CHAPTER 1

INTRODUCTION

In 1990 Pakistani economist Mahbub ul Haq had develop the explicit purpose "to shift the focus of development economics from national income accounting to people centered policies"(World Bank, 2001)[1]. To produce the Human Development Reports, Mahbub ul Haq brought together a group of well-known development economists including: Paul Streeten, Frances Stewart, Gustav Ranis, Keith Griffin, Sudhir Anand and Meghnad Desai. But it was Nobel laureate Amartya Sen's work on capabilities and functioning that provided the underlying conceptual framework. Prof. Haq was sure that a simple composite measure of human development was needed in order to convince the public, academics, and policy-makers that they can and should evaluate development not only by economic advances but also improvements in human well-being. Prof. Amartya Sen initially opposed this idea, but he went on to help Prof. Haq to develop the Index. Prof. Amartya Sen was worried that it was difficult to capture the full complexity of human capabilities in a single index but Prof. Haq persuaded him that only a single number would shift the attention of policy-makers from concentration on economic to human well-being.

HUMAN DEVELOPMENT INDEX (HDI)

The origins of the HDI are found in the annual Human Development Reports of the United Nations Development Programme (UNDP). However, HDI was first devised and launched by Pakistani economist Mahbub ul Haq, followed by Indian economist Amartya Sen in 1990. The Human Development Index (HDI) is a composite statistic used to rank countries by level of "human development", taken as a synonym of the older terms "standard of living" and/or "quality of life", and distinguishing "very high human development", "high human development", "medium human development", and "low human development" countries (HDR,2008)[2]. The HDI is a comparative measure of life expectancy, literacy, education, and standards of living of a country. It is a standard means of measuring well-being. It is also used to distinguish whether the country is a developed, a developing or an underdeveloped country, and also to measure the impact of economic policies on quality of life. There are also HDI for states, cities, villages, etc. by local organizations or companies which have interest in the matter. The HDI formula result is a number from 0 to 1, 1 being the best outcome possible and 0 is the worst.

More precisely the Human Development Index (HDI) is a summary measure of human development. It measures the average achievements in a country in three basic dimensions of human development: a long and healthy life **(health**), access to knowledge (**education**) and a decent standard of living (**income**). Data availability determines HDI country coverage. To enable cross-country comparisons, the HDI is, to the extent possible, calculated based on data from leading international data agencies and other credible data sources available at the time of writing.

India has been performing poorly in social sectors. India's rank in terms of the UNDP Human Development Index (HDI) is 126 among 177 countries, which manifests from

a stagnant and declining share of social sector in total expenditure of the Government. Similarly, India has been performing poorly in the area of Gender Development. India's rank in terms of UNDP Gender Development Index (GDI) is 96 among 177 countries, which show lack of attention being given towards gender development. In India labour force has increased from 360.6 million in 1990 to 473.3 million in 2003 with average annual growth rate of 2.1 percent during 1990-2003[3](WDI, 2005).

"HEALTH" AS AN INDICATOR OF HDI

Health is an indicator of well – being that has immediate implications for the quality of life as well as for productive capacities and capabilities. Although the National Health Policy (NHP) in India was not framed until 1983, India has built up a vast health infrastructure and initiated several national health programmes over last five decades in government, voluntary and private sectors under the guidance and direction of various committees (Bore, Mudaliar, Kartar Singh, Srivastava), the Constitution, the Planning Commission, the Central Council of Health and Family Welfare, and Consultative Committees attached to the Ministry of Health and Family Welfare[4]. The period after 1983 witnessed several major developments in the polices impacting the health sector - adoption of National Health Policy in 1983, 73rd and 74th Constitutional Amendments in 1992, National Nutrition Policy in 1993, National Health Policy in 2002,National Policy on Indian System of Medicine and Homeopathy in 2002, Drug Policy in 2002, introduction of Universal Health Insurance schemes for the poor in 2003, and inclusion of health in Common Minimum Programme of the UPA Government in 2004, National Rural Health Mission in 2005[5].

The first National Health Policy in 1983 aimed to achieve the goal of 'Health for All' by 2000 AD, through the provision of comprehensive primary healthcare services[6]. It

stressed the creation of an infrastructure for primary healthcare; close co-ordination with health-related services and activities (like nutrition, drinking water supply and sanitation); active involvement and participation of voluntary organisations; provision of essential drugs and vaccines; qualitative improvement in health and family planning services; provision of adequate training; and medical research aimed at the common health problems of the people.

Through the 73rd and 74th Constitutional Amendment Acts (1992), the local bodies (Municipalities and Panchayat) have been assigned 29 development activities, which have a direct and indirect bearing on health. These include health and sanitation (covering hospitals, PHCs and dispensaries), family welfare, drinking water, women and child development, the public distribution system and poverty alleviation programmes[7].

The Common Minimum Programme announced by the UPA government in 2004 has proposed to raise public spending on health to at least 2-3 percent of the Gross Domestic Product (GDP) over the next five years, with focus on primary healthcare. The present Government has proposed to take all steps to ensure availability of life saving drugs at reasonable prices through revival of Public Sector Units in the manufacture of critical bulk drugs.

The **Union Budget 2012-13[8]** has proposed three major initiatives in the health sector. They are: (i) redesigning the Universal Health Insurance scheme introduced in 2003 to make it exclusive for below poverty level people with a reduced premium (ii) introduction of Group Health Insurance scheme for members of Self Help Groups and Credit Link Groups at a premium of Rs 120 per person for an insurance cover of Rs 10000, and (iii) exemption of income tax for the hospitals working in rural areas.

