EMPLOYEES STATE INSURANCE SCHEME

December 1996

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**Employees's State Insurance Scheme**

The Employee's State Insurance Scheme is basically a workers social security machinery, providing certain benefits and compensations in the event of sickness, maternity and employment injury. Framed under the Employees State Insurance Act of 1948 this scheme was a landmark in the evolution of the social security system in India.

**Emergence of EIS**

With the emergence during the latter half of the nineteenth century of the modern factory system in India, the practice of providing pecuniary relief against the contingencies such as industrial fatal accidents, industrial injuries and retirement appeared on the industrial horizon of the country. The State took the first step in 1885 towards providing compensation against industrial fatal accidents when it passed a law requiring the employer to pay compensation if it was proved in a court of law that such accident was due to his obvious neglect. This statute was replaced by a much more comprehensive scheme in 1923 when the Government of India adopted a law, 'The Workmen's Compensation Act's to provide relief in the event of industrial injuries or fatal accidents. Until the thirties the social security cover for the workers did not proceed beyond the provision of relief against industrial injuries, fatal accidents and maternity. The inadequacies of the then existing social security measure was highlighted by The Royal Commission on Labour in its review of the conditions of employment of industrial labour in India in the year 1931. In pursuance of the recommendation made by the Royal Commission, the Central Government appointed a one man panel of Prof. B.P. Adarker in March 1943 to draw a scheme. A comprehensive report was prepared in consultation with a panel of advisers representing employers and workers. This report was subsequently considered in a preliminary way at the Sixth Indian Labour Conference. In the light of the suggestions made by the ILO experts, the Government of India modified the original health scheme and prepared a bill called the Employees's State Insurance Bill providing for a unified scheme of social security to cover health insurance, maternity benefit and employment injury. This bill subsequently became a law on April 19, 1948.1

**What is ESI?**

The scheme is mainly financed by contributions from employers and employees. The employers contribution is equal to four percent of the wages payable to an employee. The employees contribution is at the rate of one and a half percent of the wages payable to an employee. The state governments share expenditure on the provision of medical care to the extent of 12.5%.

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The Employee's State Insurance Scheme (ESIS) is administered by a Corporate body called the Employees State Insurance Corporation (ESIC), which has members representing employers, employees, the central government, state governments, medical profession and members of the Parliament. A standing committee constituted from among the members of the corporation acts as the executive body for the administration of the scheme. Besides the headquarters of the corporation in New Delhi, it has 17 regional offices and 4 sub regional offices at Pune, Nagpur, Coimbatore, and Madurai. 806 local offices and cash offices are spread all over the country for the administration of the scheme.

The ESI benefits can be availed by employees of factories/establishments drawing wages excluding overtime not exceeding Rs. 3000 per month. However the recent proposed amendment raises the wage ceiling to Rs. 6,500 and the rate of contribution to 6.5 per cent. The ESI act earlier applied to non seasonal factories using power and employing 20 or more persons and non power using factories employing 20 or more persons for wages, but it is now applicable to power using factories using 10 or more persons. The scheme has now extended to shops, hotels, restaurants, cinemas including preview theatres, road motor transport undertakings and newspaper establishments employing 20 or more persons.

**Benefits under ESI:**

The ESI scheme seeks to provide a multi dimensional social security cover to the insured persons. The services offered include:

- **Medical Care**

Medical benefit is available to an insured person (IP) and the family from the day of entry into insurable employment. Insured persons who cease to be in insurable employment on account of permanent disablement due to an employment related injury, are also eligible. Medical benefits are also extended to insured persons who retire on attaining the age of superannuation and have completed at least five years in insurable employment. The spouse is also entitled to medical benefit.

Medical services are provided through a network of ESI dispensaries, hospitals and panel doctors at some places, generally within the vicinity of the residential areas of insured persons. Dispensaries established under the scheme are for the exclusive use of insured persons and their families and are manned by full time medical officers who are not allowed private practice. An insured person can also obtain medical care from a panel of private medical practitioners. Currently, there are over 320 dispensaries and 120 hospitals under the ESI banner.

The ESI provides full medical care in the form of medical attendance, treatment, drugs and injections, specialist consultations and hospitalisation to insured persons and family members. In addition, prenatal and postnatal care, family welfare, immunisation and maternity and child health services are also
available. Besides providing total in-patient care, the scheme also fully finances cases of beneficiaries requiring advanced or super-speciality treatment or specialised surgery in leading medical institutions of the country. Incidental expenditure on transport, lodging charges at the treatment centre, travelling expenses for the attendants, if required, are also met under the ESI scheme.

Insured persons who suffer loss of a certain faculty due to an employment related injury, occupational disease or in the event of sickness and non-employment injuries are provided artificial limbs, hearing aids, artificial dentures, spectacles and appliances like spinal supports, cervical collars, walking callipers, crutches, wheelchairs and cardiac pacemakers. The families of insured persons are also eligible to these aids.

- **Sickness Benefits**

This includes periodical payments made to an insured person during a period of certified sickness. The maximum duration of the sickness benefit is 91 days in two consecutive benefit periods. The insured person is further entitled to an extended sickness benefit for a period of up to 309 days if the person is suffering from tuberculosis, leprosy, cancer, mental and malignant diseases, paraplegia, homoplegia and non-union or delayed union of a fracture and other specified long term diseases. The Sickness Benefit Rate is approximately equivalent to 50 percent of the daily wages of the IP. Currently 29 long term diseases have been specified for which insured persons are granted extended sickness benefits at a rate which is 25 percent more than the standard Sickness Benefit Rate. The Director General has been empowered to enhance the duration of extended sickness benefit beyond the present limit of 400 days (91 days of sickness benefit plus 309 days of extended sickness benefit) to a maximum period of two years in deserving cases. The certification of a Medical Board is required.

