A Torn and Tangled Safety Net?

Critical assessment of Performance of Employees State Insurance Scheme in Maharashtra

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About SATHI

SATHI is an action-research center of Anusandhan Trust (www.anusandhantrust.org) based in Pune. It has nationally pioneered health rights approaches in India since 1998, fostering accountability of public health system, private health sector and inter-sectoral community action through partnerships with civil society organisations.

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Preface

Until the second half of the nineteenth century states tended to play only a minimal role in social security. However, by the mid-nineteenth century, some Western European countries developed the first prototypes of the modern social security architecture. One of the important cornerstone of social security is worker's health insurance, it emerged in the early to mid-20th century, with precursors like "sickness insurance" and "industrial sickness funds" appearing in the late 19th and early 20th centuries.

In India, since 1952, the Employees State Insurance Scheme (ESIS) is one of the foundational pillars of social security system. It was envisioned as a comprehensive and inclusive system to provide healthcare and social protection to workers and their families—particularly those in the industrial and organised sectors.

This report focuses on Maharashtra, a leading industrial state that has the highest number of ESI-registered beneficiaries in the country. Yet, the promise of ESIS remains largely unfulfilled for a majority of its eligible population. In recent years, there has been growing concern that the scheme is falling far short of its potential, failing to respond to the real needs of the workers it is meant to serve. Despite workers' substantial contributions to the ESIS fund, access to quality healthcare, comprehensive services, and social security remains elusive for many.

It is in this context that SATHI undertook this critical assessment of the ESIS in Maharashtra. Through extensive research and field insights, this study attempts to unravel the gaps between the ESIS's true potential and its on-ground performance. By examining seven interrelated dimensions—ranging from policy frameworks and finances, to worker engagement, employer accountability, healthcare delivery, outsourcing, and governance structures—this report presents a comprehensive picture of how the scheme currently functions and where it falters.

Unfortunately, the findings of this study reveal a sobering picture of exclusion, inefficiency, and lack of accountability. The systemic underfunding of health services, exclusionary policies, weak state-level governance, and the marginalisation of workers and trade unions from decision-making have together transformed what was meant to be a worker-centric system into a fragmented and opaque bureaucracy. The situation is further exacerbated by the growing centralisation of power at the national level, and the broader neoliberal policy environment that privileges privatisation over public provision.

Despite these challenges, this report is not just an indictment. It is also a call to action. It offers concrete recommendations aimed at reforming the ESIS—through greater decentralisation, better fund utilisation, inclusion of currently excluded workers, and stronger participatory governance. We hope that this report will contribute meaningfully to policy dialogues, labour movements, and public debates on reclaiming the ESIS as a genuinely inclusive and accountable institution for workers' health and welfare.

ESIS is perhaps one of the last pinnacles of what civilised government can do for its workers, and therefore it must be protected and strengthened. It is time to reimagine and rebuild the ESIS system as a truly universal, participatory, and worker-owned model of social protection. This report is a step towards that vision.

Dhananjay Kakade
Director, Anusandhan Trust- SATHI

List of abbreviations

2D ECHO	Two-Dimensional Echocardiography
AIOIE	All-India Organisation of Industrial Employers
AMO	Administrative Medical Offices
ATM	Automated Teller Machine
CAG	Comptroller and Auditor General
CCU	Critical Care Units
CGHS	Central Government Health Scheme
CIS	Central Inspection System
CT	Computed Tomography scans
DCBO	Dispensary Cum Branch Office
ECG	Electrocardiogram
ENT	Ear, Nose and Throat
EPF	Employee's Provident Fund
ESI	Employees' State Insurance
ESIC	Employees' State Insurance Corporation
ESIS	Employees' State Insurance scheme
ETF	Exchange Traded Funds
GDMO	General Duty Medical Officer
GOI	Government of India
GR	Government Resolution
HR	Human Resource
ICU	Intensive Care Units
IEC	Information, Education and Communication
ILO	International Labour Organization

IMP	Insurance Medical Practitioner
IP	Insured Person
ISO	International Organisation for Standardisation
MIDC	Maharashtra Industrial Development Corporation
MO	Medical Officer
MoU	Memorandum of Understanding
MRI	Magnetic Resonance Imaging
MS	Medical Superintendent
NGO	Non-Government Organisation
NHS	National Health Service
NSSO	National Sample Survey Office
OOPE	Out Of Pocket Expenditure
OPD	Out Patient Department
OTP	One Time Password
PAC	Public Accounts Committee
PF	Provident Fund
PPP	Public Private Partnership
RMO	Resident Medical Officer
RO	Regional Office
SMAK	Shiroli Manufacturer's Association Kolhapur
SMS	Short Message Service
SST	Super Specialty Treatment

Executive Summary

The Employees' State Insurance Scheme (ESIS), instituted under the ESI Act of 1948, stands as a landmark in India's journey toward social security for various workers. Conceived as a comprehensive social protection framework to provide medical and cash benefits during illness, maternity, disability, or employment-related injury, the scheme has expanded over time in scale but continues to fall short of its promise in both breadth and depth—particularly in Maharashtra, which, despite being the state with the highest number of ESIS beneficiaries, exhibits some of the most serious shortcomings in coverage, access, quality of care, and governance. This report by SATHI team assesses the functioning of ESI hospitals and dispensaries across the state, with a focus on patient experiences, healthcare delivery, infrastructural deficiencies, and systemic inefficiencies.

The report is an outcome of an empirical study conducted using a health systems approach integrating qualitative and quantitative methods, including 81 interviews with key stakeholders, group discussions with 159 workers from diverse sectors, and observations from 11 ESIS hospitals across seven districts of Maharashtra. This research aimed to: (1) Evaluate healthcare service delivery quality across Maharashtra's ESI facilities, (2) Assess systemic bottlenecks affecting scheme implementation, and (3) Identify policy solutions to improve beneficiary outcomes.

Current implementation of ESI in Maharashtra reveals a fragmented, inadequately responsive and often exclusionary system. Despite over 1.8 crore beneficiaries in Maharashtra, the actual reach of ESIS is inadequate compared to the number of potentially eligible workers. The exclusion begins with the wage ceiling: the current eligibility limit of ₹21,000 per month excludes a majority of formal workers in Maharashtra's urban centres. Union organisers, workers, and even some officials argue that the cap should be raised to at least ₹50,000 to reflect real wages and living costs. The study exposes a stark mismatch—only about one-third of Provident Fund-contributing workers in the state are covered under ESIS, leaving out nearly 88 lakh workers who might otherwise be eligible.

Findings

Over-centralised governance, paradoxes of financing

Concerning governance, ESIS in Maharashtra is governed through a complex dual structure involving the central Employees' State Insurance Corporation (ESIC) and the State ESI Society. Despite the state's financial contribution (12.5%), Maharashtra government seems to have a peripheral role compared to the central body while taking key decisions concerning the scheme. Resulting hyper-centralisation fosters delays, weak accountability, and limits responsiveness to state-

specific needs. Even basic decisions—such as staff appointments or facility upgrades—are tied up in multi-tiered bureaucratic processes.

The financial picture of ESI adds a layer of paradox. Maharashtra state contributes over ₹2,700 crores annually to the ESIC, but only ₹997 crores were spent on healthcare for the state's insured persons (2022-23 figures). The national average medical expenditure per insured person stands at ₹3,557; Maharashtra's figure is less than half at ₹1,727. Despite substantial contributions from workers and employers in the state, ESI hospitals remain chronically underfunded. Delays in reimbursing empanelled private hospitals have discouraged their participation, limiting the scheme's reach. This scheme which has been envisioned as a social safety net, now appears below par in expanding its services and staff, and more concerned with maintaining central fiscal surpluses and speculative investment strategies, including recent shifts into equity markets.

Gaps related to worker awareness and enrolment, problems in employer engagement

Weak provision of essential information linked with low awareness among workers about the ESI scheme's benefits is a major concern. Most insured workers are only aware of basic OPD care, while sickness, disability, or maternity benefits are less known, and employers often do little to disseminate information. In many cases, ESIS enrolment is procedurally delayed or denied due to missing documentation, Aadhaar linkage requirements, confusing digital systems, and lack of handholding which further alienate workers from their entitlements.

Engagement of employers is variable, and evasion is common. Significant number of employers—particularly in the small and medium enterprises sector—either avoid registering workers, or under-report to escape contributions. The regulatory shift to a Central Inspection System (CIS) has inadvertently provided further leeway, with inspections requiring central clearance. Some employers appear to game the system by issuing artificial breaks in service, misclassifying wage payments as "honorariums," or outsourcing hiring to agencies that bypass ESI obligations. Contractual workers, especially sanitation staff and industrial labourers, are among the worst hit—excluded from ESIS coverage despite working in hazardous conditions.

Inadequate hospital infrastructure and staffing

At the ground level, ESI hospital infrastructure in the state is seriously inadequate. Maharashtra has only 15 ESIS hospitals for its 36 districts—eight of which are concentrated in Mumbai region. According to norms, the state should have over ESI 19,000 beds for its insured population; instead, only 1,580 beds are commissioned, and of these, less than half are functional. ICU services are virtually absent, and basic diagnostic services like X-ray or ultrasound are outsourced or unavailable. Workers and staff recounted experiences of leaking roofs, broken beds propped up on bricks, and rusted surgical instruments. New hospital projects remain unfinished years after being announced. Severe understaffing compounds the crisis. There is major shortage of doctors, nurses, and paramedics which has left ESI facilities understaffed, exacerbating the workload on existing personnel. Across ESIS facilities in Maharashtra, between 41% to 84% of positions for specialist doctors, nurses, and paramedical staff remain vacant, and large part of the existing doctors and staff are often engaged on temporary contracts.

Limited accessibility, high patient load, inadequate services

ESI facilities in Maharashtra, particularly in industrial hubs such as Mumbai, Pune, Thane, and Nagpur, grapple with patient overcrowding. The disproportionate ratio of beneficiaries to available hospital beds results in prolonged waiting periods and hurried consultations. Workers frequently encounter obstacles in accessing services, primarily due to limited operational hours at ESI dispensaries, which often fail to accommodate the schedules of shift workers. Geographic disparities

further exacerbate the issue, with rural and semi-urban areas suffering from a scarcity of ESI facilities, compelling workers to undertake lengthy travels for basic healthcare. Additionally, delays in securing referral approvals for specialized treatments force many to opt for costlier private alternatives, undermining the scheme's objective of affordable care.

Availability of the range of required services in most hospitals appears inadequate due to shortages of essential medicines and diagnostic equipment, often leaving patients with no choice but to procure them externally. Outdated medical equipment and deteriorating infrastructure plague older hospitals, further diminishing their capacity to deliver effective care. The inconsistent availability of doctors, particularly specialists, compounds the problem, as overburdened medical staff struggle to meet patient demands.

Administrative and systemic challenges, problems due to privatisation

Bureaucratic constraints pose a significant barrier to the scheme's effectiveness. Delays in issuing ESI cards and processing claims deter enrolment, while a pervasive lack of awareness among workers—especially migrant labourers—about their entitlements leaves many benefits unclaimed.

A worrying trend is the increasing outsourcing of healthcare by ESI to private empanelled hospitals. Patients encounter various problems in accessing care from empanelled private hospitals, attributed to cumbersome referral procedures and other factors. In Mumbai, private panel doctors attended to over twice the number of patients as ESIS-run facilities. While this arrangement might address some shortfalls in the short term, it also points to a systemic failure to strengthen public infrastructure. Moreover, private tie-ups are neither uniformly accessible nor transparently regulated. Diagnostic tests, tertiary care, and even basic consultations are increasingly referred out, pushing workers into private networks where out-of-pocket expenses continue to burden low-income families.

Recommendations for worker-centred transformation of ESI

To transform ESI in Maharashtra into a universal, worker-centred and demand-driven scheme, a sweeping overhaul is necessary at every level—from governance structures to service delivery. This transformation must combine overarching policy reforms with wide range of specific operational measures and active worker participation.

1. Demonstrate much stronger government will for ensuring ESI services and benefits for workers, launch a State-wide initiative for upgrading ESI in Maharashtra

Maharashtra government must initiate a broad-based, state-wide process for upgrading the ESI system involving the Labour and Health departments, trade unions, social organisations, workers, and employers. This effort should aim to deliver all promised benefits, drastically upgrade health services, and expand the scheme to cover all currently excluded workers. It must also include financial and administrative negotiations with the ESIC at the central level, to ensure majorly raised availability of resources and space for state specific initiatives.

2. Reverse imbalance in fund allocation and double the funding for ESI health services in Maharashtra

There is a pressing need to correct ESIC's skewed funding patterns related to Maharashtra by doubling the state's per insured person (IP) medical expenditure to at least ₹3500 in the current situation, and ensuring a minimum allocation of ₹3000 per IP—totalling ₹1335 crores annually at present. Current spending on medical care (₹997 crores in 2022–23) falls well below national standards and must be scaled up. Budget allocations must be demand-driven, not merely previous expenditure-based.

3. Expand ESI coverage to include all eligible workers

Under-coverage must be tackled by including workers with somewhat higher wage levels (above Rs 21,000 pm), as well as those who are being excluded due to being at the margin of organised and informal sector. Employers and ESI bodies should be accountable for registering all workers—especially contract workers. The wage ceiling of ₹21,000 should be removed, and the scheme must include contractual, and scheme-based government workers.

4. Majorly upgrade ESI healthcare infrastructure and appoint adequate regular staff

To meet service norms, ESI services must be majorly expanded to reach a ratio of 1 hospital bed per 250 workers and 1 dispensary per 5000 workers. Expanding ESI facilities in underserved industrial and occupational clusters, particularly in rural and peri-urban areas, is imperative. All sanctioned medical posts must be filled with permanent appointments, particularly specialists, with attractive salaries offered. Construction of newer buildings and maintenance of facilities must be prioritised, while ICU units must be fully operationalised in all hospitals. Extending dispensary operating hours to include evening OPDs would better accommodate the needs of workers and families.

5. Address problems related to referrals and reimbursements

The April 2023 order limiting referrals to public hospitals should be revoked. To ensure seamless healthcare for ESI beneficiaries, timely payments to private hospitals must be prioritized to prevent denial or delayed treatment. The referral system should be rationalised to avoid unnecessary outsourcing, and private tie-ups must be more stringently regulated for quality and accountability. The reimbursement process for non-empanelled hospitals should be streamlined, and regional offices should be strengthened with adequate, skilled staff to improve claim processing and operational efficiency.

6. Enhance awareness and delivery of social security benefits

Awareness campaigns must be scaled up to inform workers of all ESI related benefits. Processes like issuing medical certificates should be simplified. Workers should receive SMS notifications confirming ESIC contributions, similar to the Provident Fund system, to curb malpractice by many contractors and shifting employers.

7. Simplify documentation and eliminate procedural barriers for workers

Helpdesks and social workers should be deployed in all ESI facilities. A 24x7 helpline must be launched, and an ESI app launched to offer 'Know your ESIS rights' information while helping workers know about the nearby health facilities under ESIS, contribution tracking, and service availability. Workers should retain ESI registration independently of change in their employers, and Aadhaar-related glitches must be addressed.

8. Launch major publicity campaigns and strengthen worker-oriented accountability

At least 3% of the ESI budget must be allocated for widespread worker education and awareness efforts. There is need to develop a Marathi-language website with various types of service-related information and contact details of officials. Real-time data via mobile apps and revitalised governance bodies like Hospital Development Committees, Local Committees in every district, and Regional Boards will boost participation and accountability.

9. Promote worker empowerment and social audits

Broaden and democratise governance structures by setting up a State ESI Forum with wide representation from diverse trade unions and worker organisations, which could review scheme functioning as well as provide recommendations for improving the ESI system across the state. A regular system of worker-based monitoring of ESI services and facilities needs to be organised, linked

with activated HDCs and ESI Local committees. Worker committees in each area should be enabled to conduct periodic social audit of ESIS facilities and benefits.

10. Address key governance issues

It is important to resolve the dichotomy between ESIC and ESIS by creating convergence mechanisms, and oversight through bodies like an activated, expanded Regional Board and the proposed State ESI Forum. The state government must develop a wider, state level discourse about the essential role of ESI, with broad based involvement and strengthened ownership of ESI by all involved stakeholders.

11. Expand ESI to include informal workers in phased manner

ESI should extend benefits to sections of informal sector workers by proceeding in phased manner, starting with those categories which have a functional welfare board, which can provide regular employer contributions. Healthcare services of welfare board-covered workers should be merged with ESI, while retaining their other benefits. Contractual and scheme-based government workers must be included with employer contributions made by the government.

In short, this report underscores the urgent need for greater state government ownership, policy interventions, worker and stakeholder involvement, and increased, effective investment to rejuvenate Maharashtra's ESI system. Maharashtra must act decisively to reclaim ESI as a cornerstone of worker's health and social security, expanding its reach from the current 48 lakh insured persons to a much larger base. Structural reforms from above must be matched with mobilisation, monitoring and participatory inputs from below, to realise a truly transformative ESI for all workers.

Section 1

1.1 Introduction

The Employees' State Insurance (ESI) Scheme is India's oldest and most comprehensive social security programme for workers. Launched in 1952, it was envisioned as a model of contributory social insurance, providing protection to employees and their families in case of a range of health- and income-related vulnerabilities such as providing treatment for health conditions, income support during sickness, as well as benefits during maternity, disability and death due to employment injury. Over the decades, the ESI Scheme has evolved in scope and coverage, now extending its services to over 3.5 crore workers across the country.

Maharashtra is one of India's most industrialized states, having the highest number of ESI enrolled workers (over 48 lakh insured persons) in the country. With a diverse mix of large manufacturing hubs, small-scale industries, government agencies and a growing service sector, this state also leads the country in terms of number of employers enrolled under the ESI scheme (over 4.5 lakh employers). However, Maharashtra presents a major paradox since this state with highest ESI enrolment has lower number of commissioned ESI hospital beds than less populous states like Tamil Nadu, West Bengal and Karnataka, and its number of ESI beds are barely comparable to even much smaller states like Kerala, Haryana, and Delhi. Several such paradoxes make Maharashtra a key state for understanding how the scheme functions as well as falters on the ground, often failing to achieve its historic promise.

A study was undertaken to closely examine the implementation and functioning of the ESI Scheme in Maharashtra with focus on health services, and to identify systemic challenges that hinder its ability to optimally serve working people of the state. Drawing on large numbers of field visits, interviews with diverse stakeholders including ESI officials, doctors, insured persons, and staff as well as document reviews, this study offers a grounded and people-centric view of how the ESI system functions today. While ESI was conceived as a potentially universal social security programme which would be both protective and empowering, the picture that emerges from this inquiry is of decades of fragmented governance and policy neglect, resulting in a tangled and frayed safety net which has become detached from workers, and falls short of fulfilling its basic obligations.

Why this study?

Over the years, there has been limited scholarly engagement with the lived experiences of working people associated with ESI — especially from the perspective of diverse workers who depend on it, and grassroots union activists who support these workers. Although the ESI Corporation and

its regional bodies produce regular reports and data, this 'view from above' often fails to capture the realities on the ground. Maharashtra, with its large ESI-covered population and long history of implementation, can serve as a showcase for the scheme's functioning. However, the existing scattered reports and anecdotal evidence about ESI were found to be insufficient to shine a light into all corners of the reality, from diverse angles.

