Reform Pathways for Healthcare Financing in India

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Session 3

Social Health Insurance – The Broken Promise of Employee State Insurance (ESI)

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Mr. Ethiraj: On that note let me quickly introduce our panellists and invite them to speak. Our panellists are Manish Sabharwal, Chairman, and Co-Founder of TeamLease, Prof. Babu Mathew, National Law School of India University, and Prof. Mohan Mani, Centre for Workers’ Management and NLSIU, also the National Law School of India University. So, I am going to invite Manish Sabharwal to speak first, and Manish Sabharwal is the Chairman and Co-founder of TeamLease Services. It is India’s largest staffing and human capital firm. It has over 95,000 employees in 1,800 cities and is also implementing India’s first vocational university in Gujarat. Manish earlier co-founded Indialife, an HR outsourcing company that was acquired by Hewitt in 2002 and he also serves in various state and central government committees on education, employees, and also on the board of the Reserve Bank of India. He got his MBA from Wharton in 1996 and he is an alumnus of Shri Ram, Delhi, and Mayo College, Ajmer. Manish is also a large employer and a large contributor to ESI [Employees’ State Insurance]1. So, some of the points that he will mention are quite dear to him in a manner of speaking. Manish, it’s over to you.

Mr. Sabharwal: Thank you. Thanks a lot, Govind. It’s a pleasure to be here on a subject that I have obsessed about for many years, and I am glad that we are sort of going mainstream with it. India is going through its probably largest health pandemic that we’ve ever had. Yet, ESIC [Employees’ State Insurance Corporation] is nowhere to be seen, nobody has expectations of it, nobody even talks about it. This is an important question to ponder, right? I mean, policy can do long-term stuff, which is make people healthy or it can respond to the emergency room. -- And often in policy, -- policy is always breathless and people say, oh well, the patient is in the ICU, why are you telling him to quit smoking or lose weight? So when things are calm you are saying, well it’s not urgent, we don’t have to change. But when it’s urgent, you don’t have the capacity to respond.

There are so many expectations from policy. But all policy can do is to ensure that liquidity problems don’t lead to bankruptcy and disease doesn't lead to death and unemployment doesn't lead to hunger. So, while the monetary and fiscal policy may take [care of] the others, the health infrastructure of India is obviously always sort of equated with -- it doesn’t have enough resources, we only spend X percent of GDP [Gross Domestic Product]. And I am not going to take the number because I am not sure whether it includes all health expenditure but as a percentage of GDP our healthcare spending is low. But that’s not true for the only mandatory employer insurance plan in India, which is ESIC, which till last year when there was after much debate, there was a cut in the contributions, because for the last 10 years ESIC has had between 40-50% claims ratio.

1 Text in [text] format indicate editor’s notes/insertions.
Now, in most other systems in the world if your claims ratio is less than 80% you have to refund the money because you are overcharging employers. And so, I would submit that, if you think about India’s labour market problem, we don’t have a jobs problem, we have a wages problem. I am happy to spend more time on that during questions but if you think India has a jobs problem, you’ll mandate a three-day workweek, you’ll take away people’s practice and give them spoons and you’ll throw money from helicopters. But if you think India has a wages problem, you’ll focus on formalization, urbanization, industrialization, financialization over by capital. And in formalization, I think it’s really important to recognize that India has one of the highest payroll deduction regimes in the world. At low wages of income, Rs.15,000 to Rs.20,000 of income, I am required to deduct somewhere between 40 and 45% of income depending on which state you are on -- of income --. So ‘haathwaali salary vs chittiwaali salary’ in a cost to company world where all benefits are not over and above salary, [but] benefits come out of your cost to company. The ‘haathwaali salary vs chittiwaali salary’ has been a huge source of pain for people like us.

I think the question for designing a health system is obviously who pays, who delivers, and then you measure whether you are getting to the outcome. So, what is the objective of the ESIC system? Is it to substitute for the public healthcare system? Is it to get employers to pay up more wages? Because that doesn’t happen in a cost to company world. And I would submit, if you think about sort of ESI and EPFO [Employees’ Provident Fund Organisation], you have to recognize they don’t have clients. They have hostages. And it’s really important because why does EPFO fight giving a choice to employers or to employees to pay into NPS [National Pension System]? The new pension scheme works for the new civil servants. Why shouldn't it work for new private-sector employees? Because ESIC and EPFO are very inefficient. They have poor customer service. They treat their customers like crap. And frankly, they are among the most expensive programs that exist. I mean EPFO is the world’s most expensive government securities mutual fund. ESIC till the cut last year was among the world’s most expensive health insurance programs. But that’s just cost, right? And the question is who pays? Is the employer paying for ESI or is the employee paying for ESI? And I would argue in a cost to company world, employees are paying for ESI because if you made ESI, say a mandatory Rs. 3000 a month, it’s not like salaries would go up by Rs. 3000 for every employee in this country. You would just reduce take-home salaries by the incremental amount that went up. So one is, it’s a very inefficient scheme. Second is, it is taken out of employees’ salaries.

Now if this is a social security program, and employees are contributing it because salary belongs to employees, then why are we not letting employees decide where they put their money? It’s not a question of just personal property. I think salary belongs to employees and they should
choose where it goes. Now, there may be a myopia argument that you need to protect people from themselves so we should have some kind of mandatory savings. But should mandatory savings be 45% for people whose savings rate is not 45%? And I would submit, this toxic payroll regime of 45% payroll deduction has really bred informality. And informality is not only the slavery of the 21st century but informal employment – leads -- in informal enterprises creates low productivity which creates low wages and if India’s labour market problem is low wages, we need to think about how to raise formality. Obviously, GST [Goods and Services Taxes] has raised formality. Obviously many other initiatives have been taken to raise formality. But I would submit the recent four labour codes -- But we have not taken ESI head-on.

And I would say if you measure the quality of outcomes, if it is sitting on now [Rs.] 70,000 crores or [Rs.] 90,000 crores of cash, why is it missing in action in COVID? Why are ESI hospitals not usually stocked with medicines that when my, I don’t have 95,000 employees, I have 2 lakh employees, when my 2 lakh employees go there, why would they pay to go to a private-sector doctor to avoid a hospital which they have already paid for? There is no performance management in ESI hospitals. There is no fear of falling, there is no hope of rising. That may be true of government schools, that may be true of ITIs, but we are talking about an employer-funded institution. Schools are funded through the general budget. ESI is funded largely by private-sector employers deducting salary from private employees. So, I think we need to hold ESI and EPFO to a higher standard. Unfortunately, we don’t hold them to a higher standard.

