**Summer Training Report**

**Employee's State Insurance Scheme(ESIS), Mumbai**

**Government of Maharashtra.**

**Topic:**

# Evaluation of Primary Health care & Utilisation of Medical benefits provided by ESIS
# Access to health care on Analysing Rajiv Gandhi Jeevandayee Aarogya Yojana.

**Submitted by:**

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**MBAHM-19**

INSTITUTE OF HEALTH
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(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

# CERTIFICATE

This is to certify that Dr.Bhagyashree Maheshwari has completed the summer internship at Employee's State Insurance Scheme (ESIS), Mumbai, Maharashtra from 6th April to 5th May 2015 and has conducted the following project under my guidance,

- **Evaluation of ESI Scheme-Understanding Primary health care and Utilisation of Medical benefits provided by ESIS.**
- **Access to health care-Analysing Rajiv Gandhi Jeevandayee Aaroya Yojana.**

The approach to the project has been sincere, scientific and analytical. Organization found her to be motivated, good communicator and hard working. The work is in partial fulfilment to the course requirements recommended for the Master of Business Administration in Hospital and Health Management, 19th Batch from Institute of Health Management and Research, Jaipur.

I wish her success in all her future endeavours.

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Date: July 5, 2015

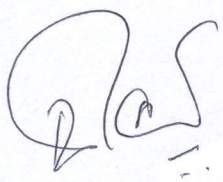
## Certificate of Experience

This is to certify that Dr. Bhagyashree Maheshwari has successfully completed two months of internship (April 6th, 2015 to June 5th, 2015) at Employee's State Insurance Scheme under my supervision and guidance.
During the course of her internship she had visited many government healthcare institutes which includes Rajiv Gandhi Jeevandayee Bhavan, J.J. Hospital, Dr. R.N. Copper Hospital etc. And had studied the following topics with keen interest

- Evaluation of ESI scheme
- How equitable ESIC is, in providing medical care
- Access to health care-on analyzing Rajiv Gandhi Jeevandayee Aarogya Yojana

Organization found her to be motivated, good communicator and hard working.
She worked sincerely on her assignment and her performance was par excellence.

We wish best of luck for her future endeavors.



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## Graphs, Table, Maps and Figures

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The internship opportunity I had with Employee's State Insurance Scheme,Mumbai was a great chance for learning and professional development. I am also grateful for having a chance to meet so many wonderful people and professionals who led me though this internship period.. However, it would not have been possible without the kind support and help of Mr. J.P. Gupta(Commissioner, IAS). I would like to extend my sincere thanks to him.

I am highly indebted to Dr.Prateek Rathi for their guidance and constant supervision as well as for providing necessary information regarding the organisation & also for their support in completing the report.
I would like to express my special gratitude to Dr.P.R. Sodani for giving me his precious time and input for successful completion of Summer Training Report .
My thanks and appreciations also go to my colleague in developing the project and people who have willingly helped me out with their abilities.
I perceive as this opportunity as a big milestone in my career development. I will strive to use gained skills and knowledge in the best possible way, and I will continue to work on their improvement, in order to attain desired career objectives.

**Employee's State Insurance Scheme:"Social Security Scheme"**

**Introduction:**

Social: Suggests relationship to society in particular culture , historical and geographical setting.

Security: Implies protection against risk.

*It is defined as the protection which society provides for its members through a series of public measures against the economic and that otherwise would be caused by the stoppage or substantial reduction of earnings resulting from sickness, maternity, disability, old age and sudden death social distress*

**Social security in India:**

The employees State Insurance Act 1948 is a social security legislation that provides medical care and cash benefits to workers and is self financed to assure sustainability.

The *Beveridge Report* of UK had its impact in the preparation of the ESI Act 1948 by Prof B N Adarkar.

*Employees' State Insurance Scheme (ESIS) is an integrated* ***social security*** *scheme mandated to provide* ***protection to workers*** *and their dependants in the* ***organized sector.***

ESIC is under administrative control of Ministry of Labor and Employment, Government of India. It is a contribution based scheme for workers deployed in organized sector labor who earn less than 15,000Rs a month. Each employee contributes 1.75% & employer 4.75% of the wages to receive benefits in contingencies.
Delivery System comprises of **Cash benefits** like maternity benefit, sickness benefit because of non employment etc which is provided by ESIC & **Medical Benefits** are provided by both ESIS and ESIC run hospitals.
*Six Contingencies covered under the scheme are:*

- Sickness
- Maternity
- Disablement due to employment injury or occupational disease.
- Death /Dependence Benefit
- Medical Benefit
- Other: Funeral expenses, Confinement, Unemployment allowance(RGSKY),Vocational training.

**Applicability:**

ESI act apply to non seasonal factories:

- Using power in the manufacturing process and employing 10 or more workers.
- Non power using factories employing 20 or more employees.

Employees of aforesaid employment receiving less than 15000Rs / month wages are covered under the scheme.

**Objective:**

· To understand Primary Health care delivery under ESI Scheme.

· To study utilization of medical benefits provided by ESI Scheme.