HEALTH (LIFE EXPECTANCY) AS THE SIGNIFICANT INDICATORS FOR 2011:

The UN population division revised its life expectancy series in 2011, creating both increases and decreases for many countries. Life expectancy at birth has increased for male and female in India at a rate 64.1 years for males and 65.8 years for females (HDR, 2005)[9] This indicates that the decrease in death rate and the better improvement of quantity and quality health services in India. However, there are inter-state, inter-district and rural-urban differences in life expectancy at birth due to low literacy, differential income levels and socio-economic conditions and beliefs. In Kerala, a person at birth is expected to live for 73 years while in states like Bihar, Assam, Madhya Pradesh, Uttar Pradesh, etc, the expectancy is in the range of 55-60 years. Healthy life expectancy at birth in India was estimated to be 53.5 in 2002. This was 53.3 for males and 53.6 for females (WHO, 2005)[10].

A Glimpses of Assam Human Development Index can be accessed through the following table [11]-

Table1.1: Status of Human Development Index, Assam 2003

Districts ranked by HDI, in descending order	Literacy (2001) %	Combined Enrolment Ratio (1991)	Education Index	Infant Mortality Rate	IMR Index	Per Capital NSDP (2000-2001) at1993-94 constant prices	Income Index	HDI Index	HDI Rank
Jorhat	77.91	60.73	0.722	47	0.664	11222	0.564	0.65	1
Kamrup	74.69	60.8	0.701	77	0.450	11424	0.573	0.574	2
Golaghat	70.36	54.31	0.650	61	0.564	8021	0.409	0.540	3
Morigaon	59.46	46.39	0.551	88	0.371	11152	0.562	0.494	4
Karbi Anglong	58.83	42.8	0.535	76	0.457	9588	0.491	0.494	4
Dibrugarh	71.21	53.72	0.654	51	0.636	4713	0.162	0.483	6
Sibsagar	75.33	59.92	0.702	75	0.464	5602	0.242	0.469	7
Cachar	68.42	53.34	0.634	97	0.307	5897	0.266	0.402	8
Barpeta	57.35	43.51	0.527	101	0.279	7616	0.385	0.396	9
Tinsukia	63.28	44.72	0.571	73	0.479	3966	0.082	0.377	10
Hailakandi	59.84	49.09	0.563	99	0.293	5507	0.234	0.363	11
NCHills	68.59	57.69	0.650	108	0.229	5234	0.211	0.363	11
Sonitpur	60.29	45.03	0.552	77	0.450	3869	0.071	0.357	13
Nagaon	62.28	50.43	0.583	97	0.307	4893	0.179	0.356	14
Kokrajhar	52.55	37.17	0.474	78	0.443	4544	0.145	0.354	15
Nalbari	68.08	56.23	0.641	96	0.314	3911	0.076	0.343	16
Lakhimpur	69.59	57.97	0.657	112	0.200	4636	0.154	0.337	17
Goalpara	58.56	43.74	0.536	106	0.243	4548	0.146	0.308	18
Karimganj	67.21	51.45	0.620	111	0.207	3931	0.078	0.301	19
Dhemaji	65.96	54.63	0.622	114	0.186	3511	0.026	0.277	20
Bongaigaon	60.27	46.64	0.557	122	0.129	4150	0.103	0.263	21
Darrang	55.92	42.33	0.514	111	0.207	3755	0.057	0.259	22
Dhubri	49.86	36.49	0.454	128	0.086	4144	0.102	0.214	23
Assam	64.28	49.78	0595	92	0.343	6158	0.286	0.407	

Source: Draft State Human Development Report(SHDR- 2013) & Statistical hand Book, Assam, 2003

SOCIAL SECURITY, HEALTH BENEFITS & HEALTH INSURANCE

Social Security has now become a fact of life for millions of people throughout the world. It is a major aspect of public policy and extent of its prevalence is a measure of the progress made by a country towards the ideal of a welfare state. The role of health care in economic development has received increasing attention in recent years. It is

therefore, in the fitness of things that the 11th Five Year Plan [12], whose central theme is "Inclusive Growth", has substantially stepped up the allocation for health. The Plan document presents a well thought out and comprehensive structure for health care in rural areas. Health Insurance in a narrow sense would be 'an individual or group purchasing health care coverage in advance by paying a fee called premium'. In its broader sense, "it would be any arrangement that helps to defer, delay, reduce, or altogether avoid payment for health care incurred by individuals and households.[13]" Rao (2002) [14], said that, a human being has to live until his death. The journey from the date of birth to date of death can be understood as sustenance; alternatively, the living. To accomplish this task of living one has to have enough economic provision or support, either earned on his own or provided by somebody else. When some body provides this, it is called dependency. Definitely, there are two phases in one's life, where one is dependent on other person or on the society. The first phase- from the date of birth until the date when he/she becomes fit to start earning his own living. This phase, we may call as the first phase of dependency. The second phase of dependency is the phase when a person ceases to work/ earn or retires from active work life. We may call it old age. There are intermediate phases of dependencies like: disability, sickness, employment injury; unemployment, loss of employment or other contingencies that might interrupt the working life of an individual. Children, non-earning women, unemployed widows are predominantly dependent on earning members of the family. Traditionally family provided this support. We also see such support provisioning by social groups, membership institutes, markets and ultimately by the state. Thus, failure in support provisioning or inadequate support provisioning by one institute makes other institute responsible for the welfare of the individual.

India is a labour abundant country and many of its population are living in the rural areas, mainly consisting of middle and low-income groups. These groups of people necessitate the provision of health services or health insurance services, although their capacities to pay insurance premiums are very low. More than 90 percent of Indian population and almost all the poor are not covered under any health insurance scheme. Their health care needs are met primarily through direct out-of-pocket expenditure on services provided by the public and private sectors. However, various studies on the use of health care services show that the poor and other disadvantaged groups (scheduled castes and scheduled tribes) are forced to spend a higher proportion of their income on health care than the better-off. For the disadvantaged, the burden of treatment, especially inpatient care, is disproportionately heavy. In India, only 3% of population is covered by some form of health insurance, either social or private. This indicates inequalities in healthcare industry (Visaria and Gumber 1994) [15].