This study responds to such a gap in knowledge and the dissonance between policy and practice regarding ESI, treating the scheme in Maharashtra as a major example of the wider issues being encountered by this important programme across the country. Drawing upon particularly the voices of workers, trade union activists, field-level ESI staff, and medical personnel — and situating their testimonies within broader systemic analyses — this report hopes to catalyse both critical reflections, and much needed corrective action.

Structure of the report

The report starts with a **review of literature** which maps the existing scholarly, policy, and legal literature on ESI to contextualize the study within broader frameworks. Next are the **rationale and objectives** which explain the justification for this study, while articulating the main research questions and aims. This is followed by the **methodology** section which describes the design, sources, tools, locations, and analytical approach used for conducting the research. The next and largest section provides the **findings and discussion,** which describe the following interrelated aspects of ESI in Maharashtra -

- **Policy and structures -** examining how policies and institutional structures shape the ESI system's functionality.
- **Budgets and finances -** documenting financial flows, expenditures, and their implications for the ESI system, especially health service delivery.
- **Worker engagement –** dealing with the aspect of critical enrolment of workers, as well as their awareness, access, and usage of ESI benefits and processes.
- **Employer involvement –** looking into the roles played by employers concerning registration of workers under the scheme, their contributions, and compliance with the ESI framework.
- **Healthcare delivery by ESI facilities -** assessing the scale, coverage and functionality of health services provided directly by ESI institutions, especially ESI hospitals.
- **Outsourcing of healthcare services -** reviewing the trends, mechanisms, and critical impacts of private-sector involvement in ESI related healthcare in form of private hospitals, as well as empanelled individual practitioners (IMPs).
- **Governance processes -** analysing the articulation of Central (ESIC) and State level administrative mechanisms and decision-making structures, and the current status of participatory stakeholder engagement in ESI governance.

The final section consists of a range of **recommendations** – spanning a wide range of systemic, operational, and participatory measures aimed at transforming ESI in Maharashtra into an optimally effective, fully accessible, worker-centred and universally oriented scheme. This covers key domains such as financial restructuring, major expansion of coverage (including to informal workers), upgradation of infrastructure and staffing, streamlining of healthcare delivery and referrals, and strengthening participation, accountability and governance mechanisms.

Relevance of the study in light of ESI emerging trends

Today the more than 70-year old ESI scheme is in a state of flux, shaken by strong winds of privatisation, and facing increasing centralisation accompanied by implementation of top-down digitalisation. In this context, the voices and perspectives emerging

from this study can offer important alternative perspectives, relevant to not just Maharashtra but the entire country, about how ESI can be re-imagined and reclaimed by workers in the early 21st century.

Today ESI is increasingly relying on private providers and proposals to merge with PM-JAY, which risk shifting it towards a hospitalisation-focused, private sector-oriented model. In this context, the study documents views from various levels, which point towards credible alternatives to privatisation grounded in public health principles and participatory governance. The report documents numerous suggestions which argue that strengthening ESI's own infrastructure through an integrated approach can rejuvenate the scheme from within. This kind of approach can provide a much-needed roadmap to steer away from privatisation, and to reclaim ESI as a public, worker-centric institution.

This is linked with study's deep dive into the 'systemic disrepair' of ESI in Maharashtra—such as inadequate expansion of ESI facilities, broken referral systems and poor primary care access. There has also been high degree of centralisation of decision-making within ESIC, with increasing top-down control and reduced autonomy for regional offices, undermining responsiveness to local needs and ability to respond to grievances. Various informants in the study highlight the need to fix core governance and service delivery gaps, through ground-up reform and more decentralised governance of ESI, especially with greater ownership and initiative being taken at the state level, and rejuvenation of participatory committees.

Further this study documents the 'digital disempowerment' being observed due to the top-down push for digitisation which has often added layers of complexity for workers who generally have limited digital literacy. These include dense online forms and complicated registration procedures, along with insistence on 'Aadhar' linkages due to which many workers find themselves lost in the system. On the other hand, simple digital solutions focussed on workers like need for a user-friendly ESI app for workers have been ignored. While digital reforms claim to improve transparency, the ESI Society in Maharashtra is itself quite non-transparent, lacking even basic web presence, and detailed information about ESI at state level being inaccessible. This reality emphasised by the study underscores the need to actively promote user-centric platforms for accountability, like activation of participatory committees, locally anchored, effective grievance redressal systems and worker-based audits. The study provides an evidence base for prioritizing transparency, responsiveness, and worker agency while rebuilding ESI.

Overall, this study makes apparent that the entire ESI system is in urgent need of reform — not just through technological upgrades or piecemeal centralised orders, but through basic reorientation focussed on the public mandate and promise of ESI, linked with restoring the dignity and agency of lakhs of existing insured workers, and including many more who are eligible but are currently excluded from this important scheme.

We invite readers to engage with this report not only as a diagnostic tool, but as a call to action. The concerns documented here are not unique to Maharashtra; they reflect deeper systemic issues that afflict the ESI scheme across India. It is our hope that this report contributes to broad based conversations, advocacy initiatives and concrete reforms — moving towards an ESI system for all workers that is truly universal, accessible, and effective.

1.2 Literature review

Review of literature adopts a funnel-shaped structure[1], beginning with a broad overview of social security schemes globally, then in India, and narrowing to the specific case of the Employees' State Insurance Scheme (ESIS), tracing its emergence, evaluating its performance, and identifying research gaps.

History of social security

The International Labour Organization (ILO) defines, '*social security as the protection that society provides to individuals and households to ensure access to healthcare and income security, especially during old age, unemployment, sickness, disability, work-related injury, maternity, or the loss of a breadwinner'.* Social security is established as a basic human right through ILO conventions and UN instruments, though only a small proportion of the global population actually enjoys this right[2].

The origins of social security schemes trace back to the early 20th century and demonstrate the evolution of welfare mechanisms intended to offer economic protection to citizens[3]. Early instances of such protection date to ancient Egypt, Greece, and Rome, where community-based systems supported the poor, elderly, and disabled. In medieval Europe, religious institutions such as churches and monasteries provided similar aid. However, these were informal and lacked state-led structure or uniformity.

In the late 19th century, Germany became the first country to implement a formal social insurance system under Chancellor Otto von Bismarck in the 1880s. It included health insurance, accident insurance, and old-age pensions, designed particularly for industrial workers. Bismarck's model sought to build worker loyalty to the state and counter the rise of socialism. Around this time, debates in the United States revolved around social welfare due to the impacts of industrialization and the emergence of economically vulnerable worker classes.

The Great Depression of the 1930s underscored the urgent need for comprehensive welfare systems. In response, U.S. President Franklin D. Roosevelt enacted the New Deal, a series of interventions that culminated in the Social Security Act of 1935. This Act institutionalized a federal system aimed at securing the economic well-being of retirees and the unemployed.

1 Verrinder G, Talbot L. Turn a stack of papers into a literature review: Useful tools for beginners. 2008 Jan. Available from: https://www.researchgate.net/publication/266395957_Turn_a_stack_of_papers_into_a_literature_review_Useful_tools_for_beginners

2 International Labour Organization. Social security. Geneva: ILO; [cited 2025 Feb 10]. Available from: https://www.ilo.org/global/topics/social-security/lang--en/index.htm

3 Social Security History. [cited 2025 Feb 10]. Available from: https://www.ssa.gov/history/briefhistory3.html

The post-World War II period saw a global shift towards comprehensive welfare states. In the UK, the National Insurance Act of 1946 created a robust social security system that included health care, unemployment benefits, and pensions, paving the way for the National Health Service (NHS) in 1948. Meanwhile, Scandinavian countries established universal welfare models grounded in principles of equality and solidarity.

In the latter part of the 20th century, however, social security systems faced financial strain due to aging populations and increased life expectancy. Chile, for example, privatized part of its pension system, introducing individual retirement accounts. These reforms, although controversial, sparked global debates about the role and sustainability of publicly funded welfare[4].

Social security systems have thus transitioned from informal charitable practices to government-managed programs aimed at ensuring economic and health security during key life vulnerabilities. Yet, the systems continue to confront issues related to sustainability, equity, and adaptation to evolving labour markets.

Social security in India

Pre-colonial India functioned largely through self-sufficient village economies, and the absence of formal wage labour meant that social security was not a central concern. Traditional occupations were hereditary, and communities often took collective responsibility for welfare. British colonial rule, however, introduced industrialization, especially through the plantation economy in tea, coffee, and indigo, which generated employment but also exposed labourers to poor wages and conditions. This, alongside the rise of urban centres like Calcutta and Bombay, exacerbated insecurity among daily wage earners. Prior to independence, India had no structured national social security. The few welfare provisions that existed—such as the Factories Act, 1881 and the Workmen's Compensation Act, 1923—targeted specific sectors and were primarily introduced by colonial administrators.

After independence, the Indian Constitution of 1950 laid a foundational legal framework for social welfare. Articles 38, 39, 41, and 42 mandated the state to promote social justice and support the elderly, disabled, and workers. Legislation such as the Factories Act, 1948 regulated working conditions, health access, and leave entitlements, while the Minimum Wages Act was passed to curb workplace exploitation. The Employees' Provident Fund Act, 1952 further extended retirement security by mandating worker and employer contributions to a provident fund managed by a statutory organization.

Emergence of the Employees' State Insurance Scheme (ESIS)

The Employees' State Insurance Act, enacted in 1948, marked India's first structured social insurance law. It targeted the organized industrial workforce, offering protection against illness, disability, maternity, and workplace accidents. The ESIS laid the foundation for India's social security system and remains one of its cornerstones.

Efforts to draft this legislation began in 1942. Discussions between representatives of employers, workers, and Labour Member Feroze Khan Noon acknowledged the idea of an 'experimental' sickness insurance scheme. However, as Labour Ministers from the Provinces and several princely states refused to provide any financial support, the scheme was ultimately pushed into cold storage though provincial governments and princely states declined to co-finance the initiative[5]. In 1943, then Labour Minister B.R. Ambedkar announced the intent to introduce a social insurance bill.

4 Lurie L, Colas-Neila E, Ortiz PA. Social participation in pension systems and their reforms: Chile, Spain and Israel. *Rev Latinoam Derecho Soc*. 2021 Jun [cited 2025 Feb 10];(32):157–83. Available from: http://www.scielo.org.mx/scielo.php?script=sci_abstract&pid=S1870-46702021000100157&lng=es&nrm=iso&tlng=en

5 Ahuja R. A Beveridge Plan for India? Social Insurance and the Making of the "Formal Sector." *Int Rev Soc Hist.* 2019 Aug [cited 2025 Feb 10];64(2):207–48. Available from: https://www.cambridge.org/core/product/identifier/S0020859019000324/type/journal_article

Consequently, Prof. B.P. Adarkar was tasked with drafting a comprehensive plan. His 1944 report—presented at the Sixth Indian Labour Conference and later vetted by ILO experts—proposed a tripartite financing model and defined benefits such as medical care, sickness and maternity leave. This report shaped the final ESI Act passed in 1948.

Implementation faced significant employer resistance, primarily around four points: the compulsory nature of the scheme, financial obligations, administrative control by the state, and the scope of coverage. The All-India Organisation of Industrial Employers (AIOIE) formally opposed the Act in 1951, arguing for delayed implementation. Despite the resistance, the Act was rolled out in 1952 and became a bedrock of Indian labour welfare.

Although the ESIS was initially envisioned as a universal scheme, its coverage has remained limited. Prof. Adarkar had recommended a phased rollout, yet universal coverage did not materialize later. As of 2022, the scheme covers more than 34 million organized sector workers (7.5% of the workforce) and their families, totalling around 132 million beneficiaries (approximately 10% of the population)[6]. However, a 2022 ILO report highlights that 90% of India's workers remain in the informal sector, excluded from ESIS benefits[7]. This imbalance reflects a critical gap in extending social protection.

Performance of the scheme—Medical benefits

There is limited comprehensive evaluation of ESIS performance across all six mandated benefit categories, with even studies on medical benefits remaining sparse. Nonetheless, recurring audits by the Comptroller and Auditor General (CAG), insights from ESIC's annual reports, and ILO publications have consistently reported systemic issues. Over the past two decades, the scheme's scale has expanded dramatically—from 0.22 million enterprises in 1999–2000 to 1.03 million in 2018–2019, with covered employees rising from 7.86 million to 31.17 million[8]. However, these expansions have not translated into improved service delivery.

Financial issues, infrastructure and human resource shortages

Despite the accumulation of vast surpluses—Rs. 74,348 crores in 2017–18, with 70% unallocated[9]—expenditure on benefits remains low. The Public Accounts Committee (PAC) report noted the inefficiencies resulting from insufficient medical staff, outdated facilities, and protracted procurement processes[10]. CAG audits (2014) revealed a discrepancy of ₹556.59 crores between generated challans and actual receipts[11].

ESIC hospitals face a critical shortage of doctors and specialists, ranging from 19% to 44%. PAC reports cite poor planning and recruitment, leading to lack of operational ICUs and underutilized infrastructure in several hospitals, including those in Maharashtra.

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6 Employees' State Insurance Corporation. Annual Report 2022-23. [cited 2025 Feb 12]. Available from: https://www.esic.gov.in/attachments/publicationfile/6a02167823f5a1023787aa394eced3e6.pdf

7 International Labour Organization. Extending Social Health Protection to Informal Sector Workers. Geneva: ILO; [cited 2024 Dec 12]. Available from: https://www.ilo.org/secsoc/information-resources/publications-and-tools/Brochures/WCMS_175750/lang--en/index.htm

8 International Labour Organization. Accessing medical benefits under ESI Scheme: a demand-side perspective. Geneva: International Labour Organization; 2022 [cited 2025 Feb 12]. Available from: https://www.ilo.org/publications/accessing-medical-benefits-under-esi-scheme-demand-side-perspective

9 Prasad S, Ghosh I. Employee State Insurance Scheme: Performance and Potential Pathways for Reform. Dvara Research; 2020 Nov [cited 2025 December 24]. Available from: https://dvararesearch.com/employee-state-insurance-scheme-performance-and-potential-pathways-for-reform

10 PAC report on ESIS 2018-1916_Public_Accounts_115.https://eparlib.nic.in/bitstream/123456789/783920/1/16_Public_Accounts_115.pdf

11 Union_Performance_Ministry_Labour_and_Employment _30_2014.pdf. [cited 2025 Dec 12].Available from: https://cag.gov.in/uploads/download_audit_report/2014/Union_Performance_Ministry_Labour_and_Employment%20_30_2014.pdf

Low awareness among workers, underutilisation of Health services

ILO study indicates widespread lack of awareness about ESIS among workers. While 89% of respondents were familiar with medical benefits, only 46% knew about cash benefits and 32% about disability provisions[12]. This awareness gap significantly contributes to the underutilisation of the scheme[13].

The 2012–13 CAG audit reported low occupancy rates in ESIC hospitals, with two-thirds of facilities having less than 60% occupancy. In 2010–11, only 4.06 lakh hospitalisations and 2.34 crore outpatient visits were recorded, which is significantly lower than morbidity estimates from National Sample Survey Office (NSSO) data. For outpatient care, ESIS recorded 390 visits per 1,000 annually, compared to 45 per 1,000 in the general population. Annual hospitalisation rates stood at 6.8 per 1,000 (ESIS) versus 26 per 1,000 (NSSO)[14].

An ILO survey has noted that hospitalisation rates doubled from 1.3% in 1999–2000 to 2.8% in 2017–18. However, outpatient consultations fell from 609 to 208 per 1,000 beneficiaries, and diagnostic investigations declined from 37 to 15 per 1,000, reflecting inadequate expansion of services.

Out-of-Pocket (OOP) expenditure by ESI users

Despite theoretically comprehensive coverage, ESIS beneficiaries continue to incur costs. The average annual medical expenditure was Rs. 38,668 per household[15]. In Assam, many respondents reported dissatisfaction with lab services in ESIC facilities and opted for private diagnostics instead[16]. In Tamil Nadu, beneficiaries accessing private care without referrals incurred higher direct expenses than those with ESIC referrals[17].

Dependence on Private Providers

Outsourcing to private providers, especially for tertiary care, has increased. In Mumbai (2009–10), 52,203 outpatients were treated in ESIS facilities, compared to 1,29,447 in private clinics. For specialist care, 48,557 accessed ESIC hospitals while 63,195 turned to private alternatives[18]. Over 1,000 empanelled private hospitals now serve ESIS beneficiaries. A 2022 ILO study found that nearly half of hospitalisations occurred outside ESIC's own facilities. Spending on super-specialty treatments at private hospitals has surged due to limited capacity within ESIC hospitals.

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12 International Labour Organization. Accessing medical benefits under ESI Scheme: a demand-side perspective. Geneva: International Labour Organization; 2022 [cited 2025 Feb 12]. Available from: https://www.ilo.org/publications/accessing-medical-benefits-under-esi-scheme-demand-side-perspective

13 Dash U, Muraleedharan VR. How Equitable is Employees' State Insurance Scheme in India?: A Case Study of Tamil Nadu. Chennai: Indian Institute of Technology Madras; 2011. Report from the Consortium for Research on Equitable Health Systems (CREHS). [cited 2025 Jan 2]. Available from: https://assets.publishing.service.gov.uk/media/57a08acfe5274a31e00007b8/india_esis_12jul.pdf

14 Duggal R. Saving the Employees' State Insurance Scheme. *Econ Polit Wkly.* 2015 Apr 25 [cited 2025 Feb 12];50(17):17–20. Available from: https://www.jstor.org/stable/24481815

15 International Labour Organization. Accessing medical benefits under ESI Scheme: a demand-side perspective. Geneva: International Labour Organization; 2022 [cited 2025 Feb 12]. Available from: https://www.ilo.org/publications/accessing-medical-benefits-under-esi-scheme-demand-side-perspective

16 An Analysis of Satisfaction Level of the Beneficiaries on Availing Services of ESIC Dispensaries in Assam.pdf. [cited 2025 Jan 5]. Available from: https://www.worldwidejournals.com/indian-journal-of-applied-research-(IJAR)/recent_issues_pdf/2014/December/December_2014_1417445791__33.pdf

17 Dash U, Muraleedharan VR. How Equitable is Employees' State Insurance Scheme in India?: A Case Study of Tamil Nadu. Chennai: Indian Institute of Technology Madras; 2011. Report from the Consortium for Research on Equitable Health Systems (CREHS). [cited 2025 Jan 2]. Available from: https://assets.publishing.service.gov.uk/media/57a08acfe5274a31e00007b8/india_esis_12jul.pdf

18 Duggal R. Saving the Employees' State Insurance Scheme. *Econ Polit Wkly.* 2015 Apr 25 [cited 2025 Feb 12];50(17):17–20. Available from: https://www.jstor.org/stable/24481815

Patient satisfaction

Studies on patient satisfaction show mixed results. An ILO report found that only half of employees were satisfied with information on costs and reimbursement. Around 61% were satisfied with staff and medication access, and two-thirds rated the overall care positively, but only 47% expressed satisfaction with hospitalisation services[19]. In Nagpur, around half of respondents reported satisfaction with registration, pharmacy, and physician services[20]. Research in Haryana and Punjab found 80.68% satisfaction with outpatient services, while key complaints included inadequate medicine supply, doctor conduct, wait times, and staff behaviour[21].

