Dhanwantari Module, the grant shall be continued. This facility is recommended for three years starting from 2014-15.
10. The HDC meetings may be held as per requirement but minimum of four meetings in a year should be held. MS in-charge shall invite the members of HDC for participation in the Suvidha Samagam meetings.
11. The work can be done by the available ministerial staff and there is no need for engaging any separate ministerial staff for HDC work.

12. The Annual Repair Maintenance (ARM) works of buildings and services shall follow the norms & yardsticks of ARM activities as defined in CPWD Maintenance Manual for all such activities including manpower required for day today maintenance, frequency of painting, etc.

13. The circular regarding functioning of HDC, issued vide U - 16/18/186/07-Med-I dated 15.04.2010 needs elaboration. The cleaning services mentioned in the circular are to be confined to the conservative cleaning of external drains in the compounds, sewer lines, manholes inspection chambers, water sumps, overhead tanks, and periodic terrace cleaning before and after the onset of monsoon. This shall be applicable to both the hospitals and dispensaries and the expenditure shall be met out from the "HDC-Repair& Maintenance of the Building Fund" as provided in the aforesaid circular.

14. However, the cleaning/mopping of floors/circulation area inside the buildings/wards and compound is part of Housekeeping Services and hence to be treated as administrative expenditure.

15. Since the buildings are owned by the ESI Corporation, the committee recommends that the ARM work of the staff quarters situated in the compound of ESI Hospitals/ Dispensaries are also to be looked after by the HDC.

XI. COMPREHENSIVE REVIEW OF MANPOWER SKILLS IN ESIC/ESIS

There is national training Academy at national level and Zonal training centres in all the zones but the goal of man power skills development of various category of personnel has not been achieved. The various reasons are: fund constraint, absence of Training Infrastructure for paramedical staff, no compulsory functional training before promotion of doctors to next grade etc. Therefore the Sub-Committee recommends the following:

1. Training funds should be placed at the disposal of SSMC. Training needs to be identified by HDC and submitted to DIMS for approval and coordination. SSMC will make payments for training activities on the same pattern as for drugs and dressing through the revolving fund mechanism, including advances if required.
2. DIMS or an officer nominated by DIMS shall be Nodal Officer Training for ESIS. About 30% of training budget should be utilized for training of paramedical and nursing staff. NTA shall develop modules for training of staff nurses and paramedical staff. NTA shall also monitor implementation of training activities in States. All possible efforts should be made to fully utilize the training budget. Each DIMS shall develop Annual Plan/ Calendar for training of doctors and other staff during the year. As far as possible, NTA should in consultation with DIMSs, develop modules and standardize budget for training programme of different kinds.
3. Feedback of DIMSs may be obtained on the training modules developed by NTA so far and based, on the feedback, the modules may be revised or new modules may be developed.
4. Due emphasis should be given on training for improving of soft skills in all the training programmes.
5. It was noted that NTA is already organizing 2-3 days training for doctors who were recently posted as SSSMC/DMS/MS. It is recommended that the duration of the training should be increased to

6 working days covering all the required aspects essential for these posts. As far as possible, this training should be organized before these doctors are posted to these administrative positions.

6. Doctors posted in dispensaries that are likely to be posted as SMC/ MS in near future should be posted as OSD/DMS at hospitals on same station or closer to their current place of posting at dispensary. This would provide them with necessary exposure to the functioning of hospitals and administrative responsibilities they are likely to handle as SMC/DMS / MS.

7. All newly recruited Revenue officers and doctors should be provided with induction training of 3 to 5 days. This training should be organized preferably within three months of their joining.

8. Each ESIC &ESIS hospital should designate one of its medical officers, preferably Deputy MS, as Nodal Training Officer for hospital.

9. Doctors to be given training in Hospital Administration after completing certain duration of service·

XII. SYNERGY OF ESI HEALTH SYSTEM WITH HEALTH SYSTEM OF STATE GOVT./NRHM

The existing scheme for providing services to non IPs at underutilized ESI Hospitals may be followed to facilitate synergy with state Govt/NRHM. The non IPs may be provided medical services and the cost may be borne/paid by State Govt/NRHM.

The following 5 Medical/Dental Colleges are good candidates for being transferred to the State/Central Govt. (This has reference to the decision of the Sub-Committee taken at its first meeting.);

1. Medical College, Dental College and other Medical Education Institution in Gulbarga, Karnataka.
2. Medical College, Mandi
3. Medical College, Alwar
4. Medical College, Bihta
5. Medical College, Bhubaneshwar

It is possible that such a transfer may take some time. In the interim, following actions may be taken for utilizing the infrastructure already constructed under construction:

MEDICAL COLLEGE, GULBARGA

It has about 19000 IPs in the catchment area. The hospital may be started with 100 beds for providing services to both IPs and non IPs. Decision about its expansion to 300 and 500 beds may be taken subsequently.

