“Assessing the Operational Challenges and Policy Gaps in ECHS/CGHS Empanelment and Renewals and Role of Hospital Administrators in Facilitating Government Health Scheme Integration: A Policy Analysis Based on Government Audits and Published Reports”

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Introduction

- **Overview:** CGHS (est. 1954) and ECHS (est. 2003) are two major health schemes by the Government of India.
- **Target Groups:** CGHS – central govt. employees & pensioners; ECHS – ex-servicemen and their families.
- **Scale:** CGHS serves 38.5 lakh people in 74 cities; ECHS serves ~55–60 lakh veterans.
- **Importance:** Ensures public health access for privileged government categories.
- **Issue:** Despite intentions, both schemes face criticism for inefficiencies and gaps.

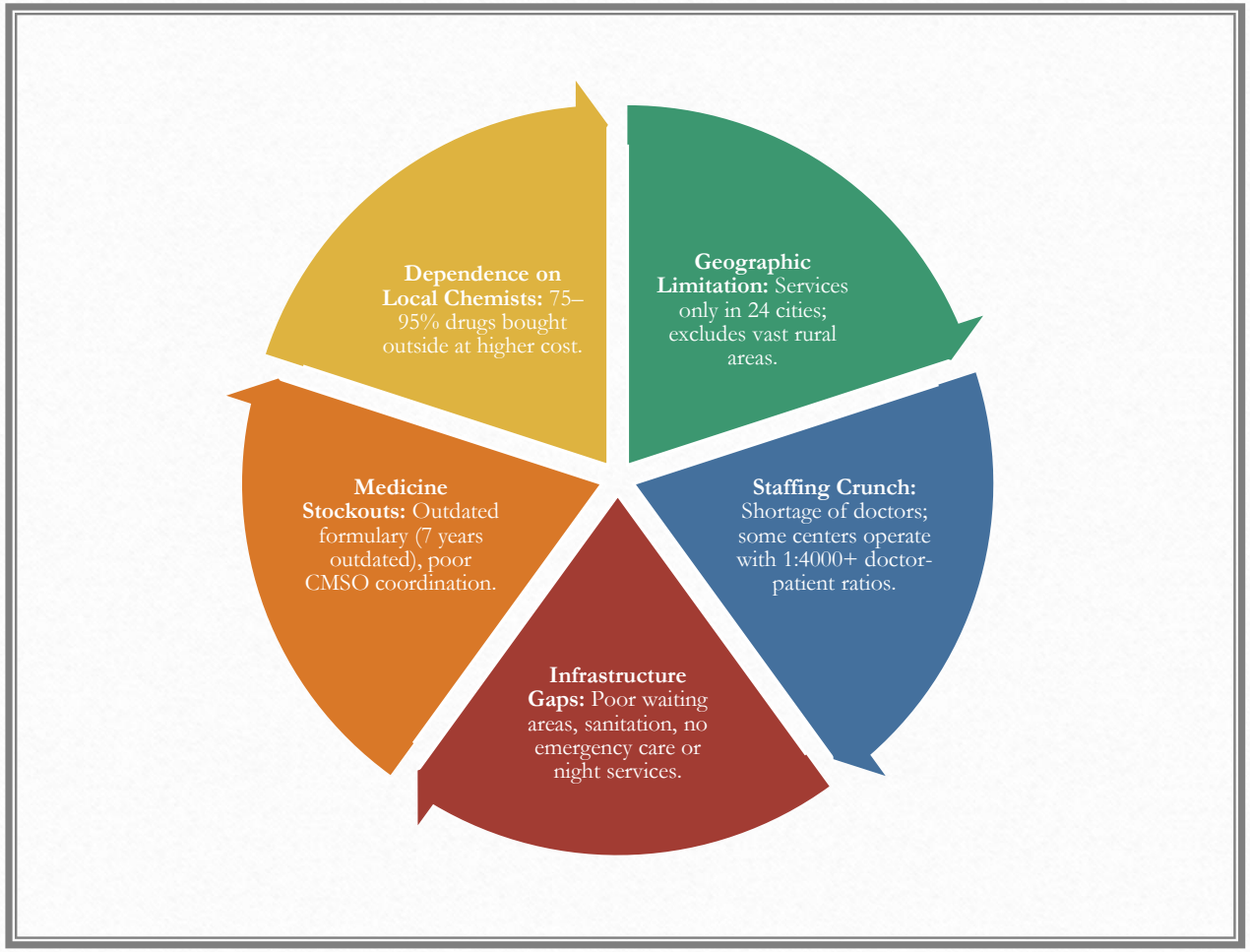
Objectives of the Study

1. **Identify key service delivery issues** in CGHS and ECHS through audit reports and publications.
2. **Compare the nature and extent** of service gaps in both schemes.
3. **Analyze root causes** related to policy, administration, and governance.
4. **Recommend evidence-based policy solutions** to enhance service efficiency and beneficiary satisfaction.

Methodology

- **Approach:** Qualitative secondary research.
- **Data Sources:**
  - CAG Reports (No. 17 of 2022 – CGHS; No. 51 of 2015 – ECHS)
  - MoHFW and MoD publications
  - News media and research studies
- **Thematic Analysis:** Categorization by service areas: access, HR, infrastructure, drugs, finances.
- **Limitations:** Lack of recent primary data; varied coverage periods.