Social Security in India was traditionally the responsibility of the family/community in general. With the gradual process of industrialization/urbanization, breakup of the joint family set up and weakening of family bondage, the need for institutionalized and State-cum-society regulated social security arrangement to address the problem in a planned manner in wider social/economic interest at national level has been felt necessary and the concept of "insurance" come into focus. Currently, ongoing measures towards transformation process for trade and industry, increasing role of market forces and increase in longevity, in general world over has added a new dimension to the issue and enhanced the requirement further towards a planned and regulated institutionalized measure in the form of social security in its common understanding.

The scope of the term social security was thus expanded to include not only contingency related measures but also several programmes aimed at improving endowments, exchange entitlements, real incomes and social consumption (GOI, 2000) [16].

Three of the eight Millennium Development Goals adopted by 189 countries in 2000 pertain directly to health, as do eight out of sixteen targets and eighteen out of forty-eight indicators (WHO Millennium Development Goal Brief). However evaluation of progress of countries to meet these goals after five years shows little progress in sub-Saharan Africa in particular, with low income countries not spending enough to ensure that these goals are met (WHO Millennium Development Goals Scorecard at Half Time Brief) [17]. Universal provisioning would prevent the wastages caused by targeting, as well as ensure that informal workers and the very poor do not slip through the targeted schemes, which has been shown time and again to happen. The notion of universal protection also situates the concept of social protection in the ambit of 'social citizenship', rather than limiting it to 'economic citizens'. Social security is also known as 'social protection 'or protection against socially recognized conditions, including poverty, old age, ill health, sickness, disability, unemployment and others through the provision for retirement pensions , disability insurance, health insurance, survivor benefits and unemployment insurance (Hickey, 2005) [18]. Social Security protects not just the subscriber but also his/her entire family by giving benefit packages in financial security and health care. The main strength of the Social Security system is that it acts as a facilitator - it helps people to plan their own future through insurance and assistance. State as an agent of society has an important duty to reduce such differences through a protective cover to the poor, the weak, the deprived and the disadvantaged. The success of Social Security schemes however

requires the active support and involvement of employees and employers. Health security is an important aspect of social security. Health security can be described as ensuring low exposure to risk and providing access to health care services along with the ability to pay for medical care and medicine. Such health security should be made available to all citizens. However, a universal health security programme for the country remains a distant goal. Overall, health insurance coverage is low. Only 9 percent of the Indian workforce is covered by some form of health insurance (through CGHS, ESIS and *Mediclaim*), and most of those insured belong to the organized sector (Gumber 1998) [19]. Twenty-five percent of the patients who enter hospital above the poverty line fall below the poverty line after hospitalization because of their health-care costs [20]. Improved health care and resultant increase in longevity call for redoubled effort to plan for and put in place appropriate institutional mechanisms and programmes to cover a much wider population base. The cover will enable workers to tide over periods of unemployment, sickness, accident or death while in employment coupled with the promise of an assured monthly income to them and their family in old age. So there is no doubt that health is an important part of social security. A healthy individual can make a positive contribution towards himself, his family, society and the country. However, ill-health can reduce his potential and productivity, thereby influencing his income generation, especially in the informal sector, and, in which, there is no safety net in the form of financial or social security. Wagstaff & Lindelow (2008) [21] report that insurance appears to encourage people to seek more care from the expensive tertiary care providers, sidetracking primary care providers in the process. Providing social security to the entire workforce, specially BPL families, has emerged as one of the major concerns in the country because, for people living below poverty line, because an illness not only represents a permanent threat to

their income earning capacity, but in many cases, it could result in the family falling into a debt trap. These tragic outcomes call for health insurance which shares the risk of major health shocks across many households by pooling them together. A well designed and implemented health insurance scheme can increase access to healthcare and improve its quality over time. So health insurance is an important form of social security towards health. Further, it is also confirmed by Wagstaff, et. al (2009) [22], who show that both outpatient and inpatient expenses of the households seems to have gone up considerably post-insurance. Now the portability scheme proposed has been introduced in non-life private health insurance schemes will improve the competition and thus the quality of services, along with expected fall in premiums.

A number of studies have been completed on the demand for health insurance products in India. In one study, Ralf Rademacher [23] mentions that only 10 percent of the entire Indian market is covered by private and public health insurance. He further mentions that secluded castes and secluded tribes often exhibit a strong preference for traditional medicine, making their incorporation into formal health provider systems difficult. Rademacher claims that approximately 80 percent of the financing of the Indian health-care system is done through private payment in spite of the existence of free universal health care and public -sector hospitals in all urban areas.

Health insurance can be either compulsory or voluntary. The former is usually known as social health insurance, while the latter is often used by people to supplement more basic state provision of healthcare (WHO/EIP, 2004, p. 2). Compulsory schemes avoid the dangers of adverse selection, but then face the challenge of affordability of membership to the poor and vulnerable workers (WHO/EIP, 2004, p. 33). In a number of instances however, social health insurance has been used as the vehicle for gradual expansion of universal coverage of healthcare financing (WHO/EIP, 2004, p. 2) [24].

The 73rd and 74th constitutional amendments have given the powers to the local bodies in some states of India. In the process, different states have adopted different stakeholders for the benefit of health services, with the help of community participation, which gives stress on safe drinking water and sanitation at village level. The ***Panchayat*** are given the power to look after the welfare of the people. In principle, Indians can access subsidized health services provided by a public sector with extensive coverage.

THE INDIAN SCENERIO OF HEALTH INSURANCE

The Indian health insurance scenario is a mix of mandatory Social health Insurance **(SHI),** Voluntary **Private Health Insurance** and Community-Based Health Insurance (**CBHI)**. The Social Health Insurance (SHI) is based on income-determined contributions from mandatory memberships. The existing mandatory health insurance scheme in India is – **Employees' State insurance Scheme (ESIS)** and Central Government Health Scheme (CGHS). Again, since, the liberalization of the insurance industry in 2000, India has been promoting private players to enter the health insurance sector. This was followed by another landmark decision in 2001 by establishing Third Party Administrations (TPA) [25] facilitate speedier expansion by providing an administrative- intermediary structure to the insurance industry. In 1883, Chancellor Bismarck of Germany introduced the first mandatory health insurance scheme in terms of which employers and workers were obliged to contribute towards the cost of low paid workers' health insurance [26].