DENTAL COLLEGE, GULBARGA

Dental Hospital may be started for providing services to both IPs and non IPs.

As this arrangement may take some time, the Dental College may be started w.e.f. 2015-16.

MEDICAL COLLEGE, MANDI

The Medical College Hospital in Mandi may be started with 100 beds for both IPs and non IPs. Decision to expand capacity to 300 and 500 beds may be taken subsequently.

MEDICAL COLLEGE AND HOSPITAL, ALWAR

It may be started with 100 beds for both IPs and non IPs. Decision to expand its capacity to 300 and 500 beds may be taken subsequently.

MEDICAL COLLEGE, BHUBANESHWAR:

In view of limited IP population and existence of other ESI Hospitals nearby, this project may be conceptualized in two phases. In phase one a 300 bed hospital may be constructed. It may be commissioned with 100 beds initially and extended to 300 beds subsequently. Based on the experience of running of 300 bed hospital, decision to undertake the 2nd phase involving construction of Medical College buildings may be taken.

MEDICAL COLLEGE HOSPITAL, Bihta

It may be started with 100 beds for both IPs and non IPs. Decision to expand capacity to 300 and 500 beds may be taken subsequently.

It is highly desirable that ESIC has a fully functional 300 bed hospital before it applies to MCI for starting the MBBS course.

The system of providing treatment to non IPs should be introduced first at Gulbarga Medical College Hospital. Based on learnings from this experience, it may be extended to other hospitals mentioned above.

XIII. RECOMMENDATIONS – MEDICAL EDUCATION

In the first meeting of the 'Sub-committee on Medical Services and Medical Education' held on 27th March, 2014, a 'White Paper' on Medical education was presented for consideration of the committee. It provided all information on all major issues confronting Medical Education in ESIC.

After detailed discussions, the following issues emerged from the 'White Paper on Medical Education'.

1. The primary objective of the ESI Scheme is to provide medical care services to IPs.

2. Medical Education Institutions (UG and/or PG) are not essentially required for providing secondary or super specialty medical services to IPs.
3. UG (MBBS) programme is not essentially required for providing PG education. The UG programme requires availability of only general specialities.
4. The medical education projects are capital intensive. It reduces 'Capital Reserves' of ESIC. These projects have high recurring costs. Therefore, the medical education projects have significant adverse effects on the finances of the ESIC.
5. All UG/PG pass outs from ESIC medical educational institutions may not be available to the ESI system due to several constraints in efficacy and enforceability of retaining them through the mechanism of Bond or some other such mechanism.
6. If full recurring cost is to be recovered from UG/PG students, it would require charging very high fees; or, the corresponding Bond amount would need to be very high. If the fees/Bond amount is to be reduced, it would require subsidy for medical education from the ESIC. This may be violative of the spirit of the ESI Act.

7. 13 ongoing medical college projects providing UG education would provide GDMOs in excess of projected requirement for both ESIC and ESIS. Moreover, the GDMOs will be available only from the year 2020 onwards.
8. It is difficult to get teaching faculty. Remuneration of teaching faculty may have to be increased so as to ensure availability of full complement of teaching faculty. This would further increase the recurring cost. It may bring-in other distortions as well.
9. In many cases in the past, the medical education projects had been approved in areas where IP population was inadequate to justify opening of 500 bedded hospitals. The spare capacity of such hospitals could possibly be utilized for providing services to non- IPs on payment basis.
10. If manpower and infrastructure is provided at ESI hospitals as per the MCI norms, it would help in providing better services to IPs. It is also noted that teaching responsibilities help in keeping knowledge of the teaching faculty up-to-date.
11. C&AG have adversely commented upon several aspects of the medical education projects such as large capital outlay and inadequate number of IPs.

The Committee considered the issues and recommended as under:

1) The focus of the ESI activities should be on providing primary, secondary and super specialty medical care services to IPs. (The ways to improve primary and secondary medical care services are being examined separately under another terms of reference of this Sub-Committee).

2) Selected ESI hospitals may be developed as 'Centre of Excellence' for providing specialist/SST services. It need not be necessarily linked to the PG programme.