So, I think it’s important to think about ESI as a payroll-deducted private program. We need to create competition for ESI, and we need to really think about how [it is] an employer payroll deducted [program]. It’s not an employer-funded program. I want to repeat myself and I would be happy to hear pushback. But in a world which has moved to cost to company, benefits are not over and above salary. So, all CFOs in most companies have one head for employee cost. They don’t have one pocket for salary and one pocket for benefits and one pocket for gratuity and one pocket for other benefits. Everything comes out of employee cost in a CTC world. So, my request is, that when we think about ESIC, let’s think about how inefficient they are, let’s think about how poor their service is, let’s think about how expensive they are, and let’s think about giving employees choice about where they spend their salary for their health insurance. But I’ll stop here, and we can come back for questions.

Mr. Ethiraj: Thanks, Manish. My apologies for getting the number wrong. I stand corrected. There are 200 thousand people now with TeamLease and not 95,000 which was obviously an older bio that I am looking at. Okay, a quick question Manish. Why is it that while the contributions have increased, and as the numbers also show, the service has not? You have given the answer in a way saying that there is no one holding them to account. But what about the companies themselves?
Companies are also unable to marshal resources and ask questions? Because you yourself saying, I mean you are giving out crores a month to ESIC, why is it that, let’s say, you are not finding either the time or let’s say the focus to go after them?

Mr. Sabharwal: Because their governance has a birth defect. Their governance is a geriatric ward. Everybody is so old. – I mean it’s populated by – It is rent-seeking. The trustees are acting on their own behalf and on behalf of the organization. ESI is not pro-employer, it’s not pro-employee, it’s not pro-health system. It is pro the organization which administers it. And it is important to shine a light on the governance of this organization. They are trustees. They are not administrators. They are not executives. They are trustees, that’s why they are called trustees. But certainly at least in my experience as one of the largest contributors, they don’t act like trustees. And obviously, they have powers. And my challenge is that I am happy to pay health insurance. I am happy to contribute to social security. But please give value for money, please create choice, please give us quality so that my employees don’t see it as tax, and I don’t see the organization as other than using its judicial powers for harassment. We don’t get quality. I think the single most important reason why we are not able to hold them accountable is the current governance structure of ESI which is not within the ministry, it’s not a private sector organization. It is a mezzanine layer and as Socrates said, a slave who has three masters is free.

Mr. Ethiraj: Just one quick question. What is the utilization amongst the 2 lakh employees? How many would have let’s say used some ESI facility?

Mr. Sabharwal: Oh, it’s less than 5%. It’s less than 5% on a flow basis. But on a stock basis, it’s less than 1%.

Mr. Ethiraj: Okay, that gives us an inkling of why there is a problem when it comes to the quality of infrastructure. Okay. Prof. Babu Mathew, you are next. Prof. Mathew has been a faculty member of NLSIU right from its founding days. He has taught legal methods, law, poverty and development, and labour law for graduate students. He was instrumental in setting up the Centre for Child and the Law and the Centre for Labour Studies. He held the Government of India Chair on Juvenile Justice. He was the Registrar of the National Law School during which time the International Training Centre was established as a successful profit centre of the university. He presently teaches in the Master of Public Policy program for which he is also the Chairperson. Along with the Institute of Public Policy, he is also the Director of the Centre for Labour Studies at NLSIU. Prof. Mathew, it’s over to you.

Prof. Mathew: Thank you, Mr. Govindraj. Let me straight away indicate that what I will be doing is to look at the Code on Social Security, 2020. I thought it is appropriate for us to take note of the legal framework and then the other related areas, my colleague Mohan Mani will come in. I want
to begin by pointing out that under this new legislation, the layout in so far as social security is concerned is quite interesting. Now we have several new authorities which have been created. The most important among them is the Central Board of Trustees of EPF, the ESI corporation is the second one. Both these bodies are the ones that attempt to meet social security needs through the contributory system about which Mr. Manish has already made references. Then you have the National Social Security Board for unorganized workers, and you also have the Social Security Board for the unorganized workers at the state level. Please note that these two bodies, the national and the state, clearly earmarked for the purpose of social security, they are based upon the collection of cess both from the builders on the one hand and from the aggregators in so far as --. I’m sorry, I’ll come to the aggregators question separately.

So, these two, the National Social Security and the State Social Security are actually based upon contributions which are supposed to come from different sources. Nothing is concretized and nothing has happened in that regard. Then you have the building and construction workers. It’s an old legislation which existed and for that there is a cess which is collected from the builders and now you have another of a similar nature which is for the gig and platform workers. There again it is the aggregators who are supposed to contribute. -- So, you have in this kind of an organizational layout, -
- I think it is useful for us to take note of the fact that the EPF and ESI, incidentally it is the EPF and ESI which is complying with what the ILO [International Labour Organization] has laid down as the minimum social security standards. Different kinds of benefits are identified and if you look at ESI, particularly ESI, and if you take along with that the EPF, then the ILO recognizes nine kinds of benefits. And in these nine kinds of benefits, eight of them are provided by the ESI. So that includes medical benefit, sickness benefit, unemployment benefit, employment injury, family benefit, maternity benefit, invalidity benefit, and survivors’ benefit. So, in terms of a global standard as accepted by the ILO, you have nine kinds of social security laid down in the ILO’s Convention way back in 1952. But what is interesting is, this comprehensive framework of social security is available only for the organized sector.

It’s only 7% of the organized sector which is entitled to this social security. Whereas when it comes to 93% of the unorganized sector, that is out of more than 500 million, you’ll find that 93% belongs to the unorganized sector. They are interestingly excluded from the EPF and the ESI. And in its place for a small segment, construction, and gig workers, you have the cess-based scheme. But so far as the bulk of the unorganized workers are concerned, it’s a no-brainer. You can’t really lay down your finger and say, what kind of benefits will those workers be entitled to? I think it’s a clear case of discrimination between the organized and the unorganized. And this is, in a sense, it’s the design of the social security code is that way. The design is that it primarily defines employees in a particular
manner. It’s a broad definition. Similarly, it defines establishment also in a broad way, and then the relevant application clause, it says that EPF will apply if there are 20 employees in an establishment and ESI will apply if there are 10 employees in an establishment. So it is in that manner that the applicability of the enactment is decided. You have I suppose, as a result of lot of discussions that had been happening, we have a situation in which there is an apology in the Social Security Code to say that the state government may extend the ESI, particularly the ESI to the unorganized sector and that is left to the central government to decide. So that’s the overall structure that we might like to take note of.