**Why ESI scheme?**

**Why not other public sector scheme?**

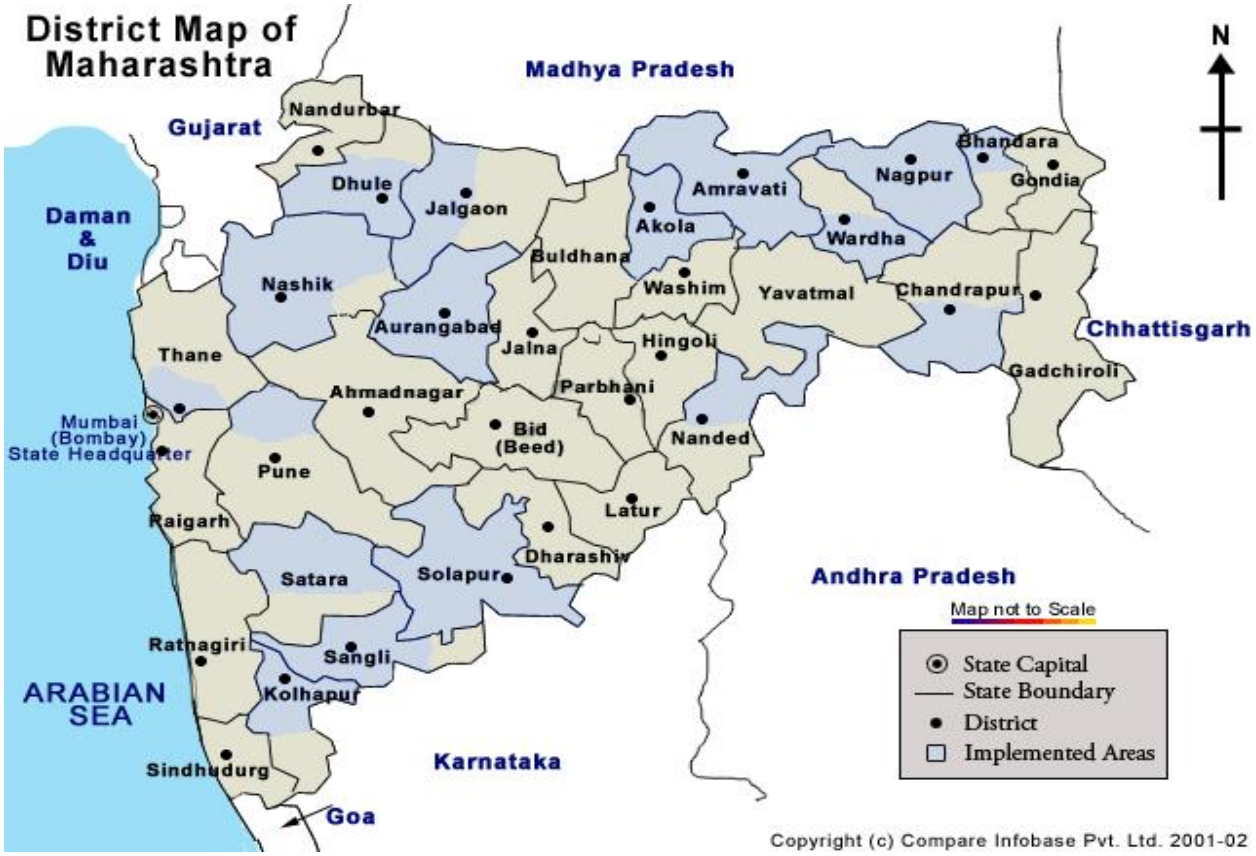
| **Public sector Insurance** | **E.S.I. Scheme** |
|---|---|
| ○ One year premium has to be paid in advance<br>○ There is no cashless transaction rather it is reimbursement of expenditure.<br>○ Medi-claims excludes many diseases(like AIDS/HIV), have waiting period & limits.<br>○ Premium secures one person with a definite ceiling for medical treatment.<br>○ Only medical facilities.<br>○ Private policies have cooling off period ,the do not cover pre existing diseases. | ○ Contribution is deducted from salary per month<br>○ Need not to spend any amount for medical treatment.<br>○ It covers all diseases.<br>○ Contribution of just 1.75% salary covers whole family for medical treatment.<br>○ Medical treatment + cash benefits in case of disability /death.<br>○ No cooling off period. All pre-existing diseases are covered . |

**Advantage of ESI Scheme:**

ESIS ensures treatment of IP and whole of his family for any amount of rupees which includes expensive treatment like Liver Transplant, Bone Marrow Transplant, chemotherapy etc. Insured person is also assured of the part wages during the course of the treatment.

**Implemented areas:**

***Map1.1***



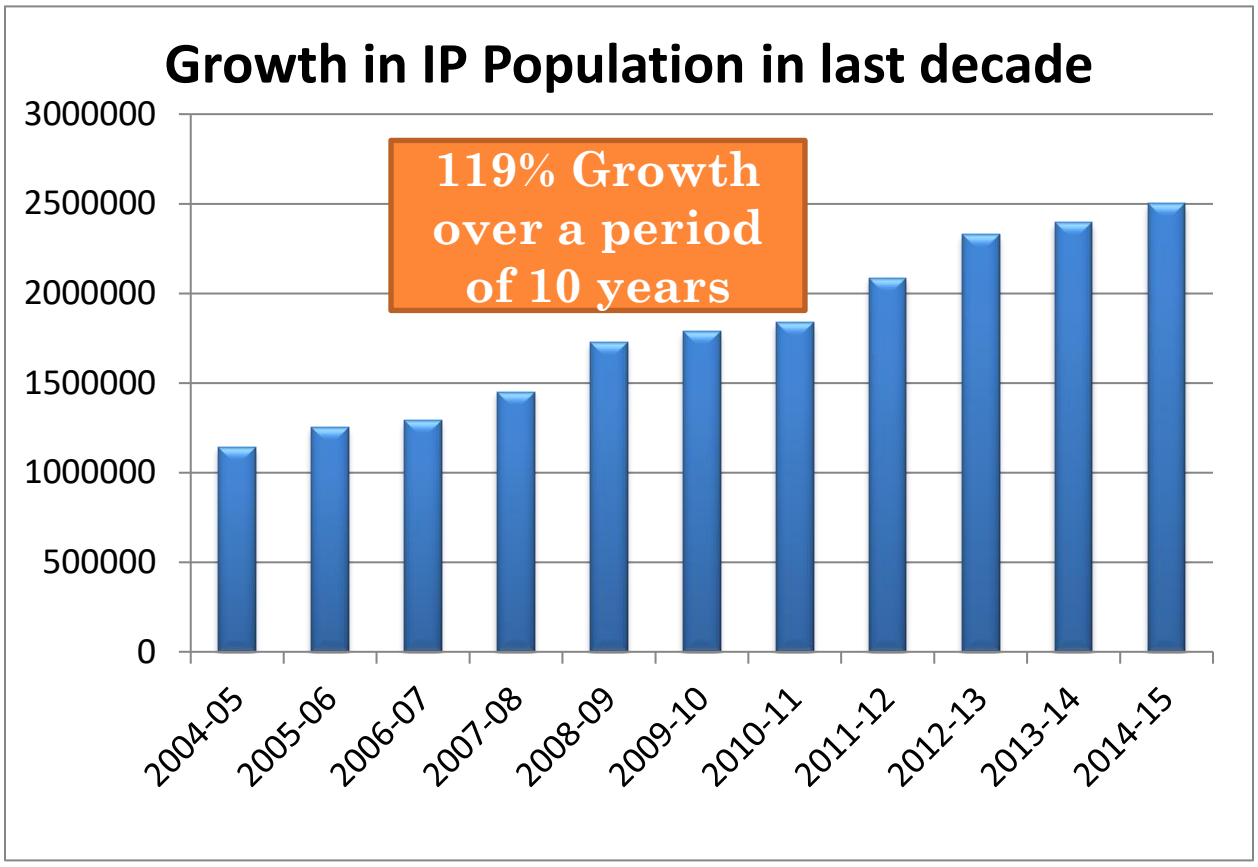

**Total Districts Covered :18**

Total IP covered:25 lakh(2014-15)

Esi Beneficiaries:1 cr.