Unfortunately, the focus of the insurance programs be it the social, private or publicly funded programs are targeted at specialists and hospital-care. While households with no financial risk protection end up spending catastrophic payments in accessing care from the hospitals, a large proportion of impoverishment occurs due to spending on

outpatient care, especially drugs. But insurance programs typically end up focusing disproportionately on tertiary care. Except ESIS, hospital-centrism is the focus of all these programs. Experiences of developed countries suggest that undue thrust on tertiary care can lead to poor value for money. Several middle-income countries such as, Chile, Brazil, Thailand have also witnessed transition from the earlier hospital centric thrust to primary care, on its way towards achieving universal coverage (WHO 2008) [27]. Commercial insurers are obviously making usurious profits. However, several states reportedly exceeded 100 percent mark, a pointer to be concerned with future premium rate setting. In these districts, the hospitalisation rates are extremely high and insurers are reported to making losses [28].

EMPLOYEES' STATE INSURANCE (ESI) SCHEME

Several schemes were drafted as a social security measures in the period preceding 1948, but yet the government of India had been able to take steps and to introduce only one, viz., and the Adarkar-Stack and Rao scheme. It is this scheme that inspires the ESI Act of 1948. Thus, this was the first social insurance measures to be introduced in India. The ESI Act encompasses certain health related eventualities that the workers are generally exposed to, such as sickness, maternity, temporary or permanent disablement, occupational disease or death due to employment injury, resulting in loss of wages or earning capacity- total or partial. Social security provisions made in the Act to counterbalance or negate the resulting physical or financial distress in such contingencies are, thus, aimed at upholding human dignity in times of crisis through protection from deprivation, destitution and social degradation while enabling the society the retention and continuity of a socially useful and productive manpower. The Act was enacted to provide certain benefits to employees in case of sickness, maternity and employment injury and to make provisions for

certain other related matters. However, most discussions of health insurance in India end after the ESIS and Mediclaim are dealt with. Yet these are not the only forms of health insurance in India. "Employer managed health facilities", and the "reimbursements of health expenses by employers" are also ways to insure people against the risk of illness. These facilities are common for large public and private enterprises. Expenses incurred on these facilities are generally not tabulated in official records. Certain observations by (Ratnam 1995) [29] on this issue are very revealing, as is this one:

Nearly half of the public sector companies did not specify financial limits because almost all public sector manufacturing enterprises covered, being large in terms of size of employment, invariably have their own dispensary and hospitals and provide medicines, etc, across the counter, usually within the company premises/township. The same applies to large private sector companies, which too have similar facilities and practices (1995:4).

COVERAGE OF THE ESI SCHEME

The ESI Act 1948 in the first instance applies to non-seasonal factories using power in the manufacturing process and employing 10 or more persons and non-power using factories or establishments employing 20 or more persons for wages (Employers' Guide, ESIC) [30]. The provision of the Act are being implemented area wise by stages. The Act contains an enabling provision under which the "Appropriate Government" is empowered to extend the provisions of the Act to the other classes of establishments-industrial, commercial, agricultural or otherwise. Under these provisions, most of the State Governments have extended the provision of the ESI Act. Followings are the main coverage of the ESI Act-

COVERAGE OF ESTABLISHMENTS

The coverage of the categories of establishments falling under section 1 (5) of ESI Act (Employers' Guide, ESIC) [31], is detailed below:-

An **'Establishment'** may be understood to be an organized body of men or an institution, not necessarily confined to a premises or place and has, therefore, a wider meaning. So long as an establishment employs the minimum prescribed number of persons for wages, it will stand covered under the Act, whether these employees are employed in one place or at a number of places, so long as they are engaged in the organized activity of the same establishment.

(a) Hotels and Restaurants

i) Hotels, restaurants and clubs employing 10 or more employees and using power in the manufacturing process and other such non power using units in the manufacturing process employing 20 or more employees are covered under the amended provisions of Section 2 (12) of the ESI Act as factories.

ii) Hotels and Restaurants employing 20 or more employees and having no manufacturing process are covered under Section 1 (5) of the ESI Act.

b) Cinemas including Preview Theatres

In the case of coverage of cinema houses, not only the persons employed directly in the cinema house, but the persons employed in cycle stand or canteen within the premises of the cinema house, are also to be taken into consideration for coverage even if these subsidiaries are run by contractors/ licensees etc.

c) Road Transport Establishments

In the case of Road Transport establishments, the main office may have only a small staff of clerks, cashiers or accountants, but, most of the employees would normally be working outside the premises, such as, drivers, cleaners, mechanics, booking clerks etc. For coverage of the establishment, all such employees will also be

taken into account irrespective of the fact, whether or not; they are working in the premises where the main business of the motor transport is located. Coverage will not, therefore, be limited to those who are working on the premises or precincts, but will extend to all those connected with the particular activity of the establishment.

Furthermore, employees of a covered/coverable Road Transport Company even though working in other States where such notification under Section 1 (5) has not been issued are also coverable under the Act.

d) Newspaper Establishments

In the case of Newspaper establishments, their printing press is covered as factory under Section 2 (12) of ESI Act. In areas, where provisions of the Act have been extended under section 1(5), employees working in newspaper establishments and failing within the scope of wage ceiling are covered under the Scheme.

e) Shop

The word 'Shop' has not been defined in the ESI Act. A shop is, no doubt, an establishment (other than a factory) to which the Act can be extended under Section 1 (5). For purpose of coverage under the ESI Act, the ordinary dictionary meaning will have to be taken as a definition. The coverage of "Shops", under the Act has, therefore, a wider meaning than its popular sense, and it cannot be limited to 'Shop" as defined under the other State statutes e.g. "Shops and Establishments Act". The essential ingredient for scope of coverage is that services must be rendered to the customers.