The other aspect in so far as coverage is concerned, -- I think why we are thinking especially since this is a discussion focused on health issues --, I think the relevant question here is, what is the health system in this country? Yes, if you go to a private hospital and if you can afford the money to pay for that private hospital, then of course you can get extraordinarily good healthcare. But what about rest of the population who can’t afford entry into a private hospital? And I think we can see that kind of a polarization having happened in a big way. And the other option that is popularized nowadays is the so-called insurance, health insurance. I am afraid that even somebody from a middle-class background, if you want to actually access the health insurance, it is not easy. By the time you have deciphered the fine print you’d have paid out all the premium and so far as the 93% of the unorganized are concerned, I cannot imagine them being in a position to actually access a private insurance scheme. It is in that context that we must look at the Employees’ State Insurance. I agree that there has been a lot of inefficiency and that inefficiency has to be addressed squarely. And I think for that, one important mechanism that the ILO has always suggested is, take tripartite functioning seriously. And if tripartism is promoted seriously, that’s the situation in which implementation can be addressed. From experience we know, that when it comes to the implementation of labour legislation, it is directly proportional to the extent to which the right holders are organized and when they come on to a process of dialogue with the employer and where necessary with government intervention, that is where systems have worked. So, I do agree that there is a lot of drawback in implementation is concerned. But it is also a sign of hope and very many things including accidents arising in the course of employment and various forms of disability benefits, all are covered by ESI. And the extent of utilization of that depends upon the place in the country, which state are you talking about, and what is the extent to which the workers there are organized and able to put pressure on the system. I’ll stop there.

Mr. Ethiraj: Thank you, Prof. Mathew. Just a quick question. When you talk about utilization, I know you did mention that different states, it varies. For instance, is it higher in West Bengal because there are more beds, or is it more to do with the labour organization?
Prof. Mathew: I think it is more dependent upon the locality and the type of unionization in that locality.

Mr. Ethiraj: The other question is, when you talk about utilization, is there any data that you can share with us? For instance, Manish says that less than 10% of his employees for whom he gives the ESIC contribution use it and it’s even less than that on a static basis. Is there any other way we can know whether it is working and to what extent and where?

Prof. Mathew: I think Mohan will come on to this aspect.

Mr. Ethiraj: Okay, thank you for that. On that note, let me invite Prof. Mohan Mani, Visiting Fellow at the Institute of Public Policy and Centre for Labour Studies at the National Law School of India University. He is an engineer from IIT Madras, has a master’s degree in Management from IIM, Calcutta, worked for 12 years in finance and business in private sector, then moved to work with trade unions for almost 30 years both in the formal and informal sector. He has helped with research and enterprise in labour issues with collective bargaining. He is also associated with the Centre for Workers’ Management, small trade union resource centre set up in the early ’90s and he is also a Visiting Fellow with the National Law School of India University. Prof. Mani, it’s over to you.

Prof. Mani: Thank you. I’ll just be very brief, and I’ll try and just touch on about three or four points. First, let me quickly take from a study we did on the garment industry in the state of Karnataka. This was a study covering about 325 workers, both in Bangalore and outside. Some of the highlights - the garment sector in Karnataka is 80% women workers. So, it’s a feminized workforce. Some of the highlights that I’ll quickly go through is that around 60% of the workers that we studied were chronic sufferers of back pain, about 50% plus suffered from leg pain, and more than 15% suffered from various forms of allergy. This was both age-dependent and dependent upon the number of years that they have spent in the industry itself. So, why I am saying this is that, when you look at employment at the bottom of the formal sector, then you are going to be seeing a lot of occupation-related ailments, which is something that ESI is supposed to be looking at, which it doesn’t do. I will first start by agreeing with what both the co-panellists have said, what Mr. Manish Sabharwal said right in the beginning that there are various problems with the way the ESIC functions.

But what is the solution to that? Is it throwing away the baby with the bathwater or is there something else that needs to be done? You asked about what is the usage of ESIC? So, we had split the study between workers in Bangalore and workers outside Bangalore, in what is termed as rural Bangalore which is between Bangalore and Mysore city itself. And what we found was very interesting. One, that around 36% of garment workers in Bangalore said that they used ESI dispensaries regularly as against 50% of the workers outside Bangalore who said that they used ESI dispensaries regularly.
Contrast this with the fact that around 66%, nearly 2/3rd of the workers in Bangalore said that they had an ESI dispensary which was five kilometers or less away from their home as opposed to just about 6.6% of the workers outside Bangalore who had an ESI dispensary which was less than five kilometers from their home. So, despite the fact that there was no ESI dispensary which was proximate to their home, they still used ESI dispensary to as much as 50% of their total usage. Rather 50% of the respondents said they used ESI dispensary regularly. This says a lot about the nature of healthcare outside the metropolitan cities today, even in the southern states which are supposedly more developed. Let us take the geographical spread of ESIC beyond the rural-urban divide itself.

Mr. Govindraj said right in the beginning that 10% of the total population in this country are beneficiaries of ESIC. But if you now look at it state-wise, it’s nearly 20% of the population in Karnataka and Tamil Nadu who are beneficiaries of the ESIC as compared to 0.7% in a state like Bihar, around 1.6% when you go to the North East - when you look at states like Assam, Nagaland, Meghalaya and Tripura, all these four states together, around 3.6% when you look at a large state like Uttar Pradesh, which is also, it is the way ESI was designed right in the beginning, which is that, it followed the formal sector employment across the country. So wherever development happened, ESIC also happened. Today, if you want to look at spreading development, as a post-COVID situation, you want to see that migration distances are shortened and that workers are able to get employment nearer home, then obviously you also have to see that they are provided with other forms of services. Not just jobs but also other forms of infrastructural support which is also closer to home. In a state like Uttar Pradesh, you have a lot of anecdotal evidence as to the abysmal state of healthcare in that state. The same thing holds good for Bihar. How do you then see that you not only provide employment, but you provide decent employment in these states so that these workers don’t have to trek these large distances to come to the southern states and then are faced with a problem like COVID, then they are between the devil and the deep blue – [communication disconnected]

Mr. Ethiraj: Okay, I think we have lost Prof. Mani there but we will come back the moment we get him. Let me start off with some questions. Okay, are you back with us Prof. Mani? We lost you for about a minute. Go ahead.