ESIS in Maharashtra

With 1.89 crore beneficiaries in 2023–24, Maharashtra has the highest ESIS coverage nationwide. Nonetheless, 14 districts remain unnotified, leaving many workers uncovered. Healthcare quality is uneven and often poor. An ILO composite performance index ranked Maharashtra lowest among Indian states, with a score of 19.2. The state has also adopted the IMP system across multiple facilities, but no comprehensive evaluation of its effectiveness exists. Despite urgent policy concerns, detailed research into ESIS functioning in Maharashtra remains limited.

19 International Labour Organization. Accessing medical benefits under ESI Scheme: a demand-side perspective. Geneva: International Labour Organization; 2022 [cited 2025 Feb 12]. Available from: https://www.ilo.org/publications/accessing-medical-benefits-under-esi-scheme-demand-side-perspective

20 Deshmukh MA, Upadhye JJ. Patient satisfaction of outpatient department at ESIS hospital, Nagpur, India. Int J Res Med Sci. 2019 Feb 27 [cited 2025 Feb 12];7(3):918. Available from: https://www.msjonline.org/index.php/ijrms/article/view/5944

21 Goyal P, Singh N, Lukhmana S. Patient perception and satisfaction are prudent for assessment and improvement of hospital services: a cross sectional study among OPD patients at ESIC medical college and hospital, Faridabad, Haryana. Int J Community Med Public Health. 2017 Oct 25 [cited 2025 Feb 3];4(11):4165. Available from: http://www.ijcmph.com/index.php/ijcmph/article/view/1948

Section 2

2.1 Rationale and objectives

In response to the dearth of updated analysis on the scheme in Maharashtra, an empirical study was conducted using a health systems approach to assess the scheme's performance and related challenges in Maharashtra, with particular focus on medical services provided under the scheme. ESIS continues as India's main programme for providing comprehensive health and social security for working populations, including employees and their dependents from factories, shops, hotels, restaurants, transport etc. Earlier studies in a few states have reported partial coverage of healthcare and significant out-of-pocket expenditure related to ESIS, exposing its beneficiaries to health-related expenses. However recent, in-depth analysis of ESIS healthcare services is relatively sparse. Also, as mentioned earlier, there is dearth of research on situation of ESIS in Maharashtra state. The goal of the present study is to generate updated evidence regarding scheme functioning, while probing into underlying factors and dynamics responsible for current shortfalls. The study makes evidence-based recommendations regarding ESIS, towards upgrading health services and social security for the working population which could also provide valuable lessons for other states grappling with similar ESIS-related policy and implementation gaps.

Specific objectives:

1. To analyse trends in ESIS healthcare utilisation, budget allocation, expenditure, and geographic distribution of hospitals in Maharashtra over the past five years.
2. To assess the status of functioning of ESIS hospitals in terms of availability of key facilities and services in accordance with the defined objectives, understand related concerns, and identify systemic factors impact the scheme's effectiveness.
3. To examine the impacts and implications of outsourcing delivery of ESIS related healthcare services to private healthcare providers.
4. To derive key insights and recommendations for improving the design and implementation of ESIS healthcare services in Maharashtra, considering operational, financial, and policy dimensions.

2.2 Methodology

This study involves a cross-sectional, exploratory design with health systems approach, integrating both qualitative and quantitative methods. The qualitative enquiry of study was conducted in seven districts of Maharashtra namely, Solapur, Kolhapur, Nagpur, Aurangabad, Nasik, Mumbai, and Pune, covering different geographical regions of the state. While quantitative analysis of secondary data was conducted for the entire state.

Data collection

Data collection methods included four methods-a. qualitative interviews with key stakeholders, b. group discussions with workers, c. facility observations using a structured checklist, d. analysis of secondary data on ESIS utilization, budget expenditure, and geographical coverage in Maharashtra and e. expert consultations

In-depth qualitative interviews with key informants including hospital staff, medical officers, state officials, civil society representatives, workers' unions' representatives, employee associations' representatives, were conducted to gain insights into the key factors influencing the implementation of ESIS. Respondents were selected using a combination of purposive and snowball sampling method. In-depth interviews were conducted using an interview guide covering topics such as structure of the scheme, level of services from the scheme, issues in awareness of the scheme and registration of workers, and systemic challenges in the functioning of the scheme. These included budget, human resources, coordination between state and national level, availability of services and infrastructure, referral services and also policy level changes, issues at employer side, and impacts of changing formal sector on the scheme. Finally, respondents were encouraged to share their suggestions for improving functioning of the scheme. Interview guides were tailored based on profile of the respondent. Most of the interviews were conducted in Marathi, while some were conducted in Hindi or English based on convenience of the respondents.

An information sheet and informed consent form were provided in advance. The research aims and interview purpose were explained to potential respondents, who were then invited to participate. Interviews were conducted only after obtaining oral or written consent. Except for one, all the interviews were conducted in-person. Of the 81 interviews, audio recording was permitted by 55 respondents, while for the rest, detailed written notes were taken.

Profile of respondents

Category of respondents	Number
Unions and CSOs, experts/local politicians	17
Private company representatives- manager/head/HR	11
Private consultants to companies for ESIS	3
ESIS officers-state, sub- regional level officials and staff	12
State/National committee/board members	4
ESIS hospital/dispensary staff	8
ESIS hospital/dispensary doctors	22
IMPs	3
Total	**81**

With workers we conducted one to one as well as group interviews. Although initially planned as individual interviews, many sessions with workers evolved into group discussions, as workers from different sectors often gathered. This approach provided a broader perspective on the diverse challenges faced under ESIS, making group interviews a more effective method for data collection with workers. We interviewed ESIS-eligible workers from various sectors, including manufacturing, sanitation, service sector, bidi workers, chemical plant workers, security guards, solid waste pickers and the steel industry. Potential respondents were primarily identified through employee associations and trade union leaders. Using a structured interview guide, we covered key topics such as awareness and registration under the scheme, experiences with ESIS healthcare services, challenges in accessing care, and any employer-related issues. We conducted a total of 42 individual interviews and 13 group interviews with 117 workers, covering total of 159 workers.

For quantitative analysis, relevant secondary data were examined to assess trends in ESIS utilization, financial allocations, resources and service coverage across Maharashtra. Where available, selected parameters were also analysed at the national level. The main source of secondary data was national ESIS annual reports from the ESIC website, with analyses covering the past 5–10 years, depending on data availability. While the annual reports provided a wide range of data, information on key aspects such as expenditure on patients referred to private tie-up and non-ESIS hospitals, as well as costs related to referral services, was not available which limited the scope of analysis.

The facility observations using a structured checklist, were conducted in 11 out of total 15 ESIS/ESIC-run hospitals to assess availability of health services, certain resources, and infrastructure. Eleven hospitals from seven districts were included in the study based on cooperation of medical superintendent of the hospital.

District wise number of hospitals included in the facility observation

Name of district	Number of Hospitals
Solapur	1
Kolhapur	1
Nasik	1
Nagpur	1
Aurangabad	1
Pune	2
Mumbai Metropolitan Region	4
Total	**11**

After completion of the data collection, we conducted two consultations with experts (around 10-15 participants in each) including trade union representatives, ex-ESIS officials and academics to share and validate preliminary findings, as well as to brainstorm on the draft recommendations covering policy, operational and budgetary aspects.

Data analysis

Interview recordings from qualitative interviews were verbatim transcribed. Written notes and verbatim transcripts were anonymised and coded in RQDA of R software. An initial set of codes was developed based on the interview guides which was then expanded with codes emerging from the transcripts. Codes were systematically grouped into categories and themes for analysis. Quantitative data were compiled and analysed using MS excel. A thematic analysis of the qualitative data informed the development of an analytical framework, which was used to integrate and present findings from both qualitative and quantitative sources.

Ethical approval

Ethical approval (Ref: IEC35/2024) for the study was taken from Institutional Ethics Committee of Anusandhan Trust.

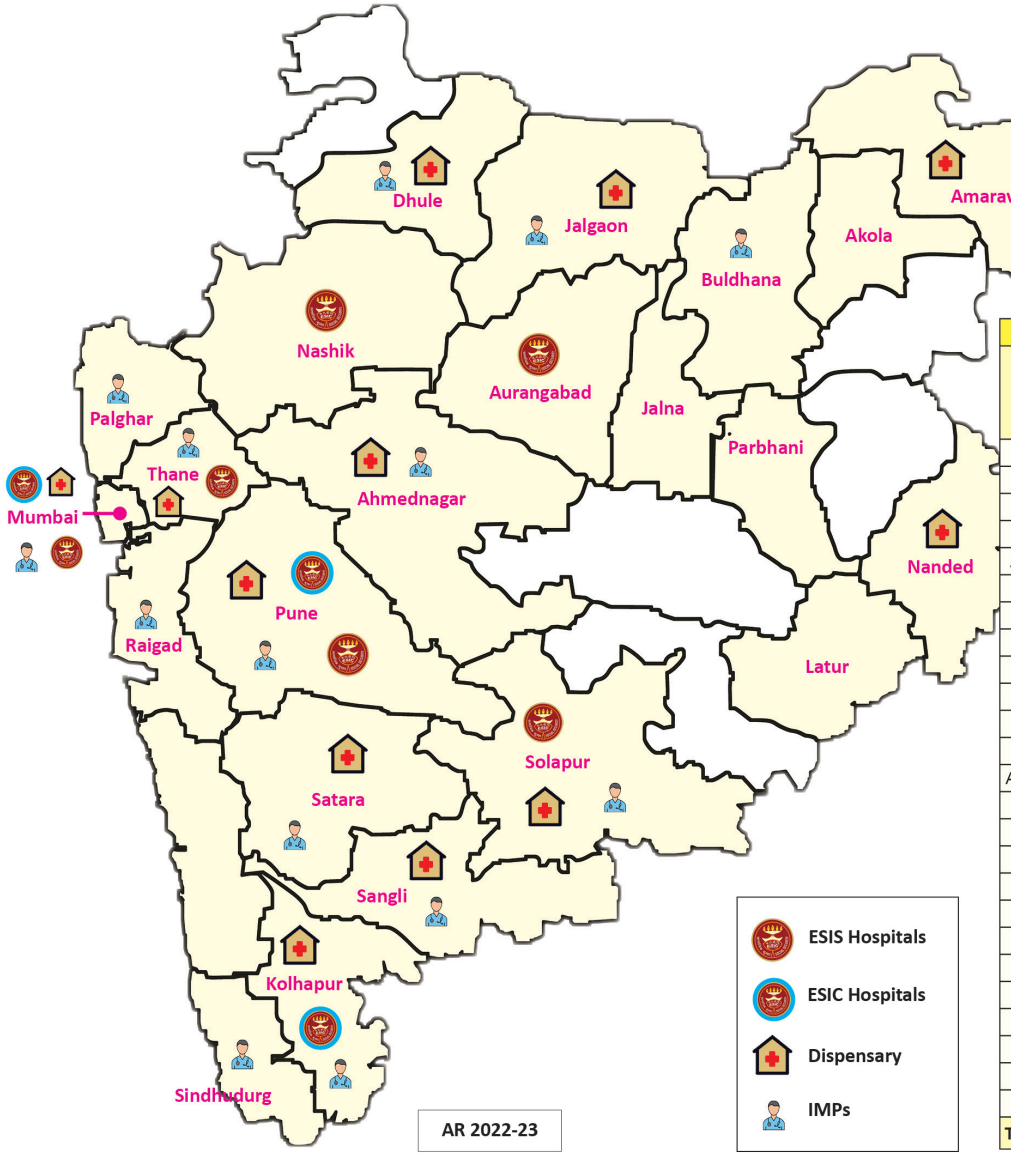
Limitations in accessing the data

The main source of secondary data for this study were the annual reports and other documents available on the national ESIC website. While these reports contain significant information, certain key data were unavailable. Specifically, we could not obtain a detailed breakdown of the budget and expenditure on various medical and non-medical benefits of the scheme, the number of patients treated in private tie-up hospitals versus ESIS-owned hospitals, and the number of IPs registered with IMPs. Also, annual reports lack uniformity in the data availability as they offer data for some indicators region wise, for some indicators it is hospital wise, and some indicators are given state wise. None of the data in public domain provides details of outsourcing of diagnostic services to private agencies and expenditure on the same.

At the state level, critical data gaps were encountered. We could not access year-wise details concerning ESIS Maharashtra on the budget demanded and budget received from ESIC, and expenditures made. Additionally, data on scheme utilization in notified districts/regions—such as the number of referrals to private hospitals, as well as OPD and IPD patients treated in various ESIS hospitals, dispensaries, IMPs, tie-up private hospitals, and non-tie-up private hospitals—were not publicly available.

As of now, there is no separate website for ESIS Maharashtra. Despite requests to the ESIS society at the state level, requested information was not provided. Instead, it was conveyed that the state government has finalized a private agency to manage such activities, and therefore, they were unable to furnish the data. As a result, we were unable to include data analysis of certain aspects of the scheme in our study.

Districtwise ESIS/C Hospitals/ Dispensary / IMPs in Maharasthra



Districtwise List of ESIS/C Hospitals/ Dispensary / IMPs in Maharasthra

Districts	ESIS/C Hospitals	Dispensary	IMPs	Secondary Tie-up Private Hospitals	Tertiary / SST Medical Care Private Hospitals
Pune	2	14	162	20	20
Mumbai	5+1	11	198		12
Thane	2	7	105		14
Nagpur	1	1	4	8	19
Aurangabad	1			4	10
Nashik	1			6	8
Kolhapur	1	19	19	23	13
Solapur	1	11	9	4	3
Palghar			42	6	1
Raigad			18	15	7
Satara		16	15	6	3
Sangli		9	9	15	6
Ahmednagar		9	9		3
Jalgaon		3	3	11	10
Sindhudurg			2		
Buldhana			1	3	
Dhule		2	1		1
Akola			1		
Amravati		1		5	1
Gondia				1	1
Nanded		1			1
Wardha		1			1
Jalna					1
Latur					1
Parbhani					1
Total	**15**	**105**	**598**	**127**	**137**

ESI in India at a glance

	2012	2013	2014	2015	2016	2017
State / Union Territories covered	**29**	**30**	**31**	**31**	**33**	**33**
ESI Hospitals	150	151	151	151	151	151
Branch Offices / Pay Offices	627 / 177	624 / 184	627 / 185	627 / 185	628 / 185	630 / 185
ESI Dispensaries / ISM Units	1372/91	1384/27	1418/140	1459/188	1467/159	1489/174
Insurance Medical Practitioners (IMP)	**1380**	**1227**	**1017**	**954**	**948**	**950**
No. of Employers covered	5,80,028	6,66,161	6,69,880	7,23,756	7,83,786	8,98,138
No. of Employees	1,63,48,908	1,65,04,500	1,74,12,130	1,79,54,970	1,89,21,250	2,93,21,060
No. of Insured persons/ Family Units	1,71,00,958	1,85,82,000	1,95,47,620	2,03,43,800	2,13,61,880	3,19,62,910
No. of Insured Women	24,07,302	26,79,552	29,22,345	33,60,697	37,86,827	40,89,773
% Insured Women	14.1	14.4	14.9	16.5	17.7	12.8
Total Beneficiaries	6,63,51,717	7,20,98,160	7,58,44,766	7,89,33,944	8,28,84,094	12,40,16,091
Average beneficiaries per family unit	**3.88**	**3.88**	**3.88**	**3.88**	**3.88**	**3.88**
India at a glance	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
State / Union Territories covered	**34**	**34**	**35**	**35**	**35**	**35**
ESI Hospitals	151	154	160	160	160	161
Branch Offices / Pay Offices	630/185	608 / 185	559 / 185	592/68	598/89	606/96
ESI Dispensaries / ISM Units	1500/48	1500/48	1520/307	1502/308	1502/329	1574/387
Insurance Medical Practitioners (IMP)	**980**	**980**	**1287**	**1182**	**1003**	**927**
No. of Employers covered	10,33,730	12,11,174	12,36,565	14,82,125	15,94,083	20,83,340
No. of Employees	3,11,18,680	3,14,01,920	3,09,66,930	2,46,72,150	2,78,62,710	3,05,42,660
No. of Insured persons/ Family Units	**3,43,31,300**	**3,49,67,080**	**3,41,44,140**	**3,39,19,370**	**3,10,20,570**	**3,42,97,410**
No. of Insured Women	45,42,029	51,20,174	62,65,035	61,63,406	58,69,434	67,60,814
% Insured Women	13.2	14.6	18.3	18.2	18.9	19.7
Total Beneficiaries	13,32,05,444	13,56,72,270	13,24,79,263	13,16,07,156	12,03,59,812	13,30,73,951
Average beneficiaries per family unit	**3.88**	**3.88**	**3.88**	**3.88**	**3.88**	**3.88**

ESI in Maharashtra at a glance

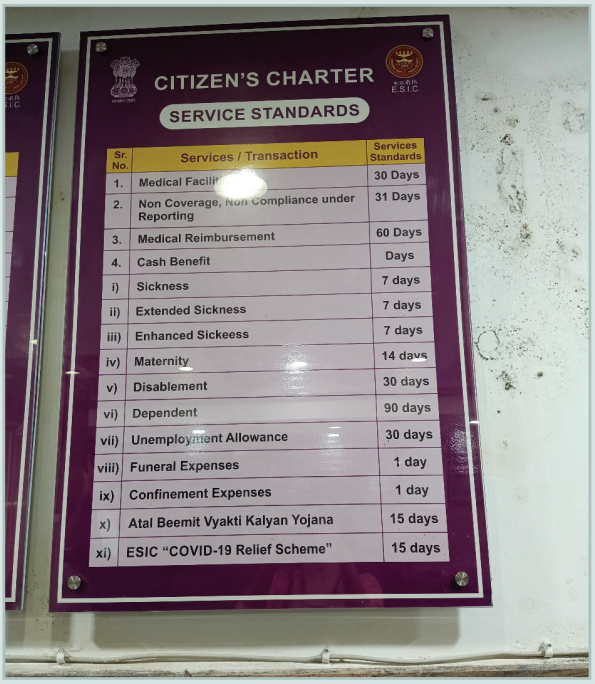
	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
ESIS state run hospitals	12	12	12	12	12	12
ESIC (corporation run) hospitals	2	2	2	2	2	3
Dispensaries	72	69	64	64	64	65
IMPs	724	522	501	501	501	501
No. of sanctioned beds	2943	2943	2913	2913	2938	2938
No. of commissioned beds						
Total Employers	1,03,021	1,03,004	1,09,562	1,16,017	1,30,023	1,48,258
No. of Employees	25,05,575	24,53,415	24,35,492	26,11,735	40,25,710	41,69,800
No. of IPs/ Family (IP) Units covered	23,95,800	23,45,340	23,51,860	24,00,290	43,58,990	45,94,170
Total No. of Beneficiaries	92,95,704	90,99,919	91,25,216	93,13,125	1,69,12,881	1,78,25,381
Average beneficiaries per family unit	3.88	3.88	3.88	3.88	3.88	3.88
Total Expenditure of State Govt./UT on ESI Scheme (₹ in lacs)	18,513	30,375	19,373	13,394	20,063	19,431
Total Expenditure (₹ in lac)	35,821	68,346	28,011	58,580	36,283	38,779
Total per Capita expenses (In Rs)	1517	2883	1193	2441	1074	866