A place where services are sold on retail basis also a shop. The delivery of goods sold to the purchaser is only one aspect of trading activities. Negotiations of the terms of sale, carrying on of the survey of the goods imported, arranging for the delivery of the goods sold, collection of the price of goods sold etc. are all trading

activities. Where such activities are carried on from premises that place is a 'Shop'. An advertising agency which sells the campaign to the client and receives the price, therefore, is a 'Shop'.

While considering the coverage of 'Shops', facilities such as departmental canteens, dispensaries, doctor's clinics, banks, insurance companies are excluded. In case a departmental store is functioning like a super bazaar, it would be covered as one shop by counting the number of employees working in various branch offices/depots and the retail outlets working as sub-tenants.

COVERAGE OF EMPLOYEES

The term **'employee'** as defined in Section 2 (9) of ESI Act (Employers' Guide, ESIC) [32], means any person employed for wages in connection with the work of a factory or an establishment to which the Act applies. The term 'employee' includes all those persons employed in clerical, manual, skilled, semi-skilled, supervisory and unskilled work.

The Act does not make any distinction between casual and temporary employee or technical and non-technical employee or time-rated and piece-rated employee. As per the definition, "employees" fall into the following categories:-

i) Those directly employed by the Principal Employer either to work in factory, establishment or elsewhere;

ii) Those employed by or through an Immediate Employer (contractor) in the premises of the factory and those employed outside the factory premises under the supervision of the principal employer;

iii) Those, whose services are temporarily lent or let on hire to the Principal Employer or his agent by the direct employer of the person;

iv) Those employed for any work connected with the administration of factory or establishment, department or branch thereof, for purchase of raw material, distribution or sale of the product of factory/establishment etc. ;

v) Part time employee on 'contract of service'.

vi) Employees employed in sales office, depot, head office, administrative office, branch office or any other office dealing with purchase of raw material, distribution or sale of products of manufacturing units or dealing with such matters which ultimately result in sale/ purchase, even if situated outside the premises of the factory.

vii) Employees employed for construction/repair, maintenance of building, extension of factory building, repair, whitewashing, machinery repair, loading, unloading, movement of raw material and packing of finished products etc.

While deciding the coverage of an employee falling in category (v) above, a distinction has to be drawn between 'contract of service' and 'contract for service'. The salient feature of the term 'contract of service' are:-

a) Master's power of selection of his servant;

b) The payment of wages and other remuneration;

c) Master's right to control and supervise the work done by the servant;

d) Master's right for suspension or dismissal.

WAGE CEILING FOR COVERAGE

The monthly wage limit for coverage under the ESI Act would be' such as prescribed by the Central Govt. in the ESI (Central) Rules 1950 (Employers' Guide, ESIC)[33].The existing wage ceiling for coverage (excluding remuneration for overtime work) is Rs. 10,000/- per month w.e.f. 1-10-2006 (Rule 50 of ESI (Central) Rules

1950). An employee, who is coverable at the beginning of a contribution period, shall continue to remain covered till the end of that contribution period notwithstanding the fact that his wages may exceed the prescribed wage ceiling at any time after the commencement of that contribution period.

Wage ceiling for the purpose of coverage is revised from time to time by the Central Govt. on the specific recommendation of the Corporation. It is to be noted that-

(a) Employees of a covered factory working in non-implemented area can be exempted on application made to the **"Appropriate Govt".**

(b) An employee of a covered factory or establishment having his Hqrs. Office in an implemented area who remains away for over 7 months in a year, on tour or deployment, can also be exempted on an application made to the **"Appropriate Govt".** Subject to certain prescribed conditions.

EMPLOYEES' STATE INSURANCE CORPORATION (ESIC):

The administration of the ESI Scheme as per the ESI Act has been entrusted to the Employees' State Insurance (ESI) Corporation. The ESI Corporation is a body corporate having perpetual succession and a common seal, set up by the Government of India on 24th February 1952, under the provision of the ESI Act, 1948 to administer

and execute the Scheme of Employees' State Insurance. The ESI Act provides various powers to the Corporation for its proper functioning. Accordingly, the ESIC has formulated the following vision and mission (ESIC Act, 2010)[34] statements as guidance to achieve the very purpose of establishment of the organisation-

VISION

- Augmenting better co-ordination and awareness of the Scheme among all stakeholders of the Scheme and
- Brining improvement
    - Towards promote delivery of services to the IPs and Employers.
    - Towards prompt handling of Grievances.
    - Towards brining better work environment in our offices.
- Expansion of the Schemes to new areas and new sectors of employment.
- Cleanliness towards upkeep of our offices records.
- Development potential skill and positive human relations (through Training and interaction among all involved in the Scheme).

MISSION

- A very large security network that encompass the sickness, disability, death and maternity.
- It is a product of simple and liberal welfare legislation.

- It is an Efficient, Honest and Consumer friendly organization and its employees act like Missionaries with Zeal.
- Security and Service in the hour of need is its motto.
- It ensures Dependence during Diseases, Disability and Distress.

ORGANISATIONAL SET-UP OF ESIC

ESIS is administered by an apex corporate body called the Employees' State Insurance Corporation (ESIC) comprising members representing vital interest groups that include employees, employers, representatives of the Central and State Governments, Parliament and medical profession. The Union Minister of Labour is the Chairman of ESIC. The Director General, appointed by the Union Government, functions as its Chief Executive Officer. A Standing Committee, constituted from amongst the members of the ESIC, acts as the Executive Body. The Medical Benefit Council comprising the Director General of Health Services as Chairman and members of different interest groups viz. representatives of the Union Government, State Government, Union Territory, Employers, Employees, and Medical Profession etc. advises the ESIC on matters relating to effective delivery of medical services to the beneficiaries of the scheme. The Director General is also an ex-officio member of the ESIC and the Standing Committee. A Medical Commissioner, an Insurance Commissioner, a Financial Commissioner and an Actuary Commissioner assist the Director General in policy planning and decision making for growth and development of the Scheme. Regional Boards have been constituted in each State and Local Committees have been formed as Advisory Bodies for smooth functioning of the

Scheme. The Regional Boards and the Local Committees have representation both from employers and employees.