Prof. Mani: So, my last point is that yes, obviously ESI has a lot of unspent money. But that unspent money needs to be spent where you can provide better services and better spread of services across the country if you want more even development, if the objective is that there is a form of development which does not necessitate the type of problem that happened after the COVID pandemic, of migrants having to trek thousands of kilometers across the country to reach home. That’s it, thank you.
Mr. Ethiraj: Okay, thank you for that, Prof. Mani. Now I was just looking at your figures again. I think you first said that in the survey that you did 36% of workers said they used ESI dispensaries and 50% of workers said they used ESI hospitalization?

Prof. Mani: 36% of workers in Bangalore city as opposed to 50% of workers outside Bangalore city. Both work in the garment sector.

Mr. Ethiraj: So even theoretically, is there a question on what about the rest? I mean, 64% are obviously not using the dispensary and I am guessing, if they are not using the dispensary they are not also accessing other facilities.

Prof. Mani: Well, you have workers who are young who may not use health facilities all that much. There are workers who have migrated without families, in which case again they are probably not going to use the dispensary all that much. And finally, you also have the private sector hospitals. Workers do use private-sector clinics. As has been said, ESI is not the most efficient of organisations but that doesn’t mean that you throw away ESI, the corporation.

Mr. Ethiraj: No, we are not saying we want to throw away. We are looking to say, how to I guess streamline, improve access, improve quality, outcomes, and so on. We will come to that in a second, I just want to get these numbers out of the way. So, for these 64% in the city of Bangalore, I know you talked about garment industries which in turn was 80% women. So, I am assuming that a lot of the people, folks who are using this are actually women, as you break it down. What would be the cost then? These are not very highly paid people and some of their, let’s say medical needs are being met by the ESIC and the rest of it is obviously being met by the private sector. I am trying to contrast with the point that Prof. Babu Mathew made earlier about, that private sector is expensive, and people are forced to go there. But even those with ESIC, are forced to go there, isn’t it? Which I would know intuitively but I am just trying to see if we can build it from the little data we have.

Prof. Mani: Well, it is like this, that if you want rational medical treatment, you need to take time off from work, you need to go to the ESI dispensary. Very often workers also cannot miss employment. So, they might prefer to go to a private practitioner who would just give them an injection and push them back onto the assembly line which may not be the best way to deal with situations but there are various costs that are involved.

Mr. Ethiraj: Right. One of the points that comes up is the timings, even the timings are unfriendly. Apart from the fact that the people are unfriendly, timings are unfriendly. And to your point, if a garment worker who is on a shift, how could that person potentially without losing a day of work visit a hospital?

Prof. Mani: Well, there are two forms of timings that are there in ESI dispensaries. There is one form which splits the time the doctors spend in two shifts, between 7 – 11 in the morning and
between 4 – 7 in the evening. And another form which is between 9 – 5 through the day. Obviously, the workers prefer the first one where there is a split timing. There is a whole rural-urban divide in this. In a larger proportion of ESI dispensaries within Bangalore city, there was a dual shift as opposed to outside Bangalore city. These are all reforms that are necessary.

**Mr. Ethiraj:** Okay, we will come to that in a moment. We will come to what needs to be reformed and how it needs to be reformed. So, Manish, let me come back to you now. You have taken an extreme position based on your own experience about what needs to be done or what needs to be resolved. If you were to look ahead now, and if we were to say that the system is creaking, it’s not serving the people it should. Even though it serves, it does not serve fully, and they incur cost in any case, and this is after they have paid some amount of their salary mandatorily to ESIC. So, if we were to start reforming the ESIC, where would you begin?

**Mr. Sabharwal:** With the governance of the institution. There is just a birth defect in us handing over money to people who don’t care about the fact that this is from the lowest-paid employees in India. They are not getting the care they want. And this is just a vested interest perpetuating a low-level equilibrium. If you can fix it, please fix it. It’s been 20 years, it’s been 30 years that I’ve been hearing, we are fixing ESI. Doing the same things again and again and expecting different results is the definition of insanity. Beyond a point, I am happy to understand proposals for reform. But we campaign in poetry, but we govern in prose. I am waiting for the prose of actual reform happening to be seen on ground. But it’ll start with governance and if you can’t fix in governance then please create competition. I am not saying shut ESI down, just create competition for ESI, and then we’ll let customers speak with their feet rather than with the handcuffs that they currently have been attached to --.

**Mr. Ethiraj:** Right and Dvara Research, the partner here has outlined three pathways for change, and we will come to that. Prof. Mathew, how would you respond to Manish’s specific points here that we begin at the governance?

**Prof. Mathew:** I would agree fully with that observation. And if you look at the way in which the new Social Security Code has tackled the ESI, it is a repetition of top-heavy bureaucracy. Extremely top-heavy bureaucracy which seeks to address this vast country. So that centralization model is absolutely out of place. Whereas if you look in Tamil Nadu and few places where there is a welfare board, those welfare boards are functioning much more efficiently. They are sector-level welfare boards and since they are closer to the ground, there is a much better feedback. It is obvious that a de-centralized model-- you need to certainly streamline the governance setup and make it tripartite so that employers and employees will take an interest in this matter and catch hold of the thugs who are a bottleneck in the system.
Mr. Ethiraj: Okay. So, when you say tripartite, can you expand that a little more?

Prof. Mathew: Well, it's the ILO's method of labour administration across the world. There should be representation for the trade union, the employer's organization, and for the appropriate level of government. You can have tripartitism at the grass-root level as well as only in Delhi. I think this present model is an attempt to centralize everything. It is the Director-General of the whole ESI corporation who has all the powers.

Mr. Ethiraj: Okay. So, Manish, two points. One is --, I think you should leave your video on as we are recording this.

Mr. Sabharwal: I am having some bandwidth trouble.