Enhanced sickness benefit at double the ordinary Sickness Benefit Rate i.e. full wages, is also provided to insured persons undergoing sterilisation procedures. This is afforded for a period of up to seven days in the case of vasectomy and up to 14 days for tubectomy. The period is extendible in cases of post- operative complications.

- **Maternity Benefits**

Maternity benefit is payable to an insured woman in case of confinement, miscarriage, medical termination of pregnancy, sickness arising out of pregnancy or confinement, premature birth of child. The benefit is double the standard Sickness Benefit Rate i.e. equal to full wages for a period of 12 weeks. This period can be extended by four weeks on medical advice.

- **Disablement Benefits**

In case of temporary disability arising out of an employment related injury,
Disablement benefit is admissible to an insured person for the entire period as certified by an Insurance Medical Officer/Insurance Medical Practitioner. The benefit is not subject to any contributory conditions and is payable at a rate equivalent to about 70 percent of the daily average wage of the insured person.

In case an employment related injury results in permanent, partial or total loss of earning capacity, periodical payments are available to the IP for life. The amount will depend on the loss of earning capacity as may be certified by a Medical Board.

- **Dependents Benefits**

  Periodical pensions are payable to dependents of an IP who dies as a result of an employment related injury. The widow or minor children are entitled to this benefit till the former’s death or remarriage.

- **Funeral Expenses**

  A lump-sum grant of up to a maximum of Rs.1000 can be given to defray expenditures incurred on the funeral of a deceased IP. The amount is paid either to the eldest surviving member of the family or to the person who actually incurs the expenditure on the funeral.

- **Rehabilitation Allowances**

  Rehabilitation allowance is admissible to IPs for the period they remain admitted in an Artificial Limb Centre for fixation or repair or replacement of an artificial limb. The amount coincides with the Sickness Benefit Rate. The benefit is not subject to any contributory conditions.

- **Vocational Rehabilitation Training**

  Under this scheme, insured persons that have been permanently disabled as a result of an employment related injury and are not in gainful employment, are covered. The loss of earning capacity must not be less than 40 percent and the person must be below 45 years of age. Such persons will be entitled to receive cash allowances equal to the expenditure charged by the Vocational Rehabilitation Centre. Such insured persons will also be paid conveyance charges for the journey undertaken by them from their normal residence to the Centre.

**Financial Summary:**

Data gathered from some past reports of ESIC throw light on the fact that ESIC has a comfortable amount in its reserve. Some available statistics of past years are:
Total Reserves of ESIC (in crores) for the financial year 1988-89

<table>
<thead>
<tr>
<th></th>
<th>1988 (in crores)</th>
<th>1989 (in crores)</th>
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<tbody>
<tr>
<td>Total reserve of ESIC</td>
<td>1119.10</td>
<td>944.42</td>
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<tr>
<td>Non earmarked reserves</td>
<td>556.79</td>
<td>525.78</td>
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<tr>
<td>Amount invested in nationalised banks</td>
<td></td>
<td>933</td>
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<tr>
<td>Amount invested with Central govt</td>
<td></td>
<td>184</td>
</tr>
<tr>
<td>Arrears from employers</td>
<td>92.84</td>
<td>116.64</td>
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<tr>
<td>Net excess income</td>
<td>117.80</td>
<td>124.05</td>
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Financial year 1993-1994

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<th>31-3-93 (in crores)</th>
<th>31-3-94 (in crores)</th>
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</thead>
<tbody>
<tr>
<td>Money of ESIC with banks</td>
<td>157.15</td>
<td>131.85</td>
</tr>
<tr>
<td>Special deposits and with central government</td>
<td>1773.51</td>
<td>1988.33</td>
</tr>
<tr>
<td>Total amount</td>
<td>1930.66</td>
<td>2118.18</td>
</tr>
</tbody>
</table>

Comparison with money spent on benefits from employees show that little is spent on benefits. For every 100 rupees spent on benefits:

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<thead>
<tr>
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<th>1987-88</th>
<th>1988-89</th>
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</thead>
<tbody>
<tr>
<td>Arrears from employers</td>
<td>Rs. 43.00</td>
<td>Rs. 50.00</td>
</tr>
<tr>
<td>Total Reserves of ESIC</td>
<td>Rs. 438.00</td>
<td>Rs. 483.00</td>
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</tbody>
</table>

Income - Expenditure = Saving

<table>
<thead>
<tr>
<th>Year</th>
<th>Savings (in crores)</th>
<th>Saving-Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989-90</td>
<td>123.34</td>
<td>39.2%</td>
</tr>
<tr>
<td>1990-91</td>
<td>116.43</td>
<td>35.74%</td>
</tr>
<tr>
<td>1991-92</td>
<td>65.73</td>
<td>17%</td>
</tr>
<tr>
<td>1992-93</td>
<td>204.48</td>
<td>54.10%</td>
</tr>
<tr>
<td>1993-94</td>
<td>98.33</td>
<td>16.5%</td>
</tr>
</tbody>
</table>

Number of beneficiaries covered under the ESI scheme:
The following data has been recorded till 31-12-94 and gives provisional figures:

| Number of employees under ESI | 66.41 lakhs |
| Number of insured persons/family (I.P) units covered | 74.11 lakhs |
| Number of beneficiaries | 287.53 lakhs |
| Number of centres | 521 |
| Number of employees under full medical care (all facilities including hospitalisation for families) | 73,62,300 |
| Extended medical care (all facilities short of hospitalisation for families) | 32,700 |
| Restricted medical care (out patient care with full supply of drugs and dressing for families) | 18,000 |