3) **Six 'Centres of Excellence' based on number of IPs and existing available infrastructure** were approved to be developed for providing specialist/SST services. The locations are as under:
   a. Delhi- Basaidarapur.

b. Tamil Nadu- K.K Nagar

c. Maharashtra- Andheri

d. Karnataka- Rajajinagar

e. Andhra Pradesh- Sanathnagar

f. West Bengal- Joka

To support 'Centres of Excellence' for secondary medical care or SST, PG teaching programme may be taken up, based on projections of requirement. ***However the PG program in ESIC may only be expanded after provision of reservation of PG seats for ESI doctors has been satisfactorily addressed.***

The Committee advised the Corporation to take up the matter with the Health Ministry for doing away with All India and State quota seats in PG programmes in a concerted manner.

4) UG (MBBS) Programme may be restricted to 13 approved and ongoing medical education projects.

5) **The Committee noted and recommended that no new medical colleges may be opened for the following reasons:**

a. Sec 59 B of the ESIC Act provides that the Corporation may establish medical colleges, nursing colleges and training institutes for its para-medical staff and other employees with a view to improve the quality of services provided under the ESI scheme.

b. However, no projections of requirement of doctors were made while approving the medical colleges. ESIC doctors (MBBS) under bond would be available only from 2020 onwards and the current requirement would have to be met from outside ESIC system. *Graduate (MBBS) doctors are readily available in the market.*

c. Similarly, all new ESI hospitals approved so far would get commissioned before 2020. Thus, requirement of doctors for new hospitals approved so far would also have to be met from outside ESIC medical education system.

d. Availability of doctors (GDMOs) graduating out of ESIC Medical Colleges under construction and their expected willingness to serve under Bond will be greater than the combined recurring requirement of doctors because of resignation/superannuation, growth etc., in the ESI system.

e. That there was no system of bond enforcement and without an effective enforcement of bonds, the availability of doctors to the Corporation would not be assured.

f. Setting up of Medical Colleges is not linked to provision of 'in-house' Super-specialty services at the outset, and will not impact super-specialty treatment expenditure.

g. Setting up and running of Medical Colleges is a cost intensive proposition in r/o capital cost, recurring cost, loss of revenue etc.

h. Based on current projections, the surplus funds of the corporation are likely to be negative by 2016-17.

i. The Committee recommended that apart from the existing 13 medical colleges under construction, no new medical college should be taken up.

j. CAG (Performance Audit) has commented adversely where IP numbers are inadequate and Medical Colleges have been constructed / started.

k. The Committee emphasized the need to document and record the present experiences at starting medical colleges so that the mistakes do not recur.

6) UG (MBBS) programme in all other approved/under consideration medical education projects may be deferred till benefits from the 13 ongoing UG (MBBS) projects have accrued to the ESI system and the same have been evaluated.

7) Central /State Governments may be approached for reimbursement of full capital/recurring cost of providing UG/PG courses at ESIC medical educational institutions. Feasibility of transferring medical education

projects having low IP population in the catchment area of the project to the State/Central Government may be examined.

8) Any future medical education (MBBS) project should meet all of the following conditions:
   a. Full capital and recurring cost should be provided by the Central/State Government.
   b. It should fulfil ESIC norms for setting up a hospital of adequate capacity as per MCI norms.

9. Recognising the difficulty in enforcing bonds, the Committee unanimously recommended option (a) (in the agenda notes) as the fee structure for MBBS courses in ESIC Medical Colleges (**based on upfront payment of tuition fee equal to the average cost of education per student divided into 9 half-year payments)**. The fee amount would have to be paid by all students uniformly, i.e. AIQ, State Quota and ESIC management Quota. The Institution should facilitate the process of education loan with suitable tie-ups. This would do away with the requirement of Bond and its attendant issues of enforceability.

10. The fee structure for PG courses in ESIC Medical Colleges was approved to be based on option (b) in the agenda notes **with subsidy from ESIC / Central Government with fee structure and Bond amount equivalent to 50% each, of the cost of education.** The student will have to furnish Bond to serve the ESIC for 5 years. Bond amount should be 50% of the cost of education, which the candidate will have to pay in event of not opting to serve ESIC. Issues of enforceability of Bond would have to be dealt with by the Corporation in consultation with its legal Advisors. **The details of options are placed at Annexure -I**

11. The Corporation may take all steps to enforce Bond already taken from students already undergoing UG/PG courses in ESIC Medical Educational Institutions. The Sub-committee noted, with concern, that the amount of Rs. 7.5 lacs under the present Bond had not been fixed by the Corporation but had been determined at the level of DG,

ESIC. The Committee also disagreed with the practise of exempting some people from the condition of Bond and **desired that no exceptions should be made and all should be required to submit the Bond.**

12. Committee approved ESIC residency scheme as proposed in the 'White Paper on Medical Education' with revision in 'mode of selection' as brought out in the agenda notes for the meeting and subject to the condition that the Corporation will ensure that the scheme is strictly in conformity with the above decisions on 'bonds' and charging of fees. **The revised ESIC residency Scheme is placed at Annexure-II**

13. The ESIC personnel policies should be reviewed so that the ESIC doctors get priority consideration in admission to PG programme, as in Armed Forces Medical Services (AFMS).