	2018-19	2019-20	2020-21	2021-22	2022-23
ESIS state run hospitals	12	12	12	12	12
ESIC (corporation run) hospitals	3	3	3	3	3
Dispensaries	65	65	62	68	104
IMPs	501	501	817	611	563
No. of sanctioned beds	2938	2390	2630	2980	2980
No. of commissioned beds				1590	1580
Total Employers	1,76,934	1,77,692	2,20,263	2,35,640	3,19,206
No. of Employees	43,64,470	43,05,660	31,14,170	35,87,100	39,99,870
No. of IPs/ Family (IP) Units covered	48,47,980	46,98,620	46,77,460	39,90,490	44,55,490
Total No. of Beneficiaries	1,88,10,162	1,82,30,646	1,81,45,544	1,81,45,544	2,02,87,301
Average beneficiaries per family unit	3.88	3.88	3.88	4.55	4.55
Total Expenditure of State Govt./UT on ESI Scheme (₹ in lac)	23,642	24,180	26,796	46,086	33,251
Total Expenditure (₹ in lac)	42,392	57,473	63,219	82,253	72,913
Total per Capita expenses (In Rs)	898	1204	1349	1898	1727

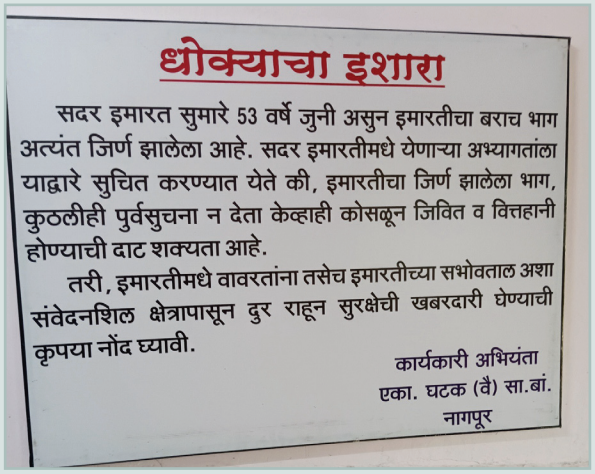
ESIS dispensary is operating in a rented space at Nagpur

Construction of the 500-bedded ESIC Hospital at Butibori MIDC, Nagpur, has been in progress since 2019

ESIS dispensary is operating in a rented space



Citizen charter displayed at ESIC branch office

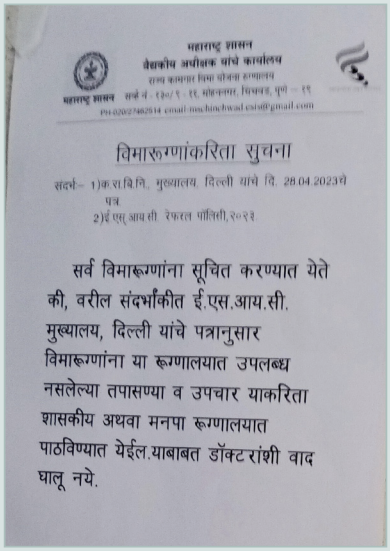


Warning boards cautioning about the risks of entering the building, due to its poor condition, are displayed at ESIS Hospital

Aadhar seeding kiosk at one of the ESIC hospital

Store room with garbage at ESIS hospital

Entrance of one of the ESIS hospital in Mumbai



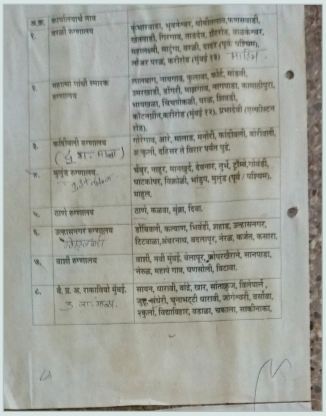
महाराष्ट्र शासन
वैद्यकीय अधीक्षक यांचे कार्यालय

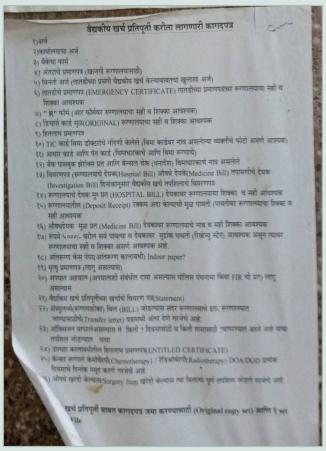
विमारूग्णांकरिता सुचना

संदर्भ– 1)क.रा.वि.नि. मुख्यालय, दिल्ली यांचे दि. 28.04.2023चे पत्र
2)ई.एस.आय.सी. रेफरल पॉलिसी,२०२३

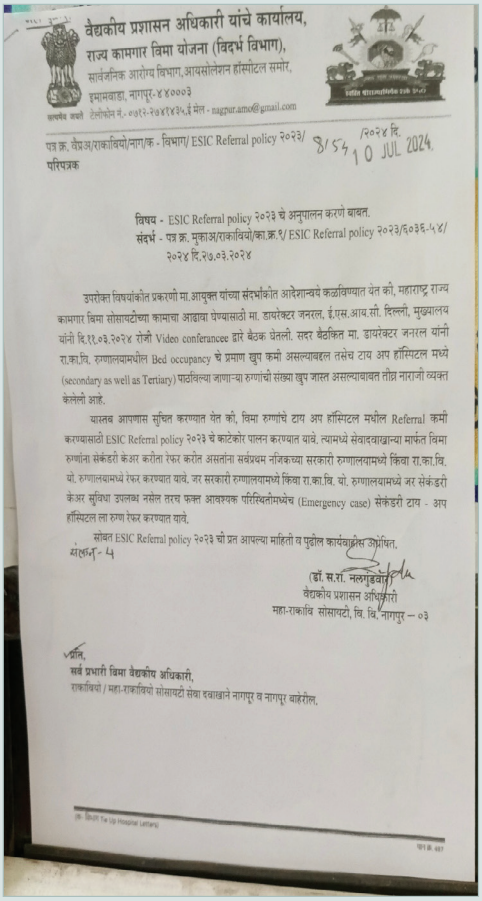
सर्व विमारूग्णांना सूचित करण्यात येते की, वरील संदर्भांकीत ई.एस.आय.सी. मुख्यालय, दिल्ली यांचे पत्रानुसार विमारूग्णांना या रूग्णालयात उपलब्ध नसलेल्या तपासण्या व उपचार याकरिता शासकीय अथवा मनपा रूग्णालयात पाठविण्यात येईल.याबाबत डॉक्टरांशी वाद घालू नये.

Construction of the 500-bedded ESIC Hospital at Butibori MIDC, Nagpur, has been in progress since 2019





A notice displayed at one of the hospitals in Mumbai provides an area-wise list of hospitals for submitting ESI claims, along with the list of required documents—printed informally on a plain A4 sheet



वैद्यकीय प्रशासन अधिकारी यांचे कार्यालय,
राज्य कामगार विमा योजना (विदर्भ विभाग),
सार्वजनिक आरोग्य विभाग, आयसोलेशन हॉस्पिटल समोर,
इमामवाडा, नागपूर-४४०००३

विषय - ESIC Referral policy २०२३ चे अनुपालन करणे बाबत.
संदर्भ - पत्र क्र. मुकाअ/राकावियो/का.क्र.९/ ESIC Referral policy २०२३/६०३६-५४/ २०२४ दि.२७.०३.२०२४

उपरोक्त विषयांकीत प्रकरणी मा.आयुक्त यांच्या संदर्भांकीत आदेशान्वये कळविण्यात येत की, महाराष्ट्र राज्य कामगार विमा सोसायटीच्या कामाचा आढावा घेण्यासाठी मा. डायरेक्टर जनरल, ई.एस.आय.सी. दिल्ली, मुख्यालय यांनी दि.११.०३.२०२४ रोजी Video conferanceद्वारे बैठक घेतली. सदर बैठकित मा. डायरेक्टर जनरल यांनी रा.का.वि. रुग्णालयामधील Bed occupancy चे प्रमाण खुप कमी असल्याबद्दल तसेच टाय अप हॉस्पिटल मध्ये (secondary as well as Tertiary) पाठविल्या जाणाऱ्या रुग्णांची संख्या खुप जास्त असल्याबाबत तीव्र नाराजी व्यक्त केलेली आहे.

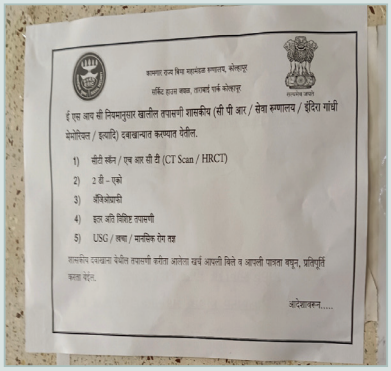
यास्तव आपणास सुचित करण्यात येत की, विमा रुग्णांचे टाय अप हॉस्पिटल मधील Referral कमी करण्यासाठी ESIC Referral policy २०२३ चे काटेकोर पालन करण्यात यावे. त्यामध्ये सेवादवाखान्या मार्फत विमा रुग्णांना सेकेंडरी केअर करीता रेफर करीत असतांना सर्वप्रथम नजिकच्या सरकारी रुग्णालयामध्ये किंवा रा.का.वि. यो. रुग्णालयामध्ये रेफर करण्यात यावे. जर सरकारी रुग्णालयामध्ये किंवा रा.का.वि. यो. रुग्णालयामध्ये जर सेकंडरी केअर सुविधा उपलब्ध नसेल तरच फक्त आवश्यक परिस्थितीमध्येच (Emergency case) सेकेंडरी टाय - अप हॉस्पिटल ला रुग्ण रेफर करण्यात यावे.

सोबत ESIC Referral policy २०२३ ची प्रत आपल्या माहिती व पुढील कार्यवाहिस अग्रेषित.

(डॉ. स.रा. नलगुंडवार)
वैद्यकीय प्रशासन अधिकारी
महा-राकावि सोसायटी, वि. वि, नागपूर – ०३

प्रति,
सर्व प्रभारी विमा वैद्यकीय अधिकारी,
राकावियो / महा-राकावियो सोसायटी सेवा दवाखाने नागपूर व नागपूर बाहेरील.

A notice displayed regarding the preference for referrals to government hospitals, in accordance with the ESIC Referral Policy, 2023



कर्मचारी राज्य विमा महामंडळ रुग्णालय, कोलकाता

ई एस आय सी नियमानुसार खालील तपासणी शासकीय (सी पी आर / सेठ रुग्णालय / इंदिरा गांधी मेमोरियल / हल्दीए) दवाखान्यात करण्यात येतील.

1) सीटी स्कॅन / एच आर सी टी (CT Scan / HRCT)
2) 2 डी – एको
3) ऑंकोलॉजी
4) इतर अति विशिष्ट तपासणी
5) USG / लघवी / मानसिक रोग तज्ञ

आदेशानुसार.....

A notice is displayed at ESIS Hospital regarding the referral of patients to government hospitals for diagnostic tests.

Section 3
Findings and discussion

The findings and analysis have been structured across seven interconnected dimensions: policy and structures, budgets and finances, worker engagement, employer involvement, healthcare delivery by ESI facilities, outsourcing of healthcare services, and governance processes, addressing both policy and implementation-level concerns.

3.1 ESI policies and operational structures

3.1.1 Eligibility criteria and related exclusion

Vast numbers of workers in Maharashtra who are eligible to be covered by ESI and should receive medical and social security benefits are being left out due to the exclusionary approach of the ESI system at various levels, which seems to be driven from the top. The huge scale of under-coverage can be estimated by the fact that in 2023, there were over 1.32 crore workers and employees in Maharashtra who contributed to the Employees' Provident Fund (although even this scheme does not cover all workers), but only 44.5 lakh workers were enrolled under ESI. Effectively, only one-third of EPF (Employees Provident Fund) -contributing workers are currently covered by ESI, which means the ESI scheme might need to be expanded threefold to cover almost 88 lakh additional workers linked with the organized sector in Maharashtra. One major reason for the exclusion of workers is the criteria with the exclusionary wage or salary ceiling for ESIS. The current salary ceiling of ₹21,000 per month excludes millions of workers from ESI, limiting their access to the benefits of the scheme. The decision to raise the salary cap for beneficiaries to ₹21,000 per month from ₹15,000 was made in 2016. The table shows the increase in the wage ceiling over the past 20 years.

Table 1: Increase in wage ceiling over the 20 years[22].

From Rs 3000 to Rs 6500	Effective 1 January 1997.
From Rs 6500 to Rs7000	Effective 1 April 2004.
From Rs 7500 to Rs 10000	Effective 1 October 2006.
From Rs 10000 to Rs 15000	Effective 1 May 2010.
From Rs 15000 to Rs 21000	Effective 1 September 2016.

22 TeamLease. ESIC raises wage threshold to Rs 21,000; aims to add 50 lakh workers [Internet]. TeamLease. 2016 Sep 1 [cited 2024 December 7]. Available from: https://group.teamlease.com/esic-raises-wage-threshold-to-rs-21000-aims-to-add-50-lakh-workers/

In many parts of the state, the majority of workers earn salaries exceeding ₹21,000, surpassing the ESI salary cap. As a result, most of them have been excluded from the ESI scheme. Additionally, city-wise disparity in salaries has not been considered. For example, the prevailing salary range in Pune may range from ₹30,000 to ₹35,000, while in Solapur it could be ₹15,000 for the same job profile. As shared by different trade union leaders, very few workers earning below ₹21,000 are part of the union and ESI members. As a result, the union's ability to leverage its influence on ESI to implement certain changes is gradually weakening.

Workers believe that, with the increase in their salaries, they should still be entitled to ESI benefits, as they cannot afford private hospital expenses. For instance, a waste-picking woman worker's experience, as shared by an official (E42, Local official):

"Her salary was raised from ₹21,000 to ₹21,200, and as a result, the contractor informed her that she was no longer eligible for ESI coverage. She has hypertension and diabetes and relies on ESI for her medications. While she desires a higher salary, she does not want to lose ESI benefits, as her monthly medical expenses amount to ₹2,000–₹3,000. The benefit for her is that even if she doesn't use other ESI services, she at least gets OPD consultations and medicines. Given her household situation, where no other family members are earning, this support is crucial for her" (woman waste picker experience).

It was shared that a person earning ₹20,000 per month has an annual income of ₹2,40,000. With two children, education expenses, living costs in a city, and necessities like vegetables, oil, and water, this amount is insufficient. One cannot bear medical expenditure from this, which is why we stated that the existing limit is not suitable for workers' (E45, Advocate associated with trade union, Kolhapur).

Nearly all the respondents mentioned the need for raising the salary cap for ESI, with proposals of at least ₹50,000 per month as the ceiling, so that much larger number of workers requiring these entitlements can be covered under the scheme.

Some union leaders also mentioned their efforts to raise the wage ceiling by sending letters to higher authorities and raising the issue in board meetings.

While the need to raise the wage ceiling and the need for ESIS coverage for workers has been highlighted by different stakeholders, a segment of workers, as reported, prefers to exit the ESIS slab so they can obtain private health insurance coverage. Upon further probing, it appeared that the main reason for this preference is that they believe private health insurance is better. Additionally, private insurance companies attract workers by promising benefits like one to two lakhs in free treatment. However, workers often later realize that these policies come with many conditions and lack the comprehensive benefits of ESIS, but they often realize these issues too late.

3.1.2 Issues in coordination between national and state level bodies

ESIS administered at national level by a corporate body is called the ESI Corporation. The Corporation is the highest policy-making and decision-making authority under the ESI Act and oversees the functioning of the Scheme. This apex body is constituted and notified by the Central Government for a four-year term and represents various interest groups, including employees, employers, the Central and State Governments, Parliament, and the medical profession. The Union Minister of Labour serves as the Chairman of the Corporation, while the Director General of ESIC is an ex-officio member[23]. It meets periodically to conduct business as required to regulate the Scheme's operations.

23 Employee's State Insurance Corporation. Corporation | Employee's State Insurance Corporation, Ministry of Labour & Employment, Government of India [Internet]. [cited 2024 December 19]. Available from: https://www.esic.gov.in/corporation

Formation of State Autonomous Body/ Society[24]-

In its 167th meeting, the ESI Corporation approved the broad structure of the State Autonomous Body. Subsequently, in the 172nd meeting, the Corporation approved the new structure of the State ESI Society, to be formed under Section 58 of the ESI Act, 1948. According to the approved structure, states are required to register the body as both a Society and a Trust. ESIC will directly release funds to the Society's bank account to ensure efficient financial management. As of now, 19 States/UTs have consented to form the State ESI Society. The Central Government has granted approval for the formation of societies in seven states: Tamil Nadu, Chhattisgarh, Maharashtra, Nagaland, Tripura, Punjab, and Arunachal Pradesh. Currently, ESI Societies are operational in Maharashtra, Chhattisgarh, Tripura, and Himachal Pradesh. The formation of the State ESI Society is expected to provide states with greater flexibility in improving medical benefit service delivery to IPs and beneficiaries of the ESI Scheme, particularly in enhancing Primary and Secondary Care services.

Formation of ESIS Society Maharashtra

The State ESI Society in Maharashtra was established in 2018–19 as an autonomous body. According to officials, its formation has been a significant step forward, particularly in addressing long-overdue vacant posts and planning expansions, such as the establishment of ICUs. Additionally, the formation of the ESIS Society has facilitated direct fund transfers from the central government to a separate ESIS account, ensuring better financial management and utilization. Before the Society's formation, funds were routed through the state government, often leading to significant delays. As one official explained:

"If the state received ₹100, only ₹20–30 was allocated to ESI hospitals, while the remaining funds were diverted to other departments." (E31, Medical Superintendent)

State officials mentioned that,

"Following the establishment of the Society, the expansion of health services has also been planned. Currently, 20 new ESIS hospitals are in the pipeline in Maharashtra, though most are expected to take 2–4 years to complete. As an interim measure, 123 additional private hospital tie-ups have been planned to ensure continued access to medical services until new ESIC hospitals are built (E17, State Official, ESIS).

Hyper-centralisation and dual control of the scheme (national vs. state bodies) –

Over time, effective policy and decision-making have become largely monopolized by ESIC at the national level. This centralization persists despite the fact that the Union Government makes no financial contribution to the ESI Scheme, while State Governments regularly contribute 12.5% of the total budget. As decision-making remains concentrated at the national level, state agencies have been relegated to mere implementation bodies, limiting their autonomy, their ability to address region-specific challenges, and ultimately, their sense of ownership over the scheme—particularly in states like Maharashtra.

