ESI ki Baat 2026

Reforming ESI Services: Evidence, Gaps, Opportunities, and Recommendations



An Opportunity to Improve India's Labour Productivity and Manufacturing Professionalism

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SII Team with Shri Praveen Khandelwal, MP, Lok Sabha and Member, ESI Corporation



SII Team Presenting Findings to Shri Ashok Kumar Singh, IAS, DG ESIC



Shri Deepak Joshi, Insurance Commissioner, ESIC, at SII's Shramik Sammelan 2023



Shri Sunil Yadav, Director (In-Charge), SRO Gurugram at SII's Shramik Sammelan 2026



Shri Sukanta Chandra Das, Joint Director, ESIC Sub-Regional Office, Pune at SII's Shramik Sammelan 2026



SII Team with Shri Prateek Garg, Deputy Director, Faridabad RO

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कर्मचारी राज्य बीमा निगम
(श्रम एवं रोजगार मंत्रालय, भारत सरकार)
EMPLOYEES' STATE INSURANCE CORPORATION
(Ministry of Labour & Employment, Govt. of India)

Foreword

Improving working conditions and strengthening social security are integral to India's ambitions for higher labour productivity, greater manufacturing competitiveness and Viksit Bharat 2047. ESIC has an important role in this national endeavour, providing social security and healthcare protection to millions of workers and their families across the country.

Over the years, ESIC has expanded significantly in both coverage and reach. As India moves towards wider social-security coverage, the opportunity before us is not only to extend that reach further, but also to continue improving the quality, accessibility and responsiveness of services for insured persons and employers. This requires sustained collaboration between ESIC, employers, State Governments, workers and other stakeholders.

Safe in India Foundation has engaged constructively with ESIC for close to a decade. Through its direct work with more than 15,000 workers, including a large number of injured workers, it has brought field-level experience and evidence into our discussions. ESIC has valued this engagement and has, over the years, considered and acted upon several suggestions emerging from it.

ESI Ki Baat 2026 is another useful contribution to this continuing dialogue. It brings together worker experience, field evidence and recommendations across several aspects of ESIC service delivery. Such independent evidence can help institutions understand how policies and processes are experienced on the ground and identify opportunities for further improvement.

ESIC remains committed to strengthening its systems, improving service delivery, making greater use of technology and data, and enhancing the experience of insured persons and employers. This is necessarily a continuing process, requiring learning, adaptation and cooperation across the different levels of the ESI system.

I appreciate Safe in India Foundation's sustained engagement with ESIC and its efforts to bring workers' experiences into the policy and administrative discourse. I hope this report will contribute constructively to the continuing evolution and strengthening of the ESI system.

ASingh

Director General
Employees' State Insurance Corporation



Letter from the CEO

Strengthening ESIC: An Opportunity to Improve Worker Social Security, Productivity and India's Manufacturing Competitiveness

For nearly ten years, Safe in India Foundation has worked directly with more than 15,000 injured and other vulnerable workers across several states, helping them access ESIC healthcare and compensation. Our recommendations are therefore grounded in Indian workers' real experience of the system.

ESIC is an indispensable national institution. India should strengthen and modernise it, not dilute its essential character. Its contributory and independent model provides healthcare and social security at a scale that would be difficult to replace. Private-sector capacity can complement ESIC in selected areas, but only with strong standards, transparent pricing, rigorous testing and protection against exclusions, over-treatment and profit skimming.

The problems identified in this report are largely systemic and have accumulated over decades. They are not a critique of any one government, Director General or administration. Indeed, we have been honoured by the engagement of successive ESIC Directors General and by the support of the Ministry, NITI Aayog, CAG and other public institutions. We also received the Ministry's recognition for supporting ESIC beneficiaries during COVID-19. Our experience has repeatedly shown that ESIC is capable of significant improvement when processes are redesigned well.

When ESIC reform works, it can change workers' lives at enormous scale. One of the best examples is when during COVID-19, our engagement helped improve access to ESIC's unemployment benefit scheme. More than 50,000 workers ultimately received over ₹100 crore through the scheme, while several crores of rupees of avoidable worker costs were saved.

ESIC needs continuous institutional improvement, not only isolated process fixes. Our recommendations include a permanent process re-engineering and continuous-improvement capability; clearer and measurable service standards; stronger focus on service quality; better use of technology and AI; stronger Centre-State-local governance; and an urgent review of ESIC's long-term financial health. ESIC reserves arise from contributions made for insured workers and should primarily strengthen healthcare and social-security protection for those workers rather than be diverted to unrelated purposes.

ESIC's data may be one of India's most powerful untapped tools for improving worker health, safety and industrial professionalism. Its nationwide data on injuries, illness and social-security usage can identify geographic, industrial and employer-level hotspots. Used intelligently, it can enable earlier intervention, better healthcare planning and more targeted enforcement - reducing unnecessary government interaction with well-run businesses while focusing attention where conditions genuinely need improvement.

A stronger ESIC is not only a worker-welfare objective. It is part of India's productivity, manufacturing and competitiveness agenda. Our decade of accident and worker-support data indicates a close relationship between ESIC compliance, safer workplaces and more professional businesses. Large companies can accelerate this improvement by strengthening ESIC compliance and working conditions across their supply chains, in partnership with government.

India cannot achieve its manufacturing ambitions without improving labour productivity and business professionalism. ESIC can be one of the institutions that helps make that possible.

This report is dedicated to that opportunity.

This report is a result of stupendous effort by my colleague, Dhanraj Balakrishna, who has brought it together with support from almost everybody in the Safe In India team. A great team effort. We are also grateful to the experts Dr Rama V. Baru, Shri Ravi Duggal, Dr Indranil Mukhopadhyay, Dr Abhay Shukla, Prof. Sophy K.J., Dr Ravi S. Srivastava, and Dr Sundararaman T., for their insights, feedback, reviews, and generosity with time, which has materially strengthened the analysis.



Sandeep Sachdeva
Co-Founder & CEO
Safe in India Foundation

Abbreviations and Acronyms

AB-PMJAY	Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana
AB1 / AB2	ABVKY claim forms
ABDM	Ayushman Bharat Digital Mission
ABHA	Ayushman Bharat Health Account
ABVKY	Atal Beemit Vyakti Kalyan Yojna
ACA	Affordable Care Act (United States)
ACMA	Automotive Component Manufacturers Association
AFP	Administradoras de Fondos de Pensiones (Chile)
AI	Artificial Intelligence
AR	Accident Report
ASHA	Accredited Social Health Activist
ASI	Annual Survey of Industries
BI-1 / BI-1(A)/ BI-3	ESIC benefit claim forms
BIS	Bureau of Indian Standards
BO	Branch Office
BOOT	Build-Own-Operate-Transfer
BPL	Below Poverty Line
BRSR	Business Responsibility and Sustainability Reporting
CAG	Comptroller and Auditor General of India
CCU	Coronary/Critical Care Unit
CEO	Chief Executive Officer
CNC	Computer Numerical Control
CPGRAMS	Centralised Public Grievance Redressal and Monitoring System
CT	Computed Tomography
DB	Dependent Benefit
DCBO	Divisional Cadre Branch Office
DG	Director General
DGFASLI	Directorate General Factory Advice Service & Labour Institutes
DGUV	Deutsche Gesetzliche Unfallversicherung (German Statutory Accident Insurance)
DISH	Directorate of Industrial Safety and Health
DL	Decision Letter
DMEO	Development Monitoring and Evaluation Office
DPIIT	Department for Promotion of Industry and Internal Trade
ECG	Electrocardiogram
EDD	Expected Date of Delivery
eKYC	Electronic Know Your Customer
EMRI	Emergency Management and Research Institute
EPFO	Employees' Provident Fund Organisation
EPS	Entidades Promotoras de Salud (Colombia)
ESI	Employees' State Insurance
ESIC	Employees' State Insurance Corporation
ESIS	Employees' State Insurance Scheme
FGD	Focus Group Discussion
FIR	First Information Report
FONASA	Fondo Nacional de Salud (Chile)
FY	Financial Year
GDP	Gross Domestic Product
GFR	General Fertility Rate
GIDC	Gujarat Industrial Development Corporation
HO	Head Office
HR	Human Resources
HRA	House Rent Allowance
ICMR	Indian Council of Medical Research
ICU	Intensive Care Unit
ID	Identification
IICA	Indian Institute of Corporate Affairs
ILO	International Labour Organisation
IMO	Insurance Medical Officer
IMP	Insurance Medical Practitioner
IOHER	Institute of Occupational Health and Environmental Research
IP	Insured Person
IPD	In-Patient Department
IPs	Insured Persons
IRDAI	Insurance Regulatory and Development Authority of India
ISSA	International Social Security Association
IT	Information Technology
IW	Insured Woman
KFF	Kaiser Family Foundation
KYC	Know Your Customer
LC	Life Certificate
LOTO	Lockout/Tagout

LWF	Labour Welfare Fund
MB	Maternity Benefit
MED 7A / MED 7B / MED 37	ESIC medical certification forms
MIS	Management Information System
MLC	Medico-Legal Case
MO	Medical Officer
MR	Medical Referee
MRE	Medical Record Envelope
MRI	Magnetic Resonance Imaging
MRO	Medical Referee Opinion
MSME	Micro, Small and Medium Enterprise
MTS	Multi-Tasking Staff
N/A	Not Available
NGO	Non-Governmental Organisation
NGRBC	National Guidelines for Responsible Business Conduct
NHS	National Health Service (United Kingdom)
NIC	National Informatics Centre
NIOH	National Institute of Occupational Health
NITI Aayog	National Institution for Transforming India
OD	Occupational Disease
ODC	Occupational Disease Centre
OECD	Organisation for Economic Co-operation and Development
OOP	Out-of-Pocket
OOPE	Out-of-Pocket Expenditure
OPD	Outpatient Department
OSH	Occupational Safety and Health
OSHWC	Occupational Safety, Health and Working Conditions (Code, 2020)
OTP	One-Time Password
PAR	Post-Accident Registration
PDB	Permanent Disablement Benefit
PF	Provident Fund
PF2	Private Finance 2 (United Kingdom)
PFI	Private Finance Initiative (United Kingdom)
PG	Public Grievance
PHC	Primary Health Centre
PLFS	Periodic Labour Force Survey
PM-JAY	Pradhan Mantri Jan Arogya Yojana
PPP	Public-Private Partnership
PSU	Public Sector Undertaking
PTRC	Peoples Training & Research Centre
QES	Quarterly Employment Survey
RAG	Red-Amber-Green (rating)
RM-3	Medical Referee referral form
RO	Regional Office
RSBY	Rashtriya Swasthya Bima Yojana
RTI	Right to Information
SB	Sickness Benefit
SDG	Sustainable Development Goal
SIAM	Society of Indian Automobile Manufacturers
SII	Safe In India Foundation
SLA	Service Level Agreement
SLAs	Service Level Agreements
SMS	Short Message Service
SOP	Standard Operating Procedure
SPREE	Scheme to Promote Registration of Employers/Employees
SRO	Sub-Regional Office
SSO	Social Security Officer
SST	Super-Speciality Treatment
STP	Straight-Through Processing
TAT	Turnaround Time
TB	Tuberculosis
TDB	Temporary Disablement Benefit
TIC	Temporary Identity Card
UMANG	Unified Mobile Application for New-age Governance
USSA	Universal Social Security Account
UT	Union Territory
WHO	World Health Organization

Table of Contents

Executive Summary
13

CHAPTER 1
ESIC: Its Important Role in Improving Working Conditions and Productivity – The Positive Case for This Report
17

CHAPTER 2
Temporary Disablement Benefit (TDB) and Permanent Disablement Benefit (PDB) Access Barriers and Procedural Complexity: Based on Data from 11,000+ Injured Workers Supported by SII
31

CHAPTER 3
Growing Maternity Cash Benefit: An excellent promise for Insured Women (IW); Process Improvements can Improve the Lives of Lakhs of Women and Children
57

CHAPTER 4
Lengthy and Cumbersome Sickness Benefit Process, Often for Small Amounts, Makes it Unattractive Even to Poor Workers
69

CHAPTER 5
Complex Bill Reimbursement & Poor Process Around Referrals Drive Delays, Denials, and Worker Losses
79

CHAPTER 6
ESI Medical Coverage: Infrastructure and service quality needs to keep pace with rising IP enrolments
89

CHAPTER 7
Non-standard Ad-Hoc Processes Across Regions, even within the Same State, should be Replaced with Standard Best Practices Available within ESIC
109

CHAPTER 8
Grievance Redressal in ESIC: Welcome Increased Accountability through Rising Filings, but Access & Quality need Improvement
113

CHAPTER 9
Common Process Issues Across Various ESIC Benefits: A Case for Process Re-Engineering
123

CHAPTER 10
ESIC's Digital Systems and AI: Uneven Adoption; Future Opportunities
127

CHAPTER 11
The Employer Perspective: Improved Specific Awareness of ESIC Benefits, especially Cash Benefits, will Increase Adoption
137

CHAPTER 12
Impact of Employer Non-Compliance on IPs: Before, During, and After Workplace Accidents/Disability
147

CHAPTER 13
Big-Picture Service Delivery: Expansion Significant; Per-IP Capacity & Governance Needs to Catch Up
161

CHAPTER 14

Status of Occupational Diseases under ESIC: Strong Expertise; An Opportunity for Better Disease Tracking

179

CHAPTER 15

ESIC's finances: improved payouts, but worsening arrears risk ESIC's financial health; potential to use non-earmarked surplus for improving capacity

185

CHAPTER 16

Impact of the Code on Social Security 2020 on ESI: Important Structural Shifts, Minimal Near-Term Change in IP and Employer Experience

195

CHAPTER 17

The Structural Case for a Single, Universal Social Security System for Workers: Risk Pooling and the Limits of Choice

201

CHAPTER 18

ESIC and Private Insurance: A Comparative Assessment

205

CHAPTER 19

Social Security: Evidence from International and Indian Experience

211

CHAPTER 20

Recommendations: Top 15 Strategic & Policy Recommendations and 100+ Tactical Recommendations

225

CHAPTER 21

Critical Need for Process Re-Engineering: A Great Opportunity for Deregulation

229

CHAPTER 22

Leveraging ESIC Data for Improving ESIC Services, Reducing ESIC Costs, and Improving Working Conditions – A Latent Opportunity for India

239

CHAPTER 23

About Safe In India Foundation

247

Major References

254

Annexure

255


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IndusInd Bank

Executive Summary

Context:

The Employees' State Insurance Corporation (ESIC) is India's principal contributory, employment-linked social insurance institution, a statutory corporation under the Code on Social Security, 2020 (earlier the ESI Act, 1948), that uniquely combines income-protection with being a direct healthcare provider for the country's formal workforce and their families. This report by Safe in India Foundation (SII), grounded in nearly a decade of direct support to over 15,000 injured and vulnerable workers across Haryana, Maharashtra and Tamil Nadu, examines how well ESIC delivers on that mandate and sets out an agenda to strengthen and modernise it, not to dilute its essential character. The weaknesses identified here are largely systemic, and ESIC has repeatedly shown it can improve at scale when processes are redesigned well.

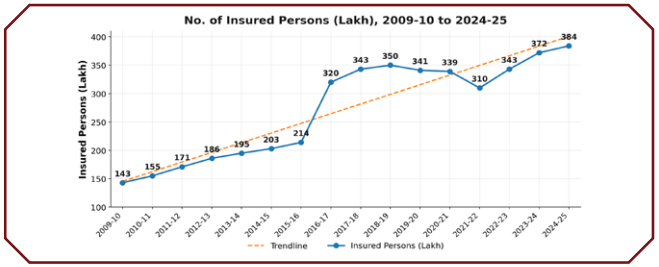
Drawing on SII's field evidence, ESIC's own data, and inputs from an independent expert panel, the report frames a stronger ESIC as central not only to worker welfare but to India's productivity, manufacturing and competitiveness agenda, where safer workplaces, better compliance and more professional businesses reinforce one another.

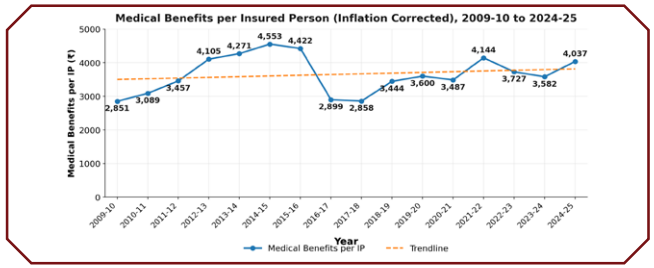
Big Picture

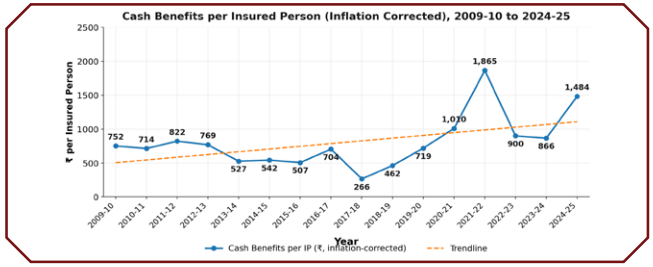
Evidence

- ESIC coverage widened to 687 of 778 districts (+294 in a decade).
- Insured Persons (IPs) up 2.7× in 15 years to 3.84 crore; women IPs faster at 3.2× to 0.83 crore; employers up 6× to 24.8 lakh, with sharp additions post-2021–22.
- Medical Benefits spend up ~3.8× (inflation-corrected) in 15 years despite stable internal capacity; real per-IP spend has seen a ~42% increase in 15 years
- Total cash benefit payments (number of payments) increased slightly (26%) across 15 years, but not in line with IP growth. Cash benefits per IP (value) trends are uneven across benefits; downward trend for Sickness Benefits, TDB & PDB, upward trend for Maternity Benefits and Dependent Benefits.
- Code on Social Security 2020: Shifts ESI from notified areas to default pan-India applicability, a positive for workers; Enables ESIC as delivery platform for unorganised, gig, and platform workers.

Data







Recommendations

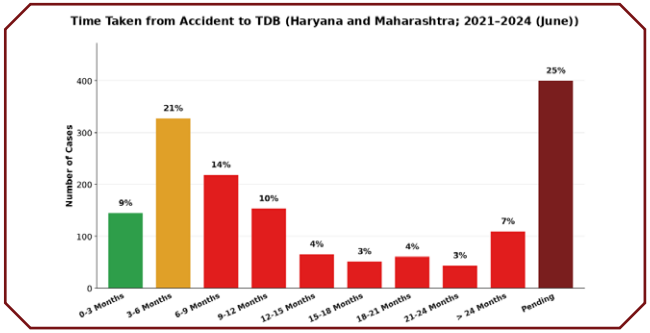
- Raise and index the wage ceiling to bring in workers who deserve coverage but have been excluded by inflation; Raise to at least ₹33,000 (inflation-corrected value for 2026).
- Improve the Social Security Code & Rules to include 'quality' in it. (The idea that ESIC is to provide certain social insurance services is now 70+ years old, and ESIC should add focus on 'quality of services')
- Improve proactive healthcare and working conditions, especially OSH (Occupational Safety & Health), by leveraging technology and using ESIC's structured and unstructured national data on sickness, injuries and death of workers to identify hot spots of accidents & sickness.
- Replace the current random/rotational selection for both inspections and coverage surveys with a risk-based algorithm
- Cover gig/platform and informal workers, but not at the cost of existing IPs, and at the same premium levels as the current formal sector IPs, funded by the state/employers.

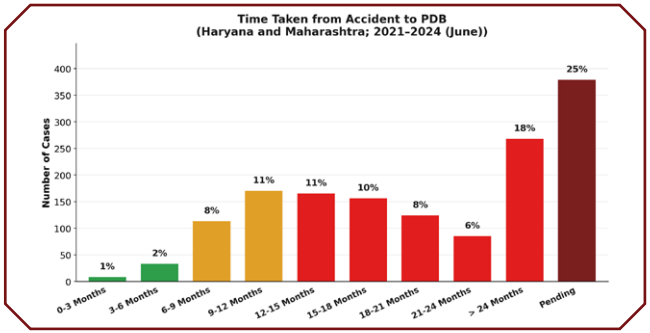
Payment Benefits

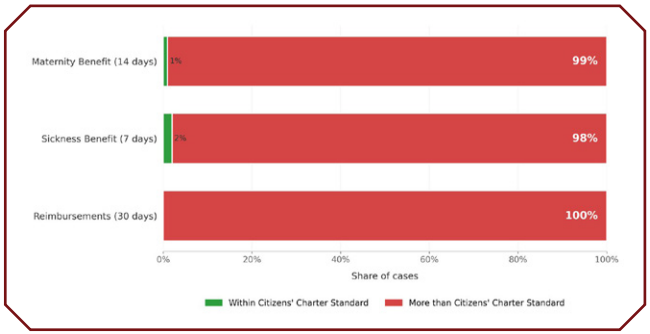
Evidence

- Among SII-supported IPs, 70% wait 6+ months for TDB (Temporary Disablement Benefits) and 78% wait 12+ months for PDB (Permanent Disablement Benefits): a year of unpaid, reduced earning capacity when they need it most. Median PDB wait: 470 days. Faridabad worst.
- Delays cut across benefits. Only ~2% of Maternity and Sickness payments meet Citizens Charter timelines; zero for reimbursements (state-handled). Median waits: 165 days (Maternity Benefits), 58 days (Sickness Benefits), & 164 days (Reimbursements).
- Causes include:
  - Process design complexity
  - Too many steps & handoffs; with IPs shuttling between counters
  - Online steps are added, but need for duplicate offline steps often continues.
  - Chronic bottlenecks & queues
  - Burden on worker: responsibility pushed to IPs
  - Excess forms and documentation
  - Structural dependence: on employers for eligibility and evidence
  - Low visibility and low observability
  - Access, inclusion & awareness gaps: Digital exclusion, language barriers and low awareness
  - Non-standard regional processes

Data







Recommendations

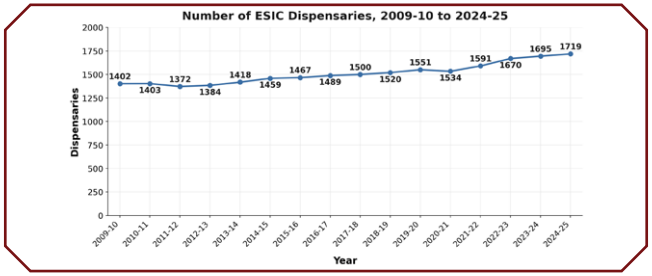
- Create a system to effectively monitor and enforce the Citizens' Charter turnaround times
- Develop IP experience metrics and publish a public dashboard of user-facing indicators and branch-level + regional-level performance
- Establish a 'process re-engineering cell' to make the processes worker-centric (All large service organisations need constant customer feedback-driven incremental and non-incremental process improvements). Select reengineering ideas:
  - National standardised document checklist for all benefits
  - Require acknowledgement of all claims received by ESIC
  - Remove unnecessary steps within processes; e.g., reengineer the steps preceding the Medical Board
  - Set firm timelines for internal document transfers within ESIC
  - Increased visibility through automated notifications and updates to beneficiaries and employers
  - Reuse ESIC's record data at different stages of the benefit process
  - Reasoned rejections and refusals
  - Separate offline and online channels, without overlap
  - Increased use of technology and AI
- Make re-engineering a continuous programme, not a one-time exercise

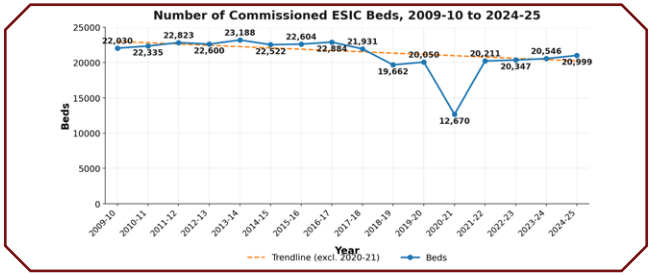
Medical Benefits

Evidence

- Dispensaries per 100,000 IPs halved from 9.80 to 4.47 over 15 years; half of ESIC's own norm.
- Beds run 56% below the 125-per-lakh IP norm.
- Doctor count doubled, but doctors-per-IP fell as enrolment outran hiring; Specialists' shortfall upwards of 50% in some states
- Paramedical and pharmacist shortfalls exceed 50% in some cases
- Under-occupancy in ESIS hospitals; likely driven by staffing and service-quality gaps
- Medicine and diagnostic shortages push the average IP to spend ~₹1,200 out-of-pocket even at ESI hospitals.
- Basic infrastructure gaps in multiple ESIC facilities, especially dispensaries

Data





Recommendations

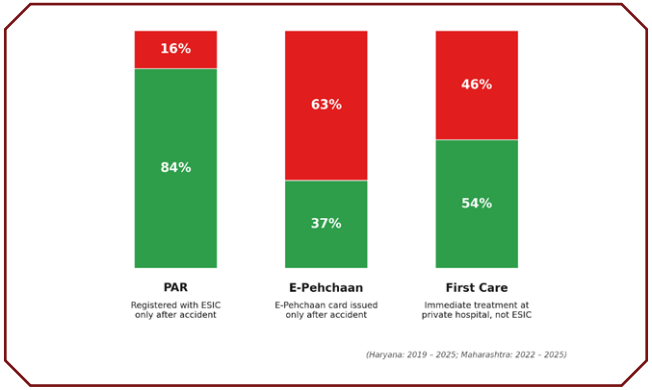
- Expanding IP coverage must be matched by proportionate additions to dispensaries/OPD, bed capacity and staff strength.
- Provide an entitlement for an annual check-up with local PHC or ESI dispensary for IPs.
- Human resource overhaul: 100% of sanctioned posts of doctors and staff should be filled
- Ensure ICUs, CCUs, and OTs meet standards and make super-speciality services reliable; decrease dependence on outsourcing
- Guarantee cashless OP/IP care by maintaining an essential-drug buffer; on-site diagnostics at all hospitals and core diagnostics at dispensaries
- Guarantee cashless treatment at empanelled hospitals

Employer Non-Compliance

Evidence

- ~16% of SII-supported injured workers in Haryana and Maharashtra are Post-Accident Registration (PAR) cases, i.e., ESIC-registered after the accident, evidencing pre-injury non-registration by employers, then met with ad-hoc, non-standard denial letters from ESIC.
- ~63% IPs receive an e-Pehchaan card only post-accident.
- One-third of workers injured in the last six months had no accident report filed.
- In ~46% of injuries, immediate treatment happens at a private hospital, not ESIC; improving, but still widespread.
- Employer arrears keep rising.

Data



Recommendations

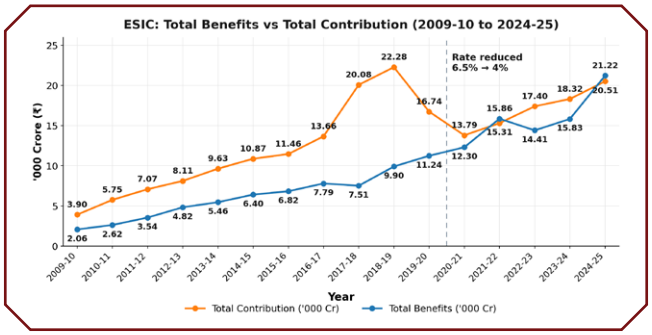
- Empower IPs on ESIC registration and details' modification
- Standardise PAR denials with a reasoned, appealable template
- Empower workers to notify accidents; impose maximum penalty on employers for AR filings beyond 48 hours; independent medical assessment where employer filings are late or inconsistent
- Create an ESIC facilitator model, similar to the ASHA or PMJAY's Arogya Mitra tasked with assisting beneficiaries and awareness.
- Enforce recovery mechanisms to recover employer arrears

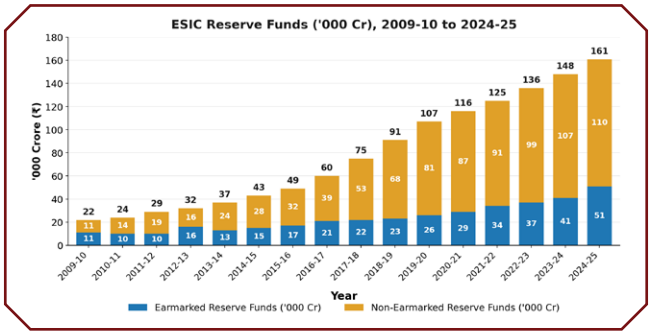
Reform

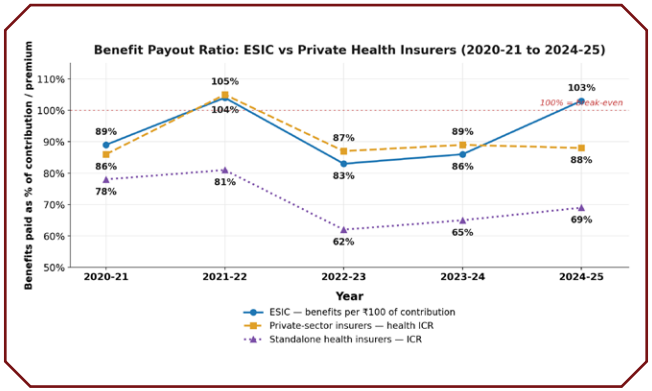
Evidence

- Finances: After the 2019–20 rate cut, ESIC's benefit-to-contribution ratio averaged 0.89, comparable to private insurers' IRDAI claims ratios. Benefits exceeded contributions in 2021-22 and 2024-25: a warning sign for long-term health. ESIC's actuarial projections point to an eroding fiscal cushion, with deficit expected to rise to ₹7,686 crore by FY29.
- Admin overhead stable at ~10% (within 15% ceiling).
- Reserves: ₹1,60,573 crore in reserves and investments, beyond actuarial need. Room to invest in benefits and access.
- Governance: Only 4 states have an ESI Society; Mixed Fund routing elsewhere throttles delivery and reimbursements.
- Corporation is bulky (59-member); Regional Boards inactive; Local Committees non-functional. CAG flagged (2013-14) committee shortfalls persist through 2019-25.
- The argument that "competition will improve outcomes" is incorrect: the market structurally cannot serve this workforce; this could result in the exit of lower-risk, higher-wage IPs, leaving the pool financially unviable for high-risk, low-wage IPs.
- “Worker choice” is, in practice, the employer’s choice; this will ultimately deny insurance altogether for IPs
- Commercial health insurance costs 2-4x ESIC and almost completely excludes Payment Benefits (TDB, PDB, Maternity).
- ILO’s 2018 report recorded privatisation reversals in 18 of 30 countries (1981 to 2014 period)

Data





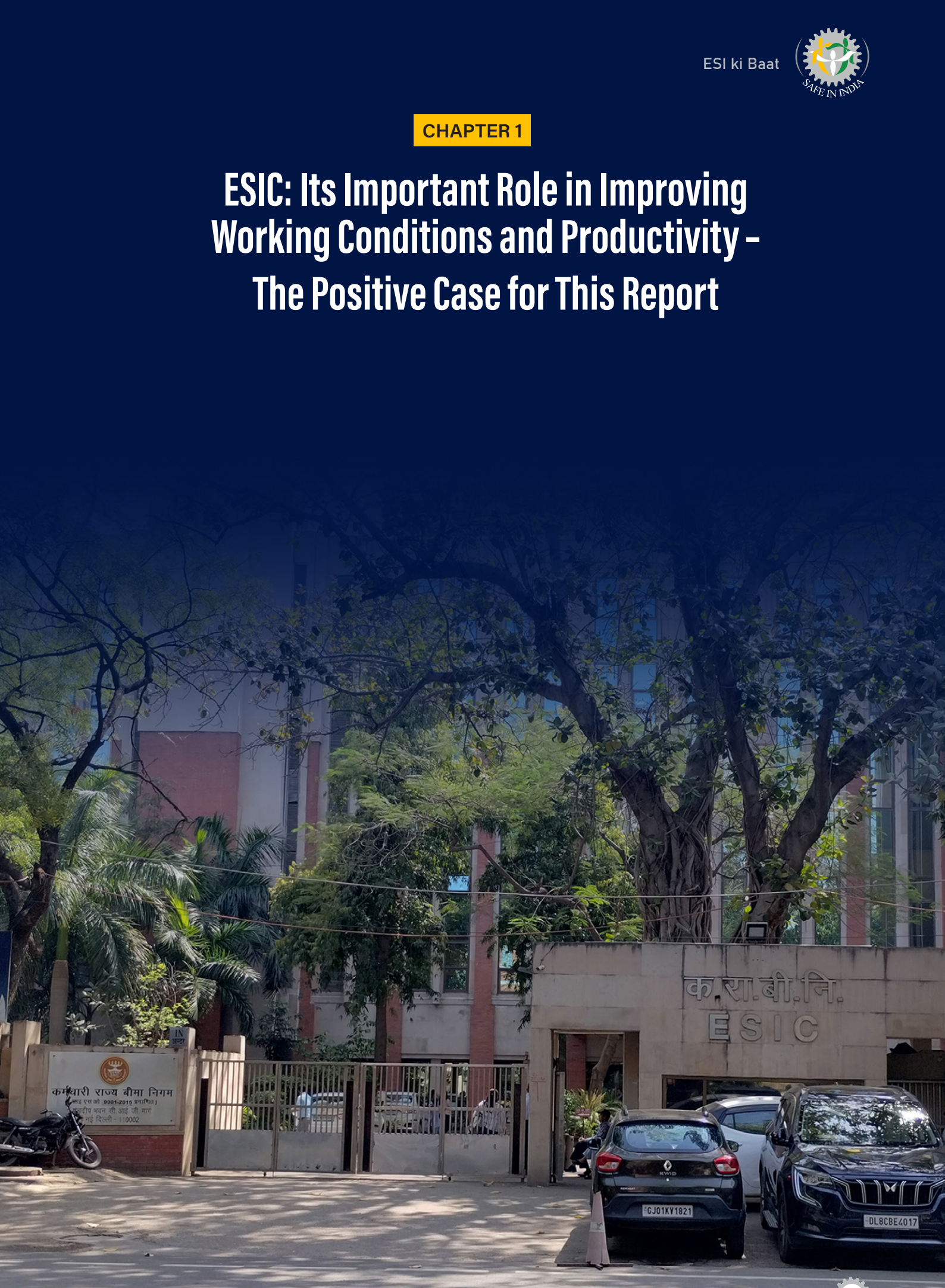


Recommendations

- Independent actuarial review of ESIC's financial viability under realistic growth and expenditure scenarios; test whether the fix is higher contributions.
- Deploy accumulated reserves toward IP benefits and access.
- Institute regular independent performance and social audits alongside financial audits.
- Restructure the Corporation: 25% each of government, employers, workers (incl. contract), independent experts, with equal power.
- Amend Regional Board and Local Committee composition to include contract and non-permanent workers (IPs themselves) and NGO/ civil society reps.
- Set up a Quality of Claims Management Council to review and improve claims processes.
- Constitute ESI Societies in all states; remove the state treasury as a gating step for in-kind delivery and IP reimbursements.
- Social security coverage for workers requires a single, compulsory, income-linked pool; For both medical and income protection insurance for workers, the financing function must remain with a single, public entity with mandatory contributions and risk pooling, i.e., ESIC.
- For medical benefits delivery, the core should stay with ESIC and be expanded/improved, with private providers brought in to fill a few geographic and specialist gaps.
- Private-sector expertise should be used to improve systems, build capacity, and raise standards, but on ESIC's terms, not as a replacement.