Mr. Ethiraj: Okay. Two points. One is the governance, the tripartite governance which of course is an established model. Would you for instance be willing to sit on the board or would someone from your organization be willing to sit on the board of ESIC and will that help?

Mr. Sabharwal: Yeah, but you'll first have to bring it down to 12 people or 8 people. You have to have sub-committees. I think there is enough experience in this country now around what is good governance. There is no information architecture, there is no focus on substantive issues and there are no board dynamics. I mean these are basics of any good board - has an information architecture and focuses on substantial issues. The agenda of ESI does not focus on health outcomes, value for money, cost, customer experience. It is focussed on administrative, inward-looking. They have their face to their organization their back to their customer. I think it is important to recognize that, of course, employers would be willing to come on board but as of now, with the current structure, the current legislation, any board member will be less effective. While a little bit is a problem of personalities, it's also a problem of structure.

Mr. Ethiraj: Right. And the second point that Prof. Mathew made on decentralization. Arguably if the ESIC were to be split up, let's say by states or by zones, would that make a difference?

Mr. Sabharwal: Of course, decentralization creates higher accountability. We would have to figure out how national employers like us with employees in 4,700 cities, it would work. But, absolutely, we have the Aadhar number, let me pay people's ESI contributions into Aadhar. Let it be cashless, let it be cardless, let it be national. I have no problems with that. I think that the plumbing of how to do it will be downstream, from fixing the governance and structure.

Mr. Ethiraj: Okay. Let's try and come back to the outcome and the reason why it exists, and why it's meant to serve. Prof. Mathew, when COVID-19 is a good occasion for re-examination of everything to do with public health, maybe other things as well, but public health for sure. And it's an opportunity to re-architect, re-draw. So, what could we do? Starting from the point, as you've agreed
and Manish has pointed out and others, that there is no direction forthcoming from the ESIC on such a serious pandemic like this. And using that as a start point, what do we do next?

Prof. Mathew: I think bulk of the crisis situation arises in factories where the migrant labour have come, and they are working on shop floors etc. and because of the sudden lockdown they all had to trek back. And during that process what we have seen is loss of employment, loss of wages, loss of health facility, and now they find that except those who have got some employment under NREGA, there is a movement back into the cities. And when they come back into the cities, there must be a special effort to take care of the basic needs. And those basic needs, I think at the top of the agenda is the COVID agenda. I agree with you, this is an opportunity to give new life to the ESI system. And we must make sure that at the shop floor level that those services are available. And there must be a proactive, joint effort by employers and employees. First of all, at least observe the three precautionary methods that every worker should observe. And so far as testing and follow-up is concerned, draw the ESI into it and I think that must expand. Myself and Mohan have been discussing this and we feel that the primary health centres must be linked up with the ESI. Because the primary health centre network is a much larger network. And that also needs to be brought in because the disease has already spread into the rural areas. -- So, the only hope of, -- Even if a vaccine comes, how are you going to administer this vaccine? It is next to impossible according to those who know what it means to actually vaccinate this country. And for that again, you’ll have to use not only ESI but primary health centres and create a new infrastructure so that the health services reach the grassroots.

Mr. Ethiraj: That's true. This is an adult vaccine after all which we've not really rolled out in this country, but other countries may have done that. Prof. Mani, on using COVID-19 as a trigger and an inspiration in a manner of speaking, to achieve what we want.

Prof. Mani: I'll reiterate what Babu has said about the fact that if you have to roll out a vaccine program, you need to make health services much more evenly available across the country. Over there, as I said earlier, ESI followed a development route where it followed formal sector employment. So ESI is much more concentrated in the states where there has been more formal employment, whereas the primary healthcare system is much more evenly distributed across the country. If you have unspent money, then use it to revive the PHC [Primary Healthcare] system. That is where you can get fast action for your bucks. When the labour codes now talk about expanding ESI coverage to all establishments which employ 10 persons or more, you are talking of increasing the ESI coverage from 3.6 crores today to 10 crores of workers. If you want to triple that, you will also be then moving out of the concentration of formal employment to where informal employment also exists, which is those states where precisely where ESI is the least effective, where coverage of ESI is the least. So yes, go with trying to integrate what is the much more decentralized healthcare system into this system.
Mr. Ethiraj: Okay. So, I am going to pick up on the three pathways of reform that have been suggested as part of research paper which also is available to everyone who is watching right now. But let’s pick up a few questions before that. Ravi Duggal asks and says, ESI utilization is low because despite being cash-rich with workers’ money, it has huge vacancies of medical staff and therefore dispensaries and hospitals are under-utilized. It has also set up medical and dental colleges which is not their mandate, and they have consequently misused workers’ funds. There is also a tendency to push voluntary insurance as an option and unfortunately, many union leaders have also fallen for this instead of demanding protection and strengthening of the ESIS. He also says that, if social security is to become universal then every worker including self-employed individuals, to your point earlier Prof. Mani, an individual should have access to ESIC, EPFO pensions, etc. So, we need to do away with the segmented definitions of the workforce. Manish, do you want to come in?

Mr. Sabharwal: I agree. -- Universal healthcare -- Is healthcare a human right? Sure. I think the constitution distinguished between directive principles and fundamental rights for a reason. I mean, we diminish the state if we make promises we can’t keep. Education was not included as a fundamental right in the original stages. It was not like they lacked ambition, they just lacked resources. So, while universal healthcare should be an objective, our per capita income, we are 138th in the world. Let’s not start believing that because we are 5th in the world in total GDP, we are somehow a rich country. I think we have to apply the filter of resources. Sure, we should have universal healthcare, who is going to pay for it? This year we are running a fiscal deficit of 12% of GDP, you may say COVID is a special year, sure. But we don’t have money to have universal healthcare paid by taxpayers right now.

Mr. Ethiraj: Okay. There is another question from Louise Tillin. It’s a fairly detailed one and Manish, it’s for you, so do hear this one. I am currently working on a history about India’s welfare regime which looks at the origins of ESI, which is the first one that was envisaged as the most comprehensive social security regime. When employers agreed to the introduction of a contributory sickness insurance model in the early 1940s, they did so as part of efforts to create a more level playing field in labour legislation across India, that is to prevent employers in one region under-cutting labour costs in another, to create a floor under labour market competition. I agree that ESI today is not performing as it was envisaged. But when thinking about how to reform, do you see that it is as important to maintain the idea of an all-India model? Or should employers and employees in different states be able to decide a regional model according to their preference?