Wage ceiling Rs. 15000

**Growth in No. of IP's**




***Graph1.1***

**Levels of Care:**

ESI scheme provides

- Primary care: IMP + Service Dispensaries
- Secondary care: Esi Hospitals
- Tertiary care: Tie Up Hospitals

Primary Care:

- Areas where ESIC did not consider it feasible to set up a Dispensary, IMP are authorized.
- IMP gets **remuneration of 240Rs** /IP/annum.
- Authorized no. of **chemists** is 42 who get incentive of 14% on mark up cost.
- No. Of IMP:**884** (which have 2.5lakh IP's Registered)
- No. of Service Dispensaries:63

Secondary Care:

- Provided by Esi Hospitals.
- There are 12 fully functional Esi Hospitals in Maharashtra.
- Bed Strength : 2065

Tertiary Care:

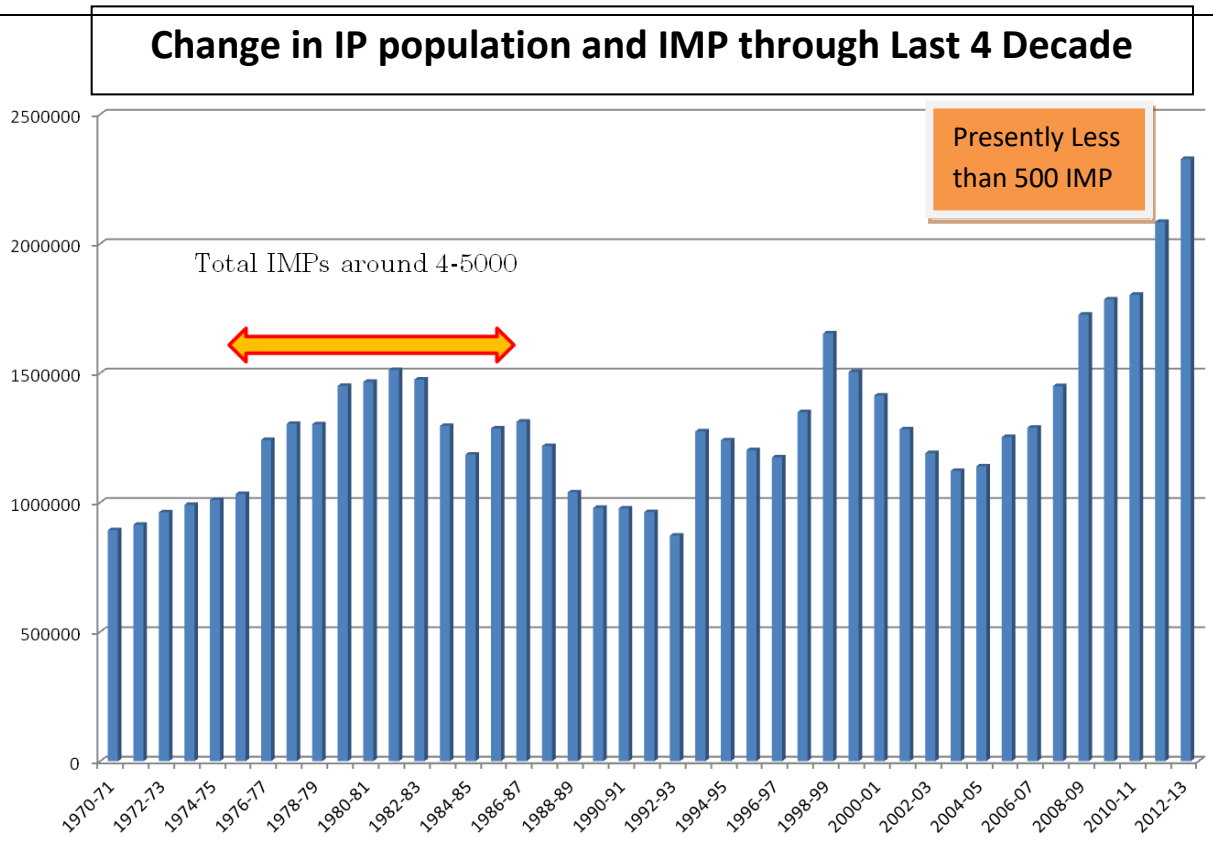
- Super specialty treatment is provided by no. of tie up hospitals since 2008.
- Currently there are as many as 155 Private hospitals for treatment of IP.

- **Analysis:**To understand Primary Health care delivery under ESI Scheme.

ESIS provides insurance for Organized Sector which forms around 10% to total labor sector

**Primary care** (Outpatient services) is provided by panel clinics (IMP-Insured Medical Practitioners) and Service Dispensaries to IP's.

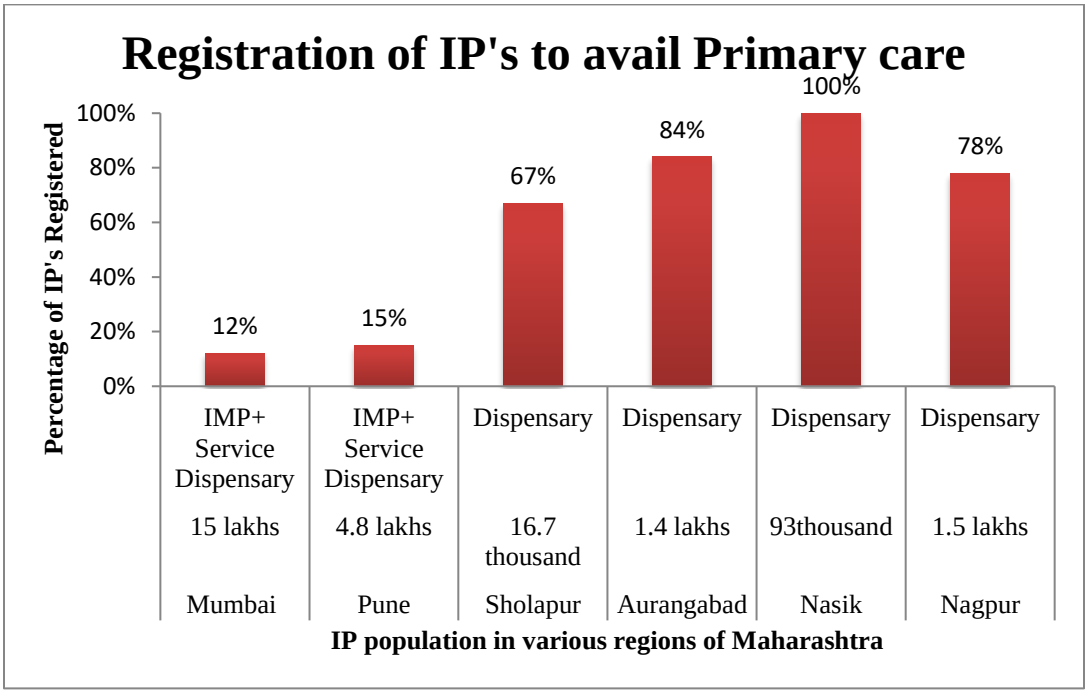
Areas where ESIC did not consider it feasible to set up a Dispensary, IMP are authorized. These IMP gets remuneration of 240Rs /IP family/annum ,in spite of incentive for the medical practitioners to register more no of IP there is no evident increase in No. of registered IP in this PPP. Mumbai and Pune have both service Dispensaries and IMP, whereas Nagpur, Aurangabad & Nasik have only Dispensaries.