CHAPTER 1

ESIC: Its Important Role in Improving Working Conditions and Productivity – The Positive Case for This Report



Since 2016, Safe In India Foundation (SII) has supported injured workers in navigating ESIC's healthcare and compensation benefits, mainly Disablement Benefits, Temporary Disablement Benefit (TDB) and Permanent Disablement Benefit (PDB), and since 2024, also supported non-injured workers in accessing other benefits, including Sickness Benefit, Maternity Benefit, and Dependent Benefit. SII began with a Worker Assistance Centre in Manesar, Haryana, and now operates six centres across Haryana, Maharashtra, and Tamil Nadu (since 2026). This report is based on more than 16,000 such workers' experience with ESIC healthcare and compensation.

SII's daily beneficiary support places it alongside workers at key points, eligibility checks, documentation, and benefit decisions that affect income stability, working conditions, and return-to-work timelines. Since 2017, drawing on this frontline view, SII has proposed structural and operational improvements to service quality; 15 of SII's 100+ recommendations have been thankfully accepted by ESIC, impacting lakhs of workers nationally.

This report draws on that experience. It describes how compensation processes and access to medical facilities intersect with the insured person's (IP's) journey and drags workplace productivity and highlights recurring process gaps that hinder these outcomes.

Narottam Singh's experience



Narottam Singh dreamt of joining the defence forces like his brother-in-law, who was with the CRPF. He was preparing for the tests when family circumstances forced him to take a job at Rockman Industries in Bawal, Haryana.

Within months, at the age of 22, on April 13, 2016, his dream collapsed when five of his fingers were crushed in a press machine. Soon, the company dismissed him.

With a pregnant wife at home, he began visiting ESIC offices, hoping for an early release of his PDB (pension) dues. While his ESIC contributions were deducted, due to document irregularities, ESIC treated his case as a post-accident registration[1], which delayed the process considerably. He visited ESIC's Suvidha Samagams for resolution twice.

It took nine months for his TDB to start, and 17 months before he appeared before ESIC's Medical Board, only after SII's intervention[2]. Unable to work while recovering, he faced travel costs to the ESIC Branch Office from his hometown, an unhelpful ex-employer, and the added responsibilities when his child was born, which he calls the most stressful period of his life.

After 3 additional months of waiting, that is 20 months of waiting in total, with SII's support, he started receiving his pension (PDB).

In 2018, he joined SII, and he now helps other workers navigate the difficult path to rebuilding a normal life after such a life-altering injury.

1.1 ESIC at 75: Origins to Today (A contributory, Employment-linked Programme)

ESIC traces its roots to B. P. Adarkar's 1944–45 blueprint for health insurance for industrial workers, itself influenced by Beveridge's social-insurance vision. Parliament enacted the ESI Act in 1948, and the Scheme was framed in 1952 as a contributory, employment-linked programme focused on expanding provision (establishments, facilities, benefits) for the formal workforce. ESIC, therefore, began and remains a contributory scheme tied to wage eligibility and since the Code on Social Security 2020, every establishment with ten or more employees, rather than a residence-based universal system. In contrast, the UK's NHS, born of the same intellectual moment, evolved as a tax-funded universal service.

[1] Please refer to Chapter 12 for details on PARs

[2] Please refer to Chapter 2 for details on TDB and PDB

1.2 ESIC: Covering 10% of India – A Strong Social-Insurance Promise

ESIC is a contributory, self-financed social insurance scheme under the Social Security Code 2020 (earlier under the Employees' State Insurance (ESI) Act, 1948) (scheme framed in 1952). It offers medical care and nine cash benefits to eligible workers (Insured Persons, IPs) and their dependants, principally Sickness Benefit (SB), Maternity Benefit (MB), Disablement Benefits (Temporary-TDB; Permanent-PDB), and Dependant Benefit (DB), plus other notified supports (e.g., funeral).

ESIC is legally supported by three layers of protection:

1. **International labour standards** through the ILO's recognition of social security as a human right and Convention No. 102 on minimum standards of social security[3].
2. **India's constitutional commitment** to social justice under the Directive Principles – Article 41 and Article 42, read with Article 37[4]
3. **Statutory entitlement** through the ESI Act, 1948 and now, the Code on Social Security, 2020[5], which retain ESIC benefits as legal entitlements for covered insured persons and their dependents.

ESIC is a statutory corporation created by Parliament (Section 5(2)) and cannot be replaced or privatised without amending the Code on Social Security 2020.

Employees earning up to ₹21,000/month (₹25,000 for persons with disability) in non-seasonal factories and notified establishments (e.g., shops, hotels/restaurants, road transport, newspaper and cinema undertakings) that meet threshold employee counts as notified by states/UTs.

ESIC is among the world's largest worker social-insurance schemes, covering roughly a tenth of India's population. Headline coverage (latest): 384 lakh IPs and 15 crore total beneficiaries (IPs + dependants).

ESIC performs two structurally different functions:

Income protection: The first is an income protection function: ESIC acts as a statutory social insurer, pooling risk across the formal workforce and paying cash benefits when a covered contingency occurs: sickness, maternity, temporary or permanent disability, occupational disease, or unemployment. The worker's entitlement is to a cash transfer.

Medical function: The second is a medical function, which itself has two distinct components. As a medical insurer, ESIC finances healthcare, determining coverage and paying for treatment. As a medical provider, ESIC and ESIS directly deliver healthcare through its own hospitals and dispensaries, supplemented by empanelled private hospitals. Unlike most health insurers, ESIC is simultaneously a financier and provider. The worker's entitlement is to treatment, not reimbursement (unless referred).

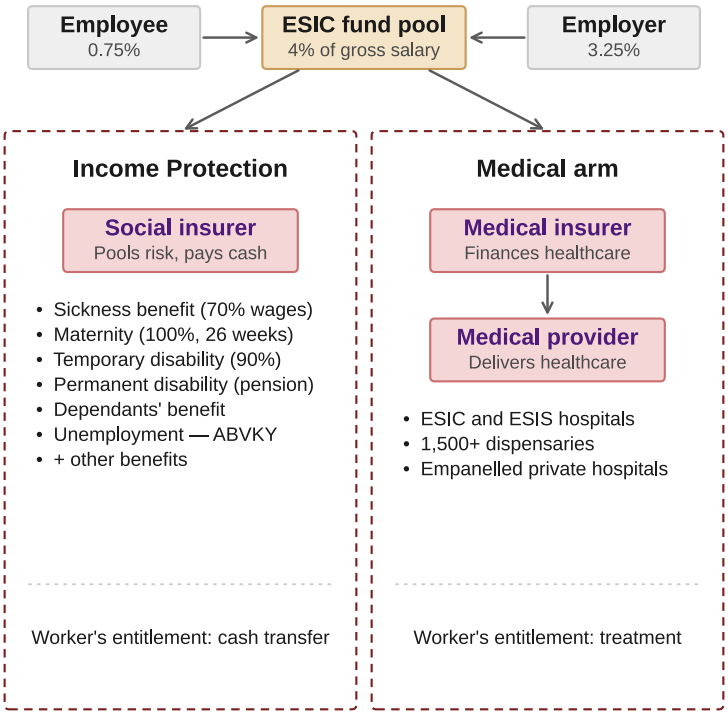


[3] International Labour Organization. (1952). Social Security (Minimum Standards) Convention, 1952 (No. 102). ILO.

[4] Constitution of India, Part IV, Article 37, Article 41 and Article 42

[5] The Code on Social Security, 2020. India Code. Sections 2(78), 28 and 32

Figure 1.1: ESIC's two broad functions – Medical Benefits and Payment Benefits



In Maharashtra, there are also IMPs (Insurance Medical Practitioners), but that experiment has not been scaled up. For the past decade and a half, ESIC has also been operating Medical Colleges.

The two broad functions are not entirely independent. E.g., ESIC's medical staff certify sickness, assess disability, and document occupational disease, determinations that directly trigger and calculate the cash benefits due.

ESIC at a glance

Eligibility (wage ceiling): Up to ₹21,000/month (₹25,000 for PwD); with effect from 1 January 2017, when the ESIC wage ceiling was increased from ₹15,000. The definition of wages under the new Code includes Basic Pay and DA and excludes overtime and other benefits. Detailed explanation in the chapter on the new labour codes.

Covered establishments: Non-seasonal factories and notified establishments (shops, hotels/restaurants, road transport, newspaper/cinema, etc.) meeting state-notified thresholds. Excludes construction (Supreme Court order from 2018).

Contributions: 4% of wages in total - 3.25% (employer) + 0.75% (employee).

Benefits: Medical care; SB, MB, TDB, PDB, DB, and other notified cash supports.

Network & access: ESIC hospitals/dispensaries and state tie-ups; AB-PMJAY empanelled hospitals in unserved/deficient areas (pan-India), with ESIC bearing costs there.

Registration & identity: IP registration by employer; e-Pehchan card for IP and family.

Care pathway: ESIC dispensary/hospital first; referrals issued for higher-level care at ESIC multi-speciality hospitals or hospitals with tie-ups; PMJAY tie-in used in notified deficient areas.

Scale (2024-25): 385 lakh IPs; 15 crore beneficiaries (IPs + dependants).

Medical and cash benefits (what they do, at a glance):

Medical Care: Primary to tertiary treatment through ESIC facilities or referred tie-ups; emergency care allowed at empanelled/non-empanelled hospitals as per procedure for IPs and their families.

Sickness Benefit (SB): Short-term income support during certified illness.

Extended/Long-term Sickness: Income support for specified prolonged illnesses.

Maternity Benefit (MB): Paid leave and related entitlements for confinement, miscarriage, or adoption.

Disablement Benefit - Temporary (TDB): Income support during certified temporary disablement from employment injury.

Disablement Benefit - Permanent (PDB): Periodic compensation based on assessed loss of earning capacity after employment injury/disease; post-assessment via ESIC's medical board/appeal mechanisms.

Dependants' Benefit (DB): Periodic support to eligible dependants in case of death due to employment injury/disease.

Other cash supports (where applicable): Funeral expenses; confinement expenses (when ESIC facility is not reasonably available); vocational rehabilitation aids per ESIC norms.

Universal entitlement supported by ESIC's contributory, employment-linked design:

While ESIC's contributory, employment-linked design may appear to limit universal entitlement, it is also what enables the system to remain financially autonomous, without reliance on annual government budgetary support. Contributions are linked to wages at fixed rates, allowing workers to contribute according to their earnings, but medical benefits are not tied to the amount contributed. Thus, a person earning ₹21,000 and contributing about ₹840 per month is entitled to the same services as a person earning ₹10,000 and contributing about ₹400 per month. Eligibility for cash benefits, meanwhile, is based on the number of days for which wages were earned and reported to ESIC by the employer, rather than on the worker's wage level or contribution amount**.**

Quality is still not adequately focused on: For decades, ESIC exclusively prioritised gross provisions: facilities, enrolment, and benefit rollouts. Although ESIC 2.0 in 2015 explicitly introduced a quality lens, however routine public reporting on user-facing metric: time to decision, payout timeliness, acceptance/rework rates, and grievance resolution remains scarce.

1.3 Locating ESIC in India's Evolving Health & Social-Protection System

Access bridge with PM-JAY: ESIC's medical network now formally interoperates with Ayushman Bharat–PMJAY in unserved/deficient areas: at the 194th ESIC meeting (8 Oct 2024), pan-India access to PMJAY-empanelled hospitals for ESIC beneficiaries was approved, with no expenditure limit for IPs at those hospitals. This theoretically widens access where ESIC's footprint is thin without altering its contributory character.

Potential Impact of PM-JAY integration:

However, even in areas where ESIC previously had workable private tie-up arrangements, these may increasingly be replaced by PMJAY-based arrangements. Since the PMJAY revenue model is reportedly not attractive for many private hospitals (please check out chapter 19), some hospitals may enrol only for higher-margin services, while lower-margin services remain nominally covered but are not meaningfully available in practice. Meanwhile, several ESIC hospitals are also enrolling under PMJAY, helping fill these gaps for the general public and generating some additional revenue for the Corporation.

Code on Social Security, 2020 and the draft national labour policy (Shram Shakti Niti 2025): The 2020 Code provides the legal basis for wider, portable social security; the draft national labour & employment policy now operationalises this by proposing a Universal Social Security Account (USSA) that integrates EPFO, ESIC, PM-JAY, e-Shram and State welfare boards, anchored on a unified Labour Stack. The proposed implementation is phased: 2025–27 (institutional setup and database integration), 2027–30 (nationwide USSA rollout and district

Employment Facilitation Cells), and post-2030 (consolidation, paperless governance), with real-time dashboards, a Labour & Employment Policy Evaluation Index benchmarking states, and an Annual National Labour Report for accountability. For ESIC, this policy direction means tighter interoperability (identity, eligibility, and benefits portability) within a one-nation social protection architecture while retaining ESIC's contributory, employment-linked design.

Where this leaves ESIC: ESIC remains India's principal contributory health and cash insurance for formal workers; policy linkages (PMJAY, USSA) are pushing toward near-universal service access through interoperability, while universal entitlement remains bounded by ESIC's contributory, employment-linked design.

SII believes that despite the proposed changes, ESIC in its current form will, for years, continue functioning largely as it does today; therefore, this report's recommendations remain valid.

1.4 SII's Proposed Principles for Reform (to achieve the best outcome for workers and employers):

Within the above context of reform, any reform of ESIC should keep the IPs' (workers') welfare at the centre. Reform should follow these principles:

1. **Risk pooling must be preserved**: The single mandatory risk pool is what makes coverage viable for high-risk, low-wage workers. Any reform permitting risk segmentation, through optional participation, separate products for worker categories, or risk-based pricing, will exclude precisely the workers ESIC exists to protect.
2. **No cross-subsidisation** - financial viability must be secured before coverage expansion: With the contribution rate reduced from 6.5% to 4% and benefit payouts now matching or exceeding contribution income, ESIC's financial sustainability must be re-established through an updated actuarial valuation before new IP categories are inducted. *Reserves built from current workers' contributions must not be used to subsidise expansion into new segments/services.*
3. **Immediate improvement in quality, capacity and awareness is necessary:** Workers' current experience of ESIC, i.e., service quality, capacity, awareness of entitlements, and accessibility, must improve immediately.
4. **Central and State governance needs rationalisation**, with equal representation from government, business, workers, including contract workers, and neutral experts.
5. **ESIC's reserves belong to premium-paying IPs and employers and should not be diverted elsewhere**: ESIC's corpus belongs to workers (Insured Persons). The fiduciary obligation is to use them for improving worker social security and not divert to other uses.
6. **Benefit continuity and adequacy: exclusions typical in private sector insurance should not be introduced**; **Workers should receive at least the same package of benefits post-reform**, i.e., the full basket of cash benefits including lifetime income-replacement for permanent disability; medical coverage *without* monetary ceilings for occupational diseases; national portability; no exclusion of procedures through cream-skimming; and no waiting periods for covered contingencies.
7. **Reform should not increase costs for workers and employers**; and not maximise profits for a few private service providers at the cost of the majority of businesses using ESI services: Reform that generates excessive private equity-type surplus for private service providers without commensurate worker benefit is not acceptable.
8. **Worker choice is in effect the employer's choice, and therefore counterproductive**: Given the power asymmetry between workers and employers, particularly in contractual employment, optionality in benefit or provider choice will in practice become employer or contractor choice. Reforms premised on worker choice must demonstrate how genuine worker agency will be protected.
9. **Attribution and latency protection**: The attribution problem, where a party disputes whether a disease or injury is work-related, and the latency problem, where occupational diseases manifest years after exposure, must not emerge as barriers to benefit access. Any reform that introduces a party with a financial incentive to deny occupational origin of illness is structurally incompatible with ESIC's mandate.
10. **Private participation only where proven**: Private involvement should be permitted only where there is demonstrated evidence of improved outcomes for workers, employers, or ESIC, and only where ESIC retains control, sets the rules, and can reverse the arrangement. Privatisation as a default or ideological position is counter-productive.

11. **Regulatory risk in the Indian context must be explicitly accounted for**: Healthcare privatisation functions only where regulatory capacity is sufficient to enforce standards, prevent cream-skimming, and hold private providers accountable. Any reform proposal that depends on the private sector must demonstrate how regulation will be designed, enforced, and sustained.
12. **Proposed reforms must learn from international experience:** Where international evidence exists on the outcomes of comparable reforms, particularly privatisation of social insurance and healthcare delivery, that evidence must inform design.

Please refer to chapters 17 to 19 for discussions on ESIC reform.

1.5 ESIC can Improve Working Conditions: An Improved ESIC Compliance and Delivery Is a Direct Lever for Improving India's Labour and MSME Productivity

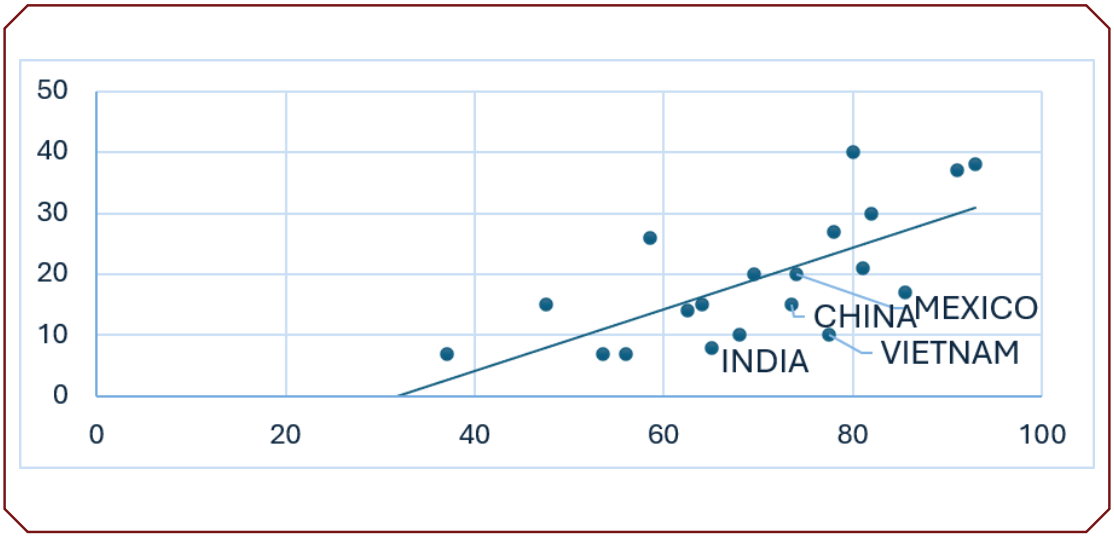
As recommended by SII, India's Economic Survey 2024–25 explicitly frames occupational safety and health (OSH) as a driver of firm performance. In short, better working conditions lead to higher productivity and profitability.

Strengthening ESIC and ensuring employers use it well turns injury and illness from disruptive shocks into manageable costs. When benefits are processed promptly, households bridge income gaps and workers return sooner; firms reduce prolonged vacancies, skill loss, and rehiring/training churn persistent sources of MSME inefficiency flagged in SII's analysis.

Fewer lost days and healthier workers also mean steadier and more productive shop-floor operations. ESIC cash benefits plus medical access shorten time away from work and reduce presenteeism after injury or illness, stabilising throughput and quality in small plants.

SII has analysed in CRUSHED 2026, its annual report, the correlation between ESIC compliance and workplace safety. Please also refer to chapter 22 in this report.

Figure 1.2: Strong Positive Correlation between Labour Productivity and Labour Rights Index scores for Top 20 Non-OECD Manufacturing Economies



Labour Rights Index Score (X-Axis): Scores based on labour policies by Wage Indicator Foundation (Netherlands)
Productivity (Y-Axis): ILO data for GDP per hour worked (GDP constant 2017 international $ at PPP) in 2023

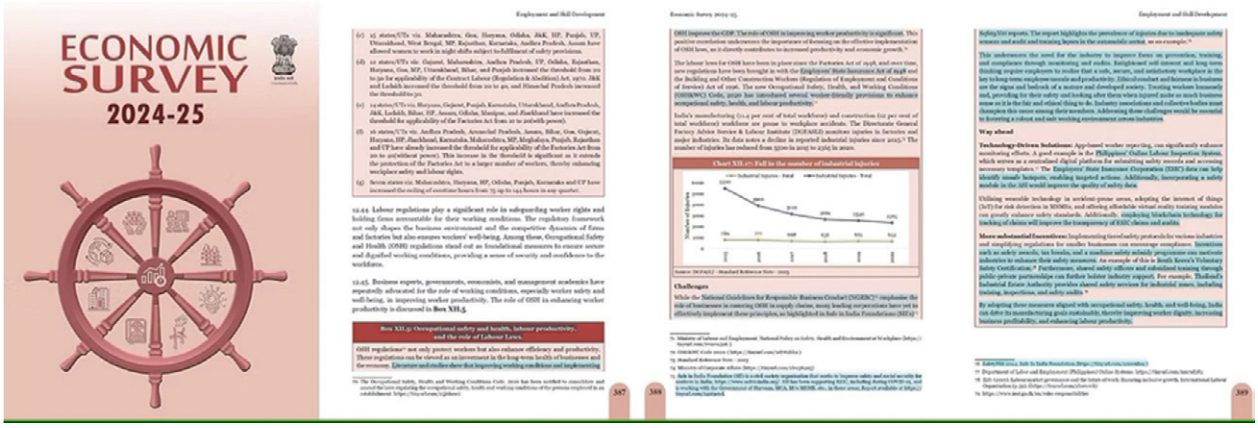
Systematic use of ESIC data can guide practical OSH fixes and early interventions at all levels (national, state, cluster, factory, etc.), lowering incident/accident rates and future costs.

Improved ESIC use also signals professionalism to buyers and lenders. MSMEs that use ESIC properly, register workers, inform them of entitlements, file on time, and support referrals can also document compliance and lower operational risk for supply-chain audits and credit. *Broad ESIC uptake in MSME manufacturing can scale firm-level gains into sectoral productivity improvements.*

With the Economic Survey 2024–25 stating that worker safety is good for business, an improved ESIC is a practical mechanism for MSMEs to turn that principle into day-to-day productivity: fewer lost days, faster return-to-work, lower churn, and steadier output.

The Economic Survey also recommended deregulation, and the removal of procedural friction without the removal of substantive protection through reengineering will deregulate ESIC for IPs and employers.

Figure 1.3: Economic Survey 2024-25: Improved Working Conditions are Good for Business



Please refer to the last section in Chapter 19 for international case studies on social security – labour productivity linkage.

1.6 The Missing User (IP) View: Why an Independent Periodic ESIC IP-Experience Report Is Needed

ESIC's own Annual Reports and Financial Estimates and Performance Budgets are detailed, but system-side focused. These reports comprehensively cover finances, infrastructure, and operations. What's still sparse is routine, public tracking of beneficiary experience (e.g., decision/payout times, acceptance/rework rates, grievance resolution).

CAG has also examined ESIC from an audit lens, not a user lens.

- Report No. 2 of 2006: Functioning of ESIC (covers 1999–2004 issues such as governance, controls).
- Report No. 30 of 2014: Performance Audit of ESIC (period 2008–09 to 2012–13). Tabled 12 Dec 2014. Focus: governance, finances, coverage/controls.
- Report No. 40 of 2015: Performance Audit of Medical Education Projects of ESIC (compliance/efficiency of ESIC's MED colleges/projects).
- CAG Rajasthan Report No. 2 of 2021 (Compliance Audit) for the year ended 31 March 2020 includes an analysis of ESIS.

There has been no national performance audit of ESIC since 2013.

Only one user-side study exists but is largely focused on medical benefits and is survey-based. The **2022 International Labour Organisation (ILO) study** titled "Accessing medical benefits under ESI Scheme: A demand-side perspective," was conducted in collaboration with the Public Health Foundation of India and others. It captured beneficiary experience mainly for medical services (four states), with limited coverage of compensation processes.

The gap: There is no regular, independent report on the insured person's experience of ESIC services, especially the compensation processes that shape income stability and return-to-work.

Why this "ESI Ki Baat" report series: SII's multi-year, multi-state beneficiary support and a track record of accepted recommendations position SII to be able to document worker-side (and some employer-side) process frictions and metrics and feed practical improvements back to ESIC; hence, this first l IP-experience report, to be updated periodically with more employer experience coverage.

SII invites healthcare and insurance professionals, academicians, researchers, other experts and other civil society organisations to join this effort.

1.7 Persistent Delivery Gaps and Why Regular Reporting Matters

SII's efforts in supporting IPs suggest there is room to make ESIC's delivery more consistent and predictable for insured persons. Processes can vary across regions and branches: checklists differ, where they exist, some online steps still require offline follow-through, and rules are read differently in similar cases. Decision timelines are not always clear to users; Medical Board scheduling and communication can be uneven, and PDB orders may take longer than expected. Facility readiness also differs by location (specialists, diagnostics, essential drugs), and referral pathways are not uniformly applied. *Publishing a small set of user-facing indicators, such as file-to-decision time, decision-to-credit time, acceptance/rework rates, and grievance outcomes/final resolution, would meaningfully improve the IP experience by making performance visible and helping teams spot and fix bottlenecks.*

Awareness among both workers and employers is low: concise, timely guidance on eligibility, required documents, and typical timelines is not consistently shared with IPs or reinforced at branch offices during applications, making first-time right submissions unlikely.

On the employer side, delays in registration (including post-accident cases), contribution arrears or under-reporting, missing KYC/bank seeding, providing employee/contractor details instead of IPs and incomplete accident/wage documentation can slow otherwise eligible claims. Simple, standard checklists and timely confirmations can lift performance without adding burden.

Taken together, constructive steps - predictable processes, practical employer support, and focused communication (awareness) can make the ESIC experience smoother for workers and more efficient for employers and ESIC.

Case study - Accident at Lifelong India Pvt. Ltd., Rewari, Haryana, resulting in 16+ deaths: when better ESIC compliance, awareness and service quality would have saved lives and provided better manufacturing professionalism

On 16 March 2024, a dust-collector blast in the buffing department at Lifelong India Pvt. Ltd. (a direct supplier to Hero) injured 39 workers; at least 16 workers have since died.

The Deputy Director, Industrial Safety & Health, Gurugram, reported multiple violations under the Factories Act, 1948 and Punjab Factory Rules, 1952, including failure to detect foreign-body contamination, a dispensary below prescribed standards, excess weekly hours, and absence of a register of accidents and dangerous occurrences (near-misses).

All injured workers were treated in government hospitals, including AIIMS, Delhi; none received care at nearby ESIC hospitals, despite all being ESIC-registered. Compensation was offered by ESIC, the company, and the state government (via the Labour Welfare Fund) to the deceased; however, families in touch with SII report uncertainty about compensation for the injured and for dependents of the deceased.

When SII met co-workers soon after the incident, most did not know what ESIC was. The non-use of ESIC facilities at first contact, despite eligibility, highlights a critical awareness and compliance gap. The episode also points to delivery gaps: unclear emergency referral pathways to ESIC hospitals, uneven facility readiness, and no simple, visible protocol to move insured victims swiftly into ESIC care and onto compensation tracks.

In the five employment-injury case papers for injured workers accessed, the *investigating notes described them as post-registration (PAR) cases*, indicating registration occurred after the accident.

Simple better maintenance would have saved lives and would have been an indicator of better manufacturing and employer practices.


TOI City Gurgaon Mumbai Delhi Bengaluru Hyderabad

40 workers, some with critical burns, in hospital after factory blast in Rewari

Ankita Anand / TNN / Updated: Mar 17, 2024, 08:46 IST

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Dharuhera factory blast that killed 16 was caused by spark

1.8 This Report's Coverage: Mainly ESIC Benefit Pathways and On-Ground Delivery

Objectives and Scope of the Report: This report documents how insured persons experience ESIC in practice, identifies the main process and delivery gaps affecting access to benefits and care, and proposes practical improvements. Its main focus is on TDB, PDB, SB, MB, reimbursements/referrals, grievance redressal, regional variation, and employer practices; medical services are covered more selectively here and will be taken up in greater depth in future editions.

Chapters 2 to 8 examine each Cash Benefit (Disablement Benefits, i.e., TDB and PDB, Maternity Benefit and Sickness Benefit) and Medical Benefit, reimbursements, regional variation, and grievance redressal.

Chapter 9 identifies common process gaps across ESIC benefits, while **Chapter 10** reviews the current role of technology at ESIC and explores opportunities to use digital systems and AI.

Chapters 11 and 12 assess employer practices and perceptions that enable or impede timely access to ESIC benefits. This includes issues with enrolment and registration of workers.

Chapters 13 to 15 provide big-picture overviews of ESIC service delivery and financials, including occupational health. **Chapter 16** examines how the new Social Security Code impacts insured persons (IPs).

Chapters 17 to 19 provide a big-picture overview of ESIC reform.

Chapter 20 lists our top 15 strategic and tactical recommendations, while **Chapters 21 and 22** present two priority recommendations, i.e., re-engineering for service quality and leveraging ESIC data to strengthen OSH and social security in India.

Chapter 23 is about Safe In India Foundation.



Note on Methodology and Data Sources

This report documents what insured persons (IPs) and some employers experience in practice when accessing ESIC benefits and care, and highlights where systems can be strengthened to deliver faster, simpler, and more reliable support. It draws on SII's beneficiary support records, worker FGDs/interviews, some employer surveys, and official and other published sources to trace the end-to-end journey for key benefits and identify the bottlenecks that most affect IPs.

Scope and Geography

Geographic focus: Industrial clusters where SII works closely with IPs and ESIC field offices, primarily in Haryana and Maharashtra (e.g., Manesar, Gurugram, Faridabad, Rewari & Bawal, and Mohan Nagar & Chakan in Pune). Some surveys from Tamil Nadu, Karnataka, Rajasthan, and Uttarakhand.