14. The various options for retaining pass outs of UG/PG programmes through Bond etc. may be examined. It was noted that AFMS have a system of Bond for this purpose. The Bond amount is Rs.25 Lakh and Rs.20 Lakh for UG and PG pass outs respectively. The degree certificate is retained till the Bond conditions are fulfilled.

15. There was an urgent need to reduce the cost of construction of ESIC medical educational institutions/hospitals/dispensaries. Pro-active steps should be taken in this regard.

16. The Committee accepted the proposal to define 'Insured Person' in the approved 'Admission policy & Procedure' for the purpose of availing benefit of ESIC Management Quota for his / her wards, as under:

"The 'Insured Person' shall be an 'employee' as defined in the ESI Act; and he/she should have been in continuous insurable employment for a period of five years as on 1st January of the year of admission and should have paid at least 78 days of contribution in eight [08] out of nine [09] complete contribution periods, during this five year period."

Other parameters of the approved 'Admission policy & Procedure' would remain same.

- The Sub-Committee recommended that the DG, ESIC may be authorized to take all necessary action to implement decisions of the Corporation on these recommendations, including any minor modifications thereof. All important orders issued in this regard may be submitted to the Corporation at its next meeting.
- The Sub-Committee also noted that the extant delegation of powers in respect of different matters would not be affected by the decisions of the Corporation of the above recommendations.

Annexure-I

1. FEE STRUCTURE – OPTIONS

OPTIONS	PROS	CONS
a. Upfront payment of tuition fee equal to the average cost of education per student i.e. Rs. 55 lac. *The total fee per student for the duration of the course will be 55 lacs. This may be divided into 9 half-year payments of Rs. 6.1 lac each* • The fee amount will have to be paid by all students uniformly, i.e. AIQ, State Quota and ESIC management Quota • The Institution will facilitate the process of education loan, if required	• The fees structure will recover the cost per student incurred by ESIC	• Introduction of very high fee structure may not be feasible. • Capability of 'Wards of IP' to pay the fee upfront by way of education loans is uncertain. • Some seats may not get filled due to high fee structure.

OPTIONS	PROS	CONS
b. Subsidy from ESIC / Central Government with fee structure and Bond amount equivalent to 50% each, of the cost of education. • The cost of education, i.e 55 lacs, may be divided (50% each) as fee and Bond amount • The fee structure would be 3.05 lacs per six months. • The student will have to furnish Bond to serve the ESIC for 5 years. • Bond amount would be Rs. 27.5 lacs which the candidate will have to pay in event of not opting to serve ESIC. • No incentive will be provided in event of candidate serving ESIC.	• Fee and Bond amount gets divided. The amount of fee up-front appears reasonable to implement. • Similarly the Bond amount also appears reasonable. • Subsidy from ESIC reduces to 50% in case the candidate is released from Bond • Financial burden on ESIC gets reduced to some extent.	• Onus to provide employment avenues will be on ESIC. • The candidate will be released from bond, if ESIC is not able to provide employment. • Enforcement of Bond will be as per prevailing systems in Government domain. The efficacy of enforcement may be an issue.

OPTIONS	PROS	CONS
c. Subsidized fee as on date + Bond amount equivalent to cost of education minus fee given, i.e. 54 lacs • The fee structure may be as prevailing, i.e. Rs. 24,000/- per annum • The student will have to furnish Bond to serve the ESIC for 5 years. • Bond amount will be equivalent to cost of education, i.e. 54 lacs • Candidate will have to pay Bond amount in event of not serving ESIC.	• Easy to implement. • Bond amount is equal to cost of education.	• Subsidy is almost 100% and is front loaded. • Onus to provide employment avenues will be on ESIC. The candidate will be released from bond, if ESIC is not able to provide employment. • In event of student being released from Bond if services are not needed, the high subsidy may be difficult to justify. • Enforcement of Bond will be as per prevailing systems in Government domain. The efficacy of enforcement may be an issue.