***Graph 1.2***

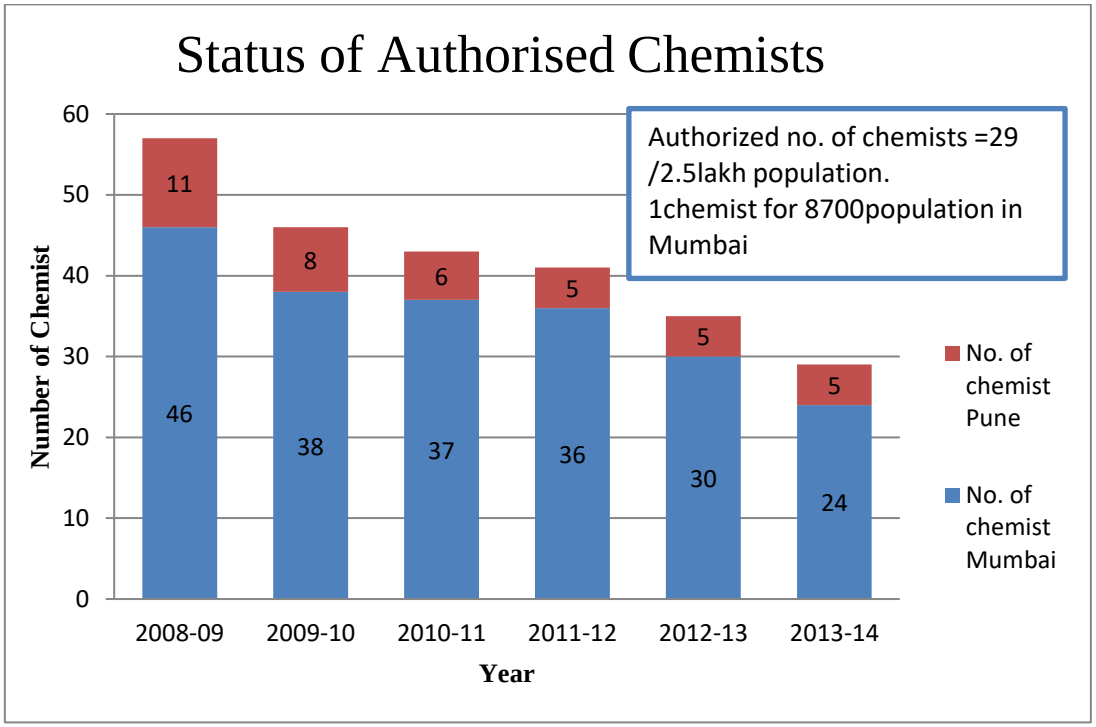
| S.N | AMO | Name of Region | Insured Persons (As per live list) | Service delivery System | Registered IPs with ESI Scheme, Maharashtra | % of Total IP Registered with the scheme |
|---|---|---|---|---|---|---|
| 1 | MUMBAI | | 14,61,500 | IMP+ Service Dispensary | 1,79,221 | 12% |
| 2 | PUNE | Pune | 4,77,737 | IMP+ Service Dispensary | 73,824 | 15% |
| | | Sholapur | 16,777 | Dispensary | 11,200 | 67% |
| | | Aurangabad | 1,40,000 | Dispensary | 1,18,000 | 84% |
| | | Nasik | 93,200 | Dispensary | Almost 100% | 100% |
| | | Other Districts of Pune region | 69,200 | Dispensary | Almost 100% | 100% |
| 3 | NAGPUR | Nagpur | 1,49,000 | Dispensary | 1,16,080 | 78% |
| | **TOTAL** | | **23,95,800** | | | |

***Table1.1: Registered IP in different districts of Maharashtra***




***Graph1.3***

- This data pulls attention towards the difference in registered IP's by PPP based IMP system and Government Dispensaries. Out of total IP's only 12-15% is registered in Mumbai & Pune. This is because of poor and delayed remuneration to the authorized IMP.
- Authorized no. of chemists is 29 catering to 2.5lakh population. Representing just .11 chemists /1000 Population or 1 chemist for 8700 population. Also no new chemist is enchanted to join the system because of poor remuneration of 14% on markup cost. Even existing chemists are also leaving because of same reason.




***Graph1.4***

- Even thought the system of primary care is installed but the functioning makes it difficult for the IP's to avail the services. The process flow is underneath:

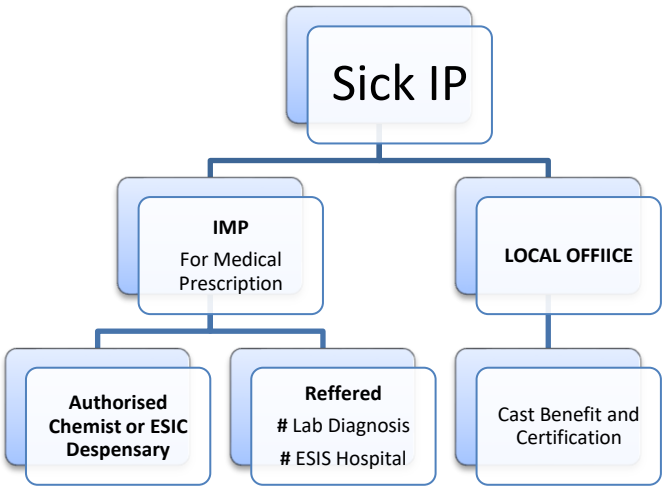



***Fig 1.1: Process Flow in seeking health care and cash benefits***

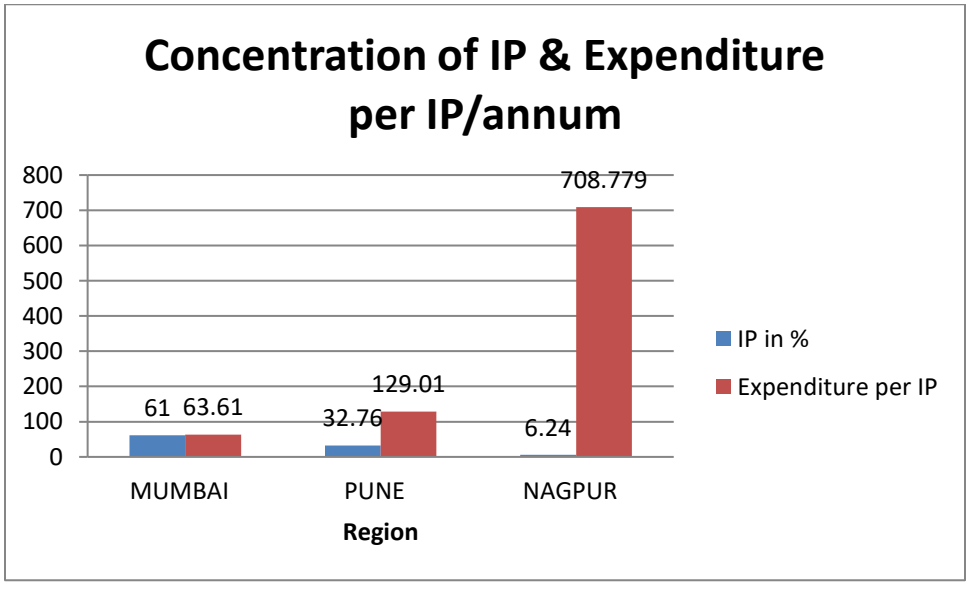
All the three services are provided by separate entities. Hence IP has to travel (at times long distance) for getting drugs and sickness benefits. This is not only time consuming but also involves transportation costs.

In nutshell total expenditure on Primary care which forms the first point of contact for IP is as low as 5% whereas HLEG Report states that we should strive for almost 70%

expenditure on Primary Healthcare/Public Health, irony is expenditure is just opposite to what is being suggested.

| Expenditure on Primary healthcare | | | | | | |
|---|---|---|---|---|---|---|
| | | | ESIS, Maharashtra. | | | (expenditure in thousands) |
| **S.N.** | **Region** | | **No of IPs** | **Expenditure** | **Percentage** | **Expenditure per IP** |
| 1 | MUMBAI (61%) | | **1461500** | **92969** | **5.025** | **63.61** |
| 2 | PUNE (32.76%) | | **760412** | **98100** | **5.303** | **129.01** |
| | | Pune City | 477737 | 18100 | | **37.89** |
| | | Solapur | 16777 | 15000 | | **894.08** |
| | | Other Districts | 32698 | 62839.4 | | **1921.81** |
| | | Aurangabad | 140000 | 20000 | | 142.86 |
| | | Nashik | 93200 | 15000 | | 160.94 |
| 3 | NAGPUR (6.24%) | | **149000** | **105608** | **5.709** | **708.779** |
| | **Total (Maharashtra)** | | **2370912** | **296677** | **16%** | **125.13** |

***Table 1.3***




***Graph1.5 Concentration of IP & Expenditure per IP/annum***

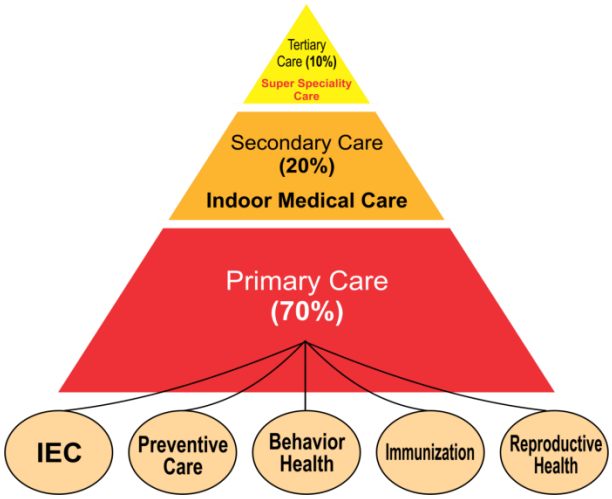



*Fig 1.2 Ideal expenditure Model by HLEG*

**Proposed plan for settlement of new Service Dispensaries and Empanelment of New IMP's**


***Map 1.2***

Service Dispensary should be located in the area where there are concentrated pockets of IPs.

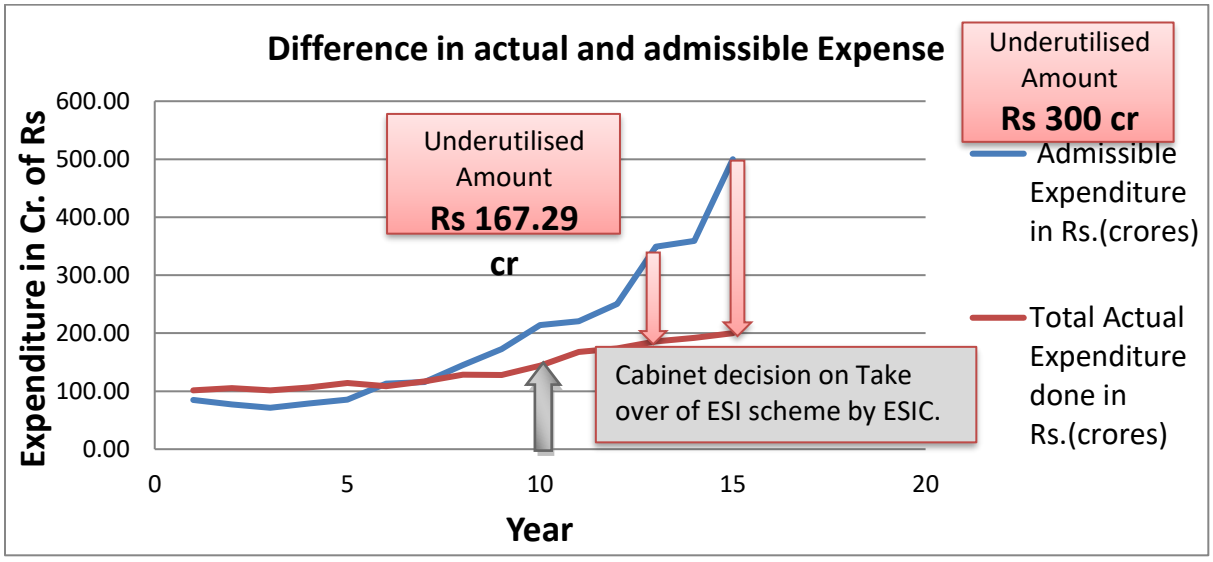
Preferably along the three train routes; Central, Western and Harbor Lines for easy approach.