Topical scope: ESIC benefit journeys and enabling systems: Temporary Disablement Benefit (TDB), Permanent Disablement Benefit (PDB), Sickness Benefit (SB), Maternity Benefit (MB), Medical Benefit (analysis is largely limited to secondary sources), reimbursement pathways, grievance redressal, and employer practices that affect access.

Time period: Quantitative trends reflect the latest available data extract at the time of drafting, i.e., June 2026 (SII's data from 2021 to 2025 and ESIC's data from 2009 to 2025); qualitative inputs reflect recent field engagement (including FGDs conducted in January 2026 in selected locations).

Evidence Streams

A. **SII's Beneficiary Support Records**
SII maintains structured records for cases where it supports IPs in accessing ESIC healthcare and/or compensation benefits (since 2016; c.15,000 workers supported). These records typically include case milestones (e.g., accident date, claim initiation, document submission, certification, medical board, payment dates), location identifiers, and outcome status (pending/closed), enabling analysis of timelines and bottlenecks.

B. **Primary Qualitative Research (FGDs, Interviews, Worker Stories)**
Findings on "how the system works in practice" draw on structured FGDs and interviews with IPs and employers (and, where relevant, other stakeholders). Qualitative inputs capture process realities, reasons for delay/drop-off, IP experience, and location-wise variation.

C. **Process and Document Review**
Documented workflows (e.g., citizen charter commitments and relevant rules) are mapped against observed practice. Where discrepancies arise, the report explicitly distinguishes documented process from observed practice.

D. **Secondary/Official sources**
National context and system-level trends draw on 16 years of ESIC Annual Reports (2009-10 to 2024-25), CAG reports (Report No. 2 of 2006, Report No. 30 of 2014, Report No. 40 of 2015, and CAG Rajasthan Report No. 2 of 2021), and other official publications, alongside relevant external research (including ILO's "Accessing medical benefits under ESI Scheme: A demand-side perspective" (2022)).

Experts Consulted

SII has consulted a range of experts drawn from academia, industry and social security policy, during the preparation of this report. Their insights, critical feedback, reviews, and generosity with time have materially strengthened the analysis. We are deeply thankful to them.

Experts:

Dr Rama V. Baru, Professor (Retd.), Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi; Honorary Fellow, Institute of Chinese Studies, Delhi.

Shri Ravi Duggal, Independent researcher and consultant on public health, health financing, and social security; formerly Country Manager, International Budget Partnership (2009–2018); previously with the Foundation for Research in Community Health (FRCH) and CEHAT.

Dr Indranil Mukhopadhyay, Professor, Jindal School of Government and Public Policy, O.P. Jindal Global University, Sonipat; formerly Research Scientist and Assistant Professor, Public Health Foundation of India (PHFI).

Dr Abhay Shukla, Senior Programme Coordinator, SATHI (Support for Advocacy and Training to Health Initiatives), Pune; National Co-Convener, Jan Swasthya Abhiyan (People's Health Movement, India).

Dr Sophy K.J., Associate Professor of Law and Director, Centre for Labour Law Research and Advocacy (CLLRA), National Law University Delhi.

Dr Ravi S. Srivastava, Professor and Director, Centre for Employment Studies, Institute for Human Development, New Delhi; former Professor of Economics, Centre for the Study of Regional Development, Jawaharlal Nehru University; former Full-Time Member, National Commission for Enterprises in the Unorganised Sector (NCEUS), Government of India.

Dr Sundararaman T., Public health expert; former Executive Director, National Health Systems Resource Centre (NHSRC), Ministry of Health and Family Welfare, Government of India; former Dean, School of Health Systems Studies, Tata Institute of Social Sciences (TISS), Mumbai; Adjunct Professor, International School of Public Health, JIPMER, Puducherry; former Global Coordinator, People's Health Movement.

Key Indicators and Measurement Choices

- **Timeliness (TAT) Indicators:** Timelines are constructed from available operational milestones (e.g., accident/claim initiation to benefit receipt/payment date, where available) and presented by location and year, where sample size permits.
- **Process Burden Indicators:** Number of visits, duplicative paperwork, re-submission cycles, and referral/board scheduling patterns are summarised from qualitative inputs and case records.
- **Ground-Reality Qualifier:** Where relevant, the report notes that in practice, in many locations, the user journey includes informal steps not reflected in the documented workflow.

Data Handling and Analysis Approach

- **Descriptive Analysis:** Quantitative sections are primarily descriptive (averages/medians, distributions, and location-wise comparisons), designed to surface operational bottlenecks rather than estimate causal effects.
- **Comparability and Recency:** Where extreme values can distort interpretation, analyses apply transparent inclusion criteria and state them alongside figures. Recent-year trends are interpreted cautiously where cases remain pending (possible undercount/incomplete timelines).

Confidentiality and Presentation

- **Anonymisation:** Most individual IP identities are not disclosed; case narratives are presented in aggregated or anonymised form to protect workers.
- **Constructive Intent:** Findings are presented to support service improvement and policy alignment, recognising that implementation practices can vary across offices and over time.

Limitations & Mitigants

- **Bias/Not a Random Sample:** SII-supported cases do not constitute a representative sample of all ESIC IPs. In practice, workers who come to SII for support, particularly injured workers, are typically those already encountering delays, barriers, or other difficulties in accessing ESIC benefits and services. Findings should be read as evidence on system performance and user experience in assistance-seeking pathways, not population prevalence.
- *However, c.40-45% of all PDB cases in Haryana (from Gurugram RO and Faridabad SRO combined) and in Pune (Pune SRO) have needed SII assistance, indicating data and experiences collected from them to be a near-universal experience and indicating systemic issues faced by all IPs.*
- **Variation Across Locations**: Processes can vary across offices/facilities; the report therefore emphasises recurring (consistent) patterns corroborated across sources.
- **Data Availability Constraints:** Some milestones (e.g., exact document-submission timestamps across all benefits) may not be consistently recorded, limiting certain measurements.
- **Consistent Pattern:** IP data has remained consistent across years, indicating *systemic issues faced by all IPs.*

Report researched and drafted by Dhanraj Balakrishna, with inputs from the SII team.





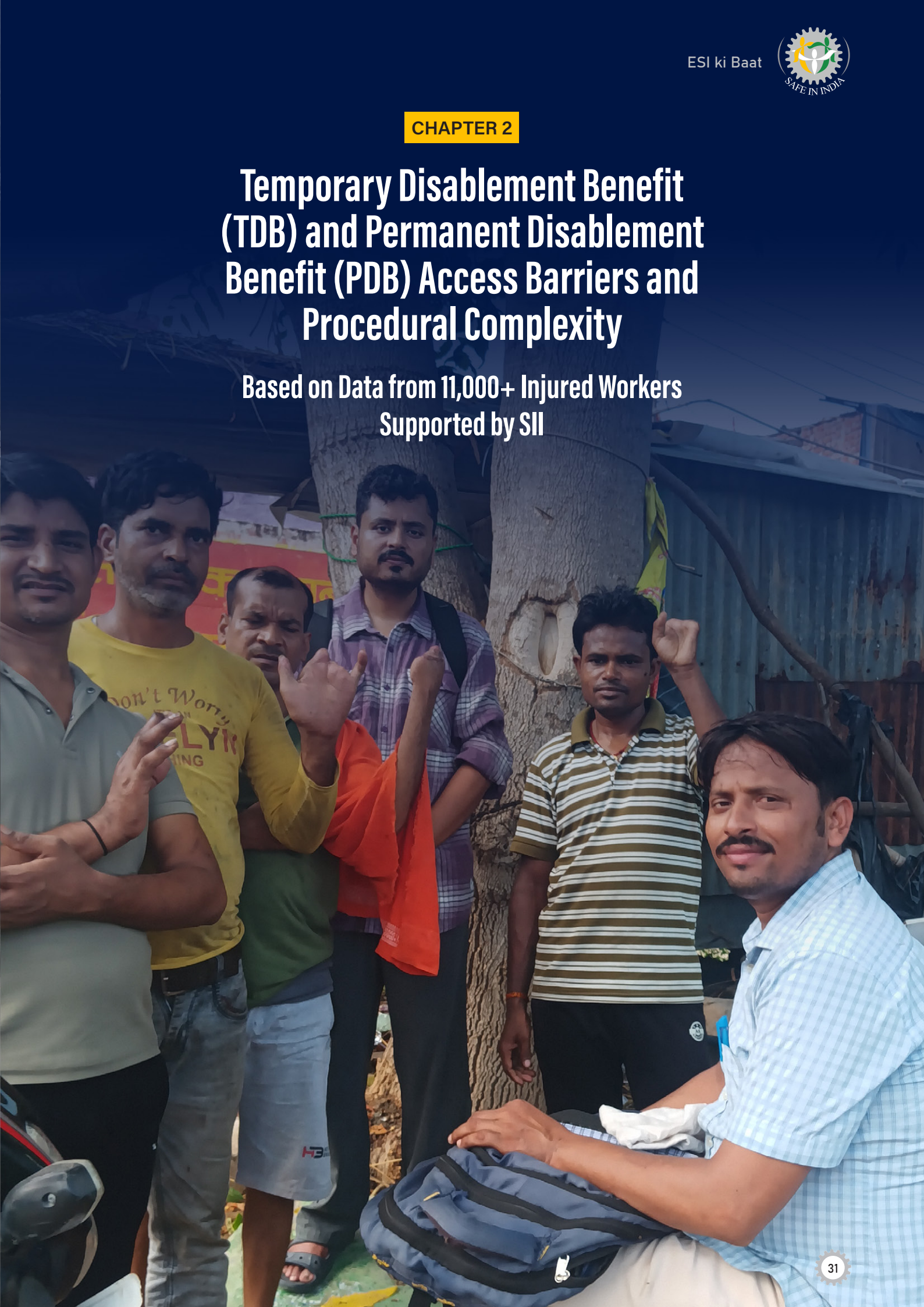




CHAPTER 2

Temporary Disablement Benefit (TDB) and Permanent Disablement Benefit (PDB) Access Barriers and Procedural Complexity

Based on Data from 11,000+ Injured Workers Supported by SII



This chapter reviews ESIC's disablement benefits - Temporary Disablement Benefit (TDB) and Permanent Disablement Benefit (PDB) - which safeguard insured workers against wage loss from employment injury/ occupational disease. TDB replaces wages during certified temporary incapacity, while PDB provides a proportionate lifelong pension (or capitalised value) aligned to the assessed degree of permanent disablement.

2.1 Reduction in the Number of IPs Accessing Disability Benefits; Increase in Amount Paid to Eligible Beneficiaries

Temporary Disablement Benefit (TDB)

ESIC's Temporary Disablement Benefit provides insured persons (IPs) 90% of their average daily wages when certified as temporarily incapable of work due to an employment injury or occupational disease.

Entitlement: Payable from the very first day of insurable employment, without any contribution condition, and continues for the entire period of certified disablement. The benefit is released for as long as the IP remains under ESIC medical certification.

Eligibility: All IPs under the ESIC scheme who suffer employment injury/occupational disease

In 2024–25, ESIC disbursed ₹94.7 crore under Temporary Disablement Benefit (TDB), broadly in line with the inflation-adjusted range observed over the past 15 years. However, when assessed on a per-insured person basis, TDB outgo has declined alongside the expansion in the insured population (2.7×). Consistent with this, the average number of TDB benefit days per employee fell to 0.06 in 2024–25, down from 0.21 in 2009–10.

In the absence of TDB numbers, taken together, these trends suggest one or more of the following possibilities:

i. A reduction in utilisation of TDB.

ii. Claims are being paid for shorter durations.

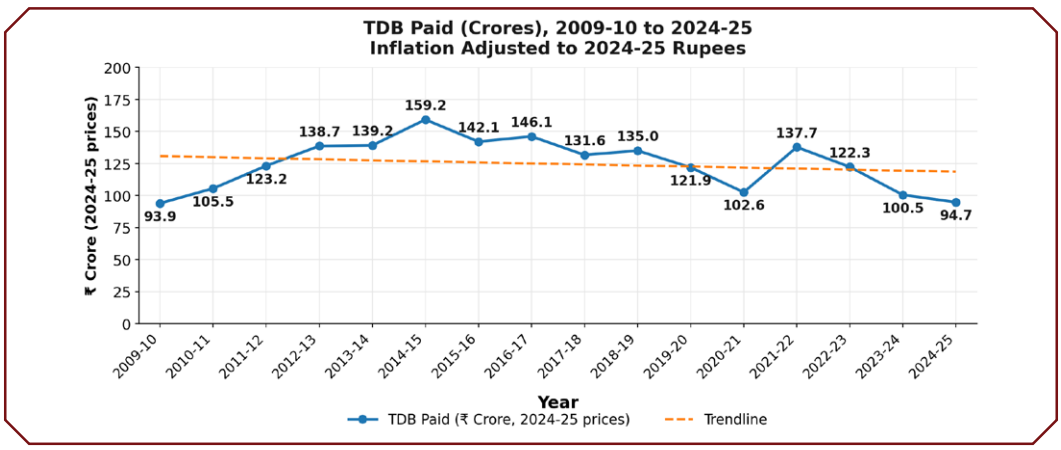
iii. Fewer IPs (as a share of total IPs) are getting injured due to improved working conditions

iv. Fewer IPs (as a share of total IPs) are getting injured due to a compositional shift in ESIC's insured base towards geographies and industries with lower injury risk.

v. Earlier, employers could sometimes bring coverable but uncovered workers within ESIC by filing a supplementary challan[1]. Since this practice appears to have been discontinued, post-accident registration has become harder, reducing one route through which employers could retrospectively enrol workers after an accident.

SII suspects that it is mainly due to a compositional shift in ESIC's insured base towards geographies and industries with lower injury risk, and is therefore not an indicator of improvement.

Figure 2.1: Temporary Disablement Benefit Payment by ESIC plateaued from 2009-10 to 2024-25 (Rupees Crores) (Inflation adjusted to 2024-25 Rupees)



ESIC doesn't publish data on the number of TDB cases as part of the Annual Reports. Please refer to Section 13.3 for per-IP analysis.

[1] Employer registers the worker retrospectively/adds them to the relevant month via supplementary contribution

Permanent Disablement Benefit (PDB)

ESIC's Permanent Disablement Benefit, a lifelong income support, ensures financial security for insured persons (IPs) who suffer permanent impairment or loss of earning capacity from an employment injury/ occupational disease. It is paid for life as a monthly pension equal to 90% of average daily wages, adjusted to the extent of disability as assessed by a Medical Board.

Entitlement: For total permanent disablement, full 90% wages are payable for life; for partial disablement, proportionate benefit is paid.

Eligibility: Available from day one of insurable employment, with no minimum contribution condition, provided the disablement is employment-related.

In 2024–25, ESIC admitted 8,371 fresh Permanent Disablement Benefit (PDB) cases (9,574 in 2023–24), continuing a decline observed over the past 15 years. Read alongside the 15-year expansion in the insured population, this decline is more pronounced on a relative basis (i.e., per insured person). This pattern may reflect a combination of the following reasons:

i. Reduced access to PDB among injured workers.
ii. Slower processing of PDBs/delays
iii. Fewer IPs are affected by permanent disability.
iv. A compositional shift in ESIC's insured base towards geographies and industries with lower injury risk.

This is in contrast to SII's own experience, where the number of disabling accidents, both TDB and PDB cases, has seen a steady increase.

The capitalised value of claims for these fresh cases totalled ₹448 crore in 2024–25. In inflation-adjusted terms, this value shows a modest, steady increase despite the fall in the number of cases, implying higher capitalised payouts per admitted case, beneficial for workers who qualify – this has doubled in the last 15 years (see graph 2.4 below).

Figure 2.2: Permanent Disablement Benefit – Fresh Cases Admitted decreased from 2009-10 to 2024-25

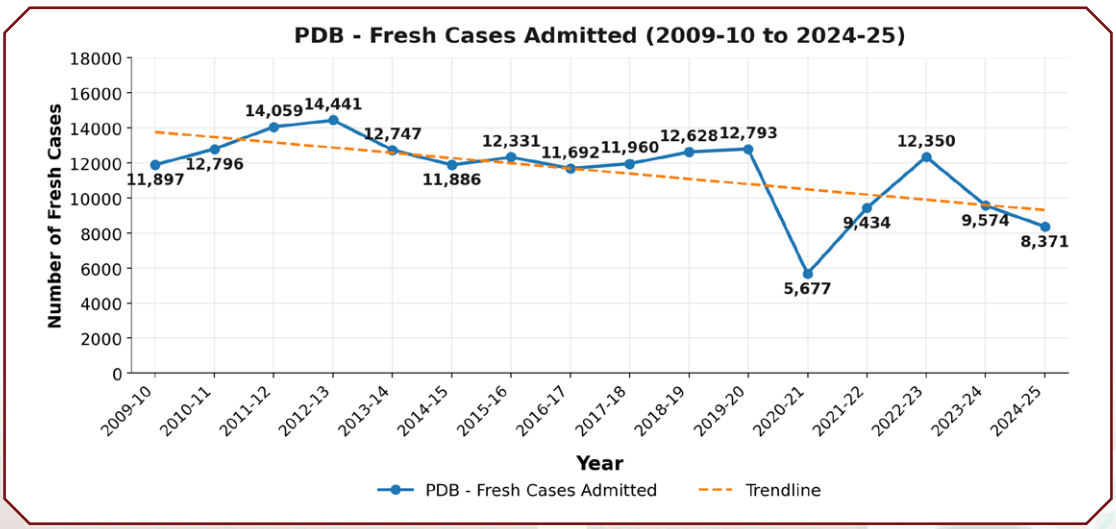
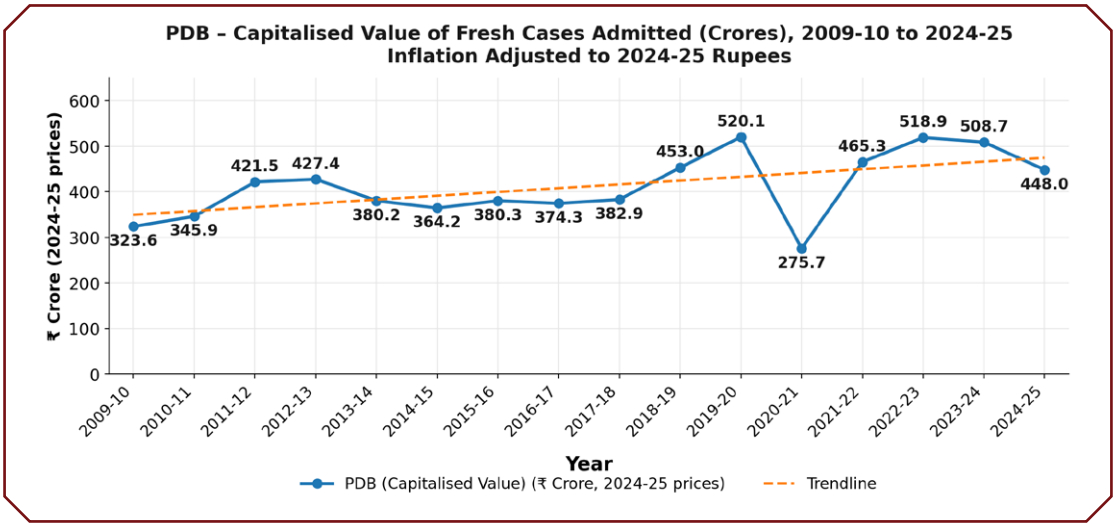
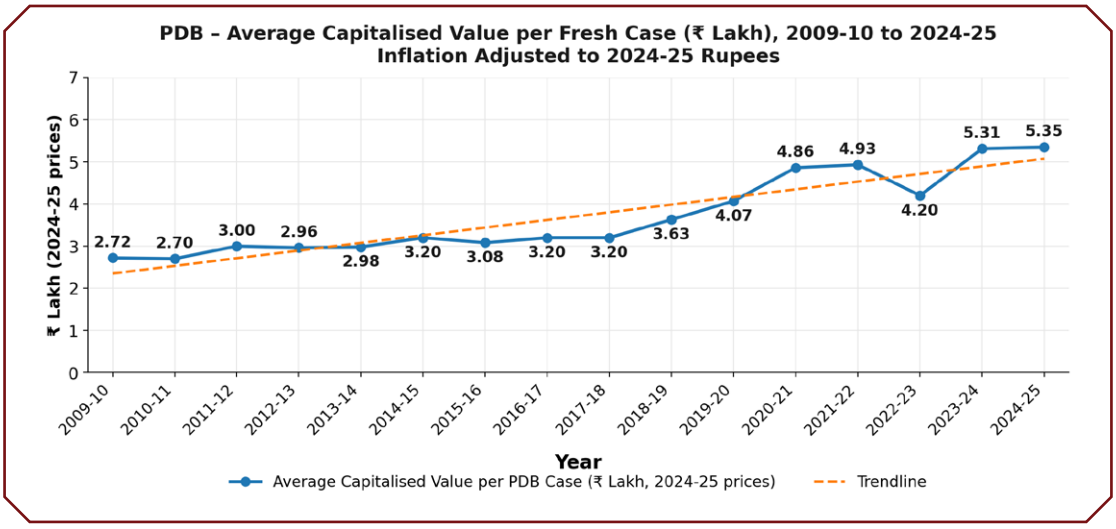


Figure 2.3: Permanent Disablement Benefit Payment from 2009-10 to 2024-25 – Capitalised Value of Fresh Cases Admitted increased steadily (Rupees Crores) (Inflation adjusted to 2024-25 Rupees)



Please refer to Section 13.3 for per-IP analysis.

Figure 2.4: Permanent Disablement Benefit Payment from 2009-10 to 2024-25 – Average Capitalised Value of Fresh Cases Admitted doubled (Rupees Lakhs) (Inflation adjusted to 2024-25 Rupees)



Mubarak, 22 years



Mubarak works at an auto-component factory in Sohna, supplying Maruti's supply chain.

On 4 April 2026, he was made to operate a power press despite a known technical fault in the machine. He lost two fingers in the accident.

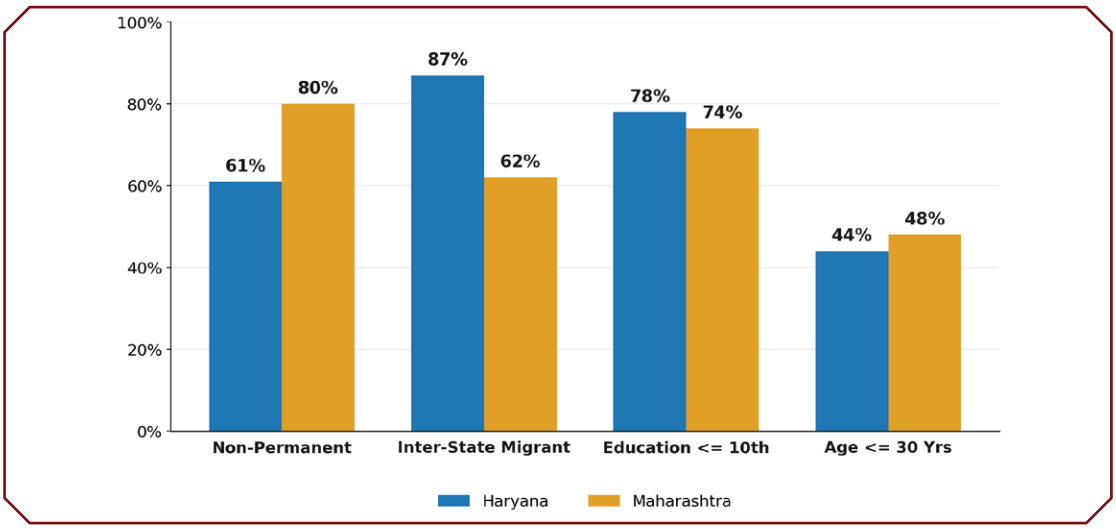
For nearly three months after the injury, he received no proper treatment or guidance from ESI, as his employer sent him to a private hospital for treatment instead of the ESIC system, and he was never informed of his rights or the ESIC process.

If he had continued treatment at the private hospital, this could have cost him around ₹41,000 in TDB and reduced his future PDB arrears. But thankfully, he reached ESIC Hospital, Gurugram, three months after the accident; the OPD doctor issued a medical certificate with one week of rest. With SII's help, his earlier medical leave was also regularised at the ESI Dispensary, Nuh, protecting his TDB and future PDB entitlements.

2.2 Injured IPs Are Among the Most Vulnerable Workers; Highlights the Need for ESIC to Strengthen Disablement Benefit Access

SII's experience shows that injured IPs are much more likely to be from vulnerable groups - young, low-educated, migrants in non-permanent roles. Most are educated only up to Class 10, almost half are under 30, and many work on short-term contracts through contractors. Migrants, who lack extended family support and strong social networks in destination states, are especially exposed.

Figure 2.5: Proportion of All IPs Assisted by SII in Vulnerability Groups



(Haryana: 2019 - 2025; Maharashtra: 2022 - 2025)

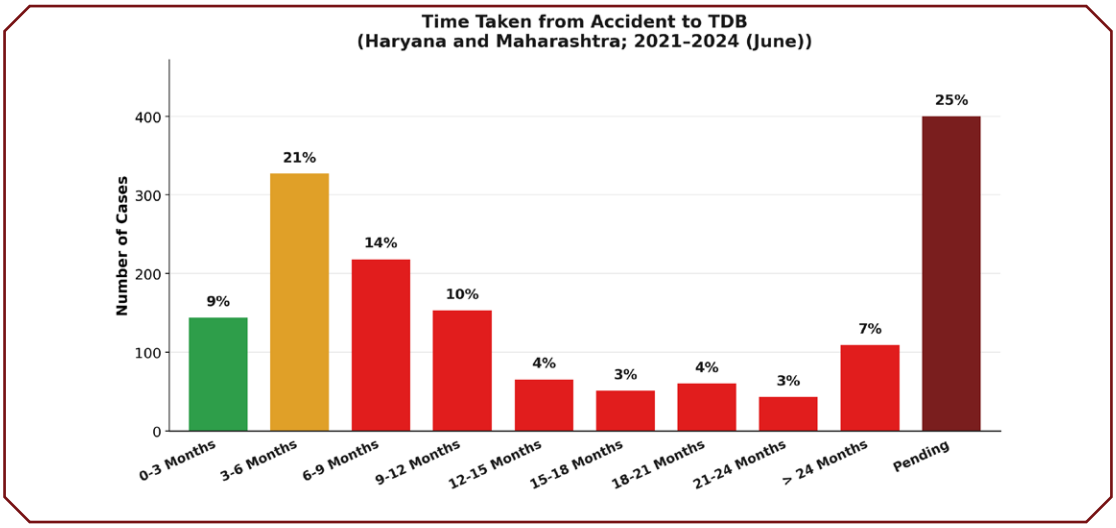
Given these realities, and the complex ESIC processes to claim benefits, SII has played a complementary role to ESIC staff, helping more than 11,000 injured IPs (TDB & PDB cases) with applications to access their entitlements. This direct engagement gives SII a ringside view of the obstacles faced, especially in securing Disablement Benefits.

2.3. Inefficiencies Extend Delivery Timelines: TDB and PDB Often Take Months Against a 30-Day Citizen's Charter Benchmark

Graphs below are based on SII's data collected from IPs in Haryana and Maharashtra

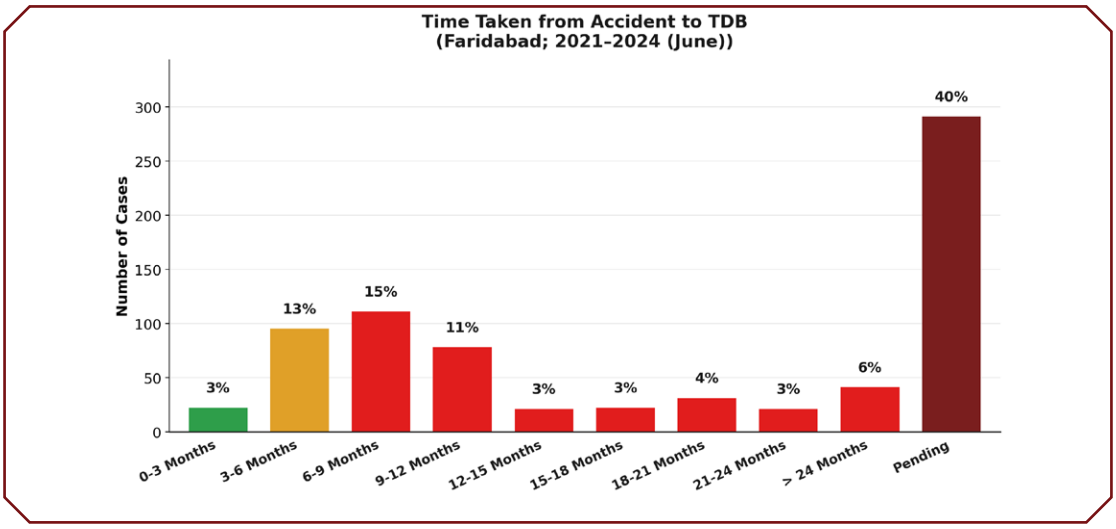
2.3.1 70% of IPs Wait More than 6 Months from Accident to Receiving TDB; Delays in Haryana worse than Maharashtra; Improvements now Reported in Both States

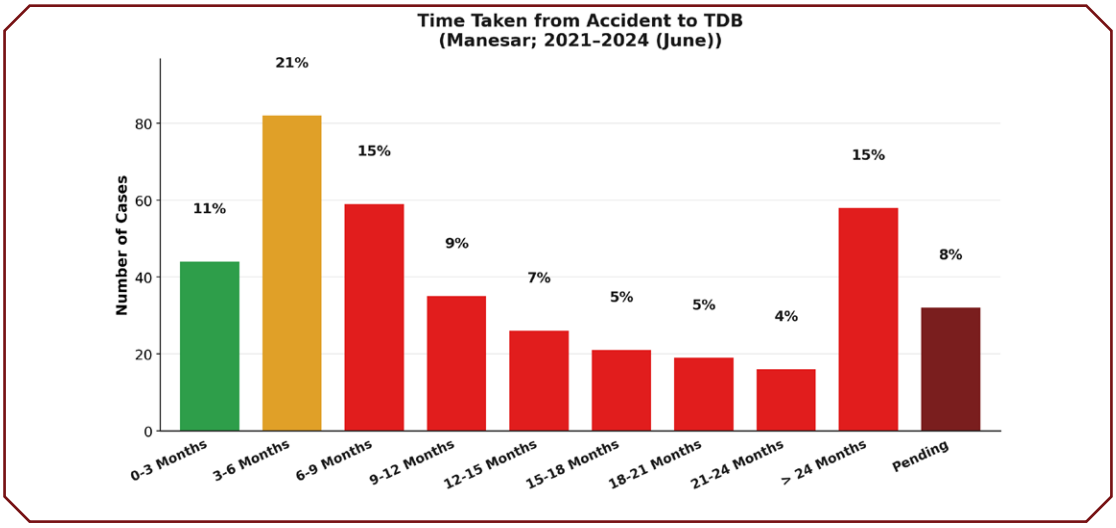
Figure 2.6 Time Taken from Accident to TDB (Haryana and Maharashtra; 2021-2024 (June))

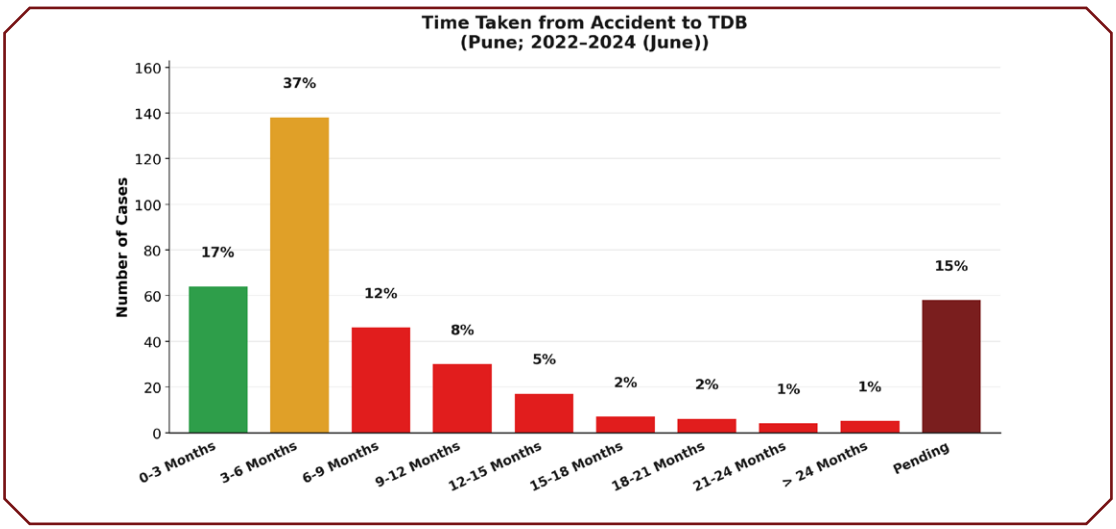


Faridabad: 84% of IPs Wait More than 6 Months from Accident to TDB.