The ESIC functions from its headquarters at New Delhi, supported by a country-wide network of 23 Regional Offices, 11 Sub-Regional Offices, 4 Divisional offices, 628 Branch offices, 180 Pay offices and 272 Inspection office for administration of cash benefits, revenue recovery, implementation of the scheme in new areas and inspection of factories and establishments. Medical care in the States is administered by the State Governments on cost sharing basis except in the National Capital Territory of **Delhi** and **NOIDA** area in **Uttar Pradesh**, where the medical facilities are being provided directly by the ESIC. There is no specific reason for ESIC providing the medical care directly in these two areas. As on 31 March 2004, ESIC has 143 ESI hospitals and 1452 service dispensaries. The organisational chart of ESIC is given in the following table 1.2-

Table 1.2: Organisational Chart of ESIC

FINANCE

The ESI Scheme is financed mainly by contributions from insured employees and their employers in the implemented areas as a small but specified percentage of wages

payable to such employees. The rate of contribution by employer is 4.75% of the wages payable to employees. The employees' contribution is at the rate of 1.75% of the wages. The State Government's share is 12.5% of expenditure on medical care on ESI beneficiaries in their respective States within the per capita ceiling. Any expenditure over and above the ceiling is borne entirely by the State Governments.

However, from 1-8-2007, employees in receipt of an average daily wage of Rs 70/- or less, are exempted from payment of their share of contribution but are entitled to benefits under the scheme. The fund generated by ESIC are deposited in a common pool known as 'ESI Fund' and utilised for providing various medical facilities including cash benefits and other administrative expenditures of the corporation.

EXTENSION OF ESI SCHEME TO NEW SECTORS OF EMPLOYMENT The Committee on Perspective Planning (1972) (ESIC Rule, 1995) [35] of the ESI Corporation which had been appointed, inter-alia to work out a viable programme for phased extension of the Scheme, had formulated the following criteria for extension of the Scheme to a larger cross section of wage earners:-

(a) Need for health insurance protection;

(b) Feasibility of building upon expanding viable medical facilities; and

(c) Amenability of the establishments to enforcement by the Corporation.

Applying the above mentioned criteria, the Committee came to the conclusion that extension of the scheme should be accomplished in three phases, as given below:-

(i) In the first phase, factories run with power and employing 10 to 19 workers; factories run without power employing 20 or more workers and shops, cinemas including preview theater, road motor transport undertakings and newspaper establishments, hotels and restaurants employing 20 or more workers are to be covered.

(ii) The organized mines and plantations might be covered in the second phase. In the case of mines and plantation the recommendation of the Committee was to extend the Scheme only partially i.e. only the cash benefits might be provided since medical care was already available to the workers free of cost.

(iii) The unorganized or semi-organised sectors about which accurate statistical data is not available would come later in the third phase.

In pursuance of the above recommendations, extension of the scheme to the categories of establishments included in the first phase has already been carried out.

PROVISION OF SOCIAL SECURITY FOR WORKERS IN THE UNORGANISED SECTOR

As the ESI Scheme framed under the ESI Act, 1948 provides a uniform package of benefits at a uniform rate of contribution; it cannot be extended to workers in the unorganized sector in its present form. However, as per amendment in the ESI Act, 1948 w.e.f. 01/06/2010 vide ESI (Amendment) Act, 2010, medical benefit under the scheme can be extended to other beneficiaries on payment of user charges subject to framing of schemes by the Central Government. Further the Govt. of India, Ministry of Labour & Employment has introduced a Scheme called "Rashtriya Swasthya Bima Yojana" for providing social security to BPL (Below

Poverty Line) workers in the unorganized sector.

AMENDMENTS IN THE ESI ACT VIDE ESI (AMENDMENT) ACT, 2010:

The ESI Act, 1948, has been amended vide ESI Amendment Act, 2010 w.e.f 01.06.2010. The scope of the Act has enlarged to include uncovered establishments, more medical benefits etc. like (ESIC Act 2010)[36]-

- Facilitating coverage of smaller factories employing 10 or more persons.
- Enhancing age limit of dependent children for eligibility to dependants benefit from 18 years to 25 years.
- Extending medical benefit to dependant minor brother/sister in case of IPs not having own family and whose parents are also not alive.
- Streamlining the procedure for assessment of dues from defaulting employers (time limit of 5 years for assessment).
- Providing an Appellate Authority within the Corporation against assessment to avoid unnecessary litigation.
- Continuing medical benefit to insured persons retiring under VRS scheme or taking premature retirement.
- Treating commuting accidents as employment injury.
- Opening of medical/dental/paramedical/nursing colleges to improve quality of medical care.
- Making an enabling provision for extending medical care to other beneficiaries against payment of user charges to facilitate providing of medical care from under- utilized ESI Hospital to the BPL families covered under the Rashtriya Swasthaya Bima Yojana and other schemes framed by Central Government.
- Reducing duration of notice period for extension of the Act to new classes of establishments from six months to one month.

- Empowering State governments to set up autonomous Corporations for administering medical benefit in the State for bringing autonomy and efficiency in the working.