Mr. Sabharwal: I think that’s a great idea. It’s basically competition in different forms. I think that we have to create competition. Whether it’s national competition, whether it’s regional competition, how is that competition governed? Whether that competition is private or public or non-
profit? It should be all three, right? If the private sector has a trust deficit, the public sector has an execution deficit and non-profits have a scale deficit. But a good ecosystem of competition includes a number of statistically independent, genetically diverse tries. I am not suggesting that India doesn’t need health insurance. I am not suggesting that we should remove the role of employers and payroll deduction. But we are currently stuck in a low-level equilibrium. Everybody talking about reform needs to now give us specific next steps because otherwise you just start killing formalization and unless we formalize we will never move India’s per capita income up.

Mr. Ethiraj: Right. Stefan Nachuk asks, stepping back and says, ESI has struggled for decades. Realistically there are three viable options. The first is integrate it with PMJAY [Pradhan Mantri Jan Arogya Yojana] or other schemes. Second, improve governance, which is very hard, he says. Three, make it optional and let employees use funds to buy private insurance and/or PMJAY along with other contributions. That also is one of the pathways that has been recommended. And we will come to that. So, Prof. Mani, would you like to respond? Or Prof. Mathew on this point?

Prof. Mani: I don’t know if privatization is the best option. I also don’t know if splitting the ESI totally into regional corporations is an option. For managerial purposes, you can structure it into regions. But as I was saying, given the way in which ESI is today, the dire necessity is in states where you have low resources. So somewhere the ESI resources have to flow from where there is more resource generation to where there is much less resource generation. That is the only way you can equalize, where you have the potential to equalize development across the country. The second thing, I just want to pick on what Manish had said about resources.

Mr. Ethiraj: Just one moment, he is saying merge it with PMJAY. He is not saying privatize it, I mean that is one option, but the first option is the integration with the big brother or sister of all the healthcare schemes.

Prof. Mani: That would make it even more of an unviable option because from a corporation you become a governmental department and then the whole bureaucratic structure that takes over would in my opinion be only a little worse than what already exists now. I just want to add one more point which is that when you look at the reduction in contribution from 6.5% to 4%, it includes 1.5% reduction from the side of the employer. If you actually look at, for instance, the garment sector which is a labour-intensive sector where 20% of the turnover is employee cost. Even there if you look at the reduction that the employer gets, is something like 0.3% of the turnover. So, it is not that large an amount of money. The employer could surely afford to pay that much more in order to keep money available with the ESIC. Sure, it is not being spent properly. All those caveats, I totally agree with. But somewhere if you want to get resources for the insurance corporation, surely reducing the fee paid is not the way forward.
Mr. Ethiraj: Okay, I am going to come to the pathways. Sathyan Ameem says Ayushman needs to get up on its feet before we can integrate ESIC, else the blind shall lead the deaf. He also says, one has been paying deductions, the care, and packages for Ayushman are limited, why should the ESI beneficiary be subject to that? They are asking for their rights and not charity. They can collaborate on provisions and should not be merged as far as benefit packages as it would short-change ESI. Manish, a question to you from Neena Seegat. Does TeamLease get a chair at any national, state, local level tripartite governance body of ESIS? Sorry, this is from Vaibhav at the ILO.

Mr. Sabharwal: No, we don’t. We tried for it, but we don’t. Trade unions and employer organizations which are aggregates get it. We don’t.

Mr. Ethiraj: Okay. Let’s pick up on the pathways to reforms. There are three pathways that have been suggested. The first is a solution, a managed care model, and essentially the managed care model--. I don’t know if I should read out the whole thing but let me first go through the three. There is the managed care, the second is where the private health insurers compete with ESIC for customers and the third is the managed competition model where the ESIC completely recedes or moves away from financing and employees choose insurers. And there is also a parallel suggestion that the wage sealing should be increased from what it is today. So, in these three situations, the managed care, where the purchasers contract with their own hospitals and providers and then deliver a defined set of services at an agreed price where the quality of healthcare that potentially the beneficiaries would get may be of a better quality or definitely more reliable. So, let’s start with that. Prof. Mani, do you want to go first, the managed care model?

Prof. Mani: I’ll wait to hear the other panellists first.

Mr. Ethiraj: Okay, Prof. Mathew.

Prof. Mathew: Well, what I want to actually say is that we need a system in which primary care, secondary care, and tertiary care are addressed in a particular manner. And in that process, yes, the private sector may have a role. We have seen that works quite well in Kerala. But what is completely missing is at the bottom. -- And there you need to --, finally, we know it is the ASHA workers who are the ones who did the ground level work when it came to COVID. So that’s not a very expensive system. So, you need activity at that level. By the way, you must take note of the fact that the present ESI law and the one that is now taken over into the new code, it does recognize the role for specialist care. So, if the ESI hospital doesn’t have the facility, you can refer it to a private hospital. And you can also associate specialists in your medical board. So, some of those elements are there thanks to the fact that this was brought into force immediately after independence. So, I think there is scope for bringing things together and creating a hybrid which will work better.
Mr. Ethiraj: Okay. I wanted to ask you about the practice. What would happen in practice, I mean if you had a cardiology problem or a pulmonological problem which is more likely these days, and you went to ESIC, would they pack you off, and would you be appropriately compensated? How would it work?

Prof. Mathew: Yes, yes. The existing ESI provides for it. You can be referred to any place. It may be a cardiology centre, it may be anything. And you can be referred there, and that hospital will be reimbursed by the ESI scheme.

Mr. Ethiraj: Right. I am not familiar with this; you are saying that that works seamlessly and smoothly?

Prof. Mathew: Actually, it works better when the employees are in a serious condition. Because in that situation they know that they can’t directly go to a private hospital. Whereas if they go via the ESI, they get the advantage of both.

Mr. Ethiraj: Okay. Manish, do you want to comment on that? On how in serious conditions or serious cases, does this work?