Figure 2.7 Time Taken from Accident to TDB (Faridabad, Manesar and Pune; 2021-2024 (June))

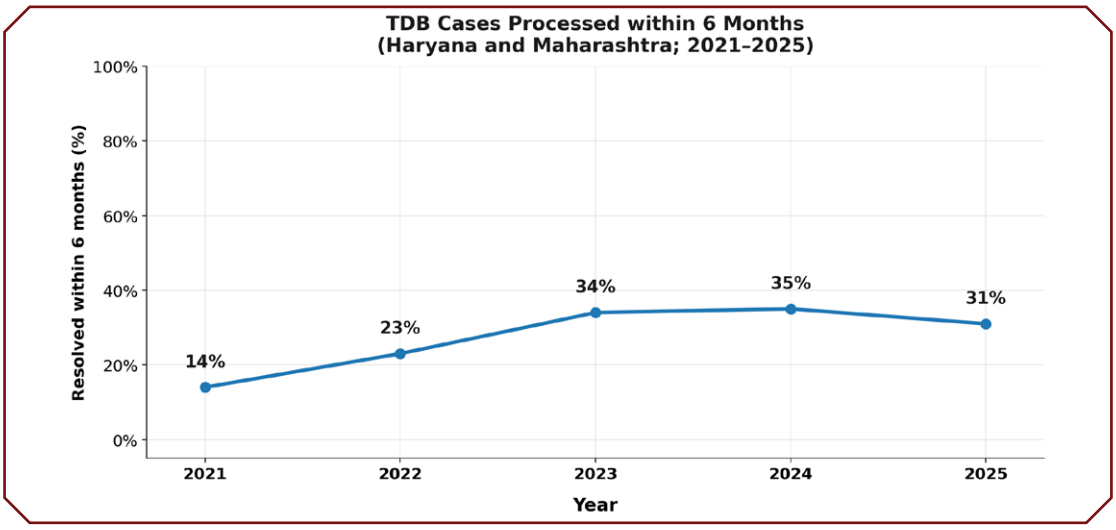






The percentage of TDB cases where payments have been made within 6 months has increased but is still less than 35%.

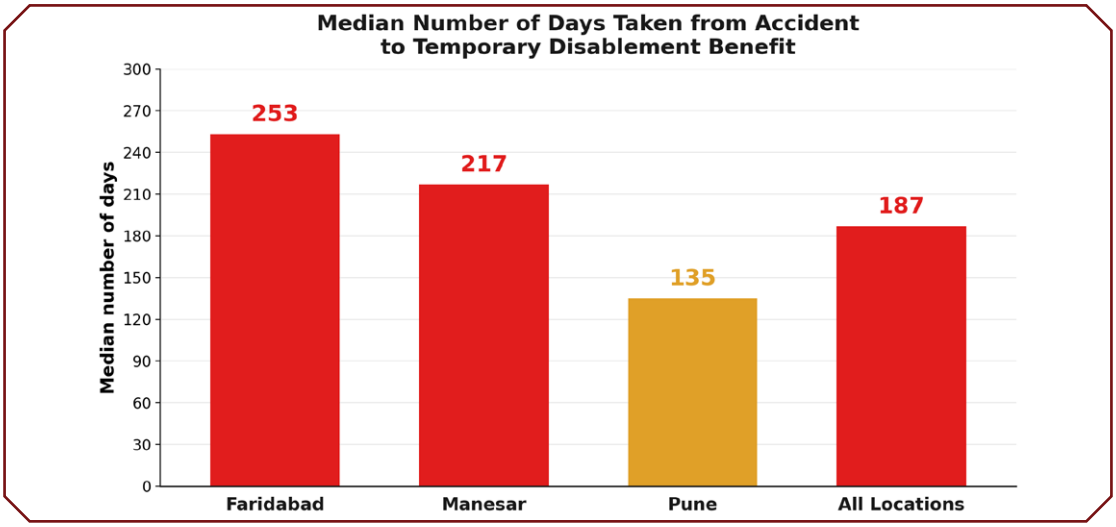
Figure 2.8 Percentage of TDB Cases Processed within 6 Months (Haryana and Maharashtra; 2021-2025)



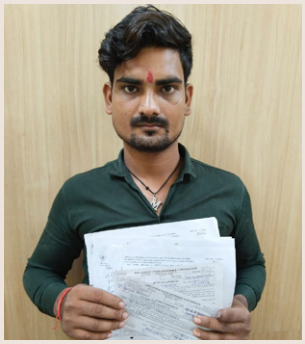
Among completed cases, it takes c.187 days for an IP to get his/her TDB post-accident.

Median IP in Faridabad, who received TDB, receives TDB c.8 months from the accident, compared to c.4.5 months in Pune

Figure 2.9 Median Number of Days Taken from Accident to TDB (Haryana and Maharashtra Data) (only completed cases)



Brijesh Ahirwar



Brijesh Ahirwar was injured at his factory in September 2024. He handed his seven medical certificates to his contractor for submission to ESIC.

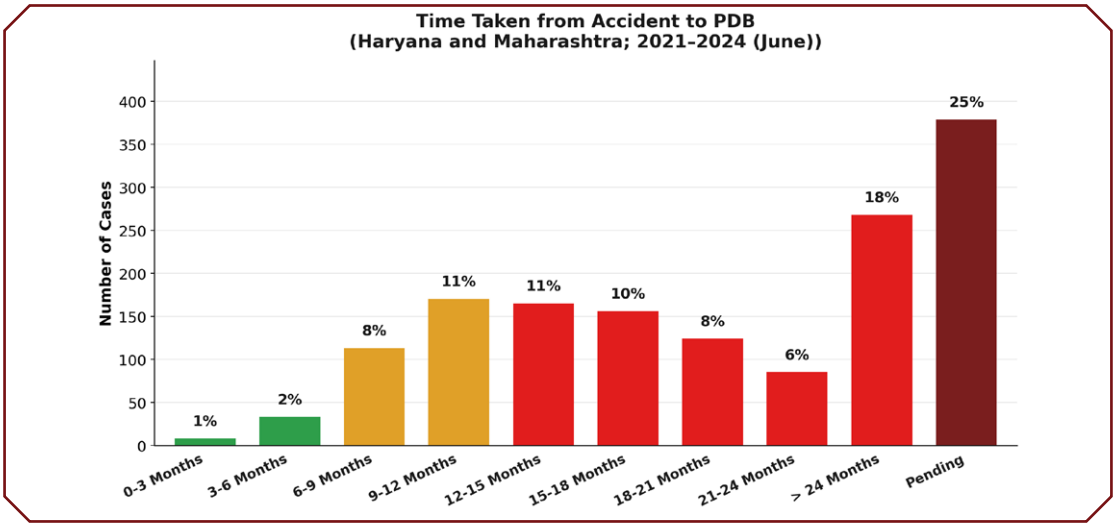
Two months later, when he went to the ESIC branch office, he discovered that the contractor had not submitted a single certificate. On being asked, the contractor returned all seven certificates to him and told him to submit them himself.

At the ESIC office, he was told the certificates had to be uploaded online. When he said he did not know how to do this, the branch pointed him to an internet café outside. The café operator asked for ₹100 per certificate, i.e., ₹700 in total, to upload them.

SII supported him with the uploads.

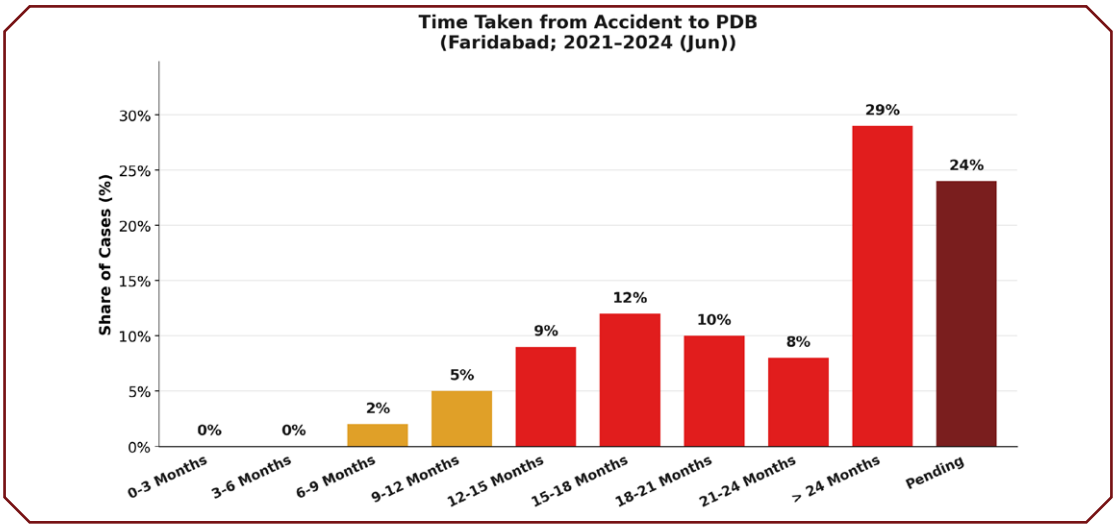
2.3.2 78% of IPs Wait More than 12 Months from Accident to Receiving PDB; – Nearly a Year of Reduced Earning Capacity, when they Need it Most, Without Compensation (and, in the worst cases, Joblessness); Delays in Faridabad worse than Other Locations

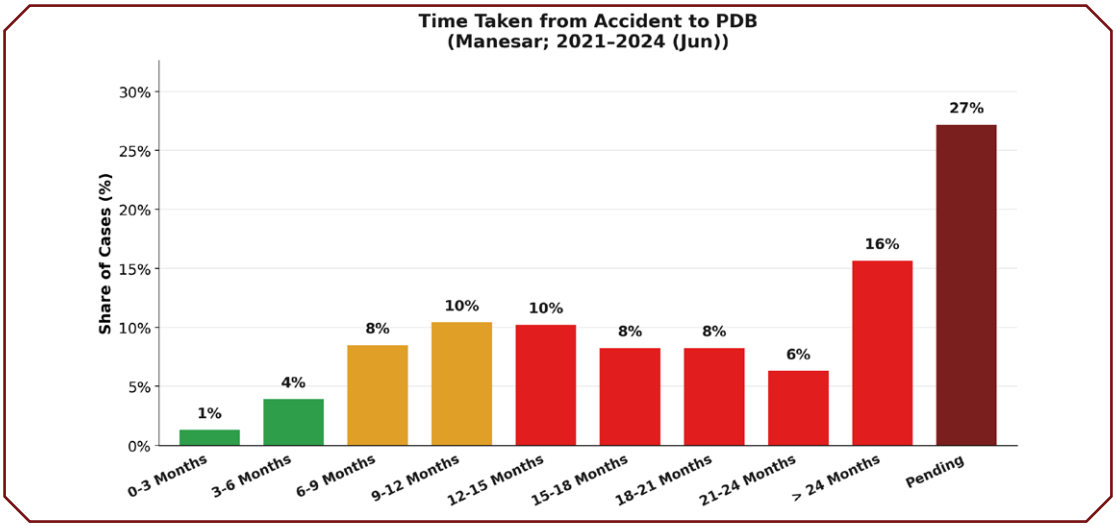
Figure 2.10 Time Taken from Accident to PDB (Haryana and Maharashtra; 2021-2024 (June))

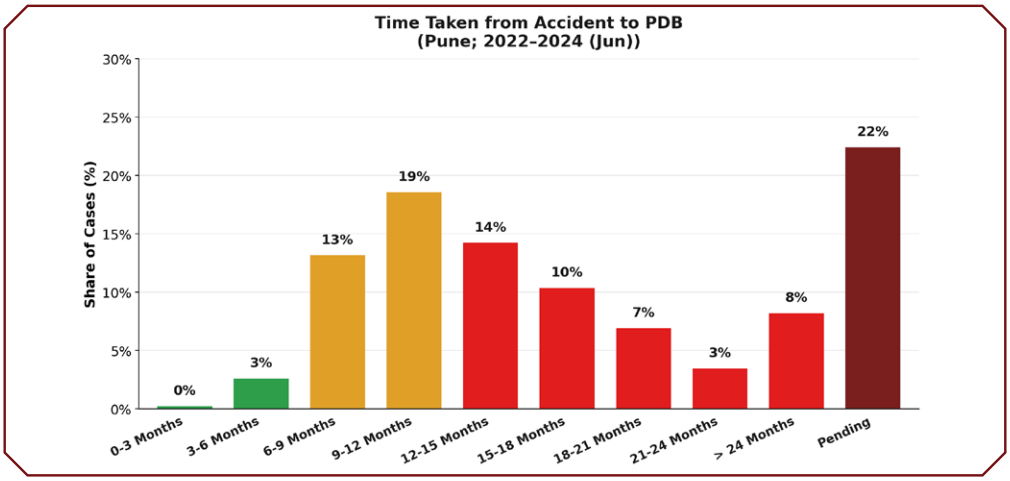


Faridabad: 93% of IPs Wait More than 12 Months from Accident to PDB

Figure 2.11 Time Taken from Accident to PDB (Faridabad, Manesar and Pune; 2021-2024(June))

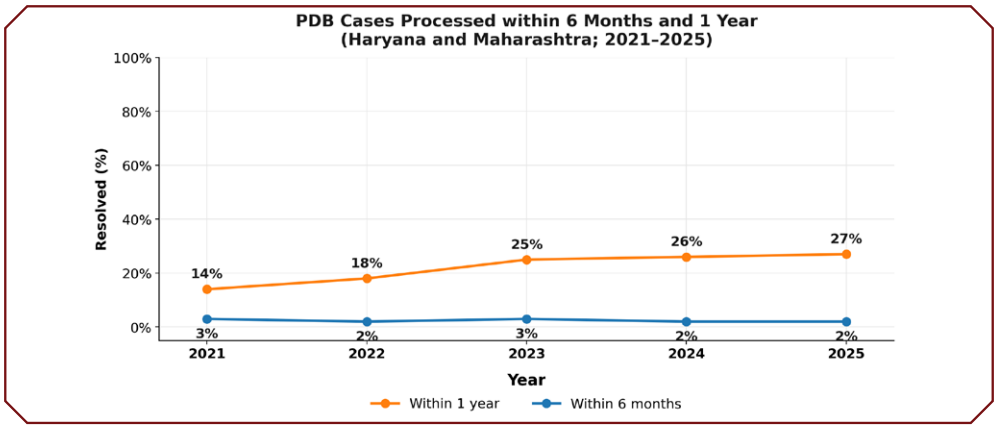






The percentage of PDB cases where payments have been made within 12 months has increased steadily but is still less than 30%.

Figure 2.12 PDB – Percentage Cases Processed within 6 Months and 1 Year (Haryana and Maharashtra Data; 2021-2025*)

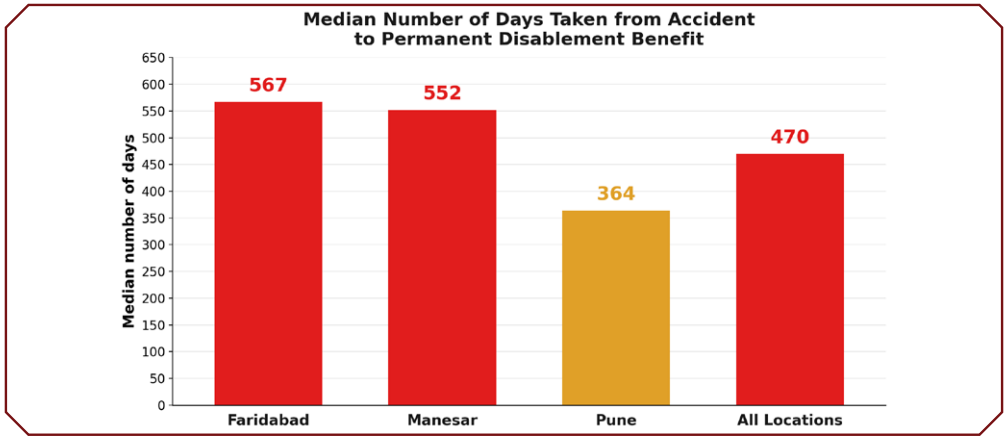


**2025 Within 1 Year data includes only the Jan-Jun 2025 period.*

Among completed cases, it takes c.470 days (16 months) for an IP to get his/her PDB post-accident.

Median IP in Faridabad, who received PDB, receives PDB c.18.5 months from the accident, compared to c.12 months in Pune

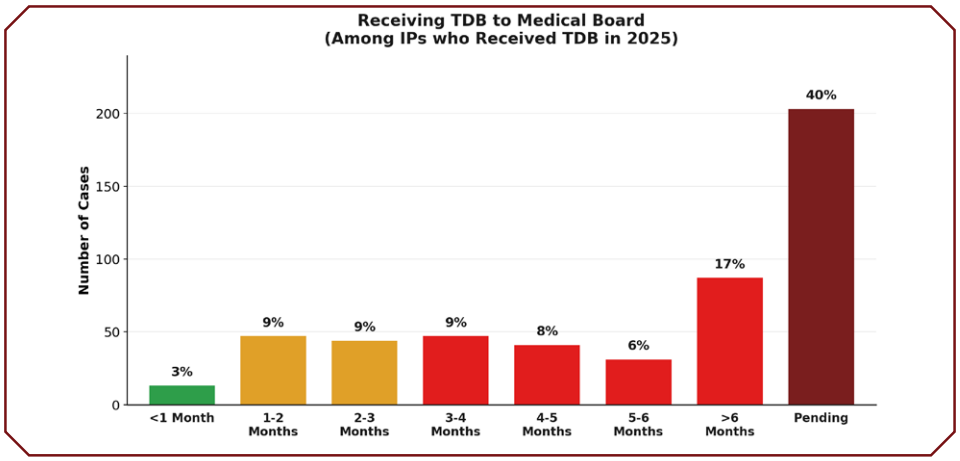
Figure 2.13 Median Number of Days Taken from Accident to PDB (Haryana and Maharashtra) (only completed)



2.3.3 57% of IPs Wait More than 6 Months from TDB to Medical Board Owing to Process Complications; Delays in Receiving Decision Letter; Maharashtra better than Haryana

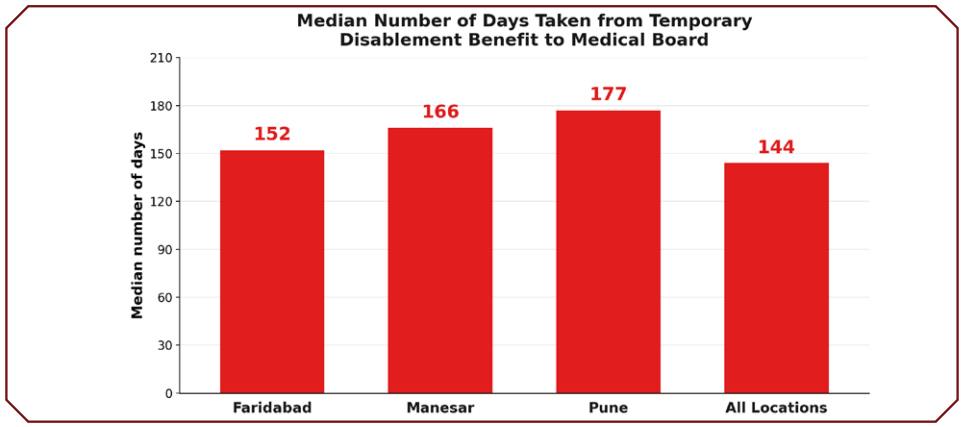
81% of IPs wait more than 3 Months from receiving TDB to the Medical Board

Figure 2.14 Time Taken from TDB to Medical Board (Haryana and Maharashtra; among IPs who received TDB in 2025)



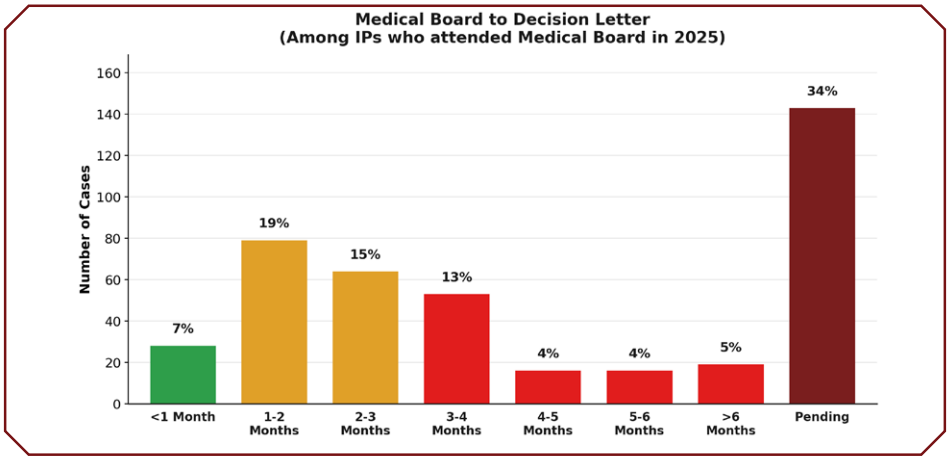
Median IP waits c.5 months from TDB to the Medical Board

Figure 2.15 Median Number of Days Taken from TDB to Medical Board (only completed)



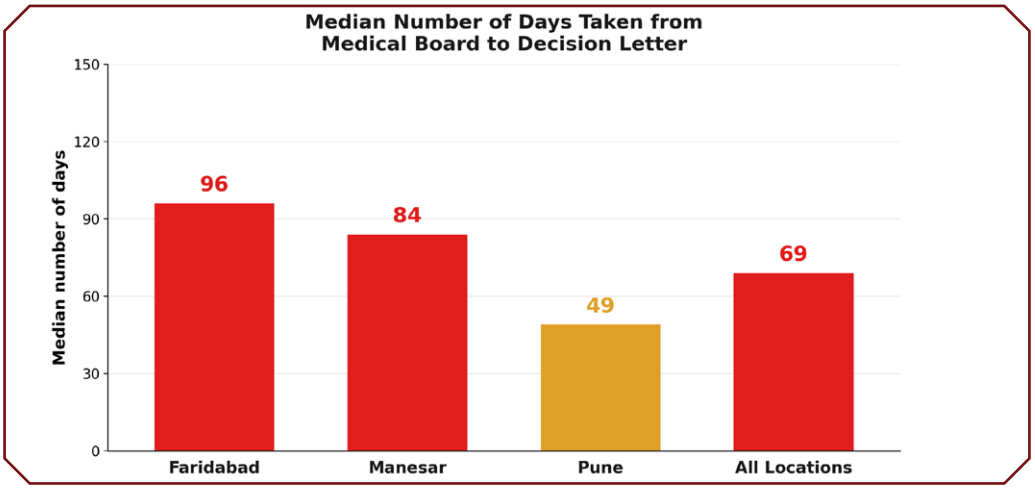
93% of IPs wait more than 1 month from the Medical Board to receive their Decision Letter

Figure 2.16 Time Taken from Medical Board to Decision Letter (Haryana and Maharashtra; among IPs who attended Medical Board in 2025)



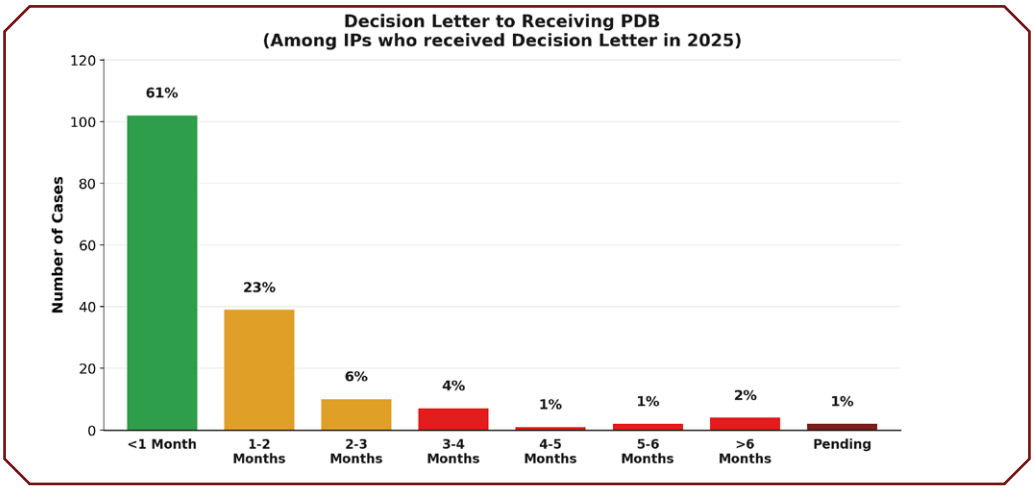
Median IP in Faridabad and Manesar waits c.3 months from Medical Board to Decision Letter, compared to c.1.5 months in Pune

Figure 2.17 Median Number of Days Taken from Medical Board to Decision Letter (only completed)



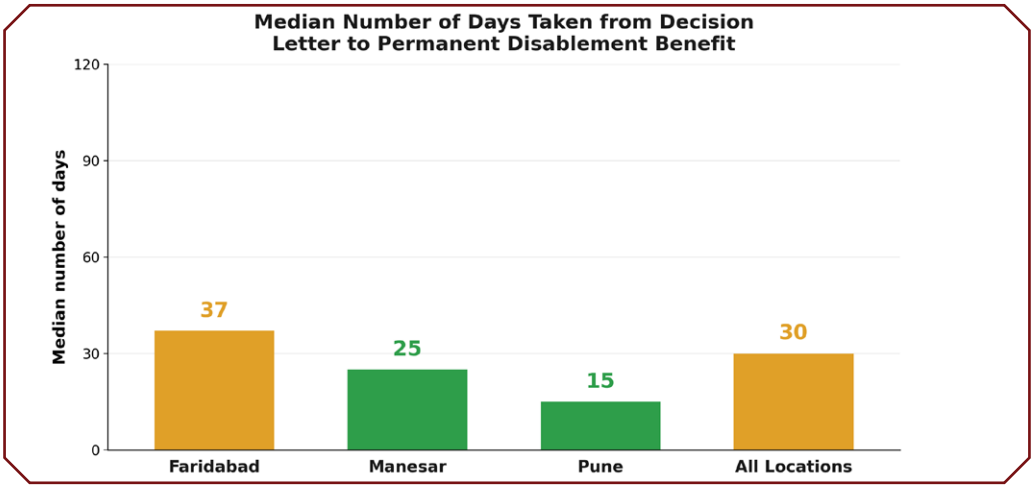
39% of IPs wait more than 1 month from receiving their Decision Letter to start receiving payments

Figure 2.18 Time Taken from Decision Letter to PDB (Haryana and Maharashtra Data; among IPs who received Decision Letter in 2025)



Median IP in Faridabad waits c.37 days from receiving their Decision Letter to start receiving payments, compared to c.15 days in Pune

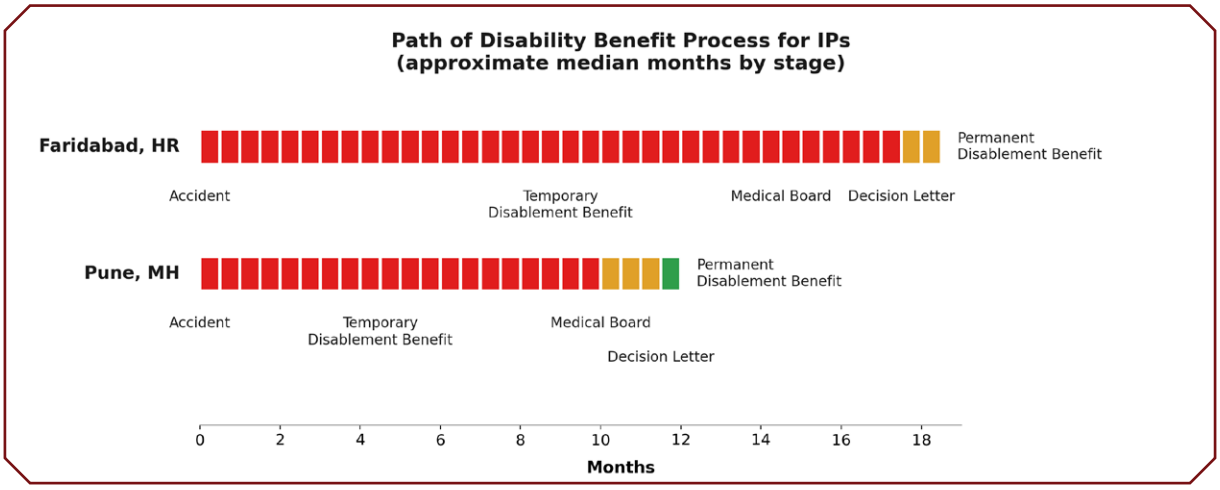
Figure 2.19 Median Number of Days Taken from Decision Letter to PDB (only completed)



Medical Board to PDB (Medical Board to DL + DL to PDB) should take under 30 days as per ESIC's Citizen's Charter, but it takes significantly longer. Even though it is largely internal processing, delays remain substantial.

2.3.4 The Median IP in Faridabad takes over 18 Months to receive both TDB and PDB, while the Median IP in Pune takes 12 months.

Figure 2.20 Disability Benefit Path for IPs based on Median Time Taken (Faridabad, Haryana and Pune, Maharashtra)



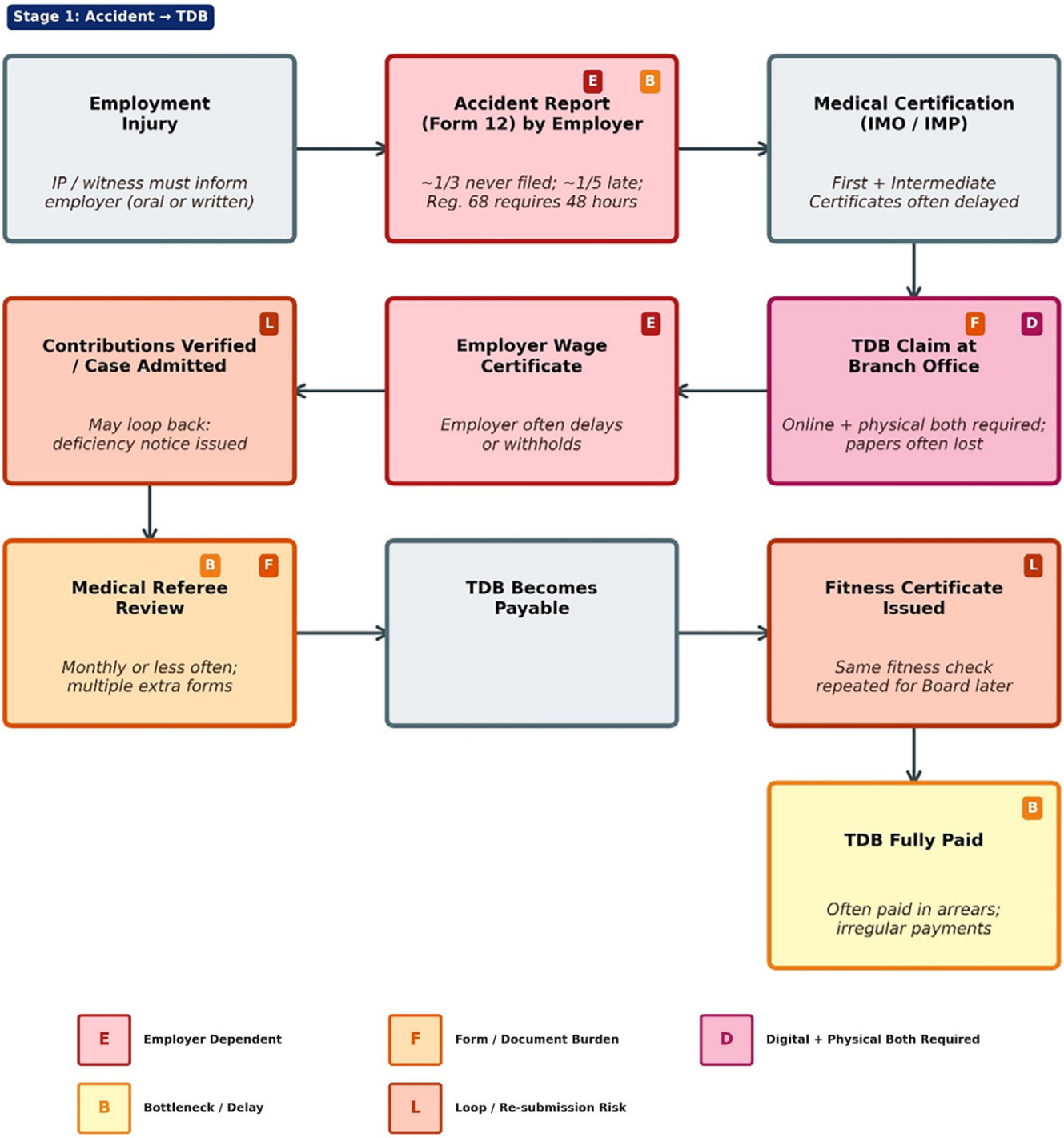
2.4 Fragmented Non-Standardised Process, Excessive & Duplicate Document Submissions, and Infrequent and Ad-hoc Medical Boards Raise Barriers to IPs' Access to ESIC Disablement Benefits

2.4.1 ESIC Disablement Benefits: Why the Process Feels Harder in Practice Than on Paper.

This section contrasts ESIC's documented disablement workflow with the lived journey, tracing, step by step, the pathway from an employment injury through TDB, subsequent Medical Board assessment and PDB claim (where eligible), and the ongoing compliance required to sustain payments.