CGHS – Core Service Delivery Gaps



CGHS – Administrative and Financial Weaknesses

Claim Reimbursements: ₹38.7 crore fund lying idle; delays in hospital bill payments.

Poor Performance of BCA: No accountability or timeline adherence.

Empanelled Hospitals: Overcharged ₹571 crore (2016–21); no penal actions.

Governance: Limited beneficiary feedback mechanisms; outdated operational norms.

Core Service Delivery Gaps

Staffing Issues: 21% staff deficit in 2015; many staff diverted to Delhi HQ.

Inadequate Polyclinics: Labs and equipment lacking; functioning as referral counters.

Drug Supply Issues: 63–76% drug indentations marked unavailable; ₹40.78 crore diverted.

Smart Card Failures: Multiple/duplicate card issuance; beneficiaries wrongly charged.

ECHS – Administrative and Financial Gaps

Fraudulent Claims: Duplicate and inflated hospital bills – ₹100+ crore loss.

Weak Audits: No MoA with billing agency; low oversight.

Delayed Emergency Reports: Hospitals often delay required EIR filings.

Dispersed Accountability: Highly decentralized with poor vertical coordination.

Comparative Summary Table

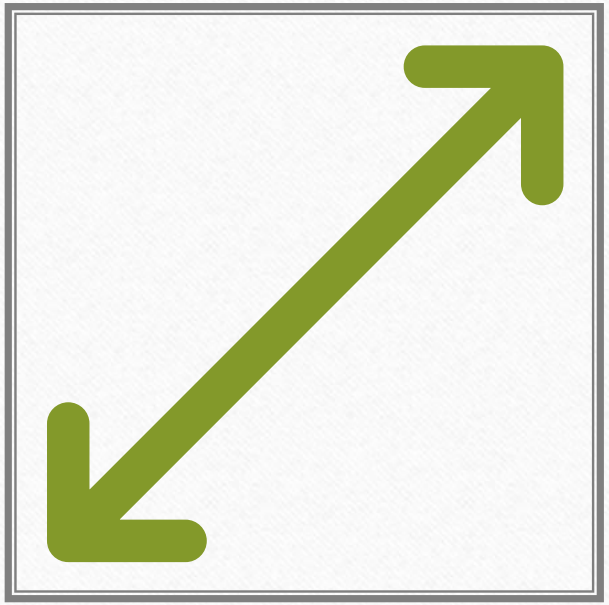
Parameter	CGHS	ECHS
Target Group	Central Govt. employees & pensioners	Ex-servicemen & dependents
Geographic Access	Urban-centric (24 cities)	Remote & urban (433 polyclinics)
Staffing Issues	High; reliance on retirees	High; ~21% shortfall
Drug Availability	Procurement delays, outdated formulary	AFMSD failure, drug diversion
Hospital Coordination	Payment delays, no penalty enforcement	Duplicate billing, fraud, poor audits

Root Cause Analysis

- **Policy Rigidity:** CGHS 6000-beneficiary city limit is outdated.
- **Underfunding:** ECHS budget gap of ₹3,500 crore in 2019.
- **Inadequate Procurement Systems:** Poor CMSO and AFMSD performance.
- **Human Resource Planning:** Limited recruitment incentives.
- **Oversight Gaps:** Delayed audits, poor grievance redressal systems.
- **Digitization Lag:** CGHS lags in e-health innovations.

Policy Recommendations for CGHS

1. **Expand Access:** Relax city eligibility norms; deploy mobile dispensaries.
2. **Strengthen Staffing:** Hire new doctors; incentivize rural postings.
3. **Upgrade Facilities:** Build government inpatient hospitals.
4. **Procurement Reform:** Real-time drug stock dashboards; automate indenting.
5. **Digitize Claims:** Online portal for empanelled hospital billing.
6. **Patient Engagement:** Launch helplines, app-based support, and feedback loops.



Policy Recommendations for ECHS

1. **Fill Vacancies:** Immediately address staff shortfalls; offer full-time roles.
2. **Card Reforms:** Biometric smart cards linked to centralized verification.
3. **Control Fraud:** Data-driven audits; use AI to detect duplicate claims.
4. **Improve Medicine Supply:** Partner with verified chemists under SLAs.
5. **Boost Rural Access:** Telemedicine, ambulance, and satellite clinics.
6. **Institutionalize Monitoring:** Formal MoA with billing agencies and KPIs.

Common Recommendations for Both Schemes

- **Create Joint Task Force:** Health + Defence ministries to align policies.
- **Standardize IT Systems:** National e-health record system integration.
- **Regular Audits:** Annual CAG audit compliance matrix.
- **Training Programs:** Healthcare management workshops for staff.
- **Publish KPIs:** Transparency in wait times, drug stockouts, claim delays.

Conclusion

- CGHS and ECHS are essential but plagued by inefficiencies.
- Audits reveal repeating problems in access, supply chains, HR, and finance.
- A modern, tech-driven, well-governed approach can fix many gaps.
- Urgent reform will protect health rights of veterans and civil servants.
- These findings provide a roadmap for impactful health policy execution.

Thank You