Mr. Sabharwal: It works with great difficulty. That’s true, it does work when somebody is in very serious conditions, it obviously sometimes does work. That’s why ESI tells you stories of that one guy whom they spent [Rs.] 3 crores on or [Rs.] 2 crores on but that’s not the overall experience, right? I don’t understand this managed care and that's above my paygrade, right. All I am saying is, the system currently doesn't have quality, it’s high cost and it’s not accountable. Now we all have to get together and see whether you can fix ESI to do that or sometimes if you don’t create governance and don't create competition, it is very hard for these organizations to reform themselves.

Mr. Ethiraj: Okay. Sathyan Ameem says, Prof. Mathew to your point you made just now, the empanelled private hospitals are not reimbursed at full value, and they are only given rate contract reimbursement. So, they do not take in the ESI beneficiaries. Anyway, this is something that can be argued back and forth. So, let me bring in another point from Stefan Nachuk. He says, I am not sure the macro-options are clear. Let me give an example. The Thais, Thailand, to this day have three large schemes which have not been integrated for political reasons. Formal sector, tax finance, and civil servants. They wanted integration but the politics were too tough. Indonesia pulled all schemes into one in 2014, JKN [Jaminan Kesehatan Nasional, Indonesia’s national health insurance program], which is a big bang approach to focus on efficiency and equity. The financing pools for JKN include tax, social health deductions, and some individual contributions. Any lesson here for us? Prof. Mathew or Prof. Mani?

Prof. Mathew: I think the real question is with reference to what kind of resources you can mobilize. And I think we must think of at least three kind of resources. One is the contributory chain
which is what ESI and EPF is based on, the other is mobilization through, like how you do it for construction workers, specific forms of cess and that will have to be sector-specific, and the third is, there is no way, you have to go in for a certain budgetary allocation. After all, India’s budgetary spend is one of the lowest in the world. So that’ll also have to be tackled.

**Mr. Sabharwal:** If I can come in here, the central government budget is [Rs.] 29 lakh crores, the state governments’ budgets are about [Rs.] 34 lakh crores. 85% of the central budget is spoken for and 70% is spoken for. In a year where GST shortfall of [Rs.] 3 lakh crores, income tax shortfall of [Rs.] 2 lakh crores, and sort of [Rs.] 3-4 lakh crores of NPAs [non-performing assets], I think we have to be a little careful in this notion that just find the money as a solution.

**Mr. Ethiraj:** Okay. Rajalakshmi from Chennai says it’s nice to see and hear Prof. Babu Mathew. Your fans are around somewhere. Let me come back to the second pathway. Private health insurance competes with ESIS for its customers. So, in this case, ESIS would cease to be the sole financier. Instead, it would compete with other private insurers for contributions of employees enrolled under ESIS with respect to purchasing and providing healthcare services to its beneficiaries. ESIS could either continue to fully own these functions or allow private health insurers to integrate forward into these domains as well. Prof. Mani, would you want to start off?

**Prof. Mani:** Yes. There are benefits of a single-payer model also which are being debated across the world today. There are definitely cost advantages that are there, potential cost advantages that are there if you can aggregate all the contributions and see that those aggregations are spent in as efficient a way as possible. One of the problems that is there with the ESI-private sector linkage is that many private hospitals do not take the referrals. Second is that very often what happens is that the worker who goes to the private hospital, the private hospital says, you pay the money upfront and you collect the money from the ESI. We are not going to take the ESI credit card as being a credit card for us because it takes a lot of time for us. So, the inefficiencies in the system get pushed on to the user which is what is going to happen in a hybrid system. I don't know how you can tackle that. And I think that the much more feasible solution is to see that the ESI itself is made a more efficient organization. It sounds a tough call, sure, but universal healthcare is a tough call.

**Mr. Ethiraj:** Right. Bindu Ananth has pointed out to Prof. Babu Mathew when we can’t even spend existing resources, then why are we talking about more resources? She is obviously referring to the [Rs.] 70 lakh crores of unspent resources.

**Prof. Mathew:** Yes, I think that is where Mohan had already referred to this. There is urgent need to extend the network of ESI hospitals instead of starting medical colleges with that money, you have to extend it. Then the primary health centre network already exists. Integrate the two things. The quicker you reach the base, the more efficient healthcare would be.
Mr. Ethiraj: Right. And the number is, reserves is [Rs.] 74,348 crores as of 2017-18. Arguably that number has gone up. Okay.

Mr. Sabharwal: Could I just add that turning up the water pressure on leaky pipes doesn’t improve them, right? So, I mean, extending the network without governance reform, without some fear of falling, some hope of rising may not give us the results.

Mr. Ethiraj: Okay. Bindu Ananth has another question for Prof. Mathew. Is the ESIC underperformance on the agenda of trade unions? Why isn’t there more pressure from them on improving scheme performance or returning the money to workers?

Prof. Mathew: Yes, I think even the trade unions have been wanting in that regard, and work has to be done at all levels including the trade unions. And I think these kind of debates help that process.

Mr. Ethiraj: Manish, I asked you this question as well, saying that why aren’t you going after them and in a way the same question has been posed here to trade unions. So, I don't know, is there some aggregation, congregation which is sort of required now to put pressure even as we talk about all these other solutions?

Mr. Sabharwal: I think that’s what we are trying to do right? Everybody is highlighting the fact of their expense ratio and that worked, right? Last year their contribution rate was cut in response to employers and many people making the case that ESI did not need to collect [Rs.] 14,000 crores a year. Now it collects [Rs.] 8,000 crores a year or [Rs.] 9,000 crores a year. But my submission is, that's not enough. Even the [Rs.] 9,000 crores they collect right now is still not being utilized, is inefficient, and is not accountable.

Mr. Ethiraj: Okay. Picking up from one of the pathways suggested, Suraj B. asks to Prof. Mani, why are we reluctant to give beneficiaries choice? Very good options would be available at the same price point as ESIC.

Prof. Mani: There are many issues here. One is that most insurance options are hospitalization-based insurance options. You do not have insurance which covers outpatient costs. And if you look at the reason for iatrogenic poverty, it is primarily, large chunk of it is outpatient costs and a bill insurance organizations should be ready to also provide insurance for that purpose. At a cost which is a reasonable cost? I doubt that. So somewhere it is that size matters and the purpose for which an organization is set up also matters.

Mr. Ethiraj: Okay. Two more points and I am going to come to the last pathway and get your closing comments. H. Sachdeva says ESIC is increasing referrals all the time. It suits the local staff for all sorts of reasons, so private sector, medical sector is quite happy with that. Ravi Duggal says, 60%
of hospitalization today, especially tertiary care are outsourced to empaneled hospitals. Would anyone want to come in on that? Prof. Mathew?