The service dispensaries should have local office under the roof or in the premises. This will help in reducing overall costs and improve IP satisfaction.

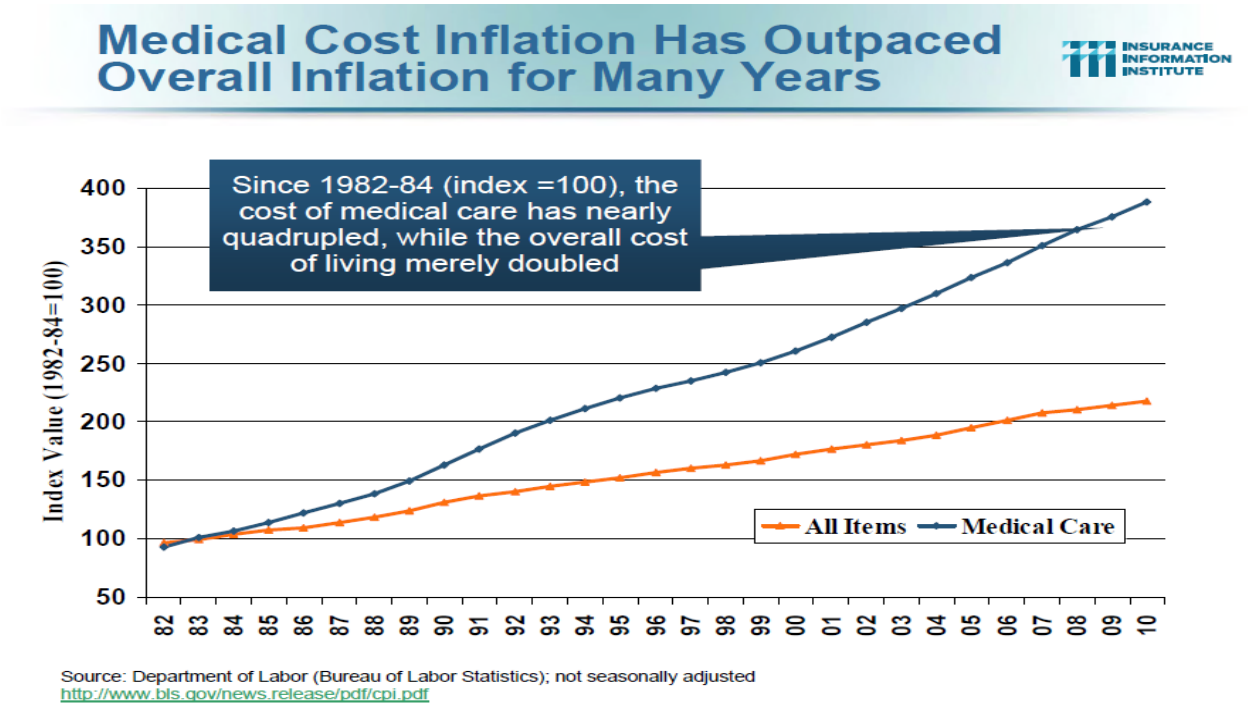
The financial expenditure on service dispensaries would be well within the ceiling limit. but the amount of benefits gained would be tremendous.

**Analysis :** To study utilization of medical benefits provided by ESI Scheme.

Analysis of admissible amount and actual expenditure shows that post cabinet decision in 2010 expenditure is constantly falling. The amount reached 300 Cr Rs in 2014-15.This suggest that expenditure per IP is Rs 1200 less dissolving the whole idea of quality care.




***Graph 1.6: Difference in Actual and Admissible Expenditure***




- Contribution from state of Maharashtra in the scheme is more than % of IP Population suggesting better wages in State of Maharashtra.

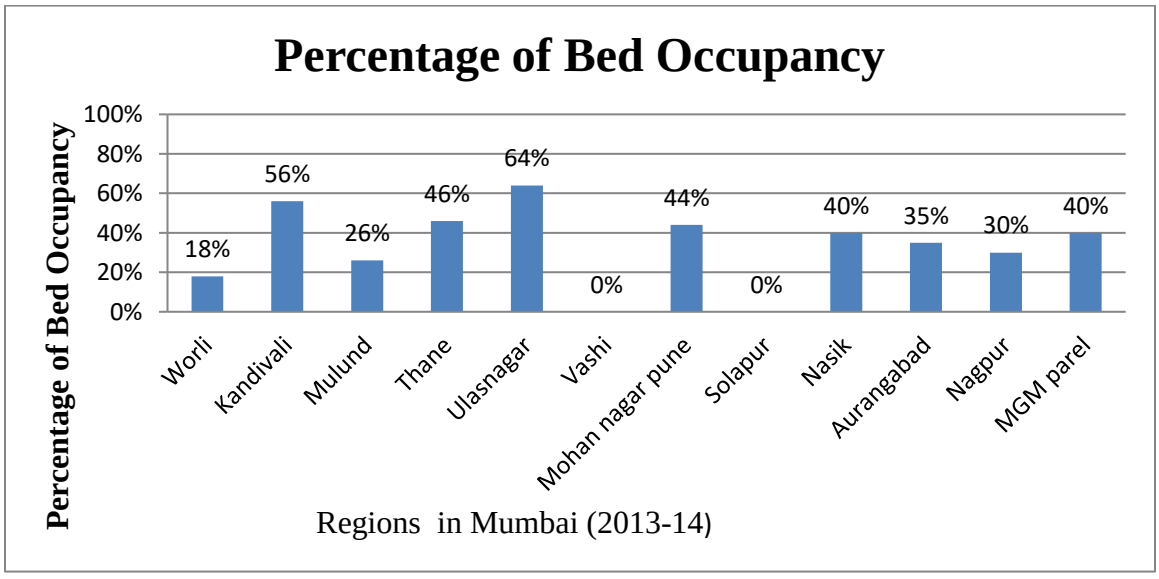
| Year | Contribution received by ESIC from Maharashtra IP's % | % of total IP's |
|---|---|---|
| 2008-09 | 19.10 | 13.34 |
| 2009-10 | 18.25 | 13.09 |
| 2010-11 | 17.18 | 11.83 |
| 2011-12 | 16.58 | 12.19 |
| 2012-13 | 16.16 | 12.52 |