Figure 2.21 ESIC's stipulated TDB Process – Ten steps
(even when steps aren't repeated, which they are in practice)



After the above TDB Process, there are an additional 9 steps to obtain PDB

Figure 2.22 ESIC PDB Process

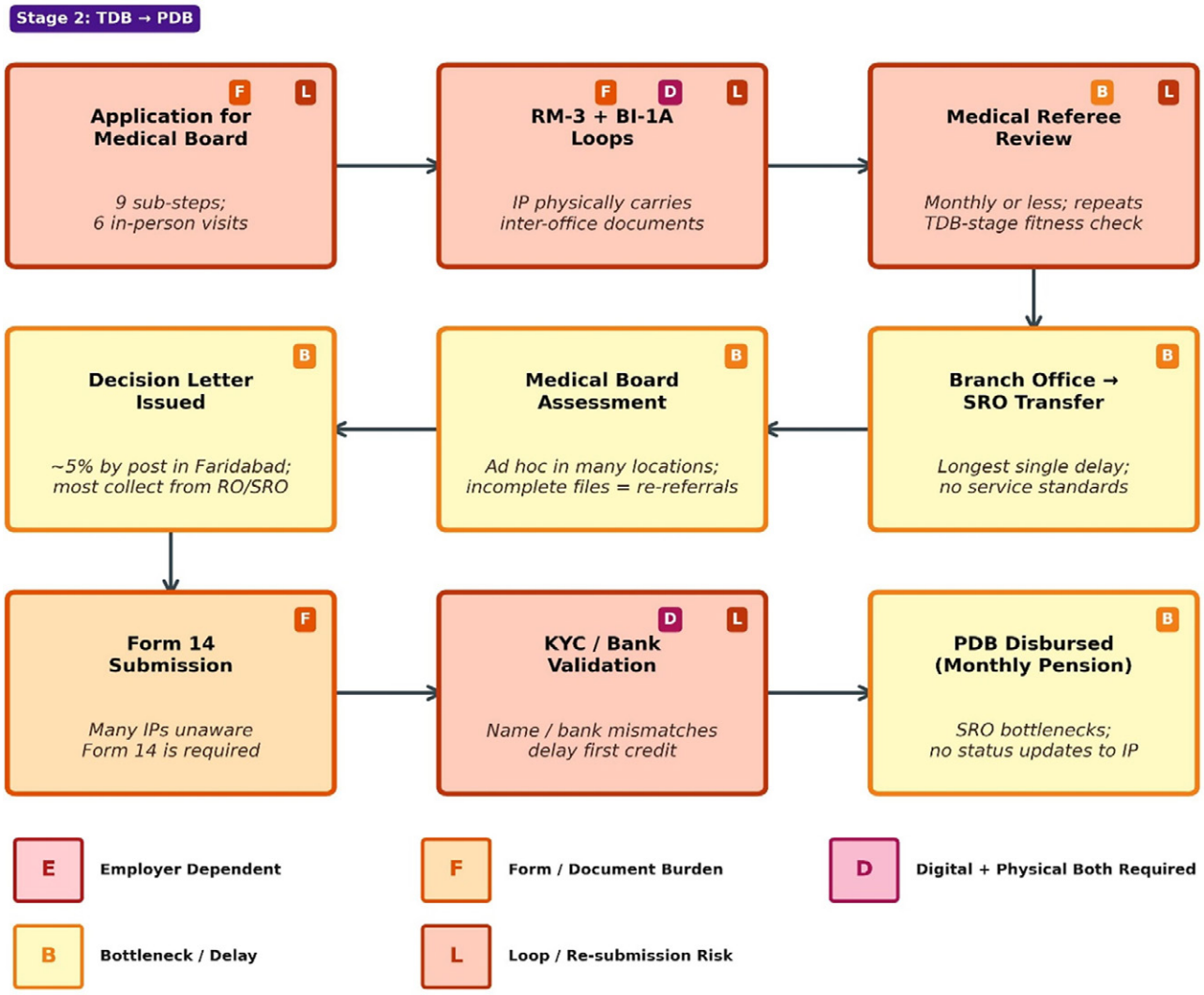


Table 2.1. Journey Map for ESIC Disablement Benefits Process – "Should Be" vs "Actually Is"

Sl. No.	Steps	What should happen (As per ESIC)	What actually happens (observed)
		Stage 1: Accident to TDB	
1	Accident Report (Form 12) by the employer	Employer sends AR (Form 12) to the Branch Office and the Insurance Medical Officer immediately for serious injury; otherwise, within 48 hours of notice/knowledge.	Often late or incomplete; IP must chase the employer; delays start here. AR is delayed or not submitted in **c.41%** of cases supported by SII.
2	Temporary Disability confirmation (medical certification for incapacity)	Examination by ESI doctor (IMO/IMP) and issue of medical certification for temporary disablement: First Certificate followed by Intermediate Certificates or Special Intermediate, as applicable.	Certificates are often delayed. TDB delayed due to incomplete/improper documentation.
3	Medical Referee referral for disputed Final Certificate / continued incapacity	Where the IP disputes the IMO/IMP's Final Certificate, or the BO/RO doubts continued incapacity, the case is referred to the Medical Referee. MR examines the IP and either endorses fitness (TDB closes), extends TDB, or recommends reference to the Medical Board.	MR examination has become the default rather than the exception. MR examination slots are irregular. MR examination requires travel at the IP's own cost.

Sl. No.	Steps	What should happen (As per ESIC)	What actually happens (observed)
4	Receive TDB (Temporary Disablement Benefit)	TDB = 90% of average daily wages; payable for the entire certified period of temporary disablement; claim supported by medical certificates.	Payments are often irregular/delayed; Median number of days from Accident to TDB (IPs supported by SII) is **185 days**
Stage 2: TDB to PDB			
5	Initiate Medical Board reference (RO/SRO)	RO/SRO initiates the disablement assessment and refers the case to the Medical Board. Where required, the Medical Referee conducts a preliminary review/ examination	Procedurally burdensome for the IP, involving multiple forms (please check Section 2.3.4), repeat submissions of information already provided, and extended waiting periods for the Medical Referee and/ or for the RO/SRO to compile and forward the file
6	Appear before Medical Board (PD% decides if eligible for PDB)	Medical Board examines the IP, assesses the % loss of earning capacity and sets the effective date; appeal/review routes exist.	Boards are infrequent or ad hoc; even fixed calendars are not always kept; weak intimation causes no-shows; incomplete files lead to re-referrals.
7	Decision Letter (DL) stating % disability & PDB amount	Decision Letter issued promptly with % loss of earning capacity, effective date, commutation option, and appeal information.	DL dispatch lags; often not sent by post (not sent by post in c.75% cases; c.95% in Faridabad).
8	Claim for payment of PDB and other documents to be submitted	Form 14 (Claim for Payment of PDB) must be submitted. Life Certificate is not a precondition to first PDB credit. KYC/bank validations are done before the first credit.	Lack of awareness about Form 14 (claim for payment of PDB); Low Awareness of LC/e-LC process; name/bank mismatches delay first credit.
9	Permanent Disability Pension is disbursed	PDB is sanctioned and paid monthly at the certified rate; arrears (if any) are paid on sanction.	First credit/arrears delayed due to SRO bottlenecks or validation issues; no status updates. Median number of days from Accident to TDB (IPs supported by SII) is **c.16 months.**
Stage 3: Ongoing Compliance			
10	Annually Life Certificate needs to be submitted	Annual Life Certificate (e-LC/physical) with proactive reminders; simple, low-rejection process.	Many IPs are unaware of the annual requirement; confusion around list of officials authorised to attest. Despite e-LC, issues with access persist.

Sections 2.4.2 to 2.4.13 highlight specific process steps that, from a worker's perspective, are marked by a lack of automation, duplication, and unnecessary complexity.

2.4.2 Documentation Delays, Outside Workers' Control, Especially with Accident Reports from Employers, Prevent IPs from Applying for Disablement Benefits

Fast TDB and PDB disbursal is a vital and immediate source of income support when an IP is unable to work or can work at less than earlier.

In practice, speed hinges on three critical steps: (i) the IP's notice of accident, (ii) the employer's Accident Report (Form 12), and (iii) collecting and safeguarding medical documents.

IP notice of accident: IP or another individual (employer in case of accidents inside factories) must promptly immediately the employer (written or verbal Notice of Accident) while seeking treatment at an ESIC/empanelled facility.

Employer Accident Report (Form 12): Employer must file the AR with ESIC "immediately" for accidents likely to cause death or disablement and within 48 hours (Regulation 68 of the ESI (General) Regulations, 1950); in practice, this is often the longest delay, stalling case creation and TDB start.

Other Documents Dependent on Employers: In addition to the Accident Report, the employer is required to submit Abstention Verification (Form 10), Wage/Contributory Record for Disablement Benefit (Form 32), Further particulars of accident (In case of demand from BO) and Accident Book entry (Form 11), which are also often delayed.

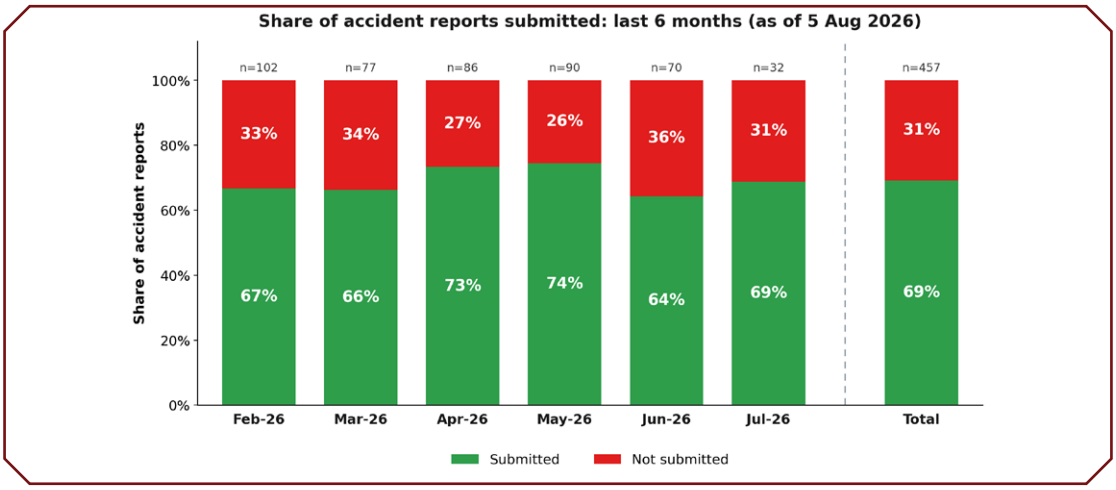
Medical documents & safekeeping: IP must obtain and keep medical documents from the hospital, including discharge summaries and other medical documents. Papers often get lost or degrade, causing rework and payment delays.

Accident reports are often delayed or not submitted at all, and even when they are submitted, IPs are usually not informed.

Penalty: Not defined specifically. Falls under the residual "non-compliance where no special penalty is provided"; Up to Rs. 4,000 under the old ESI Act; increased to Rs 50,000 under the new Social Security Code (ceiling), but the penalty requires court action to impose. The enforcement machinery isn't built in, i.e., no direct-levy administrative penalty. Therefore, it is rarely collected.

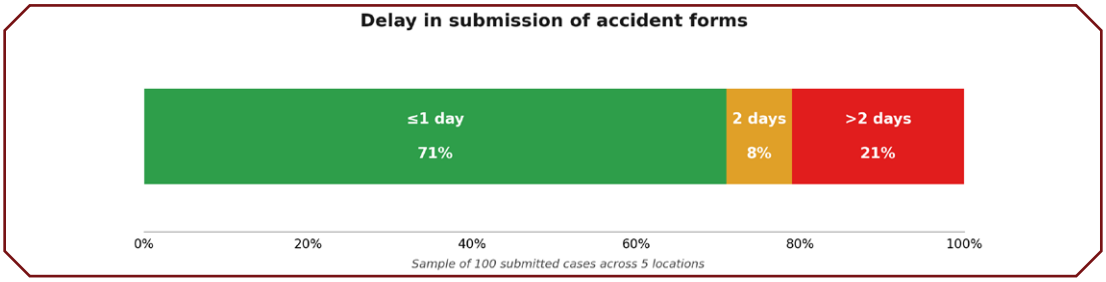
Among IPs supported by SII, around one-third of workers injured in the previous six months did not have an accident report submitted. In a separate sample of 100 cases from five locations where accident reports had been submitted, around one-fifth were filed more than two days after the accident, in breach of the requirement for timely reporting.

Figure 2.23 One-third of Accident Reports were not submitted across 6 months



Accident Month

Figure 2.24 Even when submitted, 21% Accident Reports were submitted delayed



Please refer to Chapter 12 for more details on Employer Non-Compliance.

Please refer to Chapter 4 (Sickness Benefits) for details on issues related to Medical Certificates – a cause of delay for both TDB and Sickness Benefit claims.

2.4.3 Duplicate Applications and Repeat Document Submissions Burden IPs Throughout the Application Process

Many IPs are unaware that the application pathway *requires separate applications at multiple points* - first to initiate TDB (has to be done by the employer, but if AR is not submitted, then by IP), then again to request a Medical Board examination (in practice), and later claim for PDB. Each step means fresh forms, signatures, and visits, creating avoidable delays and drop-offs.

Even after the Medical Board has assessed the injury and fixed the quantum of PDB, IPs have reported being asked to *resubmit copies of all documents*, despite having already done so for both TDB and PDB applications. *This is mainly due to the reported "loss" of hard copy documents in ESIC branches*

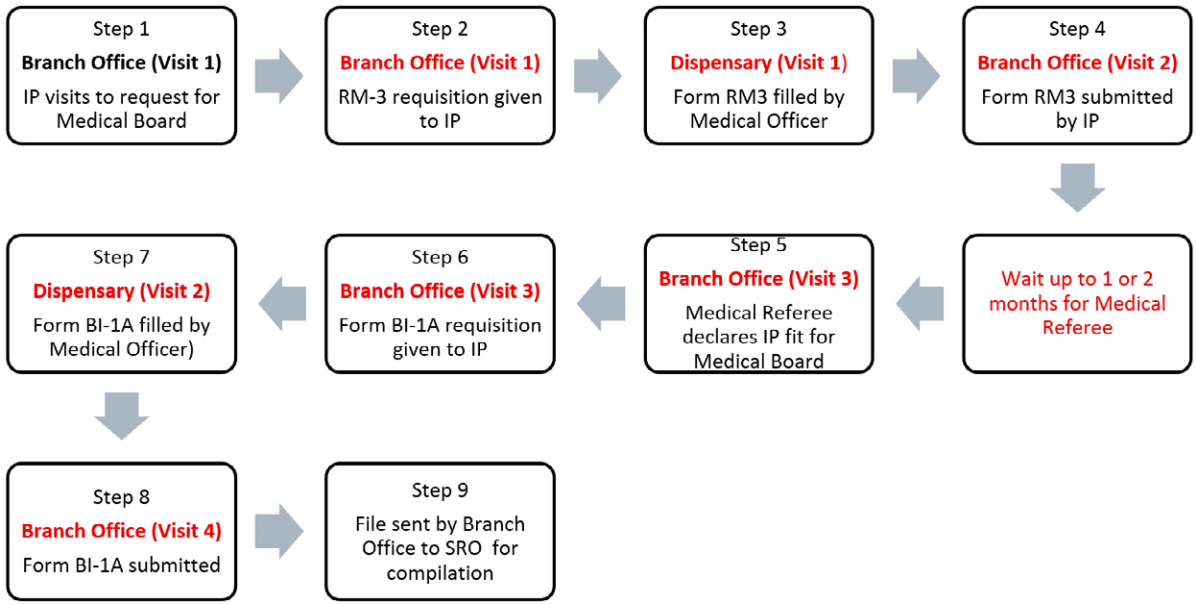
This cycle of repeated applications and document submissions not only prolongs timelines but also adds confusion and uncertainty for workers who expect the process to move forward automatically once key decisions are made.

2.4.4 At least six In-Person Visits and Duplicate Paperwork: RM-3 and BI-1(A) Loops between dispensaries, BOs and RO/SROs Drive Delays Before Medical Boards; IPs end up doing all the ESIC Paper Movement, instead of ESIC or the employer

Figure 2.25 illustrates that the "simple" request to appear before a Medical Board actually involves nine steps, and even in the best-case scenario, a minimum six in-person trips by the IP: four to the Branch Office (BO) and two to the Dispensary.

RM-3 and BI-1(a) function as a request–response loop between the RO/SRO and the dispensary/IMO. RM-3 is the covering communication issued by the RO/SRO to the IMO/IMP to requisition the required medical papers for disablement assessment, while BI-1(a) is the Injury Report prepared by the IMO/IMP in response and returned to the RO/SRO for inclusion in the Medical Board case file. In principle, *these are internal inter-office documents; however, in practice, insured persons are often asked to physically courier RM-3/BI-1(a) and related papers between ESIC offices.*

Figure 2.25 What an IP actually does between applying for the Medical Board and getting an acknowledgement to appear before the next Medical Board



Most of these trips are consumed by two near-identical form loops and a repeat fitness check:

- RM-3 loop (3 trips): BO → Dispensary → BO to issue, complete, and submit RM-3, followed by the Medical Referee's review.
- BI-1A loop (3 trips): BO → Dispensary → BO to issue, complete, and submit BI-1A for the Medical Board.
- Repeat "fitness for Board" step: The Medical Referee declaring the IP "fit for Medical Board" replicates the fitness determination already done in the TDB phase, adding another checkpoint without new information.

Because RM-3 and BI-1(a) are often run sequentially rather than in parallel, insured persons (IPs) face duplicated paperwork and repeated travel between BO and dispensaries. Any mismatch or missing document can trigger further back-and-forth beyond these six visits. In cases where the Medical Board reference is treated as time-barred, parts of the same RM-3/BI-1(a) cycle may be repeated, extending timelines and increasing the risk of drop-off before assessment and benefit sanction.

This is neither acceptable nor permitted for ESIC, as this makes the documents themselves questionable for tampering and forgery because they are being carried by the beneficiaries themselves.

2.4.5 Inadequate Technology and Automation Creates Additional Delays in Medical Board Referrals

RM-3 and BI-1A still have to be physically carried by the IP between the Dispensary and the Branch Office (manual handover within ESIC), where they are converted from physical forms to online format and submitted. Therefore, the referrals to the Medical Board are slowed further. Without digital transmission or status updates, files move only when the IP visits in person, increasing the risk of delays, missing papers, and incomplete submissions.

e-Office[2] has been implemented in 100% of ESIC offices for file work, but its use for documenting claim papers like these lacks proper guidelines and SOPs.

2.4.6 Medical Referee Scheduling Bottlenecks: Infrequent in Some Locations due to Doctor Capacity Shortage

Medical Referee reviews are often scheduled infrequently, commonly only once a month, and in some locations even less frequently (e.g., once every two months). This limited scheduling capacity creates avoidable waiting periods for insured persons (IPs), delaying completion of pre-Medical Board formalities and pushing back the overall timeline for disablement assessment and PDB initiation.

2.4.7 No Tracking System or Visibility on File Movement Forces IPs into Repeated Visits and Long Delays from Fitness Certification to Medical Board

Once the Branch Office forwards the file to the SRO for Medical Board approval, the process often stalls. This stage is *typically the longest source of delay*, with *no defined service standards for turnaround.*

IPs also receive no automatic confirmation on whether their documents have been accepted or flagged as incomplete, leaving *them to make repeated visits just to check the status.*

2.4.8 Improved Scheduling of the Medical Boards in Haryana and Maharashtra Ensures IPs Do Not Miss Their Hearings; Not Consistent Nationally

In locations where SII operates, i.e., Haryana (Faridabad & Gurugram) and Maharashtra (Pune), Medical Boards are now held on fixed dates (e.g., the 3rd Wednesday in Faridabad and the 4th Wednesday in Manesar & Gurugram). These schedules ensure that time is not additionally lost in these geographies.

That said, there have been instances in Haryana where Boards did not convene every month as scheduled, resulting in delays, which have been highlighted by SII to ESIC. This shows that while fixed calendars are a step forward, they must be reliably followed to truly benefit insured persons.

By contrast, in other locations, the assembling of the Medical Board remains ad hoc and can occur as rarely as once a year, as observed by SII in Uttarakhand.

Three Medical Boards Convened in Faridabad in a Single Month, Following SII Advocacy (July 2026)

Faridabad carries a disproportionately high volume of pending PDB cases relative to other SII locations (see Section 2.3). Under Project Hazaron Khwahishen (see Section 8.6), SII consolidated a list of long-pending cases and escalated them to ESIC for expedited disposal. In response, ESIC convened three Medical Boards in Faridabad during July 2026, against the usual one per month, directly benefiting IPs whose PDB cases had been pending the longest.

[2] NIC's electronic file-management suite

2.4.9 Medical Board Intimations Do Not Always Reach Workers

Information about Medical Board hearings does not always reach the worker, particularly if the IP has changed employers. As a result, some workers only learn of their scheduled Board date late or not at all and risk missing a hearing that is critical to their benefit. Information is also not displayed or displayed on an ad-hoc manner.

Employers often fail to record complete, verified, and accurate addresses when registering workers. In many cases, workers have even been registered under nicknames.

Aadhaar-based registration has helped address issues relating to name and date of birth, but it is still not fully implemented. Even where Aadhaar-based registration is used, address details often remain incomplete or unverified. This weakens the reliability of ESIC records and creates problems for postal communication and document delivery. The issue needs policy-level attention so that recorded addresses become accurate, verifiable, and usable in practice.

Please refer to Chapter 12 for more details on Employer Non Compliance related to registrations and e-Pehchaan cards.

In October 2025, a Medical Board sitting was scheduled for 32 cases, but only 11 IPs appeared. In one instance, an injured worker received the intimation only on the morning of the sitting; as he was in his village, he was unable to travel and attend.

Currently, intimation relies mainly on phone calls or paper notices. Without multiple channels, such as publicly accessible lists on the ESIC website, SMS, or letters, workers remain vulnerable to missed communication and uncertainty about their Medical Board dates.

2.4.10 75% IPs Often Don't Receive PDB Decision Letters by Post; Most Must Collect from RO/SRO, Adding to Burden

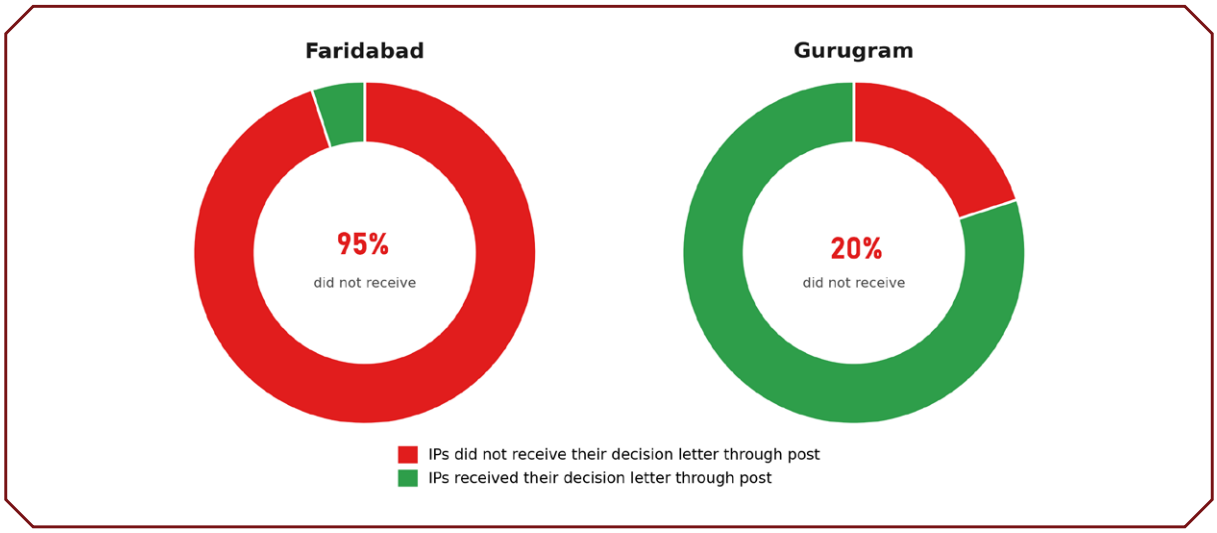
Although Decision Letters (DLs) are meant to be sent to injured workers by post, this does not happen reliably.

In Faridabad, only about 5% of IPs received their DL by post, and that too after specifically requesting it. Roughly 25% received their DL only by visiting the RO/SRO, often on SII's recommendation.

In Manesar, around 20% of IPs did not receive their DLs through the post and had to visit the RO/SRO in person.

The lack of consistent delivery not only adds extra steps for workers but also risks delaying their access to Disablement Benefits

Figure 2.26. Very Low Percentage of IPs receiving Decision Letter (DL) by post

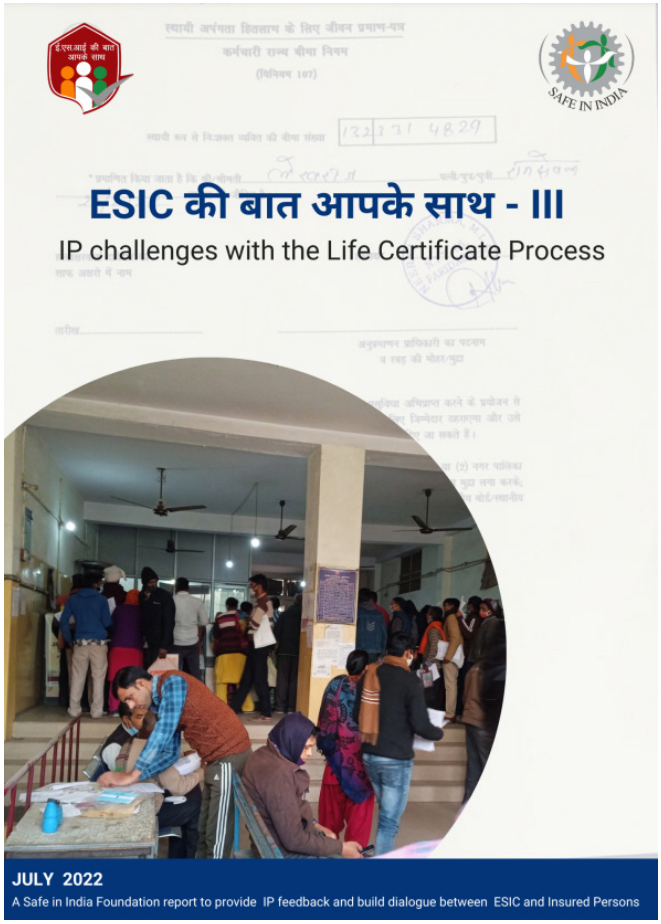


DLs are currently not issued centrally or through IP Portal, which is a lost opportunity to improve ease this burden.

2.4.11 Low Awareness Among IPs That Life Certificate Submission Is an Annual Requirement Leads to Potential Loss of Benefits

After the Medical Board decides the quantum of injury and the PDB to be sanctioned, the IP must submit a Life Certificate (ESIC Form 23) along with copies of all documents as the final step to start receiving pension. Thereafter, the Life Certificate has to be filed every year by 15 January at the Branch Office that sanctioned the pension (resulting in suspension of payments otherwise). While some IPs are not even aware of this requirement, those who are face several challenges in obtaining and submitting the certificate.

Some IPs are not aware that the Life Certificate must be submitted every year. A survey of 100 workers in Manesar, Gurugram, in 2022 showed that *12% had never submitted one*, causing them to lose out entirely on their PDB entitlement.



2.4.12 Life Certificate Has a Listed Set of Attesting Authorities, but Poor Communication and Branch-Level Discretion Leave Workers Confused

IPs, especially those from or now living in rural areas, often struggle to identify who can validly attest their Life Certificate (Form 23). Form 23 does list eligible attesting authorities; this information is not always easy for workers to access or understand. The result is confusion, extra visits, and sometimes rejection of certificates that workers believed were valid.

2.4.13 Online Life Certificate (e-Jeevan Pramaan) Implemented; Eases the Process but Digital Gaps Leave Out a Share of IPs

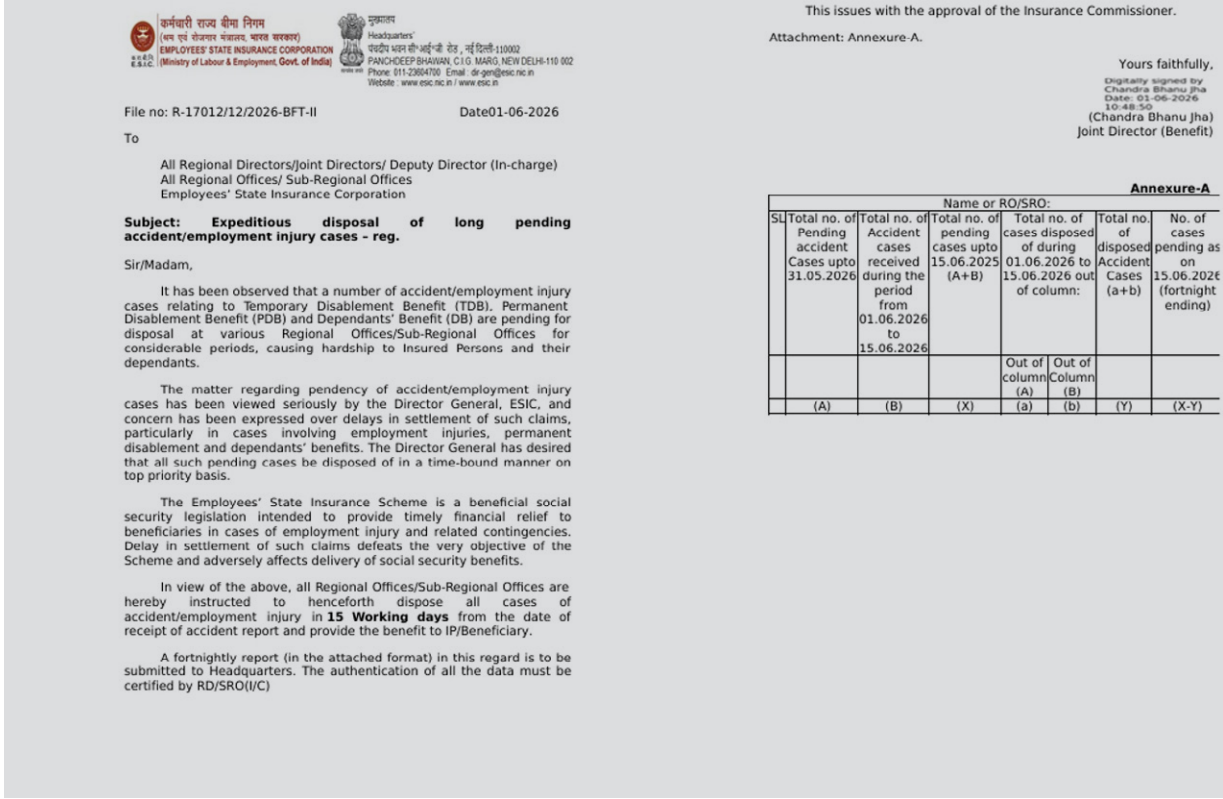
In ESIC Ki Baat, Aapke Saath III (July 2022), SII had highlighted that 83% of IPs were not satisfied with the process of submitting Life Certificates. Manual filing meant workers often travel long distances back to their original BO, losing workdays and wages. SII had recorded cases of workers travelling from Bihar and even Nepal to Haryana, just to submit their Life Certificate each January. Even when workers submitted their certificates correctly, *they often got lost or were not uploaded to the ESIC system.* This leads to repeat submissions, pension discontinuity (63% reported stoppages), and arrears not being paid (45%).