Insights from various interviews highlight that this top-heavy control at the central level, coupled with a disconnect between national and state authorities, leads to inefficiencies and significant gaps between policy decisions and ground-level needs. While states are responsible for implementation, decision-making and financial control remain centralized, resulting in fragmented accountability and responsibility shifting between national and state authorities. As one official noted:

24 Employee's State Insurance Corporation. Standard note on Employees' State Insurance Scheme (as on 01.01.2022) [Internet]. [cited 2024 December 19]. Available from: https://www.esic.gov.in/attachments/publicationfile/9decf733b65a587e3e6201914e54dbaa.pdf

"Due to dual control by ESIC and ESIS, the functioning of the scheme is adversely affected." (E19, Medical Superintendent)

It seems that the dual control by central and state authorities has also led to a lack of coordination and the compartmentalization of roles and responsibilities, further complicating the effective execution of the scheme.

3. 2 Budgetary flows, allocations and fund management

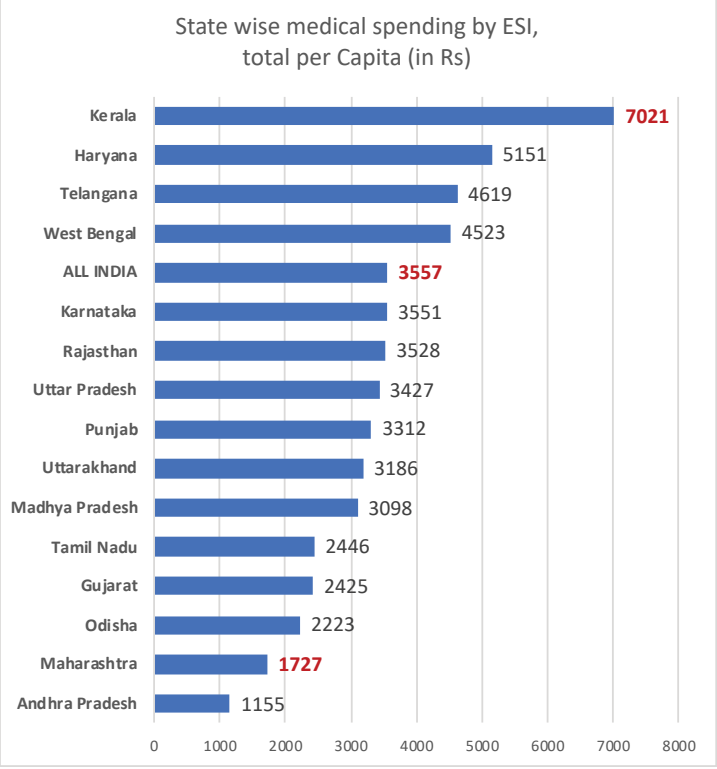
State and national level budgetary contribution

Data shows a significant gap between the ESI contributions collected from Maharashtra and the actual amount spent on healthcare for workers in Maharashtra. In 2022-23, ₹2752 crores were collected from Maharashtra, but only ₹997 crores were spent on ESI health services for the state by the State government and ESIC combined. As per norms, ESIC should provide ₹3,000 per IP, amounting to ₹1,335 crores annually for ESI services in Maharashtra. However, the current healthcare spending is much less than this amount.

Regarding the proportion of the budget to be contributed by the state and ESIC, according to norms, the state government should contribute 12.5% of the budget, while the remaining amount should come from ESIC, which is itself based on employer and employee contributions to ESI. However, we could not access data to verify how this is implemented in practice.

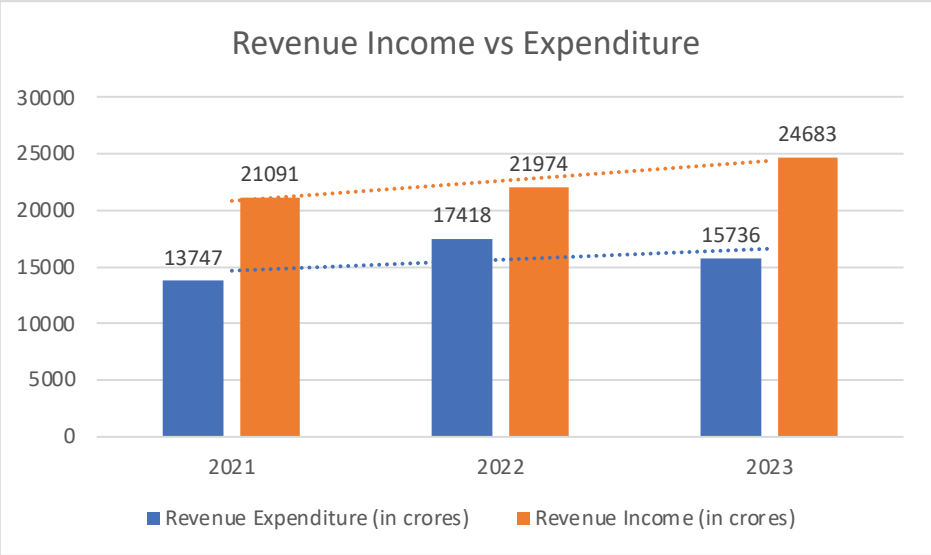
As explained by state officials, they prepare the annual budget based on the previous year's expenditure and seek approval from the governing body before submitting it to the ESIC headquarters. At ESIC, the budget is sanctioned after reviewing the average expenditure of the past three years. Funds are then released in two instalments, the first in April and the second in September. Additionally, the state can request extra funds as needed.

Graph no. 1: State wise medical spending by ESIS, total per capita (in Rs)



Source- Annual report 2022-23

Graph no. 2 Pattern of ESIC investments during 2016-2023



Source- ESIS Annual reports

"We plan and submit a sufficient budget, considering the number of IPs as of March 31. However, when disbursing funds, ESIC does not approve the full amount and provides a reduced budget." (E17, State-level official at ESIS Society).

Effectively, workers and employers in Maharashtra are regularly contributing large amounts to ESIC, helping to build its financial reserves at the central level. However, in return the state has been receiving from ESIC only around half of the state's contributions by the central ESIC funds.

According ESIS annual report 2022-23, ESIC annual spending on medical care per insured worker in Maharashtra was among the lowest in the country at just Rs. 1727 (graph no. 1), which is barely one-fourth of the amount spent per insured worker in Kerala at Rs 7021, and half of the national average at Rs 3557 (figures for 2022-23).

Assets of ESIC- growing gap between revenue and expenditure

According to available data, as of 31st March 2024, the total central assets of ESIC amounted to ₹1,72,792 crores. Out of these ESI assets, ₹1,48,605 crores were in the form of investments in the ESI general reserve, earmarked/endowment fund, and cash balance—huge invested or investible amounts that need to be utilized more effectively for workers' welfare. However, as shown in the graph below (graph no. 2), the analysis of the scheme's revenue income and expenditure reveals significant underspending and a widening gap between the two. In 2021, expenditure was 65% as proportion of income, rising to 73% in 2022, and then declining again to 63% in 2023. Around one-third of the revenue generated by ESI is not being spent, and is added to the already huge central reserves.

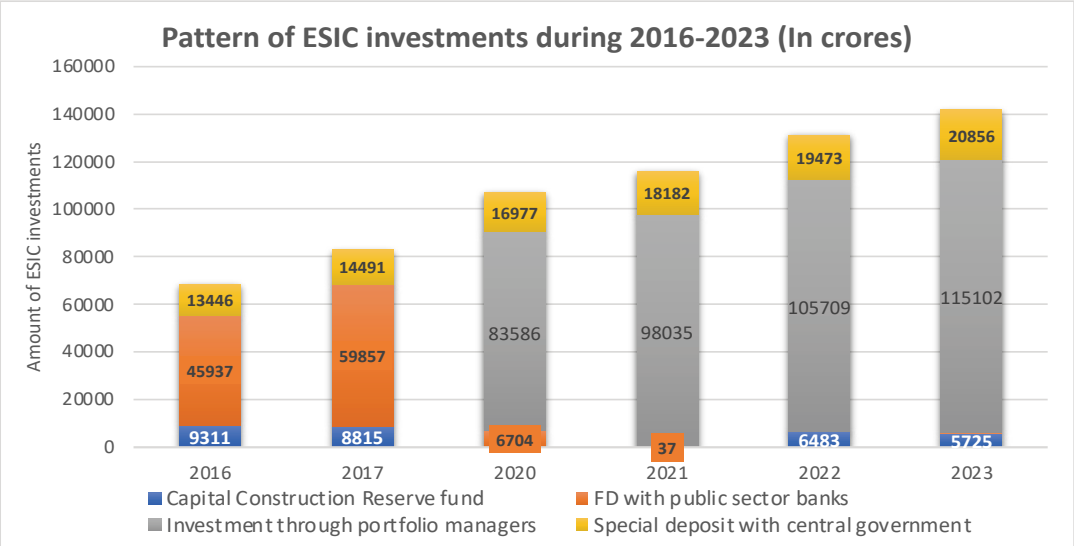
Increased proportion of ESI reserves invested into private equity

In December 2022, the Ministry of Labour and Employment approved ESIC's plan to invest surplus funds in equity, limited to Exchange Traded Funds (ETFs) [25]. According to that plan, initially, ESIC will invest 5% of its surplus, gradually increasing to 15% after two quarters and the investments will focus on Nifty50 and Sensex ETFs, managed by AMCs[26]. As

25 Livemint. ESIC to invest up to 15% surplus funds in stock market via ETFs [Internet]. 2022 Dec 4 [cited 2025 Jan 7]. Available from: https://www.livemint.com/market/stock-market-news/esic-to-invest-surplus-funds-in-stock-market-through-etfs-11670166590630.html

26 The Economic Times. Govt allows ESIC to invest up to 15% surplus funds in equity through ETFs [. 2022 Dec 4 [cited 2025 Jan 7]. Available from: https://economictimes.indiatimes.com/news/economy/policy/govt-allows-esic-to-invest-up-to-15-surplus-funds-in-equity-through-etfs/articleshow/95982945.cms

Graph no. 3 Pattern of ESIC investments during 2016-2023



Source- ESIS Annual reports

evident from the graph below, there was a major shift in the pattern of ESIC investments from public sector banks to corporate investments, with a reduction in investments in public sector banks and an increase in the equity portfolio from 2016 to 2023 (graph no. 3).

In brief, the current budget allocations for ESI in Maharashtra are insufficient to meet the scheme's comprehensive objectives. Regarding management of ESIC revenue, the 'secondary goal' of maximising central reserves and returns from related investments seems to be taking priority over ensuring healthcare coverage and social security allocating adequate funds for workers within states like Maharashtra.

3.3 Engagement and enrolment of workers

3.3.1 Inadequate awareness among eligible workers

Many workers, especially in smaller companies or among contractual staff, were not provided with information about their ESI benefits, leading to low uptake of medical and non-medical services. Larger companies with stronger HR departments were better at managing benefits and might organize awareness camps. Employers were the primary source of information about ESI for workers, but many lack the capacity and resources to educate workers effectively, as even HR staff did not have adequate information about the scheme's benefits. It appeared that most workers were not fully aware of the ESIS benefits. All they knew was that they could visit the ESI health centre (dispensary or hospital) for treatment—that's the extent of their knowledge. They were frequently unaware of other benefits, such as sickness benefit, disability benefits, etc. Many workers were also unaware of the deductions made by employers from their wages, towards ESIS contributions.

According to some ESIS officials and staff, awareness camps and health check-ups are organized on industrial campuses, to provide information about the scheme, conducted health check-ups, and addressed registration and documentation-related issues, if any. At some locations, ESIS and PF-related camps are organized together. However, according to certain officials, very few workers attended such camps. One official shared that:

"The real issue is the employer's approach. We need to get the company's permission to conduct the camps, and many times, companies do not give us permission or allow workers to attend the camps. Without employers' cooperation, we cannot conduct awareness camps." (E42, ESI local office assistant).

More importantly, ESIS has not adequately developed or distributed IEC materials among workers. As shared by various officials from Administrative Medical Offices (AMO) at the regional level, IEC materials have not been developed as such. It was believed that this needed to be done at the company level. Also, there were no budgetary provisions or awareness initiatives from the AMO office for this.

3.3.2. Complexities in registration and documentation processes

Issues in registration of IPs

It appeared that vast numbers of workers in Maharashtra who were eligible to be covered by ESI and should receive medical and social security benefits were being left out due to negligence and procedural exclusions by the government, the ESI system, and many employers. It was noted that workers moving between employers, especially in smaller companies, often faced disruptions in ESI registration and benefits. The change of employer, which was frequent in the case of contractual workers, often led to interruptions in coverage and problems related to ESI registration. Even when workers have ESI numbers, activation remains a separate challenge, requiring additional procedures, and until they fall sick, they don't realize the problem.

"Often, our experience is that a worker comes to our office saying, 'Sir, I've admitted my father to the hospital, and the expenses are piling up.' When we ask, 'Why didn't you use your ESI benefits?' he replies, 'I don't have the card, and I wasn't aware of it.' At that stage, he starts the registration process. But at that point, he's more interested in getting immediate treatment for his father. Now, when will registration happen, when will treatment happen—he realizes the importance of the information I gave him, but he gets upset with me because I started telling him this while he came to ask for money" (E12, trade union representative, Aurangabad).

Extensive and complicated documentation demanded for registration

Workers complained that extensive documentation and follow-up are often required to obtain the ESI card. There is now a compulsion to link all ESI registrations with Aadhar, which often leads to the denial of valid treatment claims by workers. There is a significant information gap regarding the required procedures and documents, which contributes to such denials. Common problems with documentation include issues with photographs, especially of family members, the requirement for Aadhaar linking, and document discrepancies, all of which frequently cause delays or denial of benefits, including treatment denials at some hospitals.

"Whenever workers submit papers or come to claim, they realize that their documents are not updated or their Aadhaar is not linked. If the documents are incomplete, we have to send them back to get the link done. Then they start arguing with us, saying that they are not getting their claims or that, even though they are registered in the ESIS and they are not receiving any facilities" (E 25, Office from AMO, Nashik).

Some officials also feel that HR dept of respective company should ensure whether employees have completed the required document and guide them.

"Now, with the system flowing online, paper work needs to be cleared. It is the responsibility of the HR department to ensure that the company provides all the correct information for its employees. This will prevent delays in paperwork when the employee comes to us, as incomplete documents often cause delays in processing. If paper work is not completed and Aadhar card is not seeded then payment to the secondary hospital will not be processed" (E26, medical officer at dispensary, Nashik).

However, despite the demanding documentation required from workers seeking an ESIS card, there was no helpdesk or support cell to guide IPs

regarding various documents. Most officials believe that ensuring enrolment is mainly the responsibility of the IP and the employer.

Online registration system

As mentioned by some officials and medical staff, up until around 1998, the ESI cards were small, without photos or identification details. Anyone could come and receive treatment using the same card. Around 1999-2000, the system started issuing new identity cards with more detailed information and a larger size, similar to ATM cards. After 2000, digitization began, and by around 2010, online registrations were introduced. The online ESIS registration system offers some advantages, such as preventing duplication of registration numbers, but it is challenging for workers, especially since most are less educated. The OTP system requires workers to have functional smartphones, further limiting accessibility.

As reported, there was no user-friendly app or simple online system that would regularly update the worker and enable them to track the status of employer contributions and active enrolment. Additionally, unlike the PF system, there was no SMS confirmation after submitting contributions by workers as well as their employers. Overall, there is a significant information gap regarding the required procedures and documents, which contributes to such denials.

3.4 Involvement of employers and related issues

Evasion of registration and contributions to ESIS scheme by employers

Larger companies/ multinational companies, especially those audited for ISO standards, are more particular about enrolling workers under ESIS. However, many small-scale businesses and subcontractors evade ESI regulations by maintaining informal worker records, along with hiring temporary labour. Some workers reported that ESI registration was done by the company, and contributions were deducted, but the card was not issued despite follow-ups, leading to the denial of ESIS services. The worker often has no clarity on whether their company has submitted the contribution to ESIC or not. Additionally, some employers do not even provide salary slips, leaving workers uncertain about whether their ESIS contributions are being deducted.

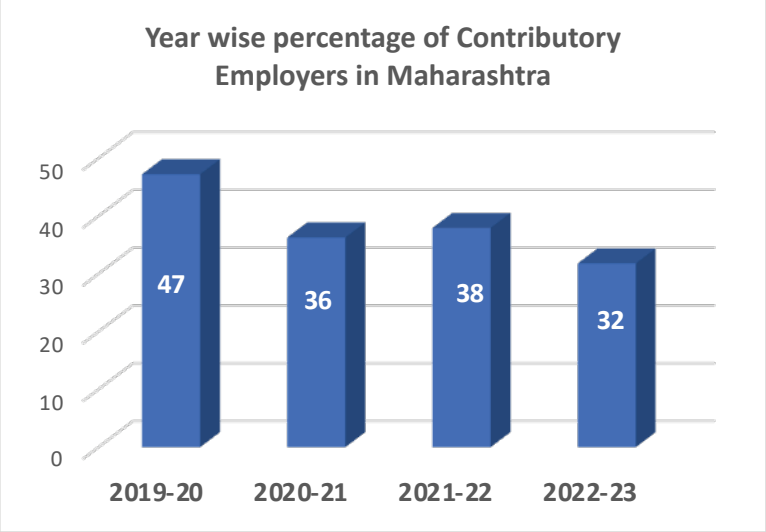
An analysis of data from 2019 to 2023 shows that (graph no.4), there was a significant gap between total employers expected to be covered under ESI and contributory employers who are actually contributing to the scheme. This leads to massive exclusion of deserving workers from the scheme. At the national level, 20.83 lakh employers were covered by ESI, but only 7.06 lakh were contributory employers (just one-third of the total). For the year 2021-22 in Maharashtra, only 38% of employers and 41.6% of employees were contributing to the scheme.

This means that over half of the employees who are expected to be covered under ESI in Maharashtra are not being covered due to lack of contributions from employers. When asked about action against non-compliance by employers, respondents shared that, a case can be filed against employers but unions or workers are reluctant as it takes several years. Also, now the provision of inspection has been changed[27]. Trade union leaders were quite upset with this change and expressed that,

"According to new GR, if there is complaint then it has to be registered in a "Central Inspection System (CIS)". It is then sent at national level, and only after receiving approval from national level, an inspection can be conducted. In a way this provides private companies to 'sanitise' their practices and records." (E 18, workers advocate, Mumbai)

27 Praveen SR. Inspection norms for industrial units amended. The Hindu [Internet]. 2021 Aug 29 [cited 2025Jan 3]; Available from: https://www.thehindu.com/news/national/kerala/inspection-norms-for-industrial-units-amended/article36164340.ece

Graph no. 4 Year wise percentage of Contributory Employers in Maharashtra



Source- annual reports

However, there was a section of employers, especially large companies, who were keen to enrol workers under ESIS, particularly to deal with any medical emergency. As mentioned by some company representatives, since they pay contributions to ESIS, their workers must receive ESIS services properly. For example, a company from Kolhapur with around 5000 workers has all the workers enrolled under the scheme and pays a contribution of 20-25 lakhs per month, but the workers do not receive ESIS services as expected.