ANNEXURE -II

REVISED ESIC RESIDENCY SCHEME

Parameter	Central Residency Scheme [1]	ESIC Residency Scheme [2]
1. Nomenclature	**a. Senior Resident (SR)** **b. Junior Resident (JR)** ♦ Teaching (PGs) ♦ Non-teaching (Houseman ship)	♦ PG pass-out: **ESIC-SR** ♦ MBBS pass-out: **ESIC - JR [Non Teaching]**
2. Method of Selection	1- Selection of SR & JR (Non-Teaching) through open advt. by duly constituted Selection Board subject to the usual reservation as per Govt. Rules. 2- Selection of JR (Teaching), *(who are essentially post-graduate students selected through open examination and designated JR-Teaching),* shall be made in accordance the rules of the University/ Institution concerned.	1- To ensure placement of meritorious candidates against vacancies of SRs and GDMOs in ESIC, candidates willing to serve under Bond or under back-ended subsidy scheme, would appear in the appropriate selection process for appointment as ESIC SR /JR after completion of UG/PG course from ESIC Medical Colleges and PGIMSRs. - *Rule of reservation will be followed as per GoI guidelines.* - *Vacancy position in ESIC/ESIS has to be assessed beforehand and interviews for selection are to be conducted around the time of final examination of the batch.* 2- Candidates selected through such process will be placed at institutions as per the selection process accordingly. *3*- Balance willing candidates who are not selected in the selection process will be placed directly against balance vacancies as ESIC SRs and JRs (Non-teaching) at ESIC/ESIS institutions for compulsory service to fulfill obligation under Bond or otherwise. *Rule of reservation is followed at*

		time of admission to UG / PG courses. *[Candidates selected during the selection process would have locational advantage in posting as SR / JR. Candidates who do not get selected in the selection process, would get posted at locations that may not be preferred locations]*
3. Tenure	SR – 3 years JR(Teaching) – 2/3 years (For diploma/degree students) JR (Non-teaching) -1 year	5 years in case of both i.e. ESIC-SR & JR (Non-teaching)
4. Nature of Service	Residency in hospitals	Compulsory Service under bond or otherwise, in hospitals and dispensaries.
5. Pay Structure	**Senior Resident (SR)** PB-3 with GP- 6600/- **Junior Resident (JR)** PB-3 with GP- 5400/-	**As in column [1]**, i.e. Pay structure for ESIC residents matching their counter parts under Central Residency Scheme.
6. Allowances admissible	DA, NPA, HRA,TA	**As in column [1]**
7. LTC	**SR-** Considered temporary govt. servants and governed by Central Civil Services (temporary Services) Rules, 1965. Not entitled for LTC anywhere in India since they serve for maximum of 3 years but entitled for Home town LTC once in two years. **JR-** Not admissible since they are under contract.	As applicable to temporary Govt. servants.
8. Leave Entitlement	**SR-** As admissible to temporary govt. employees. **JR-** 30 days (all kinds of leave included) for the First year then 36 days in subsequent years.	As admissible to temporary Govt. servants.
9. GPF	**SR-**They are eligible to subscribe to contribution towards GPF in accordance with Rule 4 of the GPF	'New Pension Scheme' provisions as applicable to Temporary Govt. servants.

	(Central Service) Rules, 1960 as per original scheme. **JR-** Not entitled to become Members of GPF scheme.	
10. Accommodation	Resident Doctors will be provided with free furnished accommodation, free electricity and water within reasonable limit as may be fixed by the Govt. from time to time.	**As in column [1].** *In event of unavailability the resident will be paid HRA.*
11. Duties and responsibilities	Duties and responsibilities of the Resident Doctors will be fixed by the Govt. from time to time. They will be required to perform such work as may be needed in the legitimate interest of patient care in the hospital.	Duties and responsibilities of the ESIC Resident Doctors **will be fixed by the Competent Authority** from time to time. They will be required to perform such work as may be needed in the legitimate interest of patient care in ESIC/ESIS health system including Hospitals and Dispensaries anywhere in India**.**
12. Hours of Work	Continuous active duty for Resident Doctors will not normally exceed for 12 hours per day. Subject to exigency of work resident doctors will be allowed one weekly holiday by rotation. The resident doctors will also be required to be on call duty not exceeding 12 hours at a time. The Junior Resident should ordinarily work for 48 hours per week and not more than 12 hours at a stretch subject to the condition that the working hours be flexible as may be decided by the MS concerned keeping in view the work load and availability of doctors for clinical work.	**As in column [1]** *consistent with duties and responsibilities in Hospitals and Dispensaries.*

**The provisions of the "ESIC Residency Scheme" would be got vetted by Administration and Finance Divisions of ESIC, HQ, before the scheme is issued in public domain. Any major issue arising out of this vetting process would be submitted to the Chairman, ESIC for orders.*