Since then, from 2023, ESIC has allowed Digital Life Certificate submission through the Jeevan Pramaan system which is a good step. But some IPs with low digital literacy or living in areas with poor connectivity still struggle with delays and payment disruptions.

ESIC currently lack a facilitator model, similar to the ASHA or PMJAY's Arogya Mitra.

There are no facilitators, similar to PMJAY's Arogya Mitras, even though the beneficiaries are of a similar profile, to educate beneficiaries on their ESI rights, support e-Pehchaan enrolment, assist with claims, and promote basic health awareness. This model can be managed by ESIC, or third party- civil society, trade union associations.

ESIC Issued a Circular on Expeditious Disposal of Long-Pending TDBs, PDBs & DBs based on SII Recommendations on 01 June 2026; Thank You ESIC.



कर्मचारी राज्य बीमा निगम
(श्रम एवं रोजगार मंत्रालय, भारत सरकार)
EMPLOYEES' STATE INSURANCE CORPORATION
(Ministry of Labour & Employment, Govt. of India)

मुख्यालय
Headquarters'
पंचदीप भवन सी-आई-जी रोड, नई दिल्ली-110002
PANCHDEEP BHAWAN, C.I.G. MARG, NEW DELHI-110 002
Phone: 011-23604700 Email : dir-gen@esic.nic.in
Website : www.esic.nic.in / www.esic.in

File no: R-17012/12/2026-BFT-II Date01-06-2026

To

All Regional Directors/Joint Directors/ Deputy Director (In-charge)
All Regional Offices/ Sub-Regional Offices
Employees' State Insurance Corporation

Subject: Expeditious disposal of long pending accident/employment injury cases - reg.

Sir/Madam,

It has been observed that a number of accident/employment injury cases relating to Temporary Disablement Benefit (TDB), Permanent Disablement Benefit (PDB) and Dependants' Benefit (DB) are pending for disposal at various Regional Offices/Sub-Regional Offices for considerable periods, causing hardship to Insured Persons and their dependants.

The matter regarding pendency of accident/employment injury cases has been viewed seriously by the Director General, ESIC, and concern has been expressed over delays in settlement of such claims, particularly in cases involving employment injuries, permanent disablement and dependants' benefits. The Director General has desired that all such pending cases be disposed of in a time-bound manner on top priority basis.

The Employees' State Insurance Scheme is a beneficial social security legislation intended to provide timely financial relief to beneficiaries in cases of employment injury and related contingencies. Delay in settlement of such claims defeats the very objective of the Scheme and adversely affects delivery of social security benefits.

In view of the above, all Regional Offices/Sub-Regional Offices are hereby instructed to henceforth dispose all cases of accident/employment injury in **15 Working days** from the date of receipt of accident report and provide the benefit to IP/Beneficiary.

A fortnightly report (in the attached format) in this regard is to be submitted to Headquarters. The authentication of all the data must be certified by RD/SRO(I/C)

This issues with the approval of the Insurance Commissioner.

Attachment: Annexure-A.

Yours faithfully,

Digitally signed by Chandra Bhanu Jha
Date: 01-06-2026 10:48:50
(Chandra Bhanu Jha)
Joint Director (Benefit)

Annexure-A

SL	Name or RO/SRO:						
	Total no. of Pending accident Cases upto 31.05.2026	Total no. of Accident cases received during the period from 01.06.2026 to 15.06.2026	Total no. of pending cases upto 15.06.2025 (A+B)	Total no. of cases disposed of during 01.06.2026 to 15.06.2026 out of column:		Total no. of disposed Accident Cases (a+b)	No. of cases pending as on 15.06.2026 (fortnight ending)
				Out of column (A)	Out of Column (B)		
	(A)	(B)	(X)	(a)	(b)	(Y)	(X-Y)

2.5 Recommendations to improve quality of TDB & PDB services

2.5.1 The Citizen's Charter should spell out stepwise, better-defined service standards for each stage of the TDB and PDB process

This means fixing timelines for Accident Report submission, disability certification, Medical Board referral, Decision Letter issuance, and start of TDB and PDB. Having clear standards at every step will make delays visible, create accountability for ESIC, and give IPs a realistic expectation of when their benefits will reach them.

Vacant positions in ESIC make the Citizen Charter impractical, and therefore, this needs to be resolved.

2.5.2 ESIC should create office-wise and regional MI that tracks time taken, pendency, overdue cases, rework, first-time-right rates, and user satisfaction against Citizens' Charter standards

2.5.3 Introduce significant monetary penalties for employers who delay accident report submission beyond 48 hours (to be levied directly by ESIC without depending on prosecution by courts)

Appoint Social Security Officers to full strength so they can chase accident reports from employers.

Independent medical/technical assessment to be conducted where employer AR filings are late/inconsistent; give presumptive weight to clinical records/IP statements.

Impose the highest penalty under the Social Security Code, i.e., Rs. 50,000.

2.5.4 Empower workers to notify accidents where employers fail to notify

Allow IPs or their representatives to submit accident notice letters online in a standard simple format. Include accident notification functionality in the Umang app.

Include accident notification functionality in the AAA+/Umang app.

AI can be used for fraud detection.

2.5.5 Eliminate Unnecessary Steps and De-Duplicate Forms: e.g., Re-Engineering the pre-Medical Board Process to Be More Worker-Centric

- ESIC should combine the RM-3 and BI-1A loops into one process instead of making IPs run through two separate loops. The "fitness for Board" check should rely on the Certificate already given at the TDB stage, instead of asking the worker to prove the same thing again. With a single sign-off at the Branch Office, the case can be moved forward to the Medical Board without repeated visits, reducing delays and confusion for the worker.
- The MRE card should be issued through all means: online, at the dispensary and the branch office and be retained with the IP.
- Rest slip should be given online to the IPs but the flexibility to issue offline should be considered, if it reduces the time delay for the IP and is occasional.
- Rest slip should be submitted in the branch office and a ledger number should be compulsorily provided.
- Introduce direct PDB application for *obvious* permanent disablement cases, i.e. no need to apply for PDB post TDB fitness
- IPs should not need to visit the BO post receiving DL to get their pension (PDB) released by themselves

2.5.6 Replace the current paper-based process with the digital upload and movement of forms and documents, including Accident Reports and documents like RM-3 & BI-1A

With such a system in place between the Branch Office, Dispensary, Medical Referee, and SRO:

- IPs will no longer have to physically carry forms back and forth to multiple offices.
- Automatic status updates (via SMS, WhatsApp, or the ESIC portal) can confirm when a form is accepted, pending, or sent forward.

Please refer to Chapter 21 on Reengineering for details.

2.5.7 Once temporary disablement is evidenced by a medical certificate, the first TDB payment should be made not later than one month after the complete claim and required documents are furnished

2.5.8 When IPs are declared fit, the branch office must fill out the MR Reference Slip/Form to meet the Medical Referee, if IPs are unable to fill it out by themselves.

2.5.9 Institutionalise fixed monthly calendars (as per current norm of 1 per month) for Medical Boards across all regions, and twice where caseloads require; extend capacity (e.g., 2 Medical Boards if pending cases > 50)

These calendars must also be reliably followed, with contingency arrangements if the Board cannot convene on the scheduled date. In places where Boards are currently ad hoc, this shift would give IPs certainty, reduce waiting times, and prevent missed opportunities for assessment. This requires a zero-tolerance policy for vacancies of OSH-related specialists like pulmonologists, orthopaedic surgeons, skin specialists, etc., in concerned hospitals. Empanelled specialists from government hospitals, medical colleges, and voluntary-sector institutions can be invited to augment capacity.

2.5.10 Publishing the list of IPs scheduled for Medical Board examination on the ESIC website and notice board outside Branch Offices, along with SMS and letter notifications, at least one week in advance, to ensure that no worker misses their hearing due to communication gaps.

2.5.11 Ensure that Decision Letters (DLs) are dispatched automatically and from Centre (HO) by post and digitally (SMS/email/portal)

Every worker should receive a timely copy without needing to visit the RO/SRO. This would reduce extra trips, cut delays in accessing Disablement Benefits, and also provide workers with a permanent record they can use for linked claims such as the Labour Welfare Fund.

The Decision Letter for Permanent Disablement Benefit (PDB) should not be linked to the IP first receiving arrears or submitting proof of receipt, as is the case currently in some BOs.

2.5.12 ESIC should publish and widely circulate a clear, authoritative list of officials authorised to sign Life Certificates (Form 23).

This list should be available at Branch Offices, Dispensaries, on the ESIC website, and in simple formats (leaflets, posters, & WhatsApp). Making this information easily accessible would prevent confusion, reduce unnecessary visits, and stop valid Life Certificates from being wrongly rejected.

Remove employer attestation requirement for Life Certificates (currently not fully implemented)

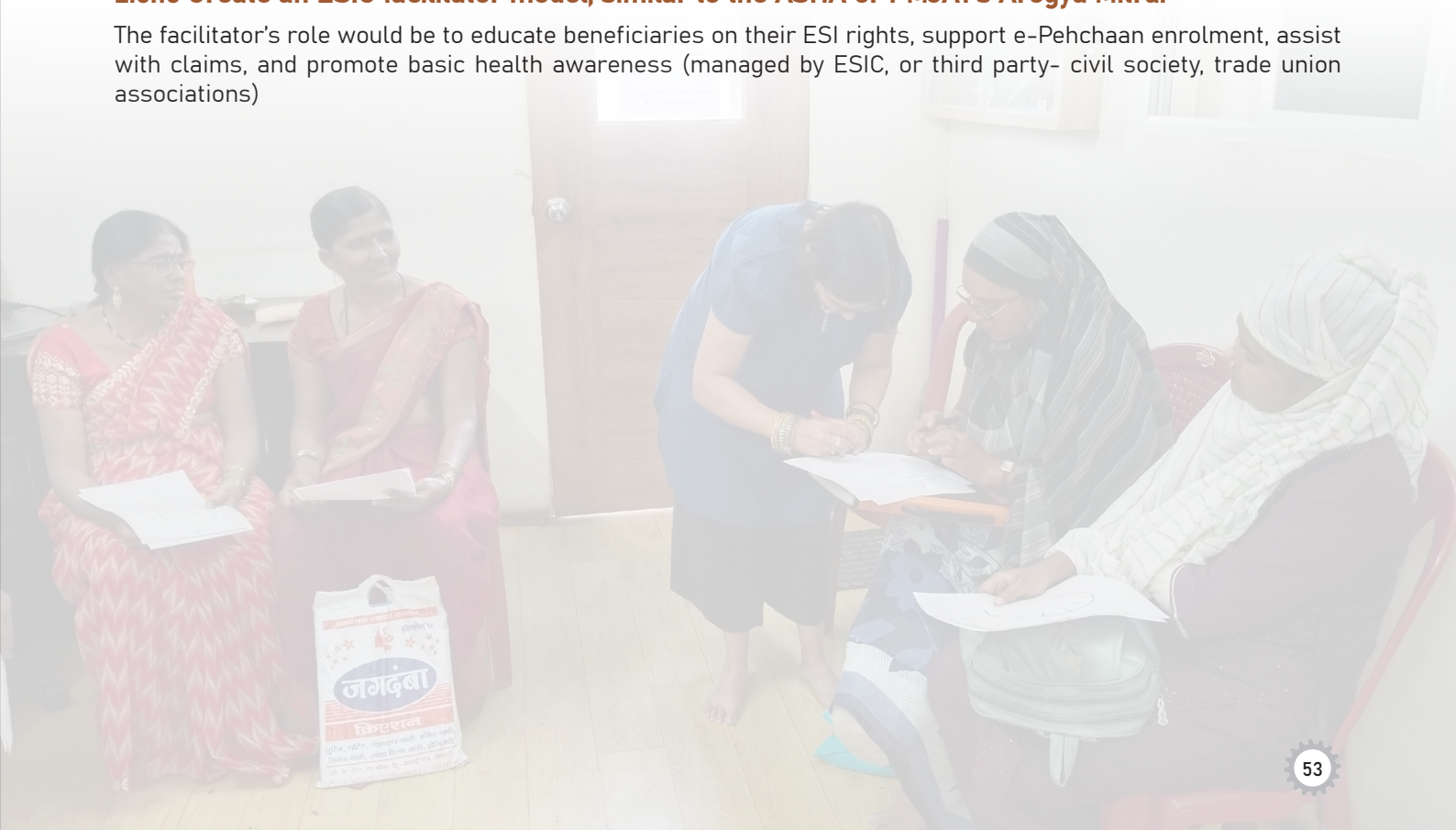
2.5.13 IPs should be able to submit their Life Certificates locally at any ESIC office, or at the bank where the pension is disbursed, in addition to online using Aadhaar verification from any location.

2.5.14 IPs should be given Form 142 with the intimation letter and, if necessary, at the medical board.

2.5.15 A printed checklist of all necessary documents and steps should be made available for TDB and PDB by the Branch Office.

2.5.16 Create an ESIC facilitator model, similar to the ASHA or PMJAY's Arogya Mitra.

The facilitator's role would be to educate beneficiaries on their ESI rights, support e-Pehchaan enrolment, assist with claims, and promote basic health awareness (managed by ESIC, or third party- civil society, trade union associations)



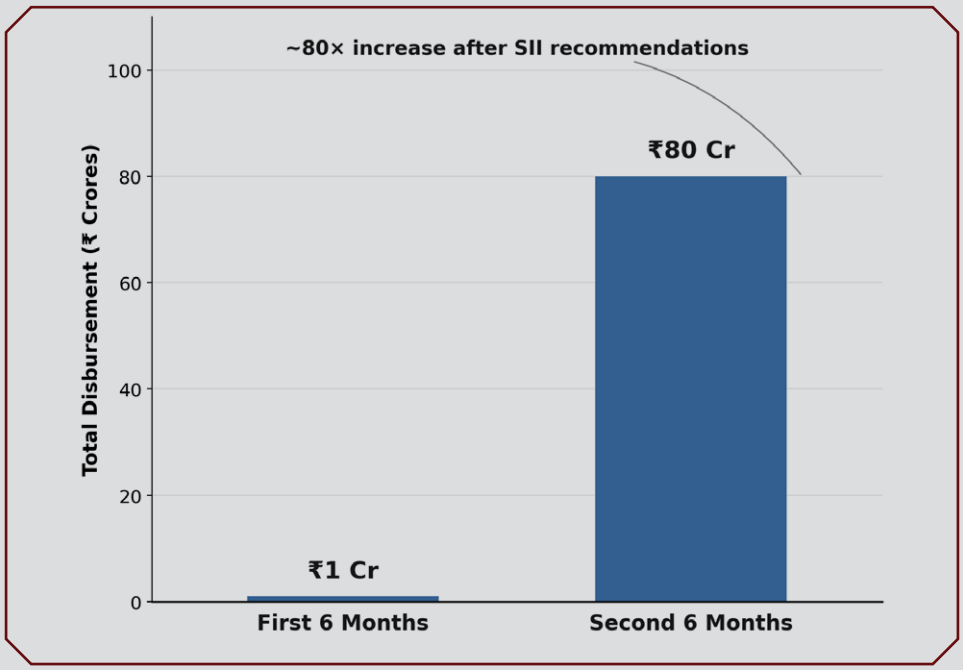
Atal Beemit Vyakti Kalyan Yojna (ABVKY) Shows Positive Impact When ESIC Accepts Worker-Centric Recommendations. Thank you, ESIC.

The Atal Beemit Vyakti Kalyan Yojna (ABVKY) was launched by ESIC in July 2018 on a pilot basis to support insured persons during unemployment by providing an Unemployment Allowance. The scheme has since been extended until 30 June 2027.

During the COVID-19 lockdowns in 2021, SII tested the scheme with 100+ workers and submitted 10 practical recommendations to improve its functioning. ESIC accepted seven, issued circulars, and as a result, disbursement rates improved significantly.

Based on the recommendations, improvements to ESIC's Covid-19 Unemployment Scheme increased disbursements from Rs. 1 Cr in the first 6 months to c. Rs. 80 Crores in the next 6 months

This experience demonstrates that when ESIC is responsive, schemes can be reengineered to scale up impact and deliver meaningful support to vulnerable IPs.



Resumption of BI-3 Issuance in Faridabad Enabled Workers to Access LWF (Labour Welfare Fund), thanks to ESIC.

In Faridabad, the BI-3 form, the handwritten record of the Medical Board's assessment, was not being given to injured workers for a few months in 2025. This led to rejections of Labour Welfare Fund (LWF) applications, since the form is required by the Haryana LWF.

After the issue was raised by SII, the practice was resumed. As a result, in the past year, 100+ workers were able to secure more than ₹1 crore from the LWF.

Steel Industry Worker in Jodhpur, Dileep, suffered a severe injury; denied an Accident Report and therefore compensation: (Aajeevika Bureau Case Study)

Across Jodhpur's industrial belts, the steel industry employs more than 50,000 workers, the majority being migrants from Bihar, Uttar Pradesh, and other states. Despite this massive workforce, **only about 30% are covered under ESIC**. Out of roughly 550 units, merely 109 are registered under the Factories and Boilers Act, employing only about 9,246 workers, possibly indicating underreporting.

Between April 2023 and October 2025, Aajeevika Bureau's e-Log documented 448 workplace injuries across Jodhpur, 52% of which originated in the steel sector. The most common injuries include finger amputations, burns, fractures, and respiratory illnesses, often caused by poor ventilation, lack of protective gear, and precarious working conditions.

The experience of Dileep, a migrant worker from Uttar Pradesh, exemplifies how employers evade responsibility. On May 24, 2025, Dileep suffered a severe eye injury at work. Like most workers in the sector, he was not registered under ESIC. **To evade liability, his employer later backdated his ESIC registration by ten days, falsely suggesting coverage before the accident.** Backdated registrations render workers ineligible for medical, sickness, or extended sickness benefits, unemployment allowance, and other entitlements under the Act. Workers in such situations are eligible only for TDB and PDB.

As per ESIC procedure, once discharged from the hospital, a worker must visit a designated ESIC dispensary to obtain a medical certificate and submit it online through the IP portal. Following this, the Branch Office must approve the claim. **However, as the employer failed to submit the required Accident Report – a legal obligation, the claim could not be initiated.**

With Aajeevika Bureau's support, Dileep filed complaints with the Factory and Boiler Department and ESIC. Although an inspection was conducted, the employer never submitted attendance records, wage slips, or the Accident Report. **ESIC officials did not initiate action, citing the missing employer documents**, even though ESIC's Manual empowers the Branch/Regional Office to require the employer to furnish further accident-related particulars and to conduct enquiries/ verification. This case illustrates how **ESIC's system depends entirely on employer compliance rather than institutional verification or worker rights.**

The ESIC web portal itself embodies this asymmetry. Workers can view contribution records and benefit claims, but there is no provision to check whether the employer has submitted the Accident Report, the key trigger for any compensation process.

As of now, Dileep remains out of work and unable to afford the surgery needed to restore his eyesight. Had the accident been properly reported by the employer and other documents collected by the ESIC Branch Office, he would have qualified for TDB and PDB. His story mirrors that of countless others trapped between employer non-compliance and institutional inertia.



Dileep



CHAPTER 3

Growing Maternity Cash Benefit: An excellent promise for Insured Women (IW); Process Improvements can Improve the Lives of Lakhs of Women and Children



ESIC's Maternity Benefit, an excellent promise, paid in addition to maternity healthcare, provides insured women (IWs) 100% of their average daily wages while they are medically certified to abstain from work due to pregnancy/ childbirth.

3.1 Maternity Benefit payment increased 4.8x in 15 Years; but share of insured women (IWs) receiving the benefit nearly halved

Entitlement: 26 weeks in case of first and second childbirth and delivery (≤8 weeks pre-delivery); 12 weeks if there are two or more surviving children; 6 weeks for miscarriage; plus, up to 1 month for illness from pregnancy/ delivery; commissioning/adopting mothers: 12 weeks.

The maternity benefit for confinement was increased from 12 weeks to 26 weeks in 2016-17.

Where ESIC facilities are unavailable, and the mother is not able to take medical care from ESI Hospitals (maternity healthcare), a ₹7,500 confinement medical bonus (with effect from 27 October 2020) is payable (up to two confinements) (not discussed in this chapter).

Eligibility: contributions payable for ≥70 days across the two immediately preceding contribution periods; applies to workers under the ₹21,000/month ESIC wage ceiling. Maternity Benefits are for IWs only and family members aren't covered.

In FY 2024–25, ESIC disbursed ₹429 crore under Maternity Benefit (MB). In real terms, MB outgo has risen sharply - 4.8× over the past 15 years. Even on a per–insured woman (IW) basis, MB spending has increased alongside the 3.2× expansion in insured women (IWs). This can be partly attributed to maternity benefits for confinement being increased from 12 weeks to 26 weeks in 2016-17 (see graph below).

However, the share of insured women receiving MB has nearly halved over the same period. At the same time, the average payout per maternity claim has increased substantially, reaching ₹89,296 in 2024–25, providing crucial income replacement during pregnancy and delivery for IWs.

Figure 3.1: Maternity Benefit Payment from 2009-10 to 2024-25 increased 4.8x (Rupees Crores) (Inflation adjusted to 2024-25 Rupees)

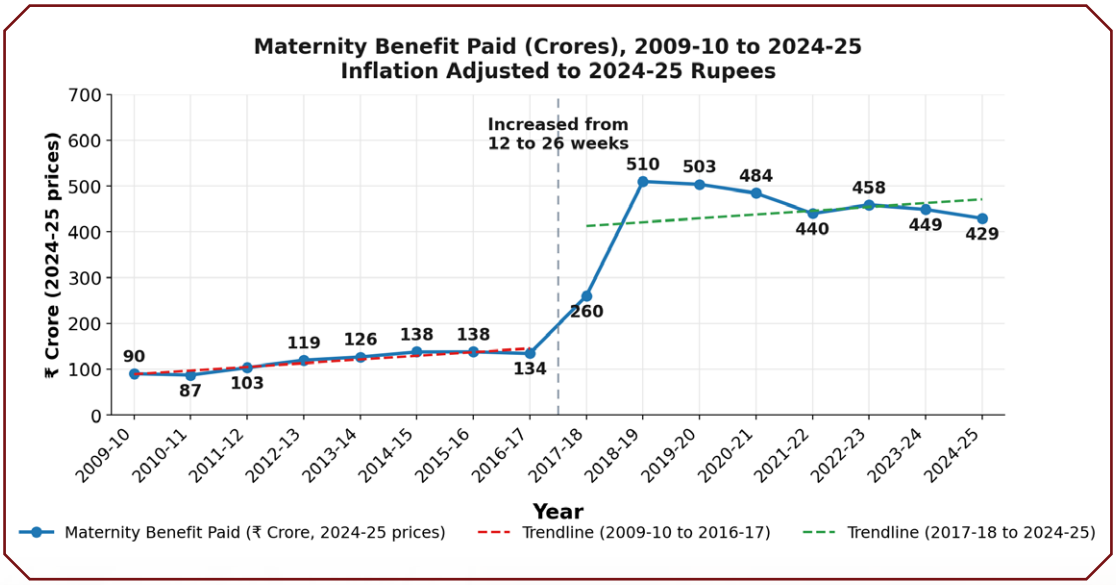


Figure 3.2: Steady Decline in Maternity Benefit Claims Per 1000 IW from 2009-10 to 2024-25

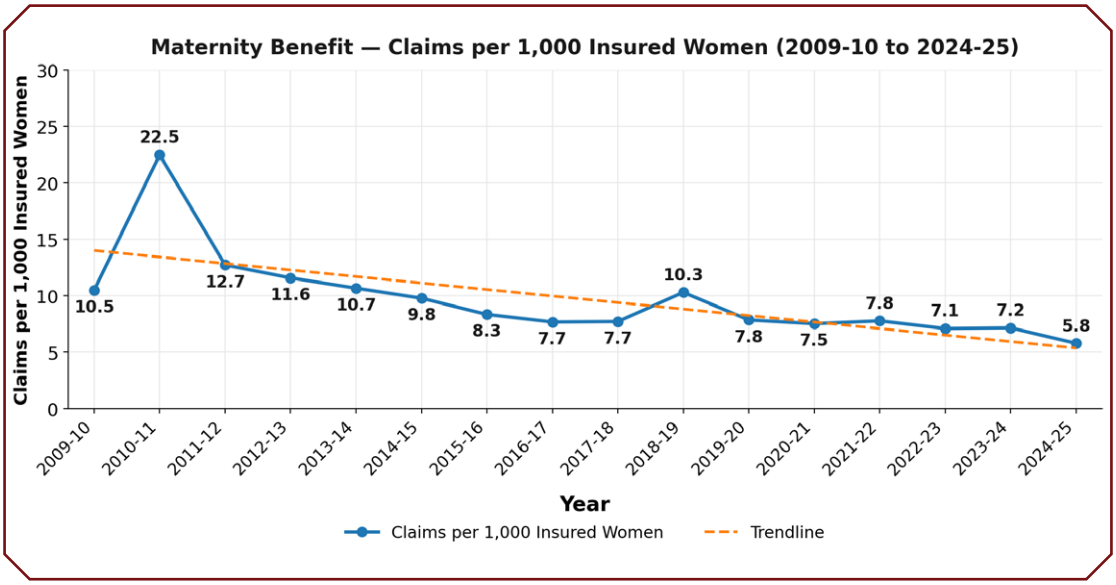
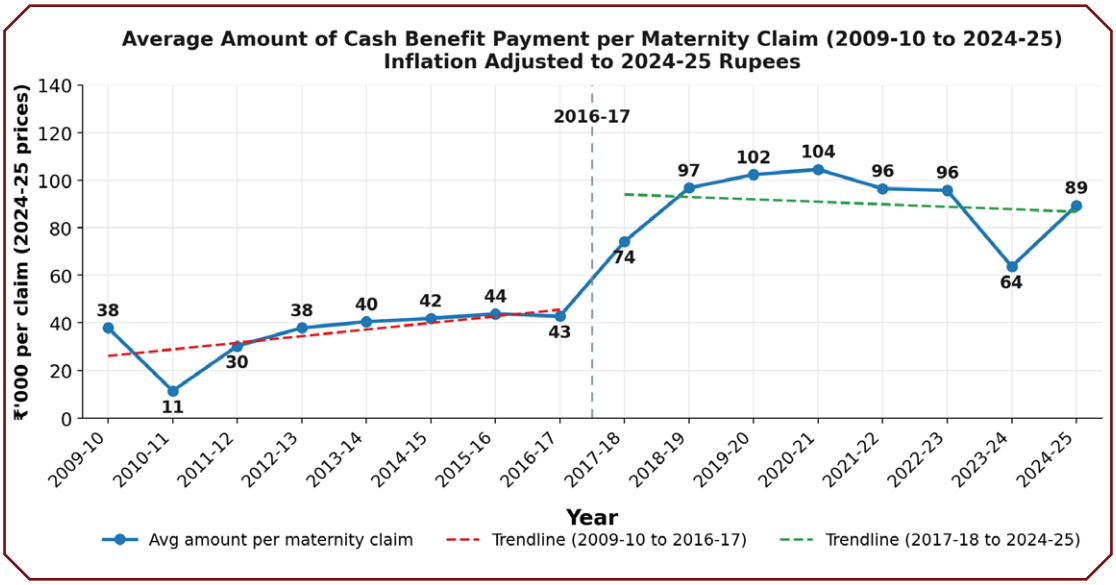


Figure 3.3: Cash Benefit (Maternity Benefit) Per Claim from 2009-10 to 2024-25 (Rupees Crores) (Inflation adjusted to 2024-25 Rupees)

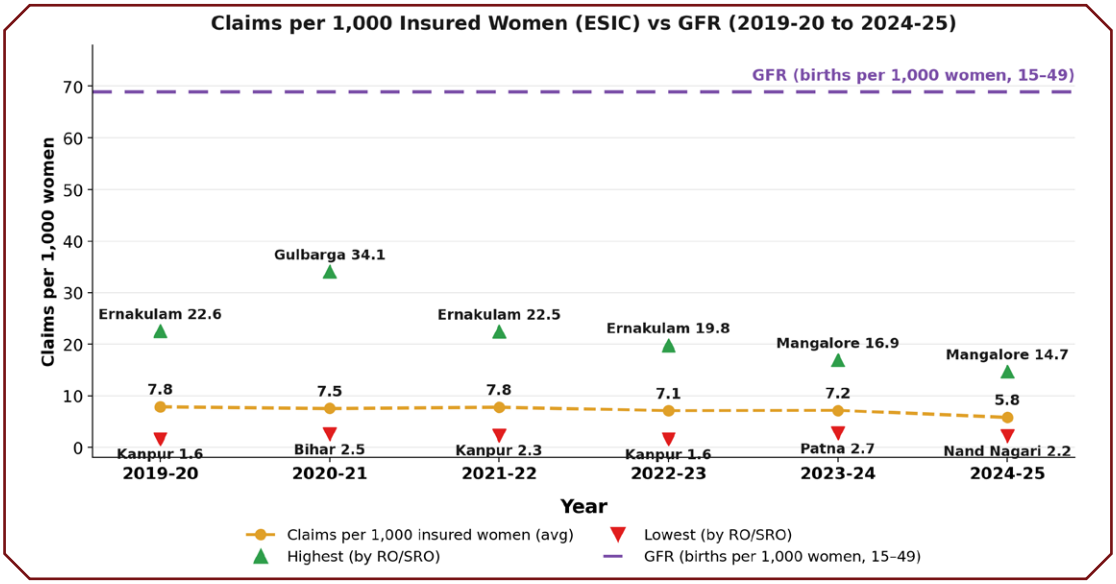


The following analysis is based on SII's experience of assisting 240+ women workers struggling with their maternity claims and discussions with 100+ women workers/families on this benefit in Haryana and Maharashtra's 20+ ESIC branch offices. Although this sample is biased, the process issues identified here are bound to be a problem for most women workers who deserve this benefit, and many may be opting out due to these onerous processes.

3.2 Low Awareness Potentially Leads to Many IWs Missing Out on Maternity Cash Benefits; around 10% of India's GFR

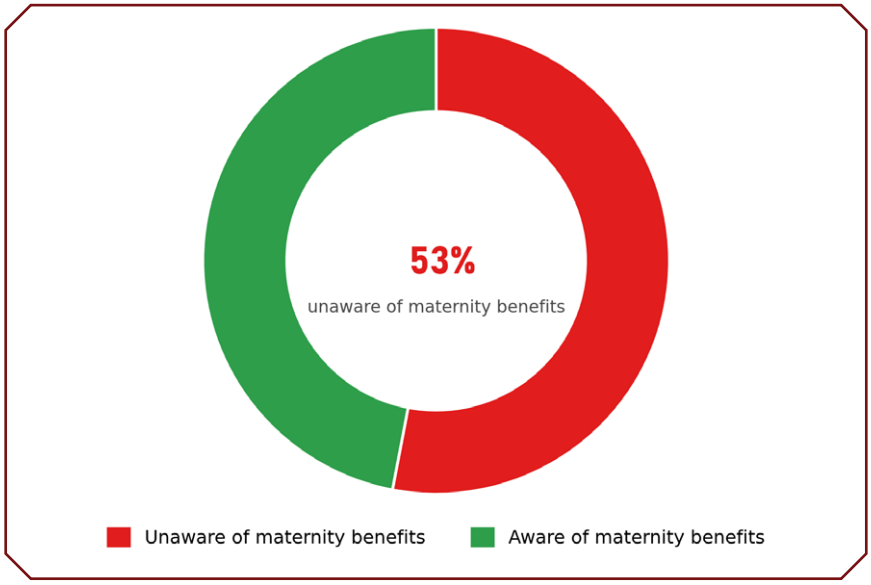
Based on ESIC Annual Reports, maternity claims remain around 7 to 8 per 1,000 insured women (Figure 3.2), substantially below India's GFR (Births per 1000 women) of ~69 births per 1,000, indicating that most births among IWs don't result in ESIC claims. Additionally, variation is stark: highs in southern states (c.20) versus lows in northern states (c.2), which actually have higher birth rates (Figure 3.4), suggesting under-claiming and uneven access.