"We contribute a huge amount of money—both from the employer's and the employee's side—but in return, we don't get the services we should. Sometimes, it feels like we could set up a good hospital by combining the resources of our 2-4 companies and run it ourselves. However, the rules don't support that. We don't even get 10% of the service for the money we pay". (E 49, Industrial association's head)

The Solapur Industrial Association started OPD services for workers health

The Solapur Industrial Association, formed in 1997, initially addressed industrialists' issues at the local level but later expanded its focus to workers' welfare. Located in the Chincholi MIDC area, home to over 36,000 workers, the association recognized a significant gap in healthcare services, especially with the large distance from the Hotgi ESI hospital. Despite various industries contributing heavily to ESIS, workers receive minimal services, with the current ESIS hospital lacking essential staff and equipment, often referring workers to private hospitals.

In response, the association launched an OPD service in June 2023, funded by its CSR initiatives, and invested `1 crore in constructing a new hospital. They plan to hand over this facility to ESIC on a lease to establish a 30-bed hospital, improving healthcare access for workers in the region.

Initiative of Private industries association from Kolhapur for workers' healthcare

In Shiroli MIDC, Kolhapur district, the Shiroli Manufacturer's Association (SMAK), including over 500 industries and thousands of workers, took the initiative in ensuring healthcare services for workers. There is an ESIC hospital in Kolhapur city, located about 25 km from the Shiroli area, but it was plagued with issues such as poor facilities and staffing shortages. To address this, SMAK demanded for an ESIC dispensary within their industrial premises, providing easier access to healthcare for workers. SMAK went through the tender process and supplied the building and infrastructure, while ESIC provided medical staff and resources. The facility has been operational since 2017-18. SMAK's focus was not on profit but on meeting workers' healthcare needs, setting a new benchmark for community-driven healthcare solutions.

Even if their workers are eligible for ESIS, some private companies offer private health insurance coverage to workers instead of ESIS, thus avoiding obligations like medical leaves and social security contributions. Many companies prefer to provide private insurance instead of ESIS coverage because it enables them to obviate their obligation to provide other benefits like PF. Evading the provision of ESI cards to such workers also proves convenient to prevent further claims for permanency by workers. While reflecting about problem of private insurance, it was shared that,

"Now, workers face challenges with private insurance because companies impose certain conditions. For example, if they take a one-month leave, they only receive payment for 2 or 3 days. When wages are based on a monthly agreement, if a weekly wage is 7,000 and the insurance company only covers 3,000, worker end up losing 4,000. This creates a new issue. Workers believe the company should compensate for the difference. However, the company argues that since they've provided insurance, they shouldn't have to compensate. These are the ongoing problems with the system" (E 12, trade union representative, Aurangabad).

Issues with contractual employment

ESIS coverage applies to contract labour as well, but contractors often avoid providing coverage unless enforced by the principal employer. For contractual workers hired through an agency, the responsibility shifts to the agency, which often does not contribute to ESI or other social security schemes. As mentioned by various respondents, employers were keen to suppress this as much as possible and not let it appear on paper. Employers were afraid that if workers were offered social security, they might claim the permanency of the job. On the other hand, as reported, workers were afraid of losing their jobs in any form and were therefore hesitant to raise their voices against the contractor.

Various municipal corporations in Maharashtra have hired contractors to engage workers for services like sanitation work. However, these municipal corporations frequently change contractors every few months, creating serious issues for the workers employed by them. While some municipal corporations have included a mandatory clause in the MOU with contractors requiring them to provide ESIS coverage for workers, there are major gaps in its implementation. By the time the newly engaged contractor completes the ESIS registration process for workers, they are often replaced, leading to another round of failed ESI enrolment. As a result, workers are required to go through the registration process again with each new contractor. It was also reported that contractors often exploit these six-month contracts to delay or avoid ESIS registration, knowing they will be replaced in six months.

Contractor never provided us with ESI or PF…

We work as contractual workers at private chemical company's hazardous plant. The water here is hazardous and contains chemicals. We spend 8 hours a day exposed to these chemicals and gases, which puts our health at risk. Despite the dangerous nature of our work, proper safety measures, like masks, are not provided. Health check-ups every 3 to 6 months are essential, but the company doesn't follow these rules. As contract workers, our concerns are ignored. Since we are on contracts, our voices are suppressed. We often experience symptoms like nausea, dizziness, and vomiting. We need health check-ups, but they are not provided.

The concept of ESI never reached us. We have been working for 13-14 years, but the contractor has not provided us with ESI or PF, despite it being mandatory. We don't get payment slips or details about our gross or net payments. (GI 10, group interview with hazardous plant workers, Aurangabad).

Categorising remuneration to workers differently also makes them non-eligible for the scheme. For example, health workers such as Anganwadi staff, ASHA workers, etc are deliberately categorized as receiving "honorarium" rather than "wages." This prevents them from being covered under ESIS. If they were declared as wage earners, the minimum wage law would apply, which the government wants to avoid.

Denied benefits denied due to technical issues

"A worker in my ward passed away, and he had an ESI card. However, he didn't receive the ESI benefits because his ESI number was created twice. The first number was active for 3-4 years, but when a new contractor took over, there was an issue with linking his Aadhaar. As a result, the link did not get updated in his records. Despite working for 5 years, he didn't receive any benefits, even after his death". (group discussion with sanitation workers, Mumbai)

We also came across a group of contractual workers from maintenance department at ESIC hospital from Mumbai, who were not offered ESIS entitlements due to their temporary contractual status of employment. Ironically, while working in an ESI hospital that provides healthcare to thousands of workers from different sectors, they themselves are denied ESIS entitlements.

ESIC hospital's own contractual workers were denied ESIS entitlements!

ESIC hospitals' own contractual workers have been denied ESIS benefits. Hired in the late 1980s with a promise of eventual regularization, they were never made permanent. In 1999, they took legal action, and a court ruled in their favour, recognizing their work as essential. Yet, ESIC refused to comply, prolonging their legal struggle. Many have since retired or passed away, leaving families without pensions or financial security.

Their wages, routed through third-party contractors, often face delays and deductions despite orders for timely payments. In 2018, the Labour Advisory Board recommended regularization, but bureaucratic hurdles persist. Many continue to fight for justice, while others have retired, spending their entire working life serving ESI, but without ever receiving ESI benefits which were rightfully theirs.

Role of consultants and agents engaged by employers, in relation to ESI

As explained by respondents about the role of consultants and agents, these intermediaries often handle legal and administrative tasks for small industries, manage their ESI and PF compliance, including registrations, returns, and claims. The consultants manage the entire process of ESI and PF compliance for companies, ensuring timely returns and responses to legal notices. They act as mediators between workers and employers, ensuring workers' benefits are properly claimed. Consultants are essential for companies, especially small and medium-sized businesses, that lack the resources to manage these processes themselves. ESI compliance requires that workers earning within

a specific limit be registered before joining, and consultants help companies with the registration process for new hires.

Many smaller companies seem to be escaping from ESIS obligations to reduce their financial burden. Some consultants were reported to be guiding employers on how to evade ESIS, such as by paying workers in cash to avoid records, using "job work" instead of subcontracting to bypass the 10-worker rule, or showing partial attendance to reduce ESI applicability.

Giving artificial breaks in employment and misreporting worker numbers are also strategies used by some employers to evade compliance. Some companies go as far as hiding their employees from inspectors during visits to show a smaller number of employees.

Agents also play a role of facilitating the ESI service claims to IPs. It was shared that,

"Workers often struggle to claim their benefits without external help due to lack of awareness. So, some persons have even started businesses which charge workers a commission of 2-5% to get their reimbursements processed" (E12, trade union representative, Aurangabad).

3.5. Shortfall of infrastructure and human resources at ESIS hospitals

Number of ESIS hospitals- As per data as on December 2024, there were total 15 ESIS hospitals in Maharashtra of which 3 were run by ESIC- national level, and remaining 12 were run by state level. Of the total 36 districts in the state, ESI hospitals were built only in 7 districts / urban agglomerations which shows major maldistribution of ESIS hospitals. There were 8 hospitals concentrated in Mumbai Metropolitan Region, 2 in Pune, and 1 each in Solapur, Kolhapur, Nasik, Nagpur and Aurangabad districts.

Table no. 2 Number of ESI hospitals in Maharashtra

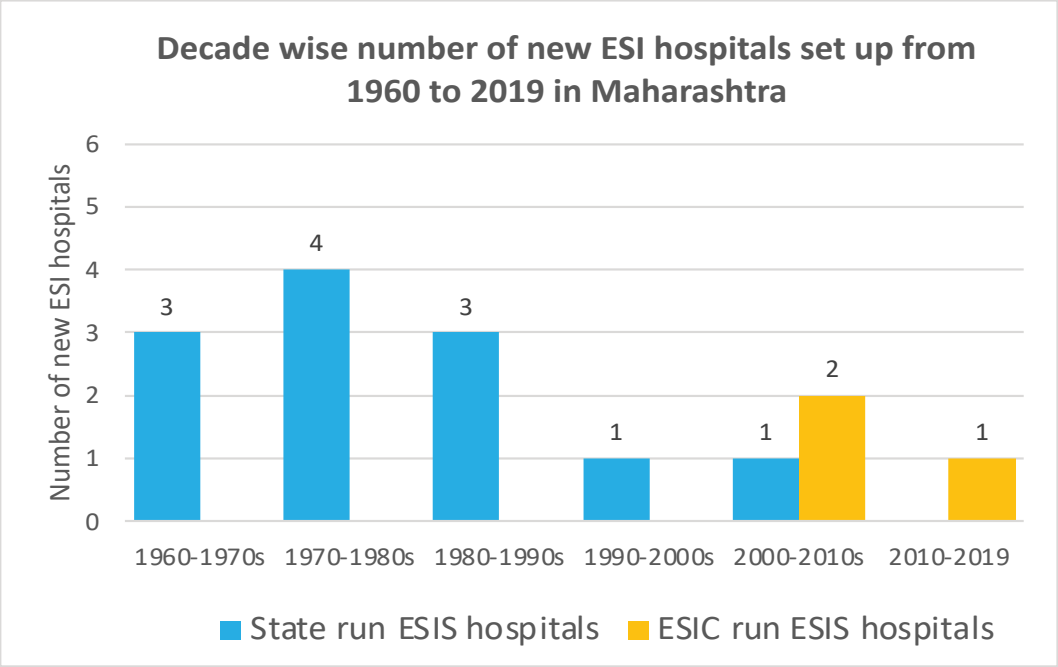
	Name of district/city	Number of hospitals
1	Mumbai and Mumbai Metropolitan Region	8 (1 run by ESIC)
2	Pune	2 (one run by ESIC)
3	Solapur	1
4	Kolhapur	1 (run by ESIC)
5	Nasik	1
6	Nagpur	1
7	Aurangabad	1
	Total	**15**

Source- ESIC website

As reported by officials, seven new hospitals have been proposed in 2019, after formation of society at the state level and are still under construction. However, as observed, none of the hospital is ready or even near completion. For example, as shared by officials,

"In Butibori area from Nagpur a 500 bedded hospital is being constructed since last five years (from 2019). Butibori is a large industrial area with 50-60 thousand workers. Two dispensaries were functional there but those were not adequate for the patient's treatment. In response to the need, ESIC took initiative, informed the collector and acquired land of 6-7 acres. However, it took them 10 years to start the construction of the building. For last two years, they have only dug holes and have put up pillars that are just 4 feet tall. Since it was initiated by ESIC, it doesn't come under state's jurisdiction so it can't be managed at state ESI level" (E 20, AMO officials and workers).

Graph no. 5 Decade wise number of new ESI hospitals set up from 1960 to 2019 in Maharashtra



Source- ESI annual reports

Number of ESI hospital beds –

As per the norm, there should be one ESI hospital bed per 250 workers. Accordingly, required number of ESI beds in Maharashtra is around 19,200, but as of 2022-23 there were only 1580 commissioned beds including all 15 ESI hospitals – which is just 8% of the required number! Further, this number of commissioned beds was just half of the sanctioned number of beds (2980 beds), meaning that even sanctioned capacity was not fully realised.

Further based on the data from the ESIC website as of December 2024, along with information shared by respective medical superintendent and the observations made during facility visits for eleven hospitals, there was a significant gap between the number of beds sanctioned, commissioned, and those that are functional (see table no.3). ***In six out of the eleven ESI hospitals, only 17.5–50% of the commissioned beds were functional***. At Andheri Hospital, which suffered a fire in 2019, renovations were still ongoing, and only OPD services were operational. Only two hospitals had the number of functional beds that matched the sanctioned and commissioned capacity.

Maintenance of ESI hospitals – Most ESI hospitals and facilities appeared to be in poor condition, with outdated infrastructure and unused medical equipment, primarily due to a shortage of skilled staff. Many older ESI facilities were located in aging, obsolete, poorly maintained buildings**.**

"The older equipment and instruments need to be replaced, especially those that are over 40 years old. Some instruments, like scissors, are so worn that they have to be sharpened and reused, while other instruments, such as artery forceps or clamps, are in such poor condition that when surgeries are performed, the gynaecologists or surgeons bring their own instruments because the ones available in the hospital are no longer usable." (E24, administrative officer).

"Even beds are so old and of poor quality that, we use bricks to elevate it for the comfort of patients" (E31, Medical superintendent)

In some hospitals from Mumbai, there was a leakage from the rainwater in their room, and the room was filled with water. The walls were damp and mouldy. In one hospital and in one AMO office,

Table no.3 Number of beds sanctioned, commissioned and functional beds in eleven hospitals

Details	No of sanctioned beds	No of commis-sioned beds	No of beds func-tional beds at the time of visit	Percentage of Functional beds
Nashik	100	100	100	100
Aurangabad	100	100	100	100
Kolhapur ESIC	100	30	30	30
Nagpur	200	130	100	50
Pune - Mohannagar	100	100	60	60
Solapur	150	100	30	20
ESIC Bibvewadi, Pune	100	100	70	70
Mulund (Mumbai)	400	200	70	17.5
Parel ESIS MGM (Mumbai)	330	100	100	30.3
Worli (Mumbai)	300	85	85	28.3
Andheri (Mumbai) ESIC model Hospital	500	230	0	0
	2380	**1275**	**745**	**31.3**

Source- ESIC website as of December 2024 and information from facility visit

public notices were displayed warning of the risks associated with entering the premises, due to the old building's deteriorating condition!

Some hospitals reported shortage of several instruments due to procedural delays including delays in approval to the proposal, disbursement of funds and actual purchases. Another experience indicates administration's apathy towards functioning of ESIS hospitals. It was shared that,

"Since the building does not have a completion certificate, there has been an ongoing issue with the power supply, preventing the installation of new machines. This issue has persisted for 4-5 years, dating back to 2016. The building still hasn't received the required certificate from the concerned Municipal Corporation. As a result, despite having X-ray and sonography machines on-site, they remain unconnected, and patients are forced to visit tie-up centres for these tests." (E 45, Trade union representative)

Lack of critical Intensive Care Units (ICUs) in ESIS hospitals- Despite a national decision to set up ICUs in ESI hospitals, none were found to be operational in Maharashtra. ESIC during its 182th meeting on 20th Aug 2020, has given approval for establishing ICU services at the scale of 10% of the total bed strength of ESIC hospitals[28]. However, according to the available information, no fully functional ICU beds were present in any

28 Employee's State Insurance Corporation. Approval for establishing ICU/HDU services: 10% of the total bed strength of ESIC hospitals [Internet]. 2020 Nov 25 [cited 2025 Jan 1]. Available from: https://www.esic.gov.in/attachments/circularfile/d73f401d94e-413a4e72e57d0af42fc84.pdf

Table no.4 Percentage of vacant posts in ESIS hospitals

As per 22-23 AR	Specialists	Nurses	Paramedical	GDMO
Nashik	0	2	14	0
Aurangabad	20	0	7	11
Nagpur	0	11	15	0
Mohannagar (Pune-)	8	4	17	11
Solapur	0	23	23	0
Mulund (Mumbai)	20	29	17	17
Parel ESIS MGM (Mumbai)	24	76	39	29
Worli (Mumbai)	43	46	47	41
Andheri (Mumbai) ESIC Hospital	59	54	68	84
Kolhapur ESIC hospital	74	76	63	58
Bibvewadi (Pune) ESIC hospital	21	21	19	8
Kandivali	0	63	50	0
Thane	25	14	41	8
Ulhasnagar	14	56	86	27
Washi	0	16	44	14

ESI hospitals across Maharashtra at the time of the study. In some hospitals, it was noted that ICU facilities were still under construction, and while some equipment had been purchased, the units remained non-operational. Additionally, none of the hospitals we visited had blood storage units or catheterisation labs. Due to the absence of these critical facilities, many major illnesses could not be treated at ESIC hospitals.

Outsourcing of Diagnostic Tests – As observed, all 11 ESI hospitals had sample collection centres for pathology tests operating on a PPP basis. Similarly, X-ray, ECG, and sonography services were also being provided through the PPP model. For most other diagnostic tests, including MRI, CT scans, 2D ECHO, etc., patients were required to visit private labs empanelled with ESIS. This point was echoed in various group interviews with workers, who complained about the non-availability of basic tests in the ESIS hospitals. However, we were unable to find information regarding the number and distribution of these private empanelled labs, as this data was not available on the website.

Understaffing in ESI Hospitals – It was noted that ESI hospitals faced severe understaffing. All three ESIC-run hospitals showed a higher proportion of vacant posts for specialists, GDMOs, nurses, and paramedical staff, ranging from 41% to 84% of vacant posts. In the hospitals located in Kolhapur and Worli, Mumbai, respectively, only 30% and 28% of the sanctioned beds were operational, resulting in limited recruitment of staff. Similarly, at the hospital in Andheri, only outpatient department (OPD) services were available, leading to staff recruitment being limited to the needs of the OPD.

It was shared that, following the formation of the society in Maharashtra, long-pending staff

Table no. 5 Bed occupancy rate in ESIS hospitals from Maharashtra

	Name of the Hospital	No of sanctioned beds	No of commissioned beds	Bed occupancy rate
1	Nashik	100	100	44
2	Aurangabad	100	100	49
3	Nagpur	200	130	64
4	Mohannagar, Pune	100	100	35
5	Solapur	150	100	34
6	Mulund (Mumbai)	400	200	27
7	Parel ESIS MGM hospital (Mumbai)	330	100	26
8	Worli (Mumbai)	300	85	18
9	Andheri (Mumbai)ESIC model hospital	500	230	46
10	Kolhapur ESIC hospital	100	30	39
11	Pune ESIC Bibvewadi	100	100	96
12	Kandivali (Mumbai)	300	225	46
13	Thane	100	50	14
14	Ulhasnagar	100	0	0
15	Washi	100	30	12
		2980	**1580**	

**Bed occupancy rate (Inpatient days of care)/ bed days available) x100*

recruitment was carried out to some extent, which proved useful. However, most of the recruits were hired on a contractual basis. According to the 2022 annual report, while there were 432 sanctioned posts for specialist doctors in ESI hospitals across Maharashtra, only 222 positions were filled—barely half of the required number. Of these, only 109 were regular appointees, meaning that only about one-fourth of the required specialist doctors in ESI hospitals were employed as regular staff.