The ESI statistics of 1995-96 records 7.3 million insured persons all over India. The recent proposed enhancement of the wage ceiling to Rs. 6,500 is expected to bring an additional 9.6 lakh employees and their dependents under the ESI cover taking the total number close to 8.3 million.
A Workers Story

This is a story of Sampat Piraji Tapre. Grey and tired beyond his 42 years, the textile mill worker is one of the victims of the disabling byssinosis. He works in the weaving department of Mumbai Textile Mill. Working in the same department for the past 22 years, he developed respiratory problems within 2-3 years of work. Doctors diagnosed his illness as T.B without going much in depth. He was treated for T.B for four years from 1990-1994. There was no improvement in his health, on the contrary his health kept deteriorating. During this period he attended a workshop organised by PRIA in which he came to know about a few diseases caused due to work. One of them was Byssinosis affecting workers in textile mills. This was the first time Sampat Tapre had heard about this illness. He also came to know that if a worker is affected by Byssinosis he can claim compensation from ESI as it is a notifiable disease under the Workmen’s Compensation Act.

This information was important for Tapre to realise that he may not be a T.B patient but suffering from Byssinosis. Later on he attended a medical camp organised by OHSC and PRIA where he was diagnosed as byssinotic. This was on May 1, 1994. From hereon his struggle for compensation started. He was unnecessarily forced to get his tests done. For this he had to run around four hospitals of Bombay to get reports of his tests. A lot of money was spent frequenting these hospitals and paying for various tests. He was sent from one hospital to another namely Tata hospital, G.T hospital, Bombay hospital and the ESI hospital at Worli. This procedure took 5-6 months.

The next step was to get a 16-A form from ESI which has to be filled and submitted to ESI for compensation. He entered another long struggle to get the form. Initially the ESI kept delaying saying that at present they did not have the form. He took help of Comrade G.V. Chitnis who helped him get the form. The form he got in hand was number 16 which is used to get compensation for accidents. He was back where he had started. Another round of visiting ESI officials started. This time they said that they would give the form either to the management or to a recognised union. It soon came to light that the ESI officials had never seen a 16-
A form! Tapre asked the officials to search for a copy of it in the files in which they keep a copy of all the forms. Being illiterate he was still able to identify the 16-A form as he had seen it in one of the booklets published on Byssinosis by PRIA. He finally got the form Xeroxed from the file.

The third step was to fill the form and get it signed by the management. The 16-A form has to be filled by the management which certifies that this particular worker has been working with them. The management has to give details regarding his nature of work, duration of work and state that he is a suspected byssinosis patient. Besides this two more workers have to sign as witnesses to certify that the concerned worker has been working in their department. Tapre got the form signed and sent it to ESI.

Till here the process is handled by ESIS but from here the ESIC takes over. After the form is checked by the medical referee the case is sent for scrutinisation by the medical board. The medical board sits according to its convenience. All the tests are repeated by the board. By this time Tapre had got used to the harassment and one more round of tests did not bother him. He underwent all the tests and finally on March 21, 1995 he was diagnosed to be suffering from Byssinosis by the special medical board of ESI. He got a compensation of Rs. 18.55 per day for 25% disability. The amount of compensation is calculated as per the worker—age, percentage of disability, and salary of the worker. The compensation amount is revised from time to time by ESI.

Tapre was the first case in the whole of Maharashtra to have got compensation for Byssinosis. Occupational Health and Safety Centre took up more cases for compensation and 32 more workers got compensation though the others had to undergo a longer and more gruelling process. In Tapre’s case he was diagnosed to have Byssinosis in 1994 and the medical board confirmed it in March 1995 but he started getting compensation from 1994 onwards. In the 32 cases which followed Tapre this was not the case and though they were diagnosed to have Byssinosis in 1994 they were entitled for compensation from 1996 onwards after the medical board cleared their cases.

The side effects of this whole procedure has been that now the management has stopped signing 16 A forms. The ESI has also stopped entry of these workers in their office. Tapre and others continue to get compensation though the money they had spent to get their tests done in other hospitals has not been reimbursed.

There are many more cases like Tapre whose problems are unheard.
How Efficient is Esi?

The case of Sampat Tapre is one among a whole lot who undergo harassment from ESI. The policy on paper may provide benefits to workers but whether the workers get these benefits is questionable. ESIC is under heavy criticism due to its failure to provide workers with benefits they are entitled to and the apathy shown towards the group for whom they function. All the three parties involved in this scheme, namely employees, employers, and the government, report severe bottlenecks in its execution. ESI hospitals lack equipment, medical supplies and specialised doctors. For workers who pay their monthly contribution, it is a nightmare to get the required treatment. The cases of disability are either rejected or the percentage of disability is rated very low as compared to the actual condition of the victim. Severe breaches have been reported in providing compensations or benefits to the workers particularly in the case of occupational diseases. The problem lies in the diagnosis of the occupational disease such as dust related lung diseases namely Byssinosis, silicosis, and asbestosis. Usually these respiratory ailments are confused with tuberculosis and the worker fails to get compensation because the latter is not a compensable disease. The ESI hospitals are not properly equipped to handle cases afflicted with occupational disease as they lack the necessary medical expertise. Moreover, once a case of dust related lung disease such as Silicosis gets diagnosed as tuberculosis, the worker is automatically admitted into a TB hospital. Here, the patient contracts tuberculosis and eventually dies of the lethal Silico-Tuberculosis, without securing any compensation. These weaknesses in the ESI system have made people develop an indifferent attitude to it. Workers use the ESI only to take medical certificates from doctors. For treatment, they use private hospitals which is a considerable drain on their meagre resources. This depressing condition also leads to the use of ESI hospitals as stop gap jobs by most of the young doctors. On the other hand, the employers are unhappy because even though they make contributions to the ESI scheme from their profits, the workers do not get proper treatment.