Figure 3.4: Claims per 1000 IWs versus GFR (Births per 1000 women) with ROs with the highest and lowest claims per 1000 IWs selected



Awareness among IWs about the maternity benefit, and the contribution and document-submission requirements, remains low. In community engagements, SII has repeatedly found around half the IWs unaware of this benefit.

Figure 3.5: Awareness of Maternity Benefit among FGD participants (IWs) in Faridabad and Manesar (January 2026; n=19)



Despite intensified outreach and a dedicated focal staff, SII has fewer than 15 open cases at any time, a pattern seen in both Haryana and Maharashtra.

Seema Sharma, Field Executive Cum Community Mobiliser, Safe In India



मातृत्व लाभ की सही जानकारी के अभाव में अनेक महिलाओं को कठिनाइयों का सामना करना पड़ता है।

Due to a lack of proper information about maternity benefits, many women face difficulties

3.3 Inefficient processes and on-ground challenges have led to a Median Turn Around Time of 165 days, compared to the Citizen's Charter target of 14 days.

3.3.1 ESIC's Citizen's Charter sets a 14-day turnaround for Maternity Benefit from the date of expected confinement

The Maternity Benefit becomes due on the later of (a) the date the certificate of expected confinement is issued, or (b) six weeks before the expected delivery date on that certificate and is payable not later than 14 days *after becoming due* (Citizen's Charter).

3.3.2 73% IWs assisted by SII have received payments after 6 months; Issue Persists Across Geographies

Figure 3.6 Turn Around Time for Maternity Benefit cases supported by Safe In India in 2024 & 2025

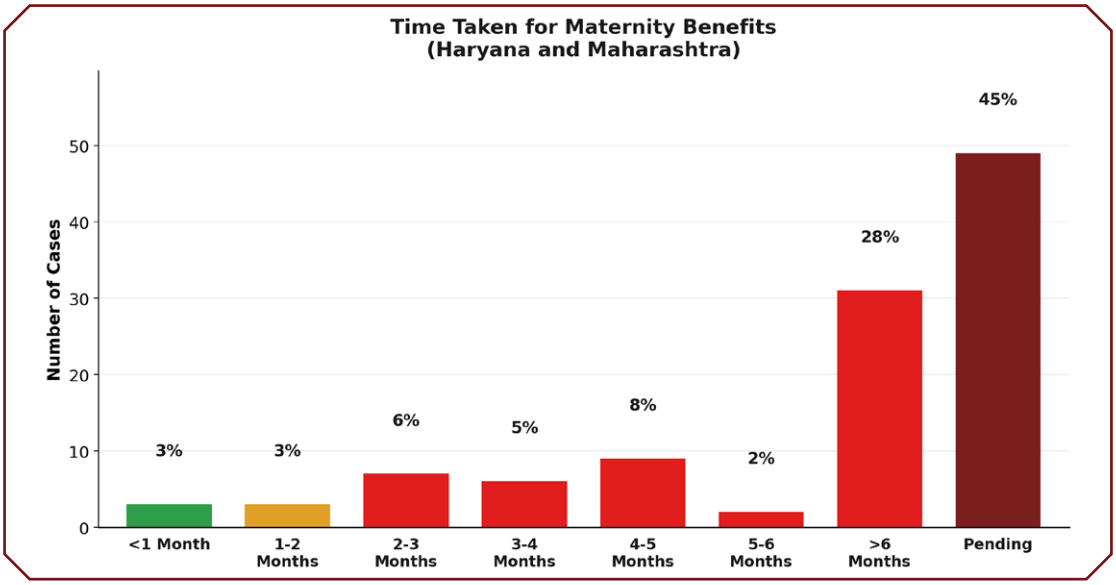
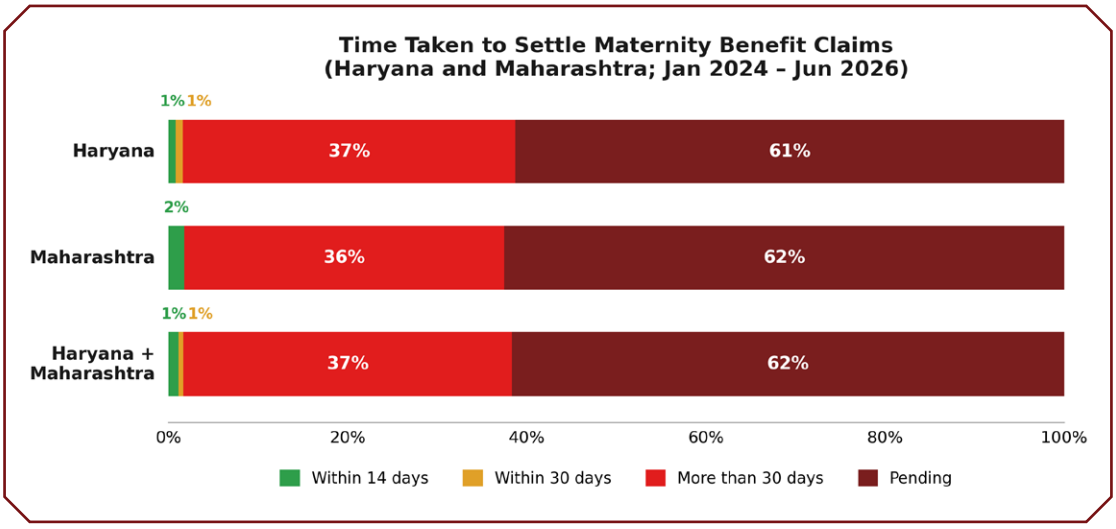
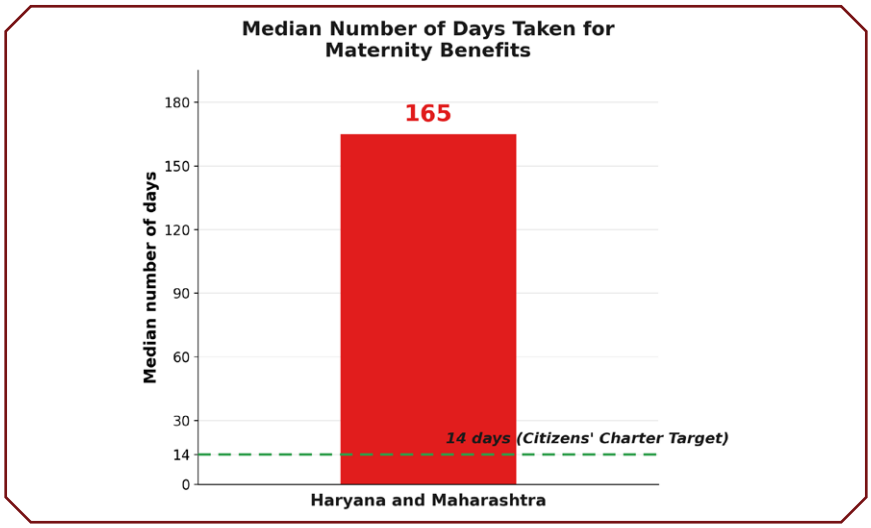


Figure 3.7 Time Taken for Maternity Benefits (State-wise Data; up to Jun 2026)



Median Number of Days: 165 days v/s Citizens Charter's 14-day target

Figure 3.8 Median Number of Days Taken for Maternity Benefits (Haryana and Maharashtra Data) (only completed)



3.4 Complicated Process, Excessive Documentation also Disincentivises IWs' Access to Maternity Benefits

3.4.1 The need for IWs to make multiple visits to dispensaries for obtaining certificates to receive the compensation, while pregnant or with a newborn and who are often not well enough, deters many from accessing Maternity Benefits

On paper, the Maternity Benefit (MB) claim process is simple: online submission through the IP Portal (with certificates digitally available/verified) or offline submission of prescribed forms and documents, followed by submission of proof of childbirth and bank details for direct transfer.

In practice, SII's engagement over the last two years with ~160 IWs suggests that the process often remains manual and travel-intensive, requiring multiple trips between the dispensary/hospital and Branch/Local Office, often twice (pre-delivery to access the pre-confinement portion, and post-delivery to submit the confinement certificate). Alternatively, IWs skip the pre-delivery claim entirely, opting to apply post childbirth, foregoing timely cash support when it may be most needed.

IWs can end up spending the equivalent of up to a month's salary on repeated visits and follow-ups to access a benefit worth up to 26 weeks of income replacement, while coping with pregnancy/newborn care, deterring many from claiming MB.

Aarti

Aarti went to her ESIC branch office to submit documents for her Maternity Benefit. The branch manager told her the claim could not be processed because her marital status in ESIC records was listed as "Unmarried", although she was married. She was told to get this corrected first (even though being married is not a prerequisite for Maternity Benefit).

Aarti requested her employer to file a correction request with the branch. The request was rejected multiple times.

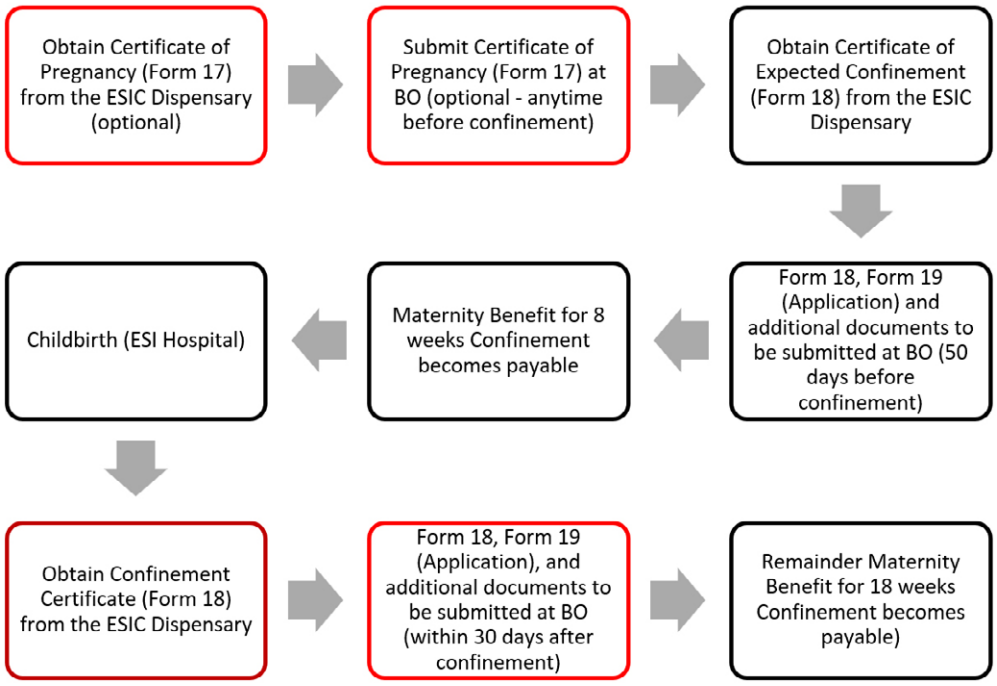
On SII's advice, she raised the issue at a Suvidha Samagam, where the officer suggested she submit an affidavit of marriage at the branch. She did so, and her company filed a fresh correction request, which was again rejected. The branch now demanded a Family ID, which she did not have.

SII advised her to take the matter to the Regional Office. There, she explained that she had already submitted the affidavit as directed at the Suvidha Samagam, yet her record remained unchanged, and a Family ID was now being demanded. The RO official directed the branch to accept the correction request.

Aarti's company resubmitted the request; her ESIC record was updated from "Unmarried" to "Married", and her Maternity Benefit claim was finally processed.

Figure 3.9 Current process for Accessing Maternity Benefits Offline

If claiming before confinement (maternity leave begins 6 weeks pre-delivery)



Unnecessary/avoidable steps highlighted in red.

If IWs require multiple visits for the same step due to any issue, the number of steps increases.

If claiming after confinement:

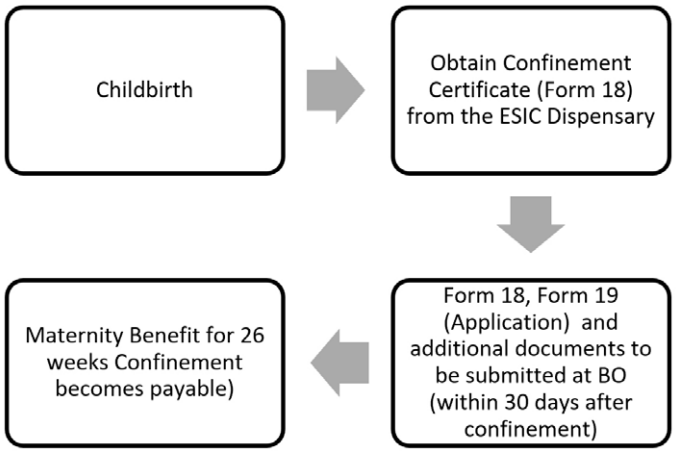
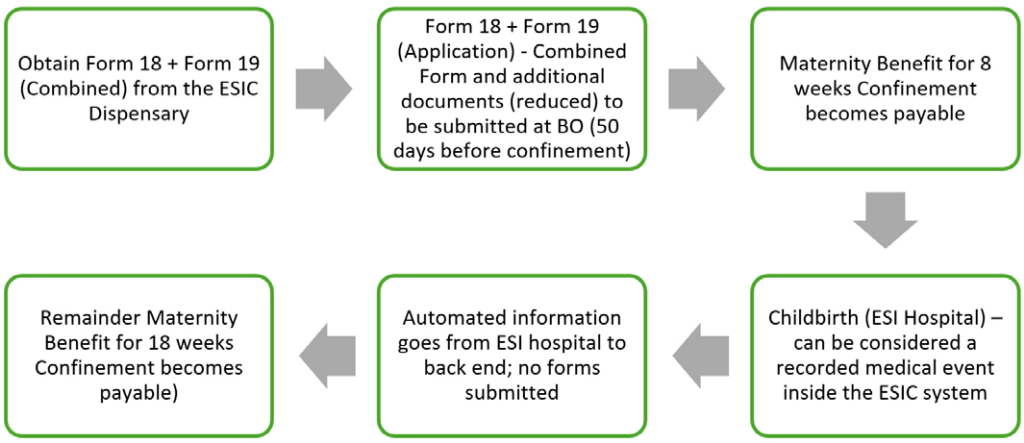


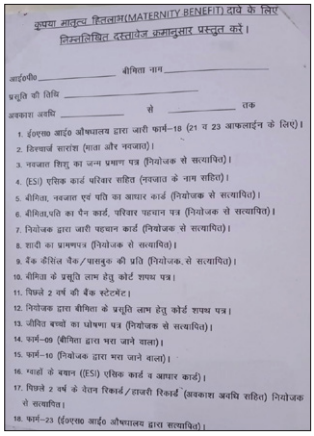
Figure 3.10 Proposed (Simplified) process for Accessing Maternity Benefits Offline



3.4.2 Additionally, non-standard document checklists in different ESIC offices create unnecessary complications for IWs

Several Branch Offices (BOs) use their own document checklists. For example, the Faridabad DCBO was using an 18-item list, including a Marriage Certificate (Image 3.1). While supporting IWs, SII found the process onerous. After SII raised the issue, the requirement for Marriage Certificates was removed (Image 3.2). In contrast, Gurugram's Rajiv Chowk BO uses a simpler 10-item checklist (Image 3.3). This underscores the need for a single, standard checklist to be applied uniformly across BOs.

Image 3.1 & 3.2. List of maternity benefit documents of Faridabad DCBO improved (reduced requirement of Marriage Certificate) based on SII recommendation



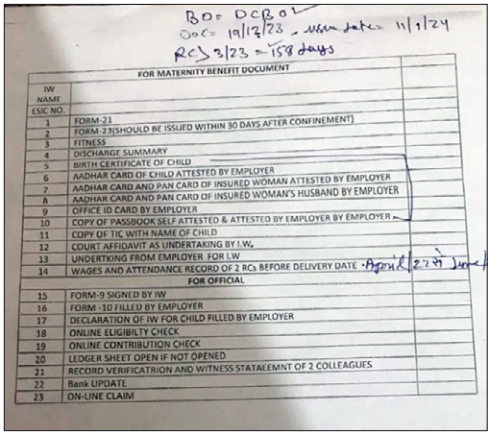
कृपया मातृत्व हितलाभ(MATERNITY BENEFIT) दावे के लिए निम्नलिखित दस्तावेज क्रमानुसार प्रस्तुत करें।

आई०पी०_____ बीमिता नाम_____

प्रसूति की तिथि _____

अवकाश अवधि _____ से _____ तक

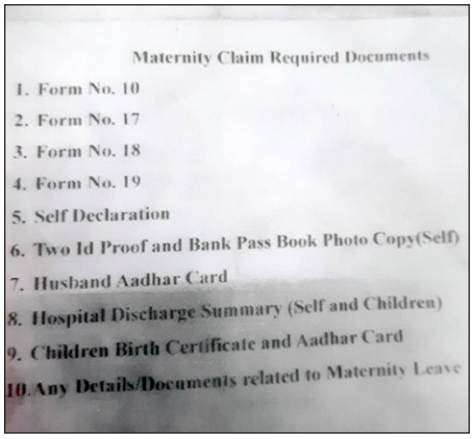
1. ई०एस०आई० औषधालय द्वारा जारी फार्म–18 (21 व 23 आफलाईन के लिए)।
2. डिस्चार्ज सारांश (माता और नवजात)।
3. नवजात शिशु का जन्म प्रमाण पत्र (नियोजक से सत्यापित)।
4. (ESI) एसिक कार्ड परिवार सहित (नवजात के नाम सहित)।
5. बीमिता, नवजात एवं पति का आधार कार्ड (नियोजक से सत्यापित)।
6. बीमिता,पति का पैन कार्ड, परिवार पहचान पत्र (नियोजक से सत्यापित)।
7. नियोजक द्वारा जारी पहचान कार्ड (नियोजक से सत्यापित)।
8. शादी का प्रमाणपत्र (नियोजक से सत्यापित)।
9. बैंक डीसिल चैक/पासबुक की प्रति (नियोजक से सत्यापित)।
10. बीमिता के प्रसूति लाभ हेतु कोर्ट शपथ पत्र।
11. पिछले 2 वर्ष की बैंक स्टेटमेंट।
12. नियोजक द्वारा बीमिता के प्रसूति लाभ हेतु कोर्ट शपथ पत्र।
13. बीमित बच्चों का घोषणा पत्र (नियोजक से सत्यापित)।
14. फार्म–09 (बीमिता द्वारा भरा जाने वाला)।
15. फार्म–10 (नियोजक द्वारा भरा जाने वाला)।
16. गर्भा के बयान ((ESI) एसिक कार्ड व आधार कार्ड)।
17. पिछले 2 वर्ष के वेतन रिकार्ड/हाजरी रिकार्ड (अवकाश अवधि सहित) नियोजक से सत्यापित।
18. फार्म–23 (ई०एस०आई० औषधालय द्वारा सत्यापित)।



BO: DCBO2
DOC: 19/12/23 - issue date: 11/1/24
RCS 3/23 - 158 days

	FOR MATERNITY BENEFIT DOCUMENT	
IW NAME		
ESIC NO.		
1	FORM-21	
2	FORM-23(SHOULD BE ISSUED WITHIN 30 DAYS AFTER CONFINEMENT)	
3	FITNESS	
4	DISCHARGE SUMMARY	
5	BIRTH CERTIFICATE OF CHILD	
6	AADHAR CARD OF CHILD ATTESTED BY EMPLOYER	
7	AADHAR CARD AND PAN CARD OF INSURED WOMAN ATTESTED BY EMPLOYER	
8	AADHAR CARD AND PAN CARD OF INSURED WOMAN'S HUSBAND BY EMPLOYER	
9	OFFICE ID CARD BY EMPLOYER	
10	COPY OF PASSBOOK SELF ATTESTED & ATTESTED BY EMPLOYER BY EMPLOYER	
11	COPY OF TIC WITH NAME OF CHILD	
12	COURT AFFIDAVIT AS UNDERTAKING BY I.W.	
13	UNDERTKING FROM EMPLOYER FOR I.W	
14	WAGES AND ATTENDANCE RECORD OF 2 RCs BEFORE DELIVERY DATE - April 27th June	
	FOR OFFICIAL	
15	FORM-9 SIGNED BY IW	
16	FORM -10 FILLED BY EMPLOYER	
17	DECLARATION OF IW FOR CHILD FILLED BY EMPLOYER	
18	ONLINE ELIGIBILTY CHECK	
19	ONLINE CONTRIBUTION CHECK	
20	LEDGER SHEET OPEN IF NOT OPENED	
21	RECORD VERIFICATRION AND WITNESS STATAEEMNT OF 2 COLLEAGUES	
22	Bank UPDATE	
23	ON-LINE CLAIM	

Image 3.3. List of maternity benefit documents of Gurugram Rajiv Chowk BO



Maternity Claim Required Documents

1. Form No. 10
2. Form No. 17
3. Form No. 18
4. Form No. 19
5. Self Declaration
6. Two Id Proof and Bank Pass Book Photo Copy(Self)
7. Husband Aadhar Card
8. Hospital Discharge Summary (Self and Children)
9. Children Birth Certificate and Aadhar Card
10. Any Details/Documents related to Maternity Leave

ESIC Responds Positively to SII's Recommendations, Ends Mandatory Marriage Certificate Demand Policy in Faridabad (but not nationally and implementation lags)

Faridabad's checklist had demanded a Marriage Certificate, even though the Rules do not require a woman to be married to claim the benefit. For many, this document is hard to produce because many marriages are not registered; late registration often entails time, paperwork, and informal costs. Following HO's enquiry, Faridabad no longer requires a marriage certificate (employer attestation of the husband's identity still applies).

Despite its removal from the checklist, all IW participants in the Faridabad FGD (January 2026) reported that they were still required to submit a marriage certificate for Maternity Benefit (MB).

Additionally, it has been reported that BOs in Pune still continue to ask for a marriage certificate as part of the documentation, and SII is working on it.

Please refer to Chapter 21 on Reengineering for an example of reengineering document checklists.

3.4.3 Need for affidavit from (often reluctant) employer blocks timely benefits

Some Branch Office checklists, e.g., Faridabad, require employer affidavits, both to "confirm the child" and to certify the mother will rejoin work. This exposes IWs to harassment; if an employer withholds the affidavit, especially where they don't intend to take her back, the claim stalls, and the IP can lose the benefit entirely.

The need for a rejoining affidavit and possible alternatives needs to be reevaluated. Under Regulation 88, ESIC requires proof of employment and wages, not employer undertakings about return to work.

The branch office manual is not updated, and later revisions and instructions of HQs have not been incorporated, although it should have been updated every year.

3.4.4 ESI BOs requiring salary slips blocks timely benefits, especially for contract workers

Some Branch Office checklists, e.g., Faridabad, require salary slip and/or attendance slips. These create impossible hurdles: as reported in CRUSHED 2026, 43% of workers report not receiving salary slips every month. As a result, claims stall, especially for contract workers, leaving IWs exposed to employer non-cooperation.

The need for salary or attendance slips and alternatives needs to be reevaluated as part of a reengineering exercise. Under Section 88, ESIC requires proof of employment and wages, not specifically payslips or attendance sheets.

3.4.5 Process gaps and uneven frontline practices persist across locations

A majority of IW participants in FGDs in Faridabad (January 2026) who availed Maternity Benefit (MB) reported receiving a printed checklist and being asked for all documents in the first instance. In Manesar (January 2026), none of the IW participants reported receiving a checklist or being asked for all documents upfront, indicating inconsistent guidance and avoidable back-and-forth depending on location.

Across both locations, no participant reported receiving an acknowledgement/receipt after submission. Further, where payments were delayed or denied, participants reported that no reason was communicated in writing. This absence of basic written confirmation and decision communication weakens transparency, makes follow-up harder, and increases repeat visits for new mothers.

The most common response at BOs faced by IWs is to "come back later".

3.4.6 Pre-delivery payment is the rule. Yet IWs are paid mostly only after childbirth, contributing to poor maternal and child health

In practice, maternity cash benefits often reach IWs only after confinement. All IW participants in FGDs in Faridabad and Manesar (January 2026) who availed Maternity Benefit reported not receiving payment before delivery. Please check Section 3.3 for related data. This forced families to absorb delivery-related expenses and cash-flow shocks. This contradicts the scheme: payments should start at least one month before the expected date of delivery when the claim is filed ≥14 days in advance (Section 45(b) read with Section 31).

35% of Indian children under five are stunted" (NFHS-5)

3.4.7 Mandatory physical presence of the neonatal mother at the dispensary/hospital and BO adds to the burden

IWs are required to physically visit the ESI dispensary/hospital within 30 days of delivery to obtain Form 18. For a neonatal mother, often recovering from delivery (including C-sections), nursing, and managing newborn care, this is onerous, especially where the facility involves a long commute.

There is no simplified process even for ESIC-hospital deliveries. Even when births occur inside ESIC hospitals, the claim steps aren't automated and still demand the physical presence of the woman IP for the MB application process, duplicating data the hospital already holds and causing avoidable delays and drop-offs. This is a missed chance to make ESIC-facility deliveries zero-touch for mothers.

All IW participants in FGDs in Faridabad and Manesar (January 2026) who availed Maternity Benefit (MB) reported that the process required physical presence at the ESIC dispensary/hospital and/or branch office soon after delivery.

3.4.8 Physical-presence requirements also deny additional Sickness Benefit to unwell pregnant IPs

IWs with difficult pregnancies can access Sickness Benefit before Maternity Benefit, but in practice, many are still asked to appear in person at ESIC facilities, untenable for someone on doctor-advised bed rest, especially with long commutes. The result: delays and drop-offs right when cash support is most needed.

3.4.9 After a miscarriage, confusion about eligibility means IWs do not access either Maternity Benefit or Sickness Benefit

After a miscarriage, IWs SII has interacted with are not clear about whether to claim Maternity Benefit or Sickness Benefit, so many end up claiming neither.

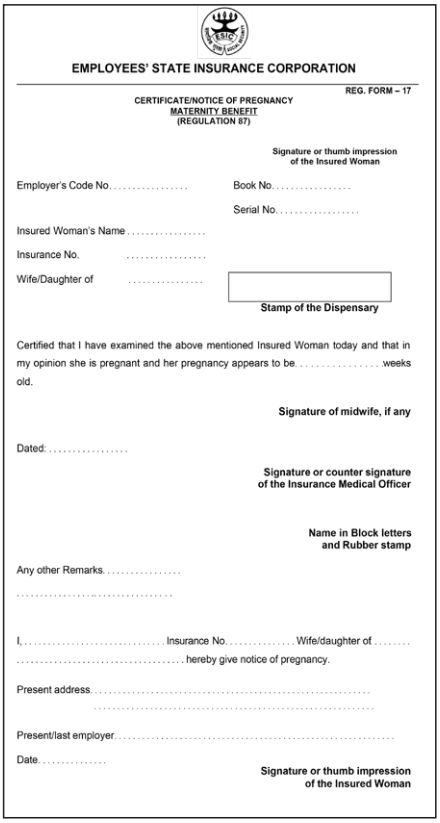
What the rules say: Maternity Benefit applies in case of miscarriage (Section 89). Sickness Benefit can cover medically certified illness/bed rest related to the miscarriage outside the Maternity Benefit period (no double payment for the same days).

3.4.10 Maternity Benefit requires multiple forms, which can be eliminated or combined

Table 3.1 Multiple forms requirements for Maternity Benefit can be reimagined.

Form	Purpose	Suggestion
Form 17	Notice of Pregnancy (Optional)	Reevaluate
Form 18	Certificate of Expected Confinement	Combine into a single form
Form 19	Claim for Maternity Benefit (Pre Confinement)	
Form 18	Certificate of Confinement	Make optional for childbirth at ESI hospitals/empanelled or tie-up hospitals – automated application
Form 19	Claim for Maternity Benefit (Post Confinement)	
Form 10	Abstention Verification	Retain but provide alternate options – e.g., salary slips + pass books; remove redundancy Move online (between ESIC & employer); not IW responsibility Automated deemed approval if employers do not respond; responsibility on the employer





EMPLOYEES' STATE INSURANCE CORPORATION

REG. FORM – 17

CERTIFICATE/NOTICE OF PREGNANCY
MATERNITY BENEFIT
(REGULATION 87)

Signature or thumb impression of the Insured Woman

Employer's Code No. ..... Book No. .....

Serial No. .....

Insured Woman's Name .....

Insurance No. .....

Wife/Daughter of .....

Stamp of the Dispensary

Certified that I have examined the above mentioned Insured Woman today and that in my opinion she is pregnant and her pregnancy appears to be ..... weeks old.

Signature of midwife, if any

Dated: .....

Signature or counter signature of the Insurance Medical Officer

Name in Block letters and Rubber stamp

Any other Remarks. .....

.....

I, ... Insurance No. ..... Wife/daughter of .....

..... hereby give notice of pregnancy.

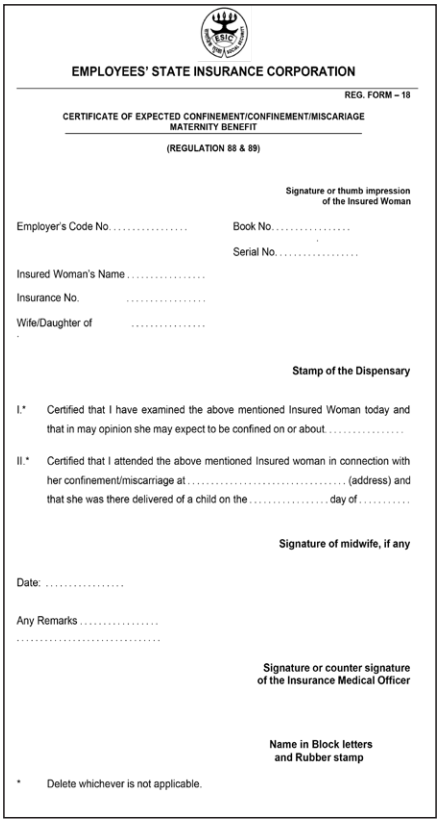
Present address. .....

.....

Present/last employer. .....

Date. .....

Signature or thumb impression of the Insured Woman



EMPLOYEES' STATE INSURANCE CORPORATION

REG. FORM – 18

CERTIFICATE OF EXPECTED CONFINEMENT/CONFINEMENT/MISCARIAGE
MATERNITY BENEFIT

(REGULATION 88 & 89)

Signature or thumb impression of the Insured Woman

Employer's Code No. ..... Book No. .....

Serial No. .....

Insured Woman's Name .....

Insurance No. .....

Wife/Daughter of .....

Stamp of the Dispensary

I.* Certified that I have examined the above mentioned Insured Woman today and that in may opinion she may expect to be confined on or about .....

II.* Certified that I attended the above mentioned Insured woman in connection with her confinement/miscarriage at ..... (address) and that she was there delivered of a child on the ..... day of .....

Signature of midwife, if any

Date: .....

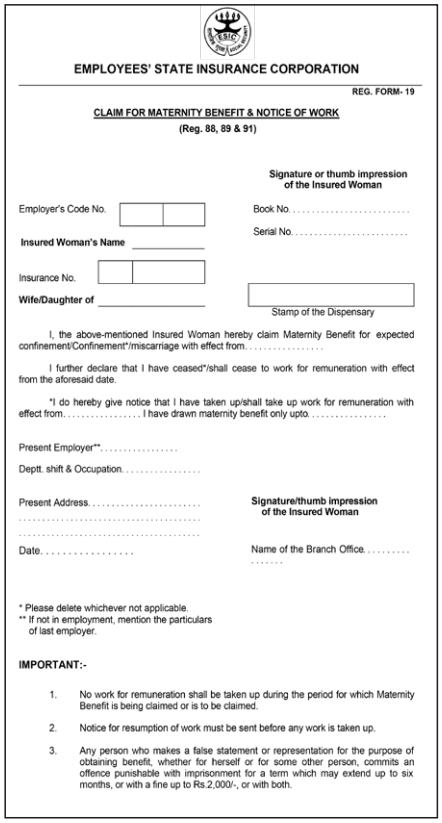
Any Remarks .....

.....