3.6 Healthcare services delivered by various ESI facilities

3.6.1 Healthcare services delivered by ESI hospitals

Given the major deficiencies in the availability of essential infrastructure, resources, and facilities provided by ESI in Maharashtra in its own hospitals, many services, including surgeries and treatments, have been reduced, and patients are now being referred to the district hospitals or other general government hospitals. As a result, the bed occupancy rate in ESI hospitals has been low. With the exception of Bibvewadi Hospital, which reported a 96% bed occupancy, bed occupancy rates in ESI hospitals in Maharashtra range from 0% to 64%, well below the desirable norm of 70-80%. In this context it is concerning that in 9 out of 15 hospitals, bed occupancy was below 40%.

Workers' seeking care in ESIS hospitals across the state often reported delays, long waiting times for OPD services and investigations, the need for multiple hospital visits, and a lack of diagnostic and specialized services, leading to frequent referrals at ESI hospitals. It was shared that,

"If medicines are not available, they give a prescription, but it becomes very difficult for people who earn only 8 to 10 thousand rupees. They can't afford to buy them." (E 45, trade union representative, Kolhapur)

Respondents mentioned the need for well-equipped multi-specialty hospitals under ESIS so that IPs can receive treatment for various ailments at ESIS hospitals only. It was shared that some basic specialties such as medicine, surgery, ENT, and gynaecology can be managed full-time, whereas for super-specialties, visiting specialists can be made available so that patients can receive treatment on-site and recover at a lower cost. Many respondents also highlighted the issue of doctors' unavailability at ESIS hospitals, along with a tendency to refer patients to private tie-up hospitals. This was attributed to both the lack of available services and an intent to avoid responsibility for patient care. This practice was particularly noted among contractual doctors. Various respondents also pointed out the long distances patients have to travel to seek care from ESIS hospitals, and when they are further referred to either public hospitals or private tie-up hospitals, IPs feel frustrated. It was shared that,

"The government's ESI hospital is not available here in Waluj. There is one in Chikalthana, but there are not enough facilities there. There aren't enough doctors. And then, the hospital in Chikalthana refers patients to the general public hospital—Ghati Hospital. So, if a person is paying ESI contribution and still has to go to Ghati hospital, what is the benefit of ESI then? You have to travel by vehicle to Chikalthana, get checked there, and then be referred to Ghati. So, why go through ESI at all? Why not go directly to the general hospital?" (E72, HR consultant, private company, Aurangabad)

Nonetheless, some positive experiences were also shared by IPs during the group interviews. Various IPs reported the benefits of having an ESIS card and saving money on treatment from private hospitals. For example,

"An IP became ill on duty, and the family took her to a private hospital instead of ESIS. After spending 60-70k, one of the relatives advised them to shift her to an ESIS hospital. From there, the patient was referred to an empanelled hospital, and due to that, the patient saved 2 to 3 lakhs on treatment." (GI 10, group interview, Aurangabad)

One of the unique features of the ESI scheme, unlike any other health or social insurance scheme in India, is that there is no upper limit on the financial coverage for medical treatment provided to IPs. We came across a few cases where IPs have benefited from unlimited medical and sickness coverage through ESIS.

ESIS covered cancer treatment of a worker worth nearly Rs 39 Lakhs

The patient, a security guard employed through a contractor, was first registered in ESIS as an IP in January 2023. He approached the dispensary in mid-February with symptoms and was diagnosed with multiple myeloma (plasma cell leukemia).

The ESIS hospital RMO referred the patient to a specialist for further management. The quotation from Tata Memorial Hospital came to ₹12,00,000 for super-specialty surgery, chemo, stem cell collection, advanced investigations, and transfusion support.

Two rounds of treatment took place between April-May 2023 and July-August 2023, totalling ₹38,86,260. This entire amount was borne by ESI. ESIC's medical referee thoroughly examined the case and also sanctioned over four months of sickness leave for the patient. The patient's journey exemplifies the unlimited medical and sickness benefits available through ESIS, showcasing the effective collaboration between the employer, ESIS hospital, and the RO system in supporting the patient through his battle with cancer.

3.6.2. Referrals regarding healthcare services under ESI

Keeping in view the very limited current capacity of ESI's own healthcare services in Maharashtra (ESI hospital beds being less than 10% of the required), there was a long-standing arrangement of referring patients to private hospitals. This complex arrangement seems to have led to a range of problems and potential denials for the IPs at various levels.

3.6.2.a. Referrals from ESIS hospitals to private tie up hospitals

As shared by various respondents, including IPs, patients were often referred to empanelled private hospitals due to the limited ESI healthcare capacity in Maharashtra. Approximately 394 private hospitals in Maharashtra are empanelled by ESI. As stated by state officials, ESIS has always relied on tertiary tie-ups for super-specialty care, as it did not have its own super-specialty services. However, secondary tie-ups were a recent development, starting only after 2020, which also reflects the declining condition of ESIS's own hospitals.

In 2023-24 the three ESIC hospitals in Maharashtra made payments to private tie-up hospitals for 937 bills, totalling Rs. 2738 lakhs. This amounted to average payment of Rs. 2.92 lakhs per patient, involving a major drain of resources due to the inadequate capacity of ESI's own system[29].

"The private tie-ups charge very high bills. In some financial years, bills up to 9 crores have been cleared. Therefore, if facilities are made available at these ESI hospitals, the government will save a significant amount of money. If the right approach is taken, many services can be improved, and everything can be enhanced, but it requires the right mentality." (E 23, Official from regional office)

A wide range of problems have been reported by IPs who have been referred under ESI to empanelled private hospitals, such as considerable procedures being involved in obtaining referrals, patients having to pay for components of care in the private hospital, despite care being supposed to be free of charge, and the lack of availability of certain services in the accessed empanelled hospitals.

"My mother's pain increased again, so we decided to have a sonography done, which revealed that her appendix was enlarged and would require surgery. We were referred to a private hospital from the ESIS hospital. They did not accept the check-up reports from the other center and insisted that the check-up needed to be done at their hospital only, and we had to spend 2000-3000 INR again. When surgery was decided, they continued to charge separately for anaesthesia charges, as well as for all other costs, such as blood tests, urine tests, and other necessary procedures, requiring additional payment, saying these are not covered under ESIS. Effectively, surgery was the only thing that got covered by ESI, and we had to spend around 2.5 lakhs for various other things." (Worker in a GI 12, Kolhapur).

Private tie-up hospitals were intended to provide free medical care for inpatients; however, it appears that workers were still having to incur substantial out-of-pocket expenses when receiving care at these private tie-up hospitals.

Many workers during the group interviews also pointed out the lack of any communication between ESIS doctors and private hospitals after referrals, which leads to confusion and financial burden for patients. Some also shared that they had experienced inferior treatment and behaviour from doctors and staff in private hospitals. The beds were labelled as ESIS patients', and when doctors came for rounds, they spent less time checking patients with ESIS compared to other cash or private insurance patients. Some also shared that private tie-up hospitals did not treat ESIS patients with dignity, and some even reported that private hospitals did not provide free meals to ESIS patients.

On the other hand, private hospitals were not so inclined toward the scheme, citing low reimbursement rates as one of the major reasons. It was shared that CGHS rates were not affordable for most procedures, but rates for some super-specialty procedures were better. Additionally, the rates varied depending on the location, with different rates for Mumbai, Pune, and Aurangabad. Due to low reimbursement rates and delays in

29 Employees' State Insurance Corporation (ESIC), Regional Office Maharashtra. Study visit of the Standing Committee on Labour, Textile and Skill Development to Mumbai; 2025 Jan 17. Internal report.

reimbursement, many private hospitals have stopped accepting ESIS patients or de-empanelled themselves. As a result, patients face denial of care or discrimination in private hospitals, with some being asked to pay upfront for services, even with valid ESIS cards.

"ESIS owes 5-6 crore rupees to the XYZ private hospital from Kolhapur. ESIS office doesn't clear the bills on time, so they have now opted to leave the ESI tie-up. They faced severe trouble. You are taking money from the workers in the form of contributions, and from the employers as well, and in return, if you don't make payments for 3-4 years, how can private hospitals provide services to ESIS IPs?" (E50, union leader, Kolhapur)

When asked about why they closed their ESIS empanelment, private hospital owners responded that either their packages were too low, making it very difficult to provide treatment, or that they had huge pending payments that they hadn't received for years. And if they want to receive those payments, they have to give a certain percentage for 'facilitation', after which they get the reimbursement.

Regarding the reimbursement process, as explained by the officials, the claim is first verified by the AMO office and then forwarded to the state authority for approval. Claims up to ₹3 lakhs are processed by the AMO office, being checked against CGHS rates, and discrepancies (e.g., unnecessary items) are deducted. Approval can take 2-3 months, depending on when the hospital submits bills and the volume of claims. Bills not submitted within 6 months may be denied. Inconsistent training among staff and large batches of bills also slow down the reimbursement processing.

3.6.2.b. Medical services from non-tie up private hospitals

ESIS has a unique provision allowing IPs to seek medical services from non-tie-up private hospitals in emergencies. In such cases, inpatients must pay the full bill upfront and later claim reimbursement from ESI. While this system is designed to help IPs, as reported, it often led to workers incurring significant out-of-pocket expenses due to delays, partial reimbursement (as claims are reimbursed only at CGHS rates), and uncertainties in the reimbursement process. Additionally, many respondents have reported that the process is complicated, lengthy, and cumbersome. Many also complained that claim processing was slower due to the absence of real-time updates and reliance on manual procedures.

As an official explained about the use of this provision:

"For example, unlike knee operations, which can be done as a planned procedure in most cases, in the case of road traffic accidents or accidents occurring at the workplace, they are considered pure emergency conditions. In the event of any accident, the company will admit the patient to the nearby hospital where treatment will be provided, and then the bills can be claimed here." (E24, regional officer)

In many cases, such claims related to non-empanelled hospitals were never reimbursed. Common issues included lengthy processing, unclear documentation requirements, and slow approvals, causing financial and emotional stress.

"I had an accident in 2014 and was treated in a private non-tie-up hospital. I submitted a bill of 2 lakh 22 thousand as given by the private hospital, but till today, there's been no update on it. No SMS, no receipt, nothing. 2014 was ten years ago, and now it's 2024. They say, whether it's an emergency or accident case, ESI refuses to provide treatment, telling us to sort it out ourselves." (GI 7, group interview, Nasik)

Some workers also talked about a challenge in getting reimbursement when treatment is taken in their hometown. It was shared that, "***if an employee's family requires treatment at home and the treatment is provided and submitted for reimbursement, the claims are often delayed for years. In many cases, reimbursements are left pending for up to two years, and even then, the full settlement is not provided". (GI 14, group interview, Aurangabad).***

Overall, this mechanism was not functioning properly and often led to workers spending large amounts out of their own pockets for treatment, rather than being protected by ESI.

3.6.2.c. Referrals from ESIS hospitals to other public hospitals

A new directive from ESIS in April 2023 mandates that patients who cannot be treated at ESI facilities for specialised care should be referred to public hospitals instead of private tie-up hospitals. This move seeks to shift the IPs from the ESI system to the already overloaded and under-resourced public health services, withdrawing the earlier entitlement for care in private hospitals without replacing it with a superior alternative.

This order seems to have resulted in significant reduction of secondary hospital tie-up referrals by ESI which reduced from 143,986 in 2022-23 to 45,043 in 2023-24.

"Basically, what should have happened is that there should have been no need to send patients to tie-up hospitals. Currently, most ESIS hospitals lack resources or facilities for certain treatments, and hence either patients have to be sent to secondary or tertiary private tie-up hospitals, or there are orders to send them to government hospitals. Now, government hospitals are already overloaded with other patients, so why would they entertain our patients? How will they entertain them is a big question. For instance, if a patient is sent to XYZ public hospital, the crowd is so large that the patient might get lost in it, and it may take until evening for them to be attended to. That patient ends up sitting at the hospital for 4 hours without any care. Looking at the current situation in these public hospitals, even sonography services are not functioning, and then the patient has to go for further referral to private diagnostic centres and spend money." (E31, official from the ESIS hospital)

While discussing problems in making referrals to public hospitals, it was explained that,

"The government has closed the ESI hospital tie-ups for secondary and tertiary care, sending patients to civil hospitals instead. However, this has caused issues, especially for workers without a ration card, who now have to pay fees at public hospitals. While senior citizens and those with yellow ration cards receive free treatment in public hospitals, others—including ESIS workers with only an ESI card—must pay, as only the ration card is considered for free services." (E40, social activist, patient guide, Solapur)

In such situations, workers often end up making double payments. While they have already made their ESIS contribution, they now additionally land up paying formal user fees at public medical college hospitals or informal payments for purchasing medicines, tests, etc., which may or may not be reimbursed by ESIS.

Several workers shared their preference for private hospitals and expressed dissatisfaction about ESIS hospitals referring them to public hospitals instead of private hospitals, saying,

"If we had to go to public hospitals, why would we require a prescription of referral from ESIS hospitals? We can go to the public hospital directly, without spending time first visiting the dispensary and then the ESIS hospital." (Group interview with sanitation workers, Nagpur)

According to some officials, the decision to refer to public hospitals instead of tie-up hospitals appears to have been driven by delayed payments to private tie-up hospitals, frequent refusals to admit ESIS patients, and probably a desire to reduce spending on private hospital arrangements. However, as highlighted by several respondents, these referrals to public hospitals have proven neither productive nor convenient for IPs. In fact, they have further complicated the process for IPs seeking medical care.

3.6.3 Healthcare services by ESI dispensaries

Currently the number of ESI dispensaries in Maharashtra is grossly inadequate compared to the requirement. There should be one ESI dispensary per 3,000 to 10,000 workers. Even if we take the norm as one per 10,000 workers, the required number of ESI dispensaries in Maharashtra should be 445, but there are only 104 ESI dispensaries in the state. Currently, ESIS dispensaries are operational in 14 districts of Maharashtra.

ESI dispensary system and related problems faced by workers

Dispensaries act as primary care centres, providing outpatient treatment for common conditions. The IP must first visit the dispensary, from where they are referred to ESIS hospitals in cases of serious issues or specialty care. Up to seven days of medical leave can be approved by the dispensary doctor. They must update the online system for the sanction of the medical leave benefit. The Dhanwantari system is used at the dispensary level for patient records and leave management. If an IP has availed services from a private non-tie-up hospital, they need to visit the dispensary for approval before submitting the claim for reimbursement. The dispensary doctor scrutinises the documents/reports and provides remarks on them. This entire process is quite time-consuming for the IP. However, if the bill for treatment from a non-tie-up private hospital is up to Rs 25,000, it can be sanctioned by the dispensary doctor. If the bill exceeds that amount, it is sent to the Administrative Medical Officer (AMO) office. In some districts, there were Dispensary Cum Branch Office (DCBO) setups, which provide dispensary-level care as well as perform administrative tasks to some extent. DCBOs were established in 2018, and there were 22 DCBOs in Maharashtra at the time of data collection.

Some dispensaries were operated in ESIS-owned spaces, while others were located in rented properties. ESIS dispensaries were found to be understaffed and only offered basic services. Many lacked the ability to conduct basic pathology tests, and doctors typically referred patients to ESIS hospitals. Thus, in effect, medical care from dispensaries was generally limited to OPD services only. Some respondents also shared that the Medical Officer (MO) barely checks the patient and mostly tends to send the patient further to an ESIS hospital.

While discussing the shortage of staff in dispensaries, it was shared that,

"As per the ESIS manual, each MO is required to check 60 IPs per day. However, we check 180 patients each. This means one person is doing the work of three people but receiving the salary of only one person." (E09, DCBO In-charge)

Some dispensaries were often overcrowded, leading to long waits. In Nagpur, workers reported waiting the entire day to access services.

3.6.4. Services from Insurance Medical Practitioners (IMPs)

As per ESIS norms[30], usually, in newly implemented/existing areas where ESIC does not have its own infrastructure, primary care medical services are being delivered through empanelment of Insurance Medical Practitioners (IMPs). At present, the panel system is in operation in Andhra Pradesh, Assam, Gujarat, Himachal Pradesh, Karnataka, Madhya Pradesh, Maharashtra, parts of Goa, Telangana and West Bengal. However, the majority of IMPs are in the states of Maharashtra.

Interested Private Medical Practitioners are appointed as panel doctors. A panel doctor is expected to have their own consulting room and dispensary. Each panel doctor is allowed to register up to 2000 IP family units. At present, the panel

30 STANDARD NOTE ON EMPLOYEES' STATE INSURANCE SCHEME (As on 01.01.2022), https://www.esic.gov.in/attachments/publicationfile/9decf733b65a587e3e6201914e54dbaa.pdf

system is in operation in West Bengal, Maharashtra, Andhra Pradesh, Goa, Gujarat, M.P, Telangana, Bihar, Assam, Odisha, Rajasthan and Jharkhand etc. The IMPs under the panel system are paid capitation fee (Rs.500/- per IP per year) w.e.f. 8th September, 2016 for providing medical care to the ESI beneficiaries which include consultation, basic lab investigation and cost of medicines. However, many IMPs have expressed that this amount (Rs. 500 per year per IP family) is insufficient to cover treatment costs, especially for chronic conditions like diabetes and hypertension, including medications. The current payment structure is considered too low to provide adequate care for patients. Many IMPs have requested that this amount be doubled to better meet patient needs and cover the expenses of chronic condition treatments.

According to some workers, some IMPs charge ₹200-500 for uploading medical certificates online. IMPs are expected to collect specified medicines from the designated nearest ESIS dispensary for supplying the same to the beneficiaries and also provides the investigations facilities of urine, haemoglobin and blood sugar. However, this does not seem to be happening in most places. Respondents also raised concerns about the non-availability of medicines at IMP clinics. IMPs provide prescriptions and advise IPs to obtain the medicines from ESIS hospitals or dispensaries. However, due to the long distance to these facilities, many IPs are forced to purchase medicines from nearby private pharmacies, leading to additional out-of-pocket expenses.

Furthermore, IMPs told us that, payment by ESI is only made for active beneficiaries or the live lists of IPs, which are updated infrequently. As a result, the number of registered IPs with an IMP may appear higher than the actual number, as individuals who have left their jobs, retired, or switched employers remain listed in the system. IMPs have also highlighted the issue of delays in payment and outdated records contribute to their financial challenges.

Also, the lists of IMPs on the ESIS website have not been updated, and many doctors who have left the scheme are still listed. It was shared that IMPs are typically offered yearly contracts, which adds a layer of instability to their role and contributes to the growing disinterest among new doctors in joining the ESI system. While there is an association of IMPs in Maharashtra and an IMPs federation in Pune, these organizations are reportedly not very active or effective in advocating for the needs of IMPs. Overall, the IMP system appears to be in a state of decline.