With the aim to explore more about the existing functioning of ESI and the reputation it holds among workers, management and doctors a study was conducted in 1995 by PRIA in collaboration with DISHA, OHI, and KSSM. Data was collected from Bombay, Ahmedabad, Delhi and Calcutta to assess the whole scenario.

A sample of 200 workers from each city was interviewed. In order to collect the necessary data, three sets of schedules were framed. Workers, ESI doctors and managers of industries were administered these schedules to elicit relevant material for the purpose.
In Ahmedabad the survey was carried out among textile workers. The nature of the work was similar and so were the various departments. The various departments from where the workers were interviewed were cardroom, blowroom, ringframe, spinning, weaving, dyeing, cleaning, engineering, warehouse etc. Out of the total of 199 workers 39 (19.59%) were unskilled and 160 (80.40%) were skilled.

In Delhi workers visiting the ESI hospital were interviewed. A total of 200 ESI beneficiaries from a wide range of industries were interviewed. These workers came mostly from export houses who dealt with garments. The other industries in lesser proportion were electronic units manufacturing televisions, refrigerators, cables etc., hotels and restaurants. The nature of occupation varied accordingly.

In Bombay workers of small scale industries were selected, and in Calcutta they were from different industries, like jute industry, glass, paper, electronics, ferroalloys, breweries, textiles etc.

The study threw light on certain issues listed below. The corresponding data gathered from the study are given in the appendix.

**Workers perspective**

**Awareness of ESI, factory and mines act**

Despite the network of ESI being spread in almost all the states of India, very few workers were aware about the various acts like ESI, Factory and Mines act. The unawareness level was seen to be very high among workers of Delhi, and Bombay while Ahmedabad and Calcutta reported a better awareness level. The high rate of awareness of mines act could be due to the fact that in none of the states the workers have been associated with mines. While the workers had less knowledge about the acts, they were aware about the benefits provided by these acts which were beneficial to them.

Regarding the knowledge about benefits, in Bombay none of the workers were aware of funeral, rehabilitation, disablement and dependents benefits. High level of awareness was seen in Ahmedabad for all the benefits. The long term campaign on dust related lung diseases in Ahmedabad is a contributory factor to the high level of awareness among workers. Workers in Delhi and Calcutta showed some awareness of maternity and medical benefits. The level of awareness was comparatively higher among workers of Calcutta though many were unaware of rehabilitation benefit.
Are ESI hospitals well equipped?

In Ahmedabad and Delhi a large majority felt that the hospitals are not adequately equipped. In response to why the workers felt that the ESI was not well equipped, the reply was that the medicines were bad and doctors inefficient. The response was different in Bombay and Calcutta where the workers felt that the ESI hospitals were equipped well.

Regarding the availability of medicines from ESI hospitals a substantial number of workers in all the states were not happy with the supply of medicines. Some found it difficult to get medicines from the hospitals as there was a constant short supply and they had to wait in long queues to get medicines. Workers also said that the medicine was bad and ineffective. Majority of them thought that it was a waste of time and money to approach ESI for medicine. They had to wait in long queues and lose their wage in the process. Sometimes they had to put in a good sum on a private vehicle. In short, the whole exercise was neither cost effective nor time effective as they did not get medicine of an appropriate quality. Some workers felt that the ESI staff in general was very rude, and this was enough to turn them away from taking ESI medicine.

Majority of workers in Calcutta, Bombay and Ahmedabad also reported that their families did not get proper treatment from ESI.

Behaviour of ESI staff, hospital and panel doctors....

In all the four states the majority of workers were not satisfied with the behaviour of ESI staff and the hospital doctors. Reflecting on the panel doctor’s behaviour, the majority of the workers in the cities of Bombay, Delhi and Ahmedabad did not show much satisfaction while the panel doctors in Calcutta had a reasonably satisfied clientele. All the four states reacted differently to hospital doctors, panel doctors and the ESI staff.

In Bombay majority rated ESI’s staff and panel doctor’s behaviour as bad and a small proportion said that the behaviour was good. In Ahmedabad a large number
complained about the bad and rude behaviour of ESI staff. There was mixed response regarding the hospital doctors' behaviour where we got approximately half of them responding negatively and the rest responded in favour of them or were indifferent towards them. One worker went to the extent of saying that the doctors threatened them if they insisted on proper care. Commenting on the behaviour of panel doctors a small number said that the panel doctors behave properly with them, a slightly higher percentage felt they did not behave properly with them and the rest had no opinion at all.

Calcutta recorded a better opinion about panel doctors among the workers. Almost all of them were satisfied with the doctors. A greater number of workers also found the hospital doctors' behaviour as good though a considerable amount were not satisfied with them.

In Delhi also the workers were not satisfied with the ESI service, doctors and hospitals. The various reasons given were bad and rude behaviour of the staff and hospital doctors, substandard medicine dispensed, and dissatisfaction prevailed mostly due to time, money and long wait at the ESI hospital. In many cases discontent arose because of harassment, unfriendly and rude behaviour of ESI doctors and staff. There was also a feeling prevalent among the workers that the ESI doctors and staff did not do them enough justice in terms of good behaviour. They harboured a feeling that the staff were obliged to behave well as they were living on the worker's contribution to ESI. They felt hurt at the ungrateful attitude of the ESI doctors and staff and demanded that they were entitled to an overall efficacious service from ESI in general.

**Doctor's Perspective: Ahmedabad, Calcutta, Delhi**

In order to get an overview of the ESI doctors' perspective on the scheme, 21 doctors were interviewed in Ahmedabad, 22 in Calcutta and five in Delhi. In Delhi, this information was collected through informal discussions rather than an interview schedule. The following picture emerged.