Signature or counter signature of the Insurance Medical Officer

Name in Block letters and Rubber stamp

* Delete whichever is not applicable.



EMPLOYEES' STATE INSURANCE CORPORATION

REG. FORM- 19

CLAIM FOR MATERNITY BENEFIT & NOTICE OF WORK
(Reg. 88, 89 & 91)

Signature or thumb impression of the Insured Woman

Employer's Code No. Book No. .....

Insured Woman's Name

Serial No. .....

Insurance No.

Wife/Daughter of

Stamp of the Dispensary

I, the above-mentioned Insured Woman hereby claim Maternity Benefit for expected confinement/Confinement*/miscarriage with effect from .....

I further declare that I have ceased*/shall cease to work for remuneration with effect from the aforesaid date.

*I do hereby give notice that I have taken up/shall take up work for remuneration with effect from. ..... I have drawn maternity benefit only upto. .....

Present Employer** .....

Deptt. shift & Occupation. .....

Present Address. .....

.....

.....

Signature/thumb impression of the Insured Woman

Date. .....

Name of the Branch Office. .....

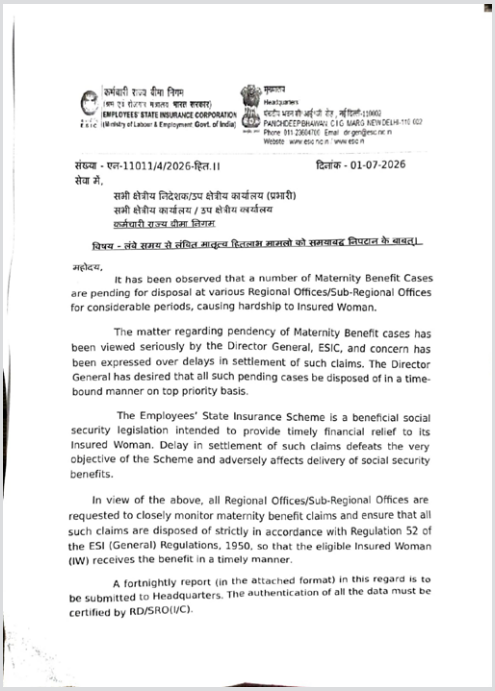
* Please delete whichever not applicable.
** If not in employment, mention the particulars of last employer.

IMPORTANT:-

1. No work for remuneration shall be taken up during the period for which Maternity Benefit is being claimed or is to be claimed.
2. Notice for resumption of work must be sent before any work is taken up.
3. Any person who makes a false statement or representation for the purpose of obtaining benefit, whether for herself or for some other person, commits an offence punishable with imprisonment for a term which may extend up to six months, or with a fine up to Rs.2,000/-, or with both.

On fraud detection in Maternity Benefit, and why data infrastructure catches what documentation cannot, see Section 22.3.

ESIC Issued a Circular on Expeditious Disposal of Long-Pending Maternity Benefit Cases based on SII Recommendations on 01 July 2026



कर्मचारी राज्य बीमा निगम
(श्रम एवं रोजगार मंत्रालय, भारत सरकार)
EMPLOYEES' STATE INSURANCE CORPORATION
(Ministry of Labour & Employment, Govt. of India)

मुख्यालय
Headquarters
पंचदीप भवन, सी.जी.ओ. कॉम्प्लेक्स, नई दिल्ली-110002
PANCHDEEP BHAWAN, C.G.O. COMPLEX, NEW DELHI-110 002
Phone: 011-23604700 Email: dir-gen@esic.nic.in
Website: www.esic.nic.in / www.esic.in

संख्या - एन-11011/4/2026-हित.II दिनांक - 01-07-2026

सेवा में,

सभी क्षेत्रीय निदेशक/उप क्षेत्रीय कार्यालय (प्रभारी)
सभी क्षेत्रीय कार्यालय / उप क्षेत्रीय कार्यालय
कर्मचारी राज्य बीमा निगम

विषय - लंबे समय से लंबित मातृत्व हितलाभ मामलों को समयबद्ध निपटान के बारे।

महोदय,

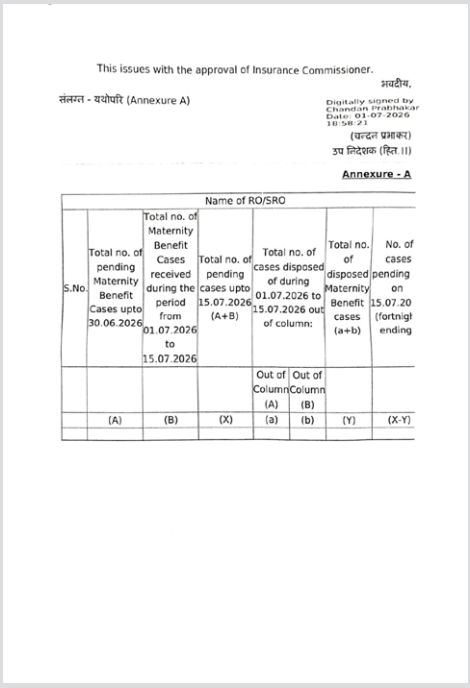
It has been observed that a number of Maternity Benefit Cases are pending for disposal at various Regional Offices/Sub-Regional Offices for considerable periods, causing hardship to Insured Woman.

The matter regarding pendency of Maternity Benefit cases has been viewed seriously by the Director General, ESIC, and concern has been expressed over delays in settlement of such claims. The Director General has desired that all such pending cases be disposed of in a time-bound manner on top priority basis.

The Employees' State Insurance Scheme is a beneficial social security legislation intended to provide timely financial relief to its Insured Woman. Delay in settlement of such claims defeats the very objective of the Scheme and adversely affects delivery of social security benefits.

In view of the above, all Regional Offices/Sub-Regional Offices are requested to closely monitor maternity benefit claims and ensure that all such claims are disposed of strictly in accordance with Regulation 52 of the ESI (General) Regulations, 1950, so that the eligible Insured Woman (IW) receives the benefit in a timely manner.

A fortnightly report (in the attached format) in this regard is to be submitted to Headquarters. The authentication of all the data must be certified by RD/SRO(I/C).



This issues with the approval of Insurance Commissioner.

भवदीय,

संलग्न - यथोपरि (Annexure A)

Digitally signed by Chandan Prabhakar
Date: 01-07-2026 18:58:21

(चन्दन प्रभाकर)
उप निदेशक (हित.II)

Annexure - A

Name of RO/SRO							
S.No.	Total no. of pending Maternity Benefit Cases upto 30.06.2026	Total no. of Maternity Benefit Cases received during the period from 01.07.2026 to 15.07.2026	Total no. of pending cases upto 15.07.2026 (A+B)	Total no. of cases disposed of during 01.07.2026 to 15.07.2026 out of column:		Total no. of disposed Maternity Benefit cases (a+b)	No. of cases pending on 15.07.20 (fortnigh ending
				Out of Column (A)	Out of Column (B)		
	(A)	(B)	(X)	(a)	(b)	(Y)	(X-Y)

3.5 Recommendations

3.5.1 The Citizen's Charter should be refined and should spell out stepwise, better-defined service standards for each stage of the Maternity Benefit Process

3.5.2 Adopt one national standard document checklist (per Operating Manual) for use across all BOs.

The standard document checklist should:

- Remove the Marriage Certificate requirement; it is illegal.
- Accept proof of employment and wages from ESIC records/portal and medical/birth documentation, making employer affidavits irrelevant
- Drop payslip/attendance-slip requirements and accept alternative proofs of employment/wages - e.g. ESIC contribution records, IP's bank statement showing wage credits, employment/contract letters, muster rolls or other reasonably available documents

3.5.3 Eliminate/combine forms to reduce the burden on IWs' application process

3.5.4 The confinement benefit should be paid before the expected date of childbirth when the claim was filed ≥14 days in advance, and within 14 days of document submission if the claim was filed post-childbirth, as per the current process and the internal ESIC process to be improved accordingly.

3.5.5 Issue Form 18 digitally by default and allow proxy pick-up (by relatives); no in-person visit should be needed by the IW. Allow remote/tele-verification for verification using videos (potential use of AI)

3.5.6 For ESIC-hospital deliveries, auto-initiate and auto-process claims at admission/discharge, with zero in-person steps (process should be digitalised).

3.5.7 Instruct BOs that if an ESI Hospital/Dispensary/IMP doctor confirms a miscarriage, pay the Maternity Benefit. If the IP needs extra recovery time beyond the maternity-benefit period, pay Sickness Benefit for those additional, medically certified days.

3.5.8. ESIC should commission surveys and take additional measures to better understand and address why many women are not availing maternity benefits.

Maternity Benefit Awareness Shifts Employer Attitude Positively to Hiring Women

Safe in India Foundation (SII), in partnership with Forbes Marshall under the Parivartan initiative, has run systematic ESIC awareness sessions across supplier units over the past two years. *Maternity benefit emerged as a striking case. Employers who had been reluctant to hire women became willing, in some cases actively keen, once they understood how the benefit works: the wages during maternity leave are paid by ESIC, not by the employer, and a woman whose leave is covered is far more likely to return to the same job.* What employers had treated as a cost of hiring women turned out to be neither their cost nor a loss of the worker.

www.youtube.com/watch?v=0_ekrX_CAv4

CHAPTER 4

Lengthy and Cumbersome Sickness Benefit Process, Often for Small Amounts, Makes it Unattractive Even to Poor Workers



Sickness Benefit refers to periodic cash payments provided to an Insured Person (IP) who is certified as "sick", requires medical treatment, and must abstain from work on medical grounds.

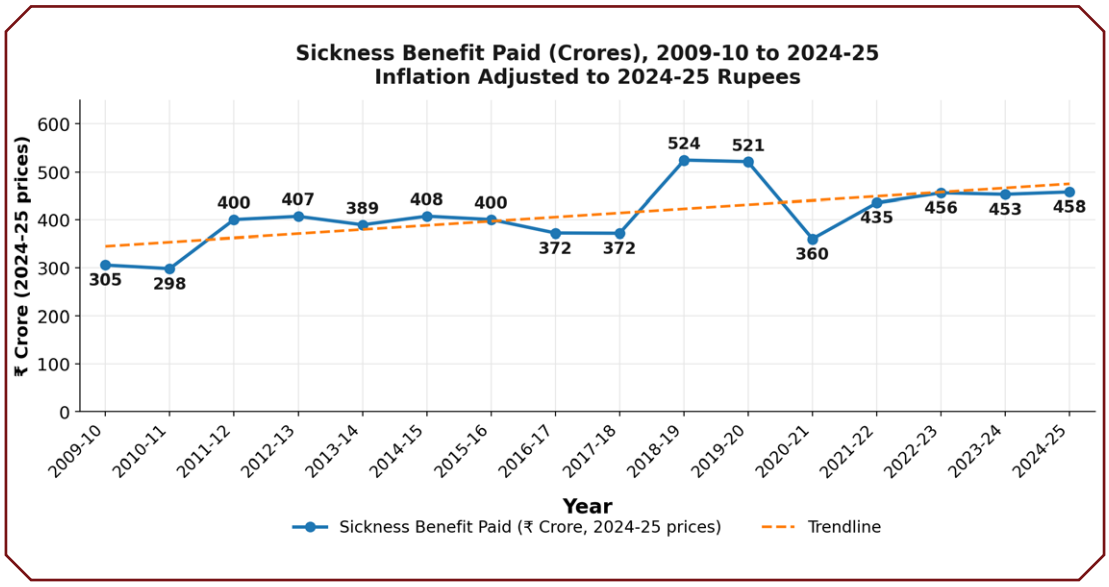
4.1 Sickness Benefit disbursements have marginally increased in 15 years, but have declined on a per IP basis

Entitlement: An IP is entitled to receive 70% of their average daily wages for up to 91 days within two consecutive benefit periods.

Eligibility: The worker has contributed to the Employees' State Insurance Corporation (ESIC) for at least 78 days during a six-month contribution period and has been an IP for a minimum of one year.

Rs. 458 Cr was disbursed under the Sickness Benefit by ESIC in 2024–25, and the amount has marginally increased (inflation-adjusted) over the past 15 years. *However, when assessed on a per-insured person basis, Sickness Benefit outgo has declined alongside the expansion in the number of IPs (2.7×).* The average daily rate of sickness benefit per employee was Rs. 385.00 during 2024-25 – a much-needed sum for survival for sick workers and their families, given that they earn less than Rs. 21,000 per month.

Figure 4.1: Sickness Benefit Payment by ESIC from 2009-10 to 2024-25 (Rupees Crores) (Inflation adjusted to 2024-25 Rupees): marginal increase despite IPs increasing 2.7x



Please refer to Section 13.3 for per-IP analysis.

This trend suggests one or more of the following possibilities:

i. A reduction in utilisation of Sickness Benefits.

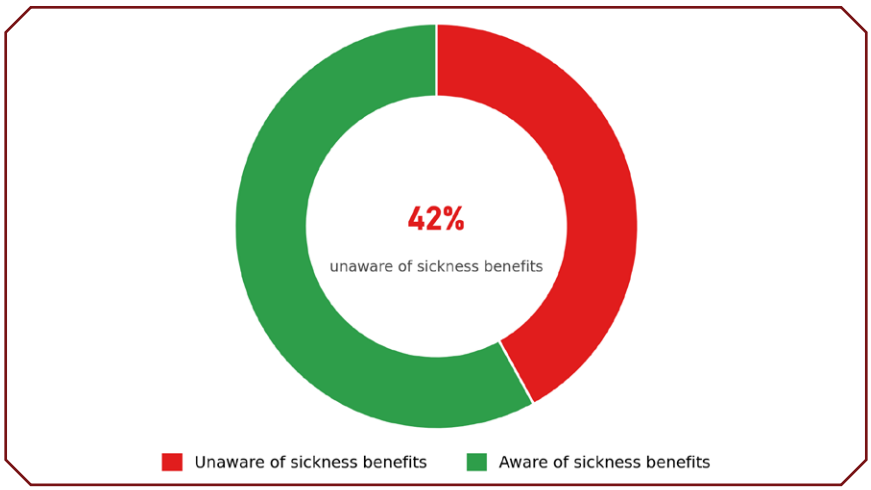
ii. Fewer IPs (as a share of total IPs) are getting sick

SII suspects that it is mainly due to reduced utilisation.

4.2 Awareness Gaps Potentially Lead to Many IPs Missing Out on Sickness Cash Benefits

Awareness gaps among IPs about the sickness benefit, process, and document submission requirements persist. In community engagements, SII has repeatedly found many IPs unaware of this benefit. This is despite SII's efforts to increase awareness.

Figure 4.2: Awareness of Sickness Benefit among FGD participants (IPs) in Haryana and Maharashtra at 58% (January 2026; n=48)



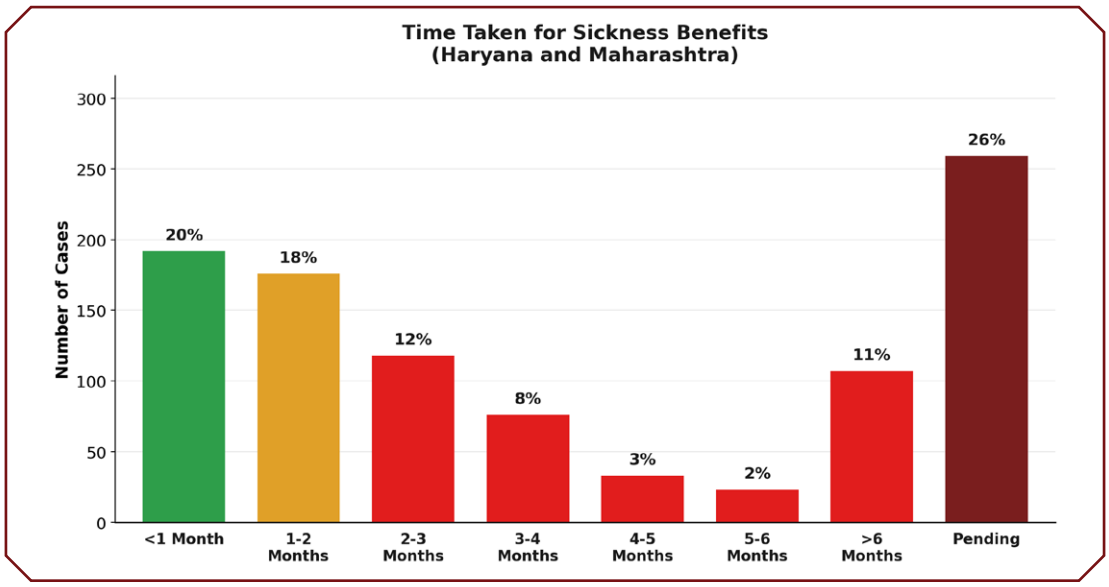
4.3 Complicated and Inefficient Processes and On-Ground Challenges have led to a Median Turn Around Time of 58 days, compared to the Citizen's Charter target of 7 days; Pune's TAT is Better than in Haryana

4.3.1 ESIC's Citizens' Charter sets a 7-day turnaround for Sickness Benefit from the date of certification

The Sickness Benefit becomes due on the date of issue of the medical certificate and is payable not later than 7 days *after becoming due* (Citizen's Charter). *However, there is no defined turnaround time for issuing the medical certificate itself.*

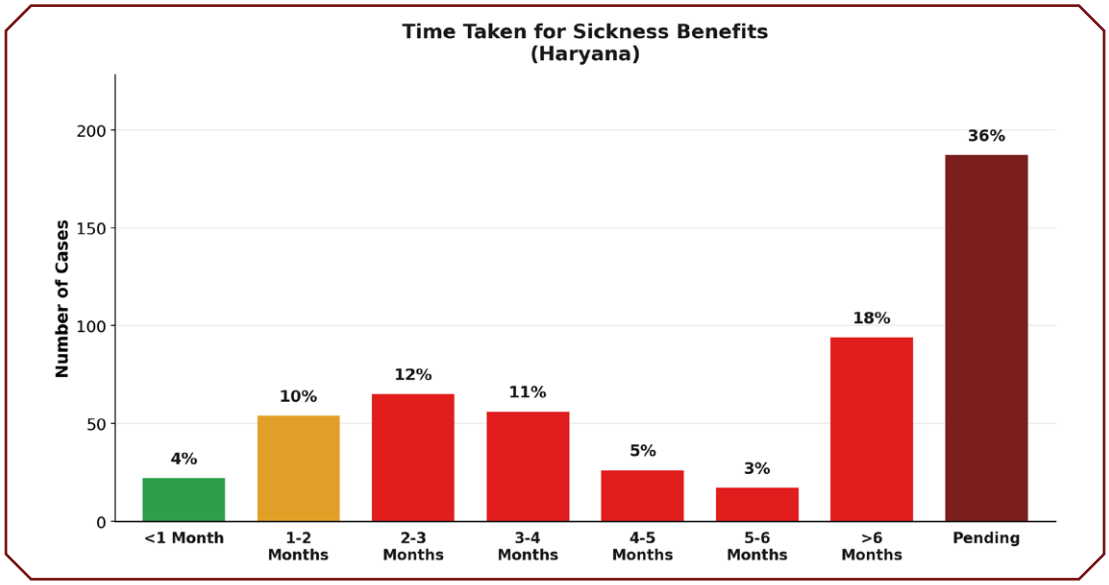
4.3.2 37% of the 1500+ IPs assisted by SII have not received payments even in 6 months

Figure 4.3. Time Taken for Sickness Benefits (Haryana and Maharashtra Combined; Jan 2024-Dec 2025)



Resolution within 1 Month: 37% in Maharashtra v/s 4% in Haryana

Figure 4.4. Time Taken for Sickness Benefits (Haryana and Maharashtra; Jan 2024-Dec 2025)



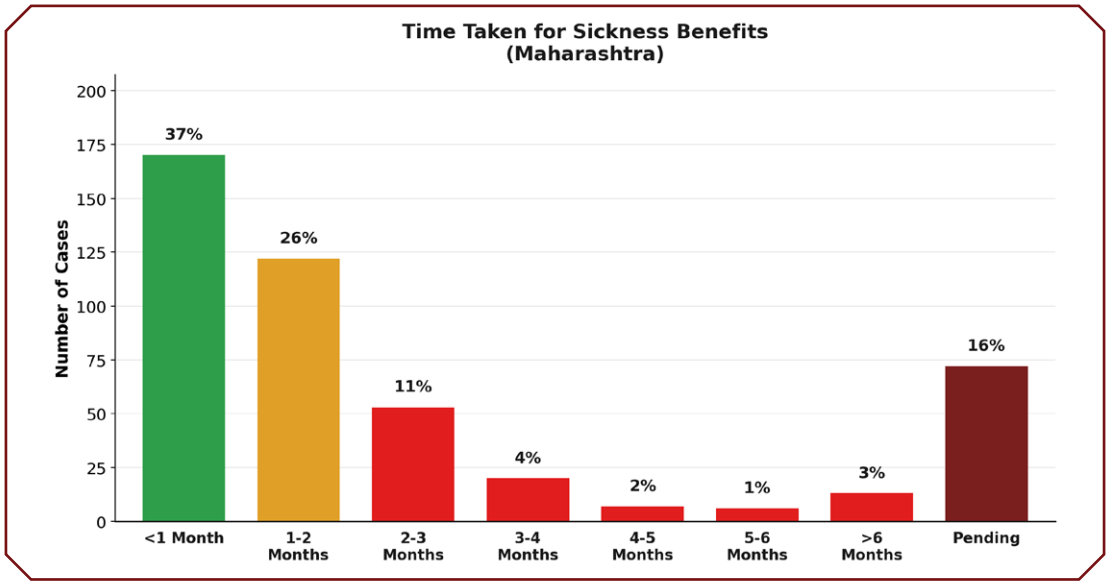


Figure 4.5. Time Taken for Sickness Benefits (State-wise Data; up to Jun 2026)

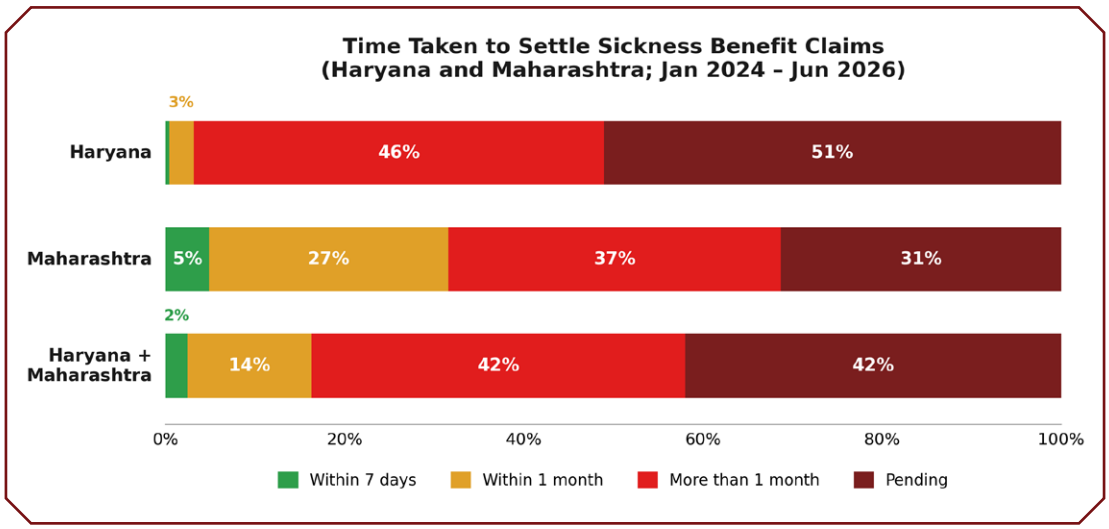
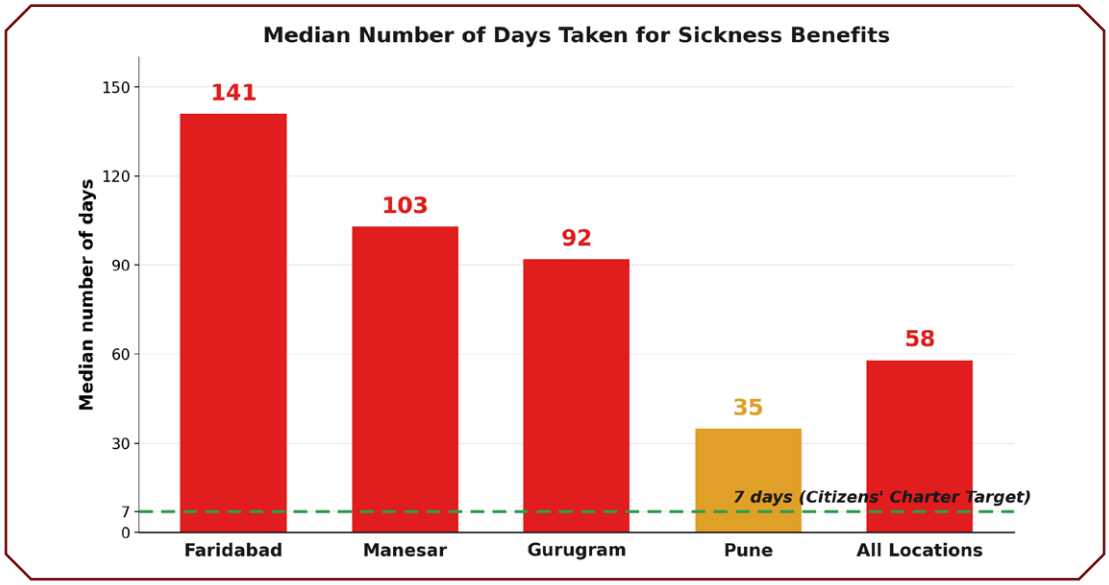


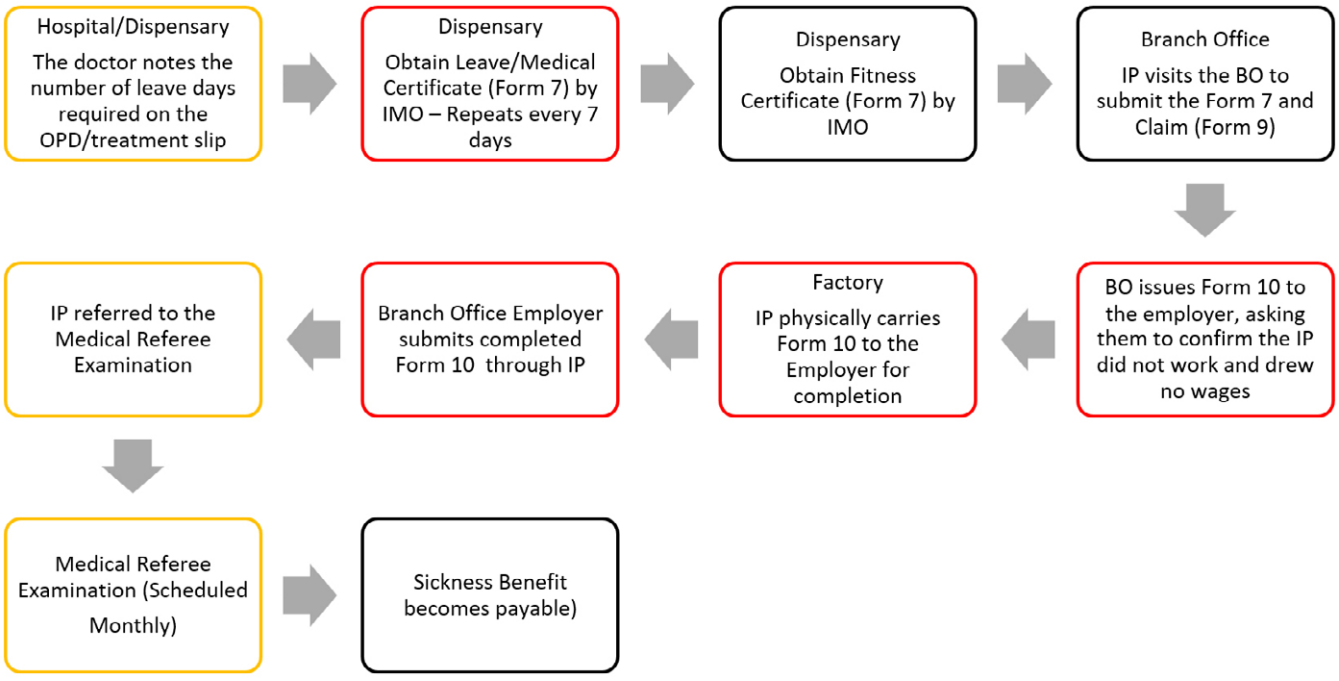
Figure 4.6. Median Number of Days Taken for Sickness Benefits (only completed) is 58 days



4.4 Long, multi-location process to claim 70% of their wages disincentivises claiming Sickness Benefits for many workers

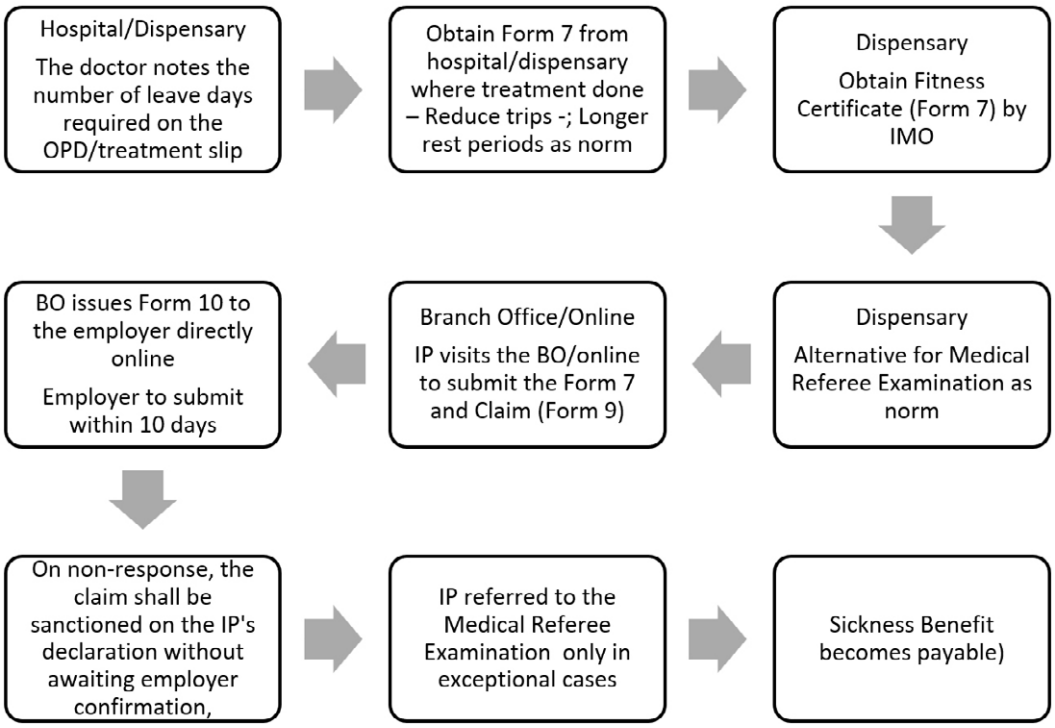
4.4.1. Multi-step process at distant, multiple locations

Figure 4.7: What an IP actually does for Accessing Sickness Benefits



Form 7 (Leave Certificate) is given for 7 days at a time; IPs are instructed to wait until Form 7 (Fitness Certificate) is issued or 4+ weeks before submitting a claim

Figure 4.8: Alternative (Proposed) Flow for Accessing Sickness Benefits



This approach includes a reduction in hospital/dispensary visits for paperwork; responsibility for Form 10 submission moved away from the IPs. This requires empowering dispensary doctors.

4.4.2. A good online submission process is present; but not followed in many locations.

ESIC has deployed modules for online submission of Sickness Benefit (SB) and other cash-benefit claims through the IP Portal, with an explicit intent to eliminate offline/physical claim submission. The same instruction also directs Branch Offices not to insist on physical hard copies of Regulation certificates/related documents when the claim has already been submitted online.

Data on the percentage of IPs using online process v/s offline process is not available. But most IPs supported by SII used the offline process.

Figure 4.9: Current theoretical process for submitting a Sickness Benefits Claim through IP Portal

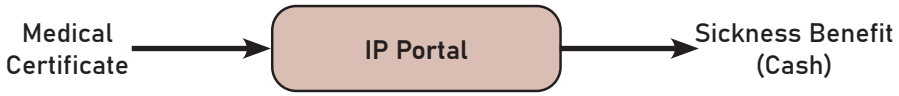