A GLANCE OF ESIC

The ESI Scheme has been performing well since its inception. But is also necessary to have a look about the performance of the scheme in the state level or regional level. It will give us a picture about the pace of the ESI Scheme in the Assam region compared with the all India level. Following **table 1.3** depicts the same-

Table 1.3: A Glance of ESIC as on 31-03-2014

Items	INDIA (as on 31-03-2014)	NORTH EAST (as on 31-03-2014)	ASSAM (as on 31-03-2014)
ESI Hospitals	148	01	01
ESI Dispensaries	1402	29	25
No. of Centres	787	38	33
No. of Employees	13912400	104199	59921
No. of Insured Person	14301550	104586	85102
(beneficiaries)	406499	3938	3251
No. of Employers	55490000	406000	-
Total Beneficiaries	360	04	04
Inspection Offices	610/187	14/3	10/ 3
Branch Offices/Pay Offices			

Source: Regional Office of the ESIC, Guwahati

THE ESI SCHEME IN NORTH-EAST REGION

The ESI Scheme, the comprehensive Social Security Scheme to provide social security to workers in organized sectors of employment was introduced on 24.02.1952 in Delhi and Kanpur. Thereafter, the provisions of the Act have been implemented gradually to other states of the Union. In Assam, with the issuance of the Notification u/s (3) of the ESI Act 1948, the Scheme has been implemented w.e.f. 28.09.1958, initially at Guwahati,, Tinsukia, Dibrugarh and Dhubri and thereafter to all over the State. Out of the 08 (eight) States in N.E. Regions, at present the Scheme has been

implemented in 04 (four) States only. The name of the States, No. of Centers under implementation and Dates of Implementations are as follows-

Table 1.4: Number of ESIS Implemented Centers of ESIC in North East India

Sl No.	Name of the State	No. of Centers	Date of First Implementation
1.	Assam	33	28.09.1958
2.	Meghalaya	02	28.09.1990
3.	Nagaland	01	01.03.2008
4.	Tripura	02	01.01.2009

However, intensive surveys have been conducted for implementation of the Scheme in the other States of the N. E. Region, namely Arunachal Pradesh, Mizoram, Manipur and Sikkim from time to time from this office. But, due to certain bottleneck as enumerated hereinafter as well as due to non fulfillment of criteria for implementation, the implementation has so far not been taken place. Fresh pre-implementation survey in the capital cities of all these states and other places where there is industrial growth is being done, for which different teams of S.S.Os / B.Ms have already been constituted with the co-operation of the different state Governments.

Altogether the Scheme is implemented in 38 (thirty eight) centers in the N.E. Regions. The status details of these 38 centers are as per the above table. Initially the Scheme was implemented in power using factories situated, in the districts of Kamrup, Dibrugarh & Goalpara, in which 20 or more persons were employed, which was gradually extended to other districts of Assam. The enabling provisions u/s 1 (5) of the ESI Act, which empowers the State Governments to extend the Scheme to Shop &

Establishments have been brought into force with effect from 26.04.1975. In respect of small factories using power and engaging 10 or more employees and other categories of Estts namely Shops, Establishments, Roadways, Hotels & Restaurants, Cinema Halls, News- Paper Establishments etc. employing 20 or more employees. In the recent years, the extension of the Scheme to New Areas is more rapid. The Scheme has also been extended to new sectors like private Educational and Medical institutions in Assam and Tripura on 01.01.2009 and 15-03-2010 respectively keeping in tune with the recent amendment of the Act w.e.f. 01.06.2010.

The implementation of the Scheme in Tripura took place on 01.01.2009, that is to say, Tripura is the youngest state to which the Act has been implemented. The State Government in Tripura has shown a very positive attitude towards the implementations of the Act and providing necessary co-operation in the right earnest. The State Government has also offered a plot of land in Agartala for construction of the ESI facilities in Agartala. So far the Act is implemented in only two centers namely Agartala & Budhjan- nagar. Survey, in another two areas namely Dharma nagar and Udaipur is also being conducted.

In Nagaland, which is brought under implementation w.e.f. 01.03.2008, only one centre i.e. Dimapur is under coverage. However, survey is being conducted in the capital city, Kohima, for exploring the possibilities of brining

In Meghalaya, the scheme was implanted on 28.09.1980, however only two centers are been operational under the scheme. One center is covered in Byrnihat (East Khasi Hill district) and another one is also the extended part of the Byrnihat area (Ri-Bhoi district).

THE ESI SCHEME IN ASSAM

The implementation of the ESI Scheme in North East took place with effect from 28.09.1958. During that point of time, it was undivided Assam and except Manipur and Tripura, all the other 5 (five) states were parts of Assam only. The scheme was first implemented in 05 centers namely Guwahati, Dibrugarh, Tinsukia, Makum and Dhubri. With the passage of time, the Scheme has been extended to 33 centres across the State.

Presently there are 25 ESI Dispensaries and 01 IMP clinic through which the primary care medical services are being provided throughout the state. For, secondary care, one ESIC Model Hospital at Beltola, Guwahati and one Annexe Hospital at Tinsukia have been established. The Government of Assam have also made Tie-Up arrangements with the some of the major hospitals in places like Tinsukia, Jorhat, Silchar etc. for secondary medical care. Again, for tertiary medical care, ESIC Model Hospitals in the States, Beltola has made Tie-Up arrangements with 8 major hospital, 7 in Guwahati and 1 in Dibrugarh.

The implementation, extension, Revenue and Cash Benefits as well as policy matters and related issues are dealt with by the Regional Office at Bamunimaidan, Guwahati. The Cash Benefits payments are done through 10 Branch Offices located across the State. Regarding implementation of the scheme, the Regional Office is continuously and constantly making efforts by indulging in pre- implementation survey in various centres where industrial growths are notice. As a result of such efforts, during the last 2-3 years, at least 5 new centres are taken under coverage. Moreover, pre-implementation survey have been carried out and completed in centres like Palashbari and Mirza, Sualkuchi and Shivasagar. The proposals for making necessary medical arrangements in all the centres have already been forwarded to the Government of Assam and necessary persuasions are also being made.