**Doctors' perception of workers attitude to the scheme**

A fairly large proportion of doctors in Ahmedabad (80.95%) replied that the overall attitude of the workers was favourable; 9.52 percent of doctors claimed that the workers harboured a mixed feeling towards the scheme; an equal percentage reported that it was negative. In Delhi, most of the doctors stated that the ESI scheme met with a lukewarm response from the workers, even while they were quite aware of the benefits under it. In Calcutta, 12 (54.54%) of the doctors stated that the workers were satisfied, seven (31.81%) felt that they were dissatisfied and the remaining three (13.63%) were undecided.

In Ahmedabad, the favourable attitude towards the ESI scheme was attributed by the doctors to their caring and attentive behaviour. In Calcutta, those who stated that the attitude was positive related it to factors like: the availability of
basic medical investigations, better services at the ESI hospitals as compared to the State hospitals, the benefits received by the workers under the ESI scheme. The doctors stated that the workers appreciated the fact that inspite of limited resources, the doctors tried to care for them to the best of their ability. According to the doctors, a negative feeling towards the scheme, was harboured by those workers who had high expectations from the scheme. They were of the opinion that the general socio-political attitude of the labour class is responsible for their bad impression about the ESI. This unfavourable attitude could also be attributed to negative experiences that the workers might have had at the dispensary/hospital. These may be related too: lack of facilities, inadequate care given by ESI staff, busy schedule of the doctors, corrupt practices of a few doctors, etc.

**Facilities availed by workers**

The doctors were questioned about the facilities availed by the workers. In Ahmedabad, most of the doctors felt that the workers fully utilised the services of the ESI doctor. However, according to them, the workers do not have the same confidence in panel doctors, whose primary motive is to make money rather than take care of the patient. In Calcutta, the services most often utilised by the workers were: outdoor patient services, specialist consultation, medical leave, medication, hospitalisation, sickness benefits. In Delhi, one doctor stated that the workers mainly availed sickness benefits; another stated that they mainly came for investigations; three doctors were ignorant.

**Reasons for visiting private doctors**

Many workers resorted to private doctors despite the facilities provided to them under the ESI scheme. In Ahmedabad, most of the doctors felt that some workers lacked confidence in the scheme and hence did not avail of the medical facilities offered. However, 9.52 percent seemed positive that if the workers visited them, they would be satisfied and would not resort to private doctors. One doctor was of the opinion that the patients believed that they would get medicines of better quality, if they paid for it. In Calcutta, the doctors felt that the reasons were to avoid unnecessary wastage of time during an emergency; expectation of better care, treatment and prompt service from a private practitioner; lack of information about the benefits accorded under the scheme; lack of facilities at the ESI dispensary. Some doctors felt that for the workers the cost of treatment defines the effectiveness of treatment. It was also mentioned that the a pathetic attitude of some doctors may have led to workers resorting to private treatment. In Delhi, most of the doctors agreed that the inadequate supply of medicines at the dispensary may have made workers resort to private doctors, inspire of their ESI membership.

**Satisfaction with the ESI system**

The doctors in the three cities of Ahmedabad, Calcutta and Delhi, were dissatisfied
with the present ESI structure. In Ahmedabad, a large number (57.14%) expressed unhappiness with the whole set up. In Calcutta, seven (31.81%) were satisfied and 15 (68.18%) were not. In Delhi, only two doctors stated that they were satisfied with the system; two were not; one was undecided.

Doctors were asked their opinion on whether the ESI hospitals were adequately equipped. In Ahmedabad, a majority (61.90%) of the doctors gave a positive response. In Calcutta, only three doctors (13.63%) stated that the ESI hospitals were adequately equipped. In Delhi, three replied in the affirmative; one did not find them adequately equipped; the fifth did not reply.

Doctors were asked their opinion regarding medicine supplies to the hospital. In Ahmedabad, 71.42 percent of the doctors were satisfied; in Calcutta, 12 (54.54%) were satisfied and nine (40.90%) were not; in Delhi, two were satisfied and one was not.

Awareness of occupational diseases

Unfortunately, it has often been found that there is a chance of confusing symptoms of occupational and non-occupational diseases. In the Ahmedabad survey, it was seen that 71.42 percent of the doctors agreed that most of the occupational diseases were identified as non-occupational. In Calcutta, 18 doctors (81.81%) agreed with this finding; three (13.63%) did not; and one (4.54%) did not reply. In Delhi, two of the five doctors that were met, admitted that they often did so. The remaining three doctors denied confusing the symptoms of occupational and non-occupational diseases.

The doctors listed various reasons for this misdiagnosis. A majority of doctors in Ahmedabad (80%), agreed that the doctors did not inquire from the workers about the nature of their occupation. In Calcutta, 13 doctors (59.09) agreed with this statement. The management was blamed for failing to inform the doctors about the presence of hazardous material at the work place. A majority of the doctors in Ahmedabad (66.66%) and Calcutta (59.09%) agreed with this. Forty percent of the doctors in Ahmedabad and 63.63 percent of the doctors in Calcutta stated that the ESI hospitals were not equipped to handle and diagnose cases of occupational diseases. The workers were blamed for not cooperating with the medical staff and hiding the fact that their ailment was related to their work. Twenty percent of the doctors in Ahmedabad and 13.63 percent of the doctors in Calcutta stated that since they did not have the facilities to treat occupational diseases, they thought it better not to inform the workers about any occupational disease that they might have contracted.

Doctors were asked as to how many cases of occupational disease were identified by them in the past year. In Ahmedabad, 57.14 percent of the doctors had not identified a single person suffering from an occupational disease; 33.33 percent had identified 1-5 patients; 9.52 percent of the doctors had identified 12
patients each. In Calcutta, doctors gave varying figures, ranging from 4 to 70. A few doctors could not give the required figures as they did not have the necessary statistics with them.