**Prof. Mathew:** Well, I think it’s the same thing which we are talking about the governance system and the governance system has to be addressed at multiple levels. But I don’t think the present Social Security Code is going in that direction. It’s going in the opposite direction.

**Mr. Ethiraj:** Right. Actually, many of the questions that have come in seem to ask that question as to why or for whom this matters, whether particularly, organizations like TeamLease and also in an environment with contractualisation increasing, why do they not have a seat at the table. So let me come to the last pathway recommended here in the Dvara Research paper that says that ESI is moving towards a managed competition model where it completely recedes from financing and allows private health insurers to instead perform the role by competing with each other for contributions of employees enrolled under ESI. ESI would continue to perform the functions of purchasing and providing healthcare services to its beneficiaries, but it would also do more. It would become a kind of sponsor in a managed competition model where it could structure and adjust the market for competing health plans, establish equitable rules, almost like a regulator of sorts rather than anything else, I would imagine. Any comments on this?

**Mr. Sabharwal:** I am not sure it has the capability to do that. Finally, capabilities matter.

**Prof. Mathew:** I think there is an underlying presumption that all is well with the private health industry. I am sorry, I can’t accept that. The moment you enter into a hospital they will ask you, are you insured? And if you are insured you had it. You will have a whole lot of diagnostics, one fellow referring to another fellow and before you know what your disease is, your purse will be empty. Plus, you know, in Gulbarga, there was a set of private clinics who did a large-scale hysterectomy and a whole Lambadi women community, there was massive amount of removal of uterus. There was an investigation, and it was proved that it was all carried out by private hospitals. So, you need to regulate the private sector also and look at the whole model afresh.

**Mr. Ethiraj:** I think the problem that we are trying to address here, which is saying that a portion of my salary is being involuntarily taken by an organization which is not providing me the healthcare service when I need it. So that problem is not solved by whether there is a well-functioning private sector or not, isn’t it?

**Prof. Mathew:** That’s true. That is where we started by addressing the governance question.

**Mr. Ethiraj:** Okay, fair enough. So, we have ran out of time almost. I am going to ask each of you in the reverse order for your summing up points. And the one thing that you could change, given where things are in the context of ESIC specifically and in the context of ensuring that we have better
healthcare access, particularly for the working class, since that’s what we are speaking about today. Why don’t you start off first, Prof. Mani?

Prof. Mani: Well, I think you cannot use a broad-brush approach to the ESIC also. Within the city of Bangalore itself, there are two ESI hospitals. One in Indira Nagar and other in Goraguntepalya. One of these is held up as the model of an efficient hospital. So there are ESI hospitals which are extremely well run, particularly so in some of the southern states. It is difficult to replicate such good hospitals in other states because of paucity of funds. It is also difficult to replicate good private hospitals in those states also. Where ESI functions reasonably well is also where the private sector functions reasonably well. Where ESI doesn’t exist is also where the private sector also doesn’t exist. So, your solution is not to say that privatize everything and things will be fine. A second point, you also have the example of the American model vs. the British model. The insurance model is definitely seen to be more expensive than the model of providing universal healthcare from a single source. Thank you.

Mr. Ethiraj: Right. Just a quick point there. You said that where you get good private care, you also get good ESI care, chances are high and vice versa. But in states like West Bengal which have very high coverage and use when it comes to ESI hospitals, but I don’t think anyone would say that the quality of private sector presence is, including hospitals, is so high in West Bengal.

Prof. Mani: I am not saying that everything is the same all over. And even if you look at the ESI hospitals also, it is not as if all ESI dispensaries-- For instance, if you compare Bangalore vs outside Bangalore city itself, ESI dispensaries in Bangalore have about 77% of their sanctioned strength filled with doctors whereas ESI dispensaries outside Bangalore have only about 36% of the sanctioned strength filled with doctors. So, there are various levels of problems.

Mr. Ethiraj: Okay. And that was something that was pointed out by one of our audience members as well. Prof. Mathew, it’s your summing up and the one thing that you feel that we should focus on to bring about change now.

Prof. Mathew: I think we are talking about this when the new Social Security Code has been enacted. It is yet to come into force and its rules are being circulated. I think it’s absolutely unethical to have two kinds of system within the same core. One for the 7% and another for the 93%. And so far as the 93% is concerned, none of their social security needs are addressed. Not just health, but none of the social security needs are addressed. And when we look at what we have in the ESI, we must not concentrate only on the medical benefit part of it. A very important part is employment injury, its family benefits, its maternity benefits, its invalidity benefit, its survivors' benefit. It’s a comprehensive thing which is in keeping with international standards. I think our debate has revolved entirely around medical benefit issue. We need to take a more comprehensive view about it. And
then, keeping in mind what Manish was saying, you must have a vision as to how will you achieve the social security benefits, if not in one go, through a process of incremental progress. None of that is present. This is a situation in which discrimination between the bulk of the workers in the informal sector and the others continues. So, we will have to address this discrimination question also upfront.

Mr. Ethiraj: Ok. That’s another point that’s been noted in our feedback as well. Manish, you have the last word.

Mr. Sabharwal: I think the only social security India can afford is formal job creation. So, we have to be a little careful with this – find the money, its unethical to not offer people, we have the resources that we have. So, my submission is, as Karl Marx said, I don’t particularly like him, but he used to say philosophers have described the world in thousands of ways, the point is to change it. So, let’s try change with governance. If we can get it done, I am fine with it. If we can’t do that, let’s try change with competition. And competition is the eighth wonder of the world. It encourages innovation, it encourages biodiversity in operating models. So, let’s try governance, and then let’s try competition will be my view.

Mr. Ethiraj: Right. Competition is something that is firmly part of the pathways that have been recommended in the research paper that I would urge all of you to read and send your feedback as well. We’ve run out of time completely. Thank you very much to Dvara Research for partnering with us at IndiaSpend and we are happy and privileged to present this and thank you to all our panellists, Prof. Babu Mathew, Prof. Mani Mohan, and Manish Sabharwal for joining me. Thank you for all for your wonderful and insightful questions from which I’ve learnt a lot and hope to see you soon. Thank you and goodbye.

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