***Table 1.5: Percentage contribution in total amount by IP***

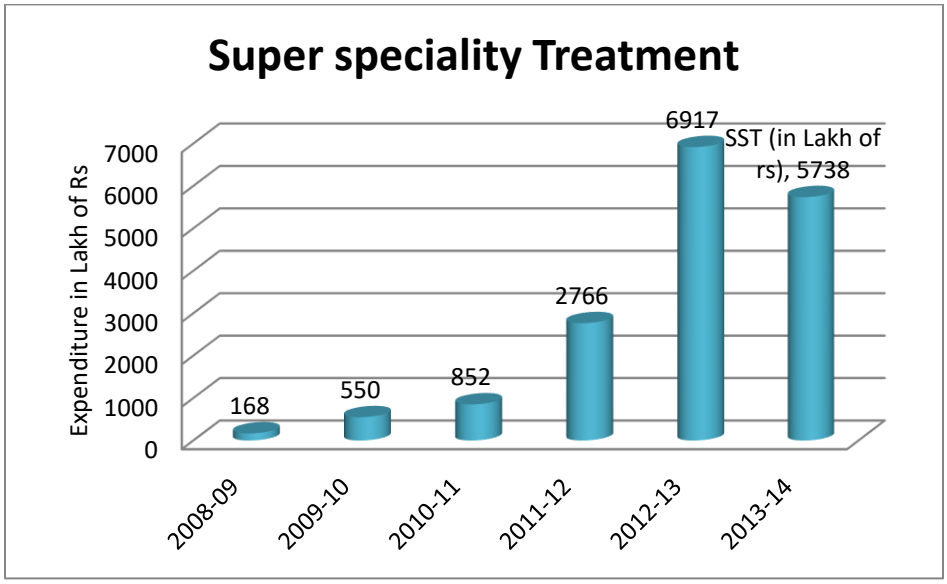
- Bed occupancy brings utilization of the hospital under the scheme into the limelight. ESIS beds are largely underutilized because of unavailability of specialty treatments and infrastructures required for the same. Average bed occupancy is 37% in 2011-12 which decreased to 33% in 2013-14.

| Hospitals | 2011-12 | 2012-13 | 2013-14 |
|---|---|---|---|
| Worli | 23% | 23% | 18% |
| Kandivali | 32% | 34% | 56% |
| Mulund | 37% | 38% | 26% |
| Thane | 47% | 77% | 46% |
| Ulasnagar | 48% | 49% | 64% |
| Vashi | 26% | 1% | 0% |
| Mohan nagar pune | 41% | 0% | 44% |
| Solapur | 35% | 0% | 0% |
| Nasik | 65% | 20% | 40% |
| Aurangabad | 27% | 26% | 35% |
| Nagpur | 36% | 37% | 30% |
| MGM parel | 33% | 33% | 40% |
| **Average Bed Occupancy rate** | **37%** | **28%** | **33%** |

***Table 1.5:Bed Occupancy in Different ESI Hospitals***




***Graph 1.7: Percentage of Bed Occupancy***




***Graph 1.8: Expenditure on SST***

ESIS has started with Super specialty Treatment (SST) to improve quality and utilization of services. Following graph depicts the same.

Even after certain efforts there are grievances regarding claim settlement and services offered under the scheme.

**Overall observations are:**

Government expenditure on health is not at par with the requirement considering the inflation which is 2-3% more than overall inflation; central government must contribute as the scheme caters to organized labor which is a subject of Concurrent list.

Even thought the expenditure is less, there exists a wide mouth gap between admissible and actual expenditure, actual expenditure is much less than the amount admissible. There is requirement of strategic planning for expenditure for improving service delivery by trained professional in the field of management.

The services in ESI hospitals are not improving reason being poor infrastructure.

IP are deprived of primary healthcare because of high opportunity cost .Expenditure on primary care must be improved to make the base of heath system stronger.

Maharashtra contribution to scheme is more than the number of IP's explaining the fact of better salary or remuneration to the organized sector of labor in state of Maharashtra.

The white paper report assumes increase in IP at 2-3 % whereas the actual no of increase % is around 10.

ESIS expenditure was constantly low for years, as the grant is given on the basis of expenditure of previous quarter. This is because of the pending cabinet decision since 2010 wherein ESIS hospitals are to be handed over to the ESIC.

**Possible Solutions:**

After cabinet decision of taking over of scheme by corporation ,no improvement is visible in the ESI services. This need to be sorted at priority for providing proper health care services to IP's.

There is duplication of services in name of CGHS,ESI, & RGJAY. These schemes can share resources for better service delivery.

Health camps can be organized at employer premises for improving no. of registered IP's.

There is a possibility of synergy with the Government health system for improving primary care. Employees at PHC can be incentivized for treatment of IP's on per IP basis.

ESI hospitals can be utilized by Non Beneficiary so as to decrease per patient cost on charging some user fee. This amount can be utilized for improvement in services for IP's.

**"Oxygen for Poor " Access to health care on analyzing RGJAY**

## Introduction:

Health care and related expenditures feature prominently as causes of impoverishment. In India, every year approx 3-4% people fall below poverty line because of OOP expense (G*upta 2009*). (*Noponen et al. 2004)* found an incidence of 1.2 monthly Illness per poor household in India. As per WHS 2011 ,74.4% of private expenditure is paid out of pocket for health care.( *Van Doorslaer et al. 2006)* found that an additional 78 million people in 11 Asian countries would fall below the extreme poverty line if conventional poverty estimates incorporated out-of-pocket expenditure for health. (*Heltberg and Lund 2009)* found that the costs associated with illness among the poor in Pakistan resulted in reduced food consumption, withdrawal of children from school, sale of major assets, putting children to paid work and even bonded labour, while only 12% were able to recover from the associated economic shock.
Within this context, a resolution to provide universal coverage— defined as access for all to appropriate promotive, preventive, curative and rehabilitative services at an affordable cost—was endorsed by World Health Organization (WHO) member states in 2005 *(Carrin et al. 2008).*
Rajiv Gandhi Jeevandayee Aarogya Yojana (RGJAY) is a unique Health Insurance Scheme made to meet the out of pocket health expenditure requirement of BPL / APL families for identified diseases. The scheme is implemented through effective use of IT based solution which is unique to the scheme in reaching out to the beneficiary. This scheme is functional across all 35 states of Maharashtra, since 21st November, 2013.
As the burden of untreated ailments is high amongst poor, it was expected that RGJAY would catapult the utilization of the inpatient services in this population group.

The paper is explicitly focused on the economically weaker families as they carry the brunt of barriers to health services.

## Methods

This is based on secondary data search of an existing framework for assessing access barriers to health services provided by Rajiv Gandhi Jeevandayee Yojana.
A retrogressive analysis is conducted on the data provide by the office of Jeevandayee and online database.