The doctors reported that the educational input regarding occupational diseases in the MBBS courses was quite inadequate. This dissatisfaction was voiced by 15 doctors in Ahmedabad, 21 doctors in Calcutta and two doctors in Delhi. However, some doctors found the input to be sufficient; six doctors were satisfied in Ahmedabad; three in Delhi; and one in Calcutta.

Many of the doctors were not aware of the courses on occupational diseases being offered in their city. In Ahmedabad, 71.42 percent of the doctors were knowledgeable on this issue; in Delhi, two of the five doctors replied in the affirmative; in Calcutta, 12 (54.54%) of them gave a positive response. A negative response was recorded from 28.57 percent of the doctors in Ahmedabad; ten (45.45%) doctors from Calcutta; three of the doctors from Delhi.

The study revealed that the doctors do not get an opportunity to attend these courses on a regular basis. This was the overwhelming response in Calcutta. In Ahmedabad, only three of the doctors (14.28%) had attended such courses. Only in Delhi, had all the five doctors that were interviewed, been given this opportunity.

Referrals

Doctors were asked if they referred cases of occupational diseases to other hospitals when the need arose. In Ahmedabad and Delhi, many doctors referred patients suffering from occupational disease to other hospitals.

Doctors were questioned regarding the cases of occupational diseases that were referred by them to the Medical Board. In Ahmedabad, eight (38.09%) doctors stated that they referred cases to the Medical Board. In Calcutta, four (18.18%) of the doctors had referred cases to the Board; the remaining 18 (81.81%) did not give any exact information. In Delhi, in the past year, only one doctor had referred 5-6 cases to the Medical Board but was unaware of how many were turned down. Doctors in Ahmedabad informed us that most of the cases were taken up by the Board and very few were turned down. In Calcutta, one doctor (4.54%) stated that 20 percent of the cases were turned down; three (13.63%) said that all cases were taken up; 11 (50%) did not know; seven (31.81%) did not answer.

Management's Perspective: Ahmedabad, Calcutta

In Ahmedabad, ten industrial managers from textile mills were contacted. These industries manufactured cloth using cotton as raw material. In Calcutta, only four industrial officers could be contacted. They worked in different industries - electrical industry, industries producing different goods, like rubber gasket fittings, hosiery and alloys.
Facilities availed

The management staff was asked to list the facilities that the workers avail from ESI. In Ahmedabad, the management stated that as the workers medical requirements were not satisfied at the ESI centres, they resorted to private practitioners, even while continuing to contribute to the ESI. Eight (80%) of the respondents claimed that the workers used the ESI facilities mainly to get sick leave.

On an average, workers took four to seven days of medical leave per month. The workers as reported by the management, mainly suffered from seasonal diseases, stomach ache and breathlessness. The third being a occupational disease the management fails to recognise breathlessness as a result of work related disorders.

Compensation received

In both Ahmedabad and Calcutta, the management unanimously reported that workers received compensation from ESI authorities. In Ahmedabad, the feedback received was that the ESI authorities did not provide adequate facilities in lieu of the contributions taken. In Calcutta, three replied that it provided adequate facilities while one replied in the negative.

Health and safety at the work place

The management was asked to identify the hazardous tasks in their industry. In Ahmedabad, working in the card room and blow room was considered to be injurious to health. In Calcutta, while one of the four interviewed denied that there was any hazardous work, two others stated that working near the furnace might adversely affect the health of the workers.

The management was asked if they could add any new diseases to the current list of notifiable diseases. In Ahmedabad, most of them replied in the negative; only three of them noted that eye and stomach problems should be added. In Calcutta, all of them replied in the negative.

Contributions from hazardous industries

The management was asked whether hazardous industries should contribute more
money to the ESI. In Ahmedabad, only one respondent felt that they should pay more while the others gave a negative response. In Calcutta, a similar response was obtained; one respondent felt that they should pay more, two of them gave a negative response and the fourth did not reply.

Training on Occupational health

When asked if the worker's are given any training about their work area, in Ahmedabad, eight (80%) of the managers stated that they educated their workers on health and safety at the workplace. A similar claim was made in Calcutta. Four respondents (40%) in Ahmedabad and one (25%) in Calcutta felt that the ESI scheme should be given autonomy at the State level.

Summing Up : Workers, Doctors And Management

- The study sharply brings into focus the lack of awareness amongst the workers regarding their legitimate claims from ESI. For instance, their ignorance regarding their right to compensation is glaring. It was observed that even concerning serious injuries such as amputation of fingers, the workers were not informed that they were entitled to compensation. Many remain ignorant about the existence of a Medical Board. The workers were surprised when they were informed that the ESI corpus is reported to be in the range of Rs.1200 crore.

- The study also reveals that even while the workers were highly critical of the lacunae within the ESI system, they continued to avail of the facilities offered. In addition, these beneficiaries spent a considerable sum on private treatment inspite of the routine contribution to ESI from their meagre salaries.

- The beneficiaries continue to lack sufficient knowledge about the various Acts and benefits accruing to them under the ESI scheme. There is a general lack of awareness among the workers regarding the disability criteria adopted by ESI. This was found to be true not only among workers but among doctors as well.

The workers were highly critical of the behaviour of the ESI staff and doctors. Their conduct dissuades several workers from utilising the ESI medical facilities. It forces the workers to visit private doctors, despite the fact that they make a considerable contribution from their meagre salaries to the scheme. The supply of medicines was also found to be inadequate. There is a general grievance that the families of IPs do not get adequate medical treatment.