Again, the only referral ESI Hospital in the entire North- East Region is located in the eastern most corner of the Guwahati city. This is a 50 bedded hospital which was constructed in the year 1982-83 and commissioned in the year 1985. It was initially run by the Government of Assam. Later on it was taken over by the Corporation w.e.f. 04-04-2003 and upgraded as ESI Model Hospital. The bed occupancy of the hospital is quite high throughout the year as it caters to the secondary health care needs of around 2,63,000 beneficiaries of the North- East Region. The hospital has made some Tie-Up arrangements with 08 private hospitals for providing tertiary care i.e. Super Speciality Treatment to the beneficiaries. A Grievance Redressal Machinery is in place in the hospital and the same is supervised by a medical officer. Any complaints received is looked into and settled at the earliest by this machinery.

1.8 THE PROBLEM STATEMENT

ESI Scheme of India is a major multi-dimensional social insurance programme that has over the last six decades emerged as the largest social security setup in South-East Asia with its phenomenal growth in terms of geographical reach, demographic coverage, multi-faceted services and an infrastructure that has no parallel (Vasanthagopal & Mathew, 2009)[37]. Despite all the endeavours made by the Corporation for the effective functioning of the ESI Scheme in the country, public discernment of the Corporation has not been very positive.

Today India has the largest demographic dividend. For such a large number of the working force (63% in between the age group of 35 years to 65 Years) a comprehensive measure that provides social security is utmost necessary. In reference to this, the ESI Scheme has been formulated in the way back in the year 1948 in India and in Assam in the year 1958. But, after it's more than 55years of implementation in the state like Assam, it has not been able to execute the scheme effectively. People's

mix- responses to the scheme is something to be considered seriously. Only 33 centers are been established in entire Assam during this period, most of the areas are poorly covered. Moreover, the numbers of ESI dispensaries are very limited considering the size of the population. Most of the dispensaries are also running on rented premises. Again, in the entire North-East Region there is only a single ESIC hospital, situated in Guwahati. Therefore most often it becomes inconvenient for most of the people to approach the hospital. Besides, some secondary data shows that, most of the cases in EI Court are pending, grievances lodged are not addressed in due time, lots of arrears are to be recovered etc.

From the review of various literatures it appears that the person insured with the ESI Scheme benefits are not satisfied. Moreover the working of the machinery of the corporation for the administration of the ESI Scheme is also ineffective. Besides the fund management of the corporation for the ESI Scheme is also not properly utilized. The level of satisfaction in the service and facilities provided in ESI dispensaries for medical care among the insured persons in factories and establishments are also minimum. Again, it is also seen that in government based health services, there are too much of administrative formalities which prevent a good number of insured persons from availing of the various cash and other benefits in time. Thus the study will mainly deals with social security, effectiveness of the ESI Scheme and organizations, functioning, and fund management of the ESI Corporation as well as how can the ESI Scheme be made more efficacious.

Thus even though the scheme is well formulated, there are many problems in managing this scheme: Large numbers of employers try to avoid being covered under the scheme. A large number of posts of medical staff remain vacant because of lengthy recruitment procedures. In rural areas, the low access to services is also a problem. Rising cost and technological advancement in super specialty treatment

and Information system is not satisfactory. There is low utilization of hospitals. The beneficiaries are not satisfied with the services they get.

Such as, they felt that the Corporation has not given any regard for the quality of services and benefits provided to the beneficiaries and their dependents. Further, no adequate steps are being taken to improve the awareness of the Scheme among the beneficiaries and employers. Therefore, a complete review of the functioning of the ESI Corporation so as to cure the various maladies that afflict it is profoundly relevant.

NEED OF THE PRESENT STUDY

Thus, there is need for such studies because of variations in institutional, social, political and economic conditions from state to state and from region to region within the country. Further, there is need to throw light on the factors to find answers of some questions related to the administration and its effectiveness of the ESI Scheme by the Corporation. It is in this context the present study is undertaken. However, the study will be undertaken to examine the working of the ESI Corporation. More specifically, the study will attempt to find answers of some questions related to the administration, effectiveness and about the funds of the ESI Scheme by the Corporation. The study on "An Assessment of the Workings of Employees' State Insurance Corporation in the Assam Region" is found to be limited in Assam and therefore this study is carried out to throw light about the functioning of the ESIC in

Assam and to share the experiences with the public in general about the Scheme and the Corporation.

SCOPE OF THE STUDY

The ESI Scheme, engineered to suit health insurance requirements of employees, provides full medical care to insured persons and their dependents, as well as, cash benefits to compensate for loss of wages or of earning capacity in different contingencies.

However, the study will be undertaken to examine the working of the ESI Corporation. More specifically, the study will attempt to find answers of some questions related to the administration of the ESI Scheme by the Corporation.

Even though the ESI Scheme has been implemented in different States of India except, Manipur, Sikkim, Arunachal Pradesh and Mizoram, the present study is confined to the state of Assam only. It will attempt to assess the perceptions of the beneficiaries and employers both in factory and establishments as well as some formal aspects of the working of the ESI Corporation. However, the focus of the study will be on the beneficiaries.

CONCLUSION

The ESI Scheme, no doubt plays a catalytic role in fostering the initiative to undertake social security for the people working in the organized sector in factory and establishments. It is seen that the growth of the ESI Scheme as the first social security measures to be introduced in India has a prolonged impact upon the entire nation. Today, the availability of the scheme is widely accepted (except a few states in India) as the most important determinant of social security in the process of growth and

development of the country with the vital role in the fulfilling of our socio-economic issues basically related to the health sector. In fact, one of the most important reasons for the poor economic growth of the country has been the lack of proper social security measure and more specifically in the health sector. However, the growth of the ESI Scheme is plagued by several factors particularly in backward regions that stand in the way of spontaneous and accelerated growth of the Scheme in each and every region. Hence, an in depth study of the Scheme and about its beneficiaries has been considered as a powerful instrument for realizing the objectives social security measures which are always influenced by some socio-cultural, socio- economic factors and the support systems provided by the governments.