A search of the research database was conducted to identify published articles on access barriers to health services and the interventions designed to overcome them. Additional peer-reviewed or grey literature was identified from the reference lists of the retrieved papers.

These frameworks were combined and enriched by findings on barriers from the literature review to develop a more comprehensive structure capturing additional aspects that hinder access to care.

**Background of RGJAY:**

RGJAY covers 484 Hospital including both private and all government hospitals in Maharashtra. Hospital having at least 30 beds, functional ICU & requisite infrastructure and expertise are eligible and are entitled to provide 25% of their total beds to RGJAY patients.

The specialities covered under the scheme are 30 in number with 971 surgeries and therapies.

Health Camps are to be conducted in Taluka Head Quarters, Major Gram Panchayat and Municipalities.
The Insurance Company settles the claims of the hospitals online within 7 working days on receiving necessary documents. RGJAY provides Hospitalization coverage up to 1.5lakh Rs per family per annum. State government selects insurance company through open tendering process and technically qualified low bid is selected. Government pays premium amount of 333Rs to insurance company for each person enrolled. Hospitals are empanelled and reimbursed for inpatient care provided to enrolled household. The hospitals can be both public and private.

**Barrier To health care**

Access to health care can be defined as Utilisation of Services. Access to health care can be an underlying barrier for those who are suffering from chronic diseases. Access has four dimensions: availability, geographic accessibility, affordability and acceptability (O'Donnell 2007). Barriers to accessing health services can stem from the demand side and/or the supply side (Ensor and Cooper 2004; O'Donnell 2007).
They are tabulated underneath:

| Dimension of barriers (Peters et al. 2008) | Barriers (Ensor and Cooper 2004) |
|---|---|
| Geographic accessibility | ➢ Service location (S)<br>➢ Indirect costs to household (transport cost) (D)<br>➢ Household location (D) |

| | |
|---|---|
| Availability | ➢ Health workers, drugs, equipment (S) Waiting time (S)<br>➢ Demand for services (D) _ Wages and quality of staff (S)<br>➢ Price and quality of drugs and other consumables (S)<br>➢ Information on health care choice/providers (D)<br>➢ Education (D) |
| Affordability | ➢ Costs and prices of services (S)<br>➢ Direct price of service, including informal fees (S)<br>➢ Household resources and willingness to pay (D)<br>➢ Opportunity costs (D) |
| Acceptability | ➢ Characteristics of the health services (S)<br>➢ Management/staff efficiency (S)<br>➢ User's attitudes and expectations (D) Technology (S)<br>➢ Household expectations (D)<br>➢ Community and cultural preferences, attitudes and norms (D) |

Source: Adapted from Peters et al. (2008) and Ensor and Cooper (2004).
Notes: D¼demand side; S¼supply-side.

*Info & Enrolment*

The basic idea behind the scheme is to provide tertiary care to economically less efficient section of the society. As on 15 April 2015 there are 4.9 lakh (494238 )families are enrolled with the scheme. Total population of Maharashtra is 11Crore., out of which 2Crore families(21717478) fulfils the criteria of availing health care services(Source; Food and Supply department, Maharashtra last updated on 31.12.2014).This means that 19% of total population are entitled to receive benefits, But as of now only 2% of the entitled population are enrolled under the scheme, Signifying inequity in fund utilisation.

Out of all the enrolled members almost 92% seeks medical benefit. This can be also viewed as only those people enrol who are need treatment invariably or people gets information about the scheme only when they come to hospitals or get hospitalised. This means that many people who are not informed about the benefits of the scheme never report to hospital as cost is the biggest barrier.

*Registration*

Even after many efforts, cashless transfer ;total IPD+ OPD patient turnout under RGJAY is 76 % of the enrolled no. Creating concerns for the remaining 24% of the patients who in spite of No cost tertiary treatment never converts into actual patients.

Expenditure on private facilities is almost 2.5 times implying patient's preference towards private hospitals.

*Access:*

60% of the total empanelled hospitals are in west Maharashtra, Mumbai shares largest no of hospitals, as many as 68 .The density of this hospitals is as high as 1 hospital for every 14 km with speciality treatment, In contrast with the remaining 416 hospitals foe whole of the Maharashtra averaging to 1 hospital for every 740km.

This involves transportation and opportunity cost for the patients which are nowhere considered under the scheme.Women,Low Income patients and patients with lower heath status are more ikely to be in front of geographical barrier(**Illias-Ioannis Kyripoulus et al.2014*)

In terms of population 1 hospital for approx 73000 population for Mumbai which is much high for state i.e. 1 hospital for every 2.6 lakh population. Therefore there exists wide disparity in service delivery system.

The burden of cases is more in areas where there are less Hospitals empanelled. Underserved area includes Satara, Solapur,Raigad, Nanded,Dhule and Gadhcharoli districts of Maharashtra.

The need of RGJAY services are in districts where the scheme has less number of empanelled hospitals, exception to all this is Mumbai as it has many hospitals still there are significant no. of patients flooding in. Mumbai has more no. of patients because of referrals as most speciality treatment is not available across other hospitals associated with the scheme.

It is found that the age group of >65 years had undergone more than 12 lakh surgeries. This group requires special attention as they are the vulnerable section of society.

Other than access it is also identified that there is no mechanism of performance analysis for the empanelled hospitals Pay for performance (Janovsky et al. 2006) involves a

contractual arrangement with staff of a health unit to deliver certain health services to a specified target population in exchange for financial incentives. Performance-based financing can be utilised as a strategy to address all dimensions of barriers to access moreover it affects quality of care by motivating health care providers.
Further only 8 out of 969 hospitals are NABH Accredited which signifies the quality of care provided by the scheme.

**Discussion:**

A number of interventions appear to address all four dimensions of access barriers. Such interventions include community participation and community-based interventions, health equity funds, provision of essential services, improved management & pay-for-performance . Other interventions, such as social marketing, accreditation and emergency transport, touch upon only a various dimensions of access .
In India where context-specific cultural aspects have a substantial influence on access to health care, the framework requires adjustment prior to application so that these cultural factors are fully captured.

**Conclusion:**

Inequality in access to health care may deteriorate health status and further widen the gap especially for the less affluent section of the society. This imply consequence of adverse health expenditure in future.
Interventions for effectively reducing barriers to access will depend on the dimensions and aspects of the barriers to be tackled, their cultural and geographical context, the human and financial resources available.
Further studies are needed to assess the contextual factors that influence the effectiveness and efficiency of interventions designed to address access barriers, and to identify what combination of interventions may produce the optimum result .