- It was opined by most workers that the ESI hospitals were not adequately equipped to manage accident cases. They also demanded that doctors qualified in the treatment of occupational diseases be recruited. In fact, many doctors themselves admitted that they confuse occupational and non-occupational
diseases and that there is need for more specialists to cope with occupational diseases. A dire need exists to train them in this area.

- The management stated that the services offered by the ESI were inadequate. Most of them denied that the work environment posed any health hazard and were almost completely ignorant about occupational diseases. They also claimed that the workers always get compensation. They stated that workers mainly availed of the ESI scheme to get sick leave. This was endorsed by some doctors.

- It was found that as per the present policy, the same contribution is taken from all industries, irrespective of the number of accidents taking place in it. As a result, an industry which has spent a considerable amount on accident and hazard prevention and has less number of accident cases, pays the same amount as those industries who do take such measures and have a high accident rate. The industry with a lower accident rate, does not get any indirect or direct incentive to encourage it to continue with its plans to control occupational hazards. On the other hand, there are no stringent penalties on industries with a higher accident rate to enforce a better working environment and install safety measures.

- Another point which emerged was that the management did not pay the contributions punctually to ESI. The workers' contribution is automatically deducted by the industry from the salary, the management puts this money into a fixed deposit and earns substantial interest on it. It pays the workers contributions and its own dues to ESI only at a later date. By this time, the ESI takes out a defaulters list and the workers on this list are not eligible for medical benefits. Consequently, the worker suffers for the fault of the management. ESI does not have any strict late fee penalty. The Employers get away even by not paying to ESIC. The corporation is very soft towards the employers. The arrears from employers are 116 crore rupees. If things do not improve and resources are not used for proper medical care of employees, ESIC will really become Employer's State Insurance Scheme.

- Necessary forms and diagnostic instruments are not available with ESIC doctors and hospitals.

- Medical boards decide the percentage of disability of injured workers. But medical boards do not meet frequently. They are more concerned in reducing the percentage of disability and compensation paid to us, complained workers in a asbestos factory.
Suggestions and Recommendations

A multi-dimensional approach is required to bring fruitful changes in the existing ESI scheme which is not satisfying the workers, doctors or the management. The ESI scheme sounds very impressive on paper but unfortunately the implementation of this scheme has failed drastically. It is the need of the hour that all of us take efforts to bring back the implementation of this scheme on its right track. A few suggestions gathered from workers, managers, doctors and from activists involved in this field are listed below:

Better monitoring of the ESI scheme

- The behaviour of the ESI personnel came under severe criticism as it was reported to be unhelpful and inhumane. The workers complained that the doctors did not examine the patients adequately and suggested that more time should be spent by the doctors on diagnosis. Their other grievance was that as the doctors were not punctual, the patients had to wait in queue for a long time for them. Not only was it a waste of time and a source of annoyance, it also deprived the worker of the day's wages. The workers were of the opinion that they were entitled to expect the ESI staff and doctors to provide the necessary services in a disciplined, professional and efficient manner as it was the workers' contribution to ESI from which their salaries were paid.

- The medicines prescribed and dispensed at the ESI hospital/dispensary were claimed to be of substandard quality. A fair number of workers demanded that they should get medicines which were as effective as that prescribed by private doctors. It was suspected that the same medicines were prescribed for different diseases.

- The ESI hospital should be better equipped with up-to-date machinery. For the benefit of the workers there should be a full-time primary hospital and extra doctors should be recruited. Doctors should stress on treatment rather than on granting sick leave. A professional attitude towards the service should be strengthened amongst the doctors.

- There was general agreement that the implementation of the present scheme should be properly carried out before any fresh plans and policies were framed.

- Medical officers are drawn from the general health cadre of the state governments and they reluctantly join the scheme and so are uninterested. Service condition of doctors also need to be improved.

- When worker’s/employees contribution is cut from the wages, but not paid to ESIC by the employer, this should be treated as a criminal breach of trust and ESIC should not simply stop at the recovery of fines or writing off dues as bad debts.
• The union representatives on ESIC bodies at National Level as well as local
tools need to take more active interest in ESIC affairs.

• ESI should spend money on hospitals, making doctors permanent, employing
more doctors, and paramedical staff, ensure better drugs, better equipment, etc.

• The management should be made answerable to ESI authorities.

Decentralisation of the scheme

• A supervisory board over and above the medical professionals to regulate their
efficiency and conduct should be founded. It was also suggested that the panel
system should be scrapped.

• The medical officer in charge should have complete authority to prescribe
appropriate medicines, irrespective of the cost. Dispensaries/hospitals should
be adequately stocked with medicines.

• Autonomy should be granted to the ESI at the State level. A State level
corporate body with members from ESI, the environmental sector, State
government, ILO/WHO, ISI, should be set up to run the scheme efficiently.
Decentralisation of the entire ESI machinery at all levels, was found to be
necessary. Reimbursement facilities need to be streamlined and bureaucracy
within the administration should be minimised.

• Industrialists are having the facility of one window clearance. Employees
should also get one window clearance of their dues from ESIC. They should not
be made to run around to get forms, which are generally not available, to wait
in long queues at various offices and windows. Simple procedures need to be
developed, in consultation with employees.

Training Doctors

• ESI hospitals should be better equipped with modern equipment and new
departments, with special emphasis on the diagnosis and treatment of occupa-
tional diseases. Doctors should be specially trained to handle occupational
diseases. There should be a specialist in occupational disease for every five
dispensaries. Ayurvedic doctors should also receive necessary training in this
area. Research facilities should be made available.

• Train doctors in Occupational Health. Institutes such as NIOH, Ahmedabad,
CLI, Bombay and ITRC, Lucknow may help ESIC in organising these trainings.