Despite these challenges, the IMP system is still considered beneficial for workers, as it provides accessible healthcare services, particularly in areas lacking nearby dispensaries. However, to ensure the optimal functioning of the IMP system, improvements are needed at multiple levels, including the increase in the amount of compensation and the mechanisms for monitoring and governance.

3.7. Governance, monitoring, and accountability

Overall fractured and weak governance of ESI within the state: Various respondents from the ESIS hospitals and regional offices, highlighted the issues of a major dichotomy between the Central government-managed ESIC and the State government-managed ESIS, which hampers the coordination at various levels of the system, particularly around purchases.

"There is significant dysfunction within the ESIS system, as it involves both the state and central governments, who act like "dual controlling bodies" passing responsibilities back and forth without clear authority. The state government requests funds from the central government, but the state has little control over how these funds are spent". (E20, AMO officer)

The current lack of ownership for ESI by the Maharashtra State government, with seemingly low implementation related involvement of the State Health Department, has left this important scheme almost leaderless at the state level. The

state government and political leadership have consistently neglected this crucial scheme, thus compromising its potential to provide much needed healthcare and social security to the working population of Maharashtra.

Some hospital authorities also mentoned,

"at the hospital level, the hospital management lacks the authority to set policies. All decisions come from the higher corporation level, and the staff's role is mainly to handle documentation and refer patients to other hospitals when necessary. Many essential services, especially specialist care, are unavailable locally, leading to patient referrals and reliance on external hospitals". (E23 regional officer)

Dysfunctional participatory governance bodies: As reported by various respondents, various important governance and accountability bodies related to ESI in Maharashtra were not actively involving workers representatives, some have lapsed, were inactive or have not even been formed. This includes the regional board at state level, Local committees in every district, and Hospital Development Committees to be associated with every ESI hospital.

"After 2015, no one has called for meetings anymore. Previously, the Labor Commissioner would organize meetings with the local committee members, the company's team, and representatives from both staff and workers. These meetings would involve around 10-15 people, including representatives from the company and workers, along with the Labor Commissioner but it has been stopped now since 2016". (E45, Advocate, trade union representative, Kolhapur)

Respondents from many other places echoed it as committee meetings were not conducted regularly and members were not invited for years.

Contractual workforce within the ESI system: ESIS in Maharashtra is registered as a society / trust (NGO) without formal status as an official body. Additionally, the ESI Society (ESIS), a para-statal body, lacks formal status and operates with a largely contractual workforce, leading to major transparency and accountability issues. The organization's opaque structure and complete lack of web presence make it difficult to ensure its accountability to workers and employees. Large numbers of doctors and healthcare workers across various levels of ESI lack secure employment, health and social security benefits. This situation adds to another layer of compromised functionality to the already under-resourced and poorly managed ESI system, ultimately affecting ESIS entitlements to IPs.

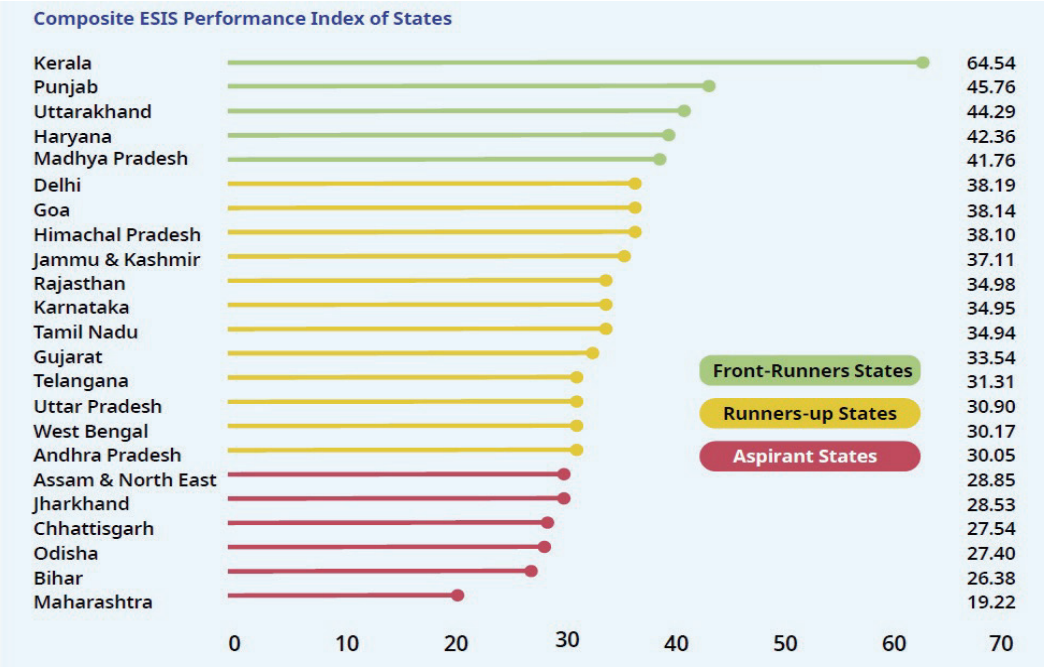
Overall ESI in Maharashtra today does not appear functioning as a worker centred, demand driven, comprehensive system in practice, since the range of needs of workers and their families (those covered, as well as many more who need to be covered), and the voices of these workers in diverse situations, find hardly any expression in the planning, expansion and accountability of the ESI system. Linked with this is the marginalisation of trade unions in ESI governance, since major trade unions in Maharashtra do not appear to be represented in state level ESI bodies, and crucial decisions are taken mostly at level of the national ESIC driven by the bureaucracy.

To conclude, in the state of Maharashtra, which has by far the largest number of ESI beneficiaries in the country, it seems a tragedy that such an important scheme as ESI has been seriously neglected. According to a ranking of Indian states by the International Labour Organisation (ILO) related to ESI performance based on a composite index, Kerala claimed the top ranking with index value of 65.5, while ***Maharashtra scored at absolute bottom, below all other states*** with index value of just 19.2.

Based on these findings we need to ask if ESI has become 'an ideally conceptualized, but practically faltering' scheme for workers' health and social security in the state. Although most of the resources for ESI flow from workers (directly as their own contribution, and indirectly as employers' obligatory payment for their social security), today this scheme

funded by workers themselves has become detached from the needs of workers on the ground. ESI systems seem to be largely beyond collective control or accountability to workers in any effective sense. The public servants (ESI officials, particularly at national level) now appear in the role of masters of the scheme, while the real owners (workers) have been reduced to supplicants, or even worse are excluded from the scheme. Trade unions which traditionally represent worker's interests are also largely marginalised from actual governance of ESI, although some representatives have a nominal seat at the table. In principle, ESI is a scheme which should be 'of the workers, for the workers, by the workers'; but in practice, especially in context of Maharashtra, the locus of governance has moved completely away from workers, trade unions, and even employers, and has been appropriated by the ESI bureaucracy especially at national level, although ironically the central government makes no significant financial contribution to this scheme. The overall policy framework which is constricting public systems while promoting privatisation of the social sector, constitutes the larger stage on which the paradox of ESI in Maharashtra is unfolding today.

Graph no. 6 composite ESIS performance Index of states



Source- ILO report, 2022

Section 4

Recommendations for worker-centred transformation of ESI in Maharashtra

ESI is a major national scheme which has a sound basic design, ample financial reserves with regular receipt of contributions, and wide acceptability among workers as well as employers in Maharashtra, who contribute hundreds of crores rupees every year to this scheme. However as we see from the findings of this study, due to major gaps in governance, fragmentation of responsibilities, underfunding of medical services, lack of accountability to users and other factors, currently millions of workers in the state are not receiving quality healthcare and effective social security from this scheme. For ESI in Maharashtra to be converted into a worker-centred, demand driven, fully effective and universally oriented scheme, a range of integrated measures need to be taken urgently at various levels, including the following:

1. State government needs to demonstrate much stronger political will, and launch a major public initiative for improving ESI in Maharashtra

- Maharashtra government should launch a state-wide, intensive public campaign to provide much greater visibility to ESI, while developing consensus for upgradation and expansion of the scheme, with the active involvement of the State Labour Department, State Health Department, trade unions, social organisations, workers, and employers.
- The objective of further policy and programmatic processes should be to ensure proper delivery of all benefits to all eligible workers, to majorly upgrade ESI health services as per requirements, and to significantly expand the scheme to include the large number of workers who are presently not covered or not being effectively served by the scheme.
- This process must be accompanied by renegotiation between the Maharashtra State Government - ESIS and ESIC at the central level, to ensure financial and administrative support as well as adequate state level autonomy to implement large-scale upgradation, expansion and responsiveness of the scheme in the state.

2. Correct major imbalance in allocation of funds by ESIC to ESI in Maharashtra, incerase the scale of funding for ESI medical services

- Given the large gap between the revenues for ESI collected from Maharashtra (Rs 2752 crores in 2022-23) versus the amount which is actually spent by ESI on medical care in Maharashtra (Rs 997 crores spent in 2022-23), there is need to correct this imbalance. At least Rs 3000 per insured person should be provided annually by ESIC, translating

to Rs 1335 crores annually for ESI medical services in Maharashtra. Significant portion of such expanded funds can be used to upgrade and expand ESI hospitals, dispensaries, and services across the state.

3. Majorly expand ESI coverage to include all eligible workers

- Keeping in view the vast numbers of workers in Maharashtra who are eligible to be covered by ESI, but are being left out due to various administrative problems and employer-related gaps, it important to promptly overcome under-coverage of eligible workers. For identifying and including all eligible workers, ESI should use available lists of workers from Factories act registration, Shops and Establishments act registration, PF enrolment etc.
- For all eligible workers, it must be ensured that the related employer is enrolled under ESI, and they should regularly pay their ESI contribution, ensuring that the workers properly receive all ESI benefits. Workers should have the option of self-enrolment by approaching ESI offices directly in case their employer is negligent in ensuring enrolment, and ESI must then take prompt time bound action to enrol their employers and ensure their contributions.
- The current wage ceiling which is nationally excluding crores of workers from ESI benefits should be either eliminated completely, or the ceiling level should be more than doubled (from Rs. 21,000 pm to Rs. 50,000 pm at present) to bring in huge numbers of deserving workers who have been unjustifiably excluded from the ambit of ESI.
- All eligible contract workers must be registered under ESI by strictly holding employers / principal employers (including the State Government and Municipal Corporations) accountable for enrolment under ESI. Coverage should also be expanded in phased manner to include various sections of informal sector workers (see section 11 below).

4. Significantly upgrade ESI healthcare infrastructure and appoint regular staff

Given the major deficiencies in quantity of facilities as well as quality of healthcare services provided by ESI in Maharashtra through its own hospitals and dispensaries, the following measures are overdue and should be implemented now.

- Increase the number of ESI hospitals and beds to meet the desirable ratio of one bed per 250 workers (equivalent to around 1 bed per 1000 beneficiaries). As a first phase even if we take the revised norms of 1 ESI bed per 500 to 750 IPs, there is need for four-to-six-fold expansion of commissioned ESI hospital beds in Maharashtra. This includes as an immediate step, expediting the completion and commissioning of 18 new ESI hospitals, mostly located in districts which lack ESI hospitals, which would add around 1800 beds. Similarly expand the number of ESI dispensaries to achieve the norm of one dispensary per 5,000 to 10,000 workers, which would involve at least four-fold expansion of dispensaries. Such expansion should be done in a manner that ensures equitable and need-based geographical distribution of newer ESI healthcare facilities across the state.
- Fill sanctioned posts for specialist doctors and other staff, and convert contractual positions into regular appointments. In case of specialist doctors this would involve four-fold regular recruitments to just fill the currently sanctioned posts. It is necessary to prioritize permanent hiring for critical positions to improve accountability and continuity of care. For medical staff, particularly specialists, offering competitive salaries is essential to attract and retain them. Operationalise a robust recruitment

process for permanent staff through MPSC or equivalent frameworks.

- Establish functioning ICU units in all ESI hospitals, ensuring that 10% of ESI beds are ICU beds. Improve maintenance and repair / replacement of outdated ESI hospitals and office buildings. At the hospital level, Medical superintendent (MS) can currently approve medicine purchases only up to ₹2.5 lakh. Larger expenses require society-level approval, causing delays. Increase the financial limit for MS to expedite purchases, and streamline the state level medicine procurement and distribution system.

5. Address serious problems with referrals and reimbursements related to private hospitals

- Revoke the April 2023 ESIS order restricting referrals of IPs from ESIS/ESIC hospitals only to general public hospitals and reinstate the option of referrals to empanelled private hospitals. This must be combined with resolving the existing problems with such referrals (as given below), along with expected expansion of ESI's own hospitals and facilities in accelerated manner, which will reduce the need for such referrals in the future.
- Ensure timely payments to tie-up private hospitals, while also effectively monitoring them to prevent denial or delay of care for ESI beneficiaries. Streamline and simplify the reimbursement process for care from empanelled as well as non-empanelled private hospitals, reducing delays and ensuring reimbursement at realistic rates rather than CGHS rates. Enhance regional administrative support with adequate and qualified staff for timely claim settlements and operational efficiency.

6. Simplify documentation and eliminate procedural barriers

- Establish helpdesks and appoint social workers in all ESI hospitals and higher utilisation dispensaries, to guide workers and facilitate procedures. Set up a 24x7 ESI helpline to provide immediate support so that workers can access services and benefits. Consider appointing agents such as 'Kamgar Mitra', to facilitate/ ensure registration of workers, they can be paid and incentivised to help enrol, register and guide workers related to the scheme.
- Eliminate pre-condition of Aadhaar linkage for ESI registration. Effectively address and prevent interruptions in ESI coverage caused by a change of employer, and outdated family member photographs. Currently, workers are completely dependent on employer assistance for renewing ESI registration, however the proposal should be considered to allow workers to continue their ESI registration on their own, even if they change employers, as long as they maintain continuous registration.
- Like the case of Provident fund, there should be a provision of the worker receiving SMS after submission of contribution to ESIC by the employer/contractor. This will reduce instances where the employer / contractor deducts the amount of contribution from IPs but does not submit this to ESIC.
- Ensure proactive delivery of ESI related social security benefits, such as simplifying the process of obtaining medical certificates required for wage compensation during illness.
- ***A worker-focussed ESI app should be launched***, which would include information like- 'Know your ESIS dispensary', helping

workers know about the nearby health facilities under ESIS. Similarly availability of services in various nearby ESI and empanelled hospitals, as well as updated status of employer and employee contributions should be accessible to workers through the app.

7. Enhance worker awareness and improve transparency

- Periodic state-wide worker awareness campaign should be conducted with involvement of audio-visual media, print media and social media. Such initiatives should communicate about ESI's comprehensive benefits and key procedures. Allocate 3% of the state ESI budget for awareness generation activities involving trade unions, worker activists, and employers.
- Workers should be informed about ESI services and entitlements through pamphlets, posters and videos, along with conducting awareness meetings about the importance and benefits associated with ESI.
- At state level there should be a dedicated website in Marathi with information about all annual reports, services related data, details of officials, functionaries and members of committees at all levels. List of services and medicines expected to be available, as well as guidance for grievance redressal should be displayed in every ESI dispensary and hospital.

8. Promote worker-oriented accountability and social audits

- Various important governance and accountability bodies related to ESI in Maharashtra need to be activated and reorganised / expanded. This includes the ***Regional board*** at state level, ***Local committees*** in every district, and ***Hospital Development Committees (HDCs)*** to be associated with every ESI hospital. There is urgent need to review, re-form and expand all three levels of accountability committees across the state, with active involvement of trade unions and worker representatives at each level.
- Since only a few employee representatives are allowed to be part of the Regional board at state level, ***a broader State ESI Forum should also be set up as an advisory body with wide representation from diverse trade unions and worker organisations from across Maharashtra***, which could meet once in six months and review functioning and identify gaps for correction, as well as provide structural and policy recommendations for improving the ESI system across the state.
- ***A regular system of worker-based monitoring of ESI services and facilities*** needs to be organised which could be linked with activated HDCs and ESI Local committees. Through this process, based on trade union and workers inputs, resolutions and decisions could be taken for required local improvement in services. Worker committees in each area should be enabled to conduct periodic social audit of ESIS facilities and delivery of benefits.

9. Address key governance issues

- The serious dichotomy between Central government managed ESIC and State government managed ESIS runs a fracture through various levels of the system and hampers effective coordination. This needs to be overcome through appropriate convergence mechanisms; one option could be an ESIC - Maharashtra ESIS Joint steering committee, including related senior officials from both bodies and selected representatives of employees and employers drawn from the Regional board.
- There is also urgent need for the state political leadership and state government to accord

much higher priority to this crucial scheme and to develop a state level discourse about essential role of ESI, keeping in view its huge potential to provide much needed healthcare and social security to the working population of Maharashtra. This should be associated with in-depth participatory review of the ESI system and relevant decisions being taken at the highest levels of government.

- Another governance issue requiring attention is the insecure status of large number of contractual workers under ESI, linked with peculiar nature of the ESI Society (ESIS). This body is entrusted with the entire management of ESI services in Maharashtra state, but occupies a grey zone in terms of its official status, since ESIS is registered as a society / trust and employees engaged by ESIS are entirely on contractual basis. This semi-official body appears lacking in public transparency, it has virtually no web presence, and ensuring its accountability to ESI covered workers requires more systematic mechanisms and processes.

10. Expand ESI to include informal workers in phased manner

- In the current situation, it is estimated that ESI covers only around 25% of the non-agricultural workforce in Maharashtra. Numerically huge sections of informal and contractual workers, along with platform and gig workers definitely require health and social security. In this situation, ESI should be expanded in phased manner to include various sections of informal sector workers, while appropriately dealing with the associated legal, administrative and financial issues. This is crucial for making the scheme demand driven and for moving towards universalism.
- As one of the key steps in this direction, all contractual and scheme-based workers whose principal employer is the government – like large numbers of contractual workers and Safai karmacharis under various Municipal corporations, ASHAs, Anganwadi workers etc. should be immediately covered by ESI, with the employer contribution being made by respective governments.
- In case of workers covered by sector-specific welfare boards like Mathadi workers, construction workers, domestic workers, beedi workers etc. their healthcare coverage could be coordinated with ESI, while maintaining other board-specific benefits and arrangements in each case. The employer contribution for ESI health services could be made by the respective boards. During this process, certain technical issues related to provisions under various welfare boards will need to be resolved, since these boards have been formed under different acts, and with diverse financial arrangements.

To conclude, it is high time that the central and state governments, political parties, trade unions and social organisations in Maharashtra all wake up to the crucial importance of ESI, which presently is covering almost one-sixth of the population of the state (over 1.8 crore beneficiaries). As described briefly here, there is urgent need for wide-ranging reform and expansion of ESI, which requires an integrated range of measures from above (actions by state government and the ESI official framework) as well as below (mobilisation, monitoring and participatory inputs by workers, trade unions and organisations of informal sector workers). Such a comprehensive overhaul would enable the range of working people of Maharashtra to reclaim their right to health services and social security, through a transformed ESI which would match the dreams of its founders, and the aspirations of its current and potential users.

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