Training Workers

• Workers should be trained and properly educated about the ESI Act and
scheme and the facilities offered under it. Steps should be undertaken to
enhance better understanding among the workers and ESI doctors and staff.
Workers should be checked at their work place.
• It is important that health education programmes be planned to inform the workers about the ESI Act and scheme. This would help them to make better use of the facilities and benefits. Intervention programmes through film shows, posters, flip books may be prepared.

**Increasing benefits**

• Develop Occupational Health and Safety Centres all over India - at least one in each district, more in industrial cities. These centres should be well equipped and should have specialists. They should cater to the employees of ESIC hospitals as well.

• Regarding compensation rates, the disability benefit rate should be linked to the average price index. The amount rewarded to a worker should change every year depending upon the average price index of that year. The disability compensation for the loss of earning capacity should synchronise with the price index.

We hope that a debate will be initiated on the issue of social security for the entire workforce, with special focus on the issue of medical facilities and compensation policies. In a situation of rapid industrial growth where government is off-loading its social welfare responsibilities and the employer has no responsibility or accountability in the case of accidents or diseases, there is need to review the situation. Already there are demands to scrap the ESI scheme. If that happens the workers will be the worst losers. The need of the hour is that trade unions and other concerned authorities, should think about suitable modifications and advocate a more comprehensive policy for all workers. Only accountability and sharing the compensation and rehabilitation burden will make industries realise that prevention is cheaper than producing victims.
## Appendix

Data gathered from workers interviewed from Delhi, Bombay, Calcutta & Ahmedabad

### Age Distribution Female

<table>
<thead>
<tr>
<th></th>
<th>20-30</th>
<th>31-40</th>
<th>41-50</th>
<th>51-above</th>
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<tbody>
<tr>
<td>Delhi</td>
<td>56.25%</td>
<td>37.5%</td>
<td>6.25%</td>
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<tr>
<td>Bombay</td>
<td>55.55%</td>
<td>27.77%</td>
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<tr>
<td>Calcutta</td>
<td>10%</td>
<td>50%</td>
<td>30%</td>
<td>10%</td>
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<tr>
<td>Ahmedabad</td>
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<td>0</td>
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### Age Distribution Male

<table>
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<tr>
<th></th>
<th>Below 20</th>
<th>20-30</th>
<th>31-40</th>
<th>41-50</th>
<th>51-above</th>
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<tbody>
<tr>
<td>Delhi</td>
<td>1.63%</td>
<td>58.15%</td>
<td>33.69%</td>
<td>5.43%</td>
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<tr>
<td>Bombay</td>
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<td>37.15%</td>
<td>32.24%</td>
<td>22.4%</td>
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<td>Calcutta</td>
<td>0</td>
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<td>46.31%</td>
<td>27.36%</td>
<td>11.05%</td>
</tr>
<tr>
<td>Ahmedabad</td>
<td>0</td>
<td>6.53%</td>
<td>34.67%</td>
<td>38.69%</td>
<td>20.01%</td>
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### Separate board of ESI at State Level

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<thead>
<tr>
<th></th>
<th>Delhi</th>
<th>Bombay</th>
<th>Calcutta</th>
<th>Ahmedabad</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>--</td>
<td>76.11%</td>
<td>27.5%</td>
<td>97.98%</td>
</tr>
<tr>
<td>No</td>
<td>--</td>
<td>1.49%</td>
<td>47%</td>
<td>2.01%</td>
</tr>
<tr>
<td>Do not know</td>
<td>--</td>
<td>22.38%</td>
<td>8%</td>
<td>--</td>
</tr>
<tr>
<td>No comments</td>
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<td>17.5%</td>
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### Do you get medicines from ESI Hospital?

<table>
<thead>
<tr>
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<th>Delhi</th>
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<th>Ahmedabad</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
<td>79.5%</td>
<td>69.65%</td>
<td>70.5%</td>
<td>19.59%</td>
</tr>
<tr>
<td>No</td>
<td>20.5%</td>
<td>30.34%</td>
<td>27%</td>
<td>80.4%</td>
</tr>
<tr>
<td>Do not know</td>
<td>--</td>
<td>--</td>
<td>2.5%</td>
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### Unaware of ESI benefits

<table>
<thead>
<tr>
<th></th>
<th>Medical</th>
<th>Maternity</th>
<th>Funeral</th>
<th>Rehabilitation</th>
<th>Disablement</th>
<th>Dependents</th>
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</thead>
<tbody>
<tr>
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<td>43%</td>
<td>89.5%</td>
<td>85%</td>
<td>55%</td>
<td>55.5%</td>
</tr>
<tr>
<td>Bombay</td>
<td>14.42%</td>
<td>93.53%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Calcutta</td>
<td>1.5%</td>
<td>66%</td>
<td>17.5%</td>
<td>81%</td>
<td>34.5%</td>
<td>33%</td>
</tr>
<tr>
<td>Ahmedabad</td>
<td>18.6%</td>
<td>5.03%</td>
<td>8.55%</td>
<td>2.02%</td>
<td>11.06%</td>
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### Availed Medical Benefits

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<th>Calcutta</th>
<th>Ahmedabad</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>83.5%</td>
<td>81.59%</td>
<td>59.5%</td>
<td>86.93%</td>
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### Is ESI Hospital equipped to handle accidents

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<th>Do not know</th>
</tr>
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<tbody>
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<td>Bombay</td>
<td>6.46%</td>
<td>90.04%</td>
<td>3.48%</td>
</tr>
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<td>Calcutta</td>
<td>14.5%</td>
<td>70.05%</td>
<td>15%</td>
</tr>
<tr>
<td>Ahmedabad</td>
<td>74.37%</td>
<td>21.6%</td>
<td>4.02%</td>
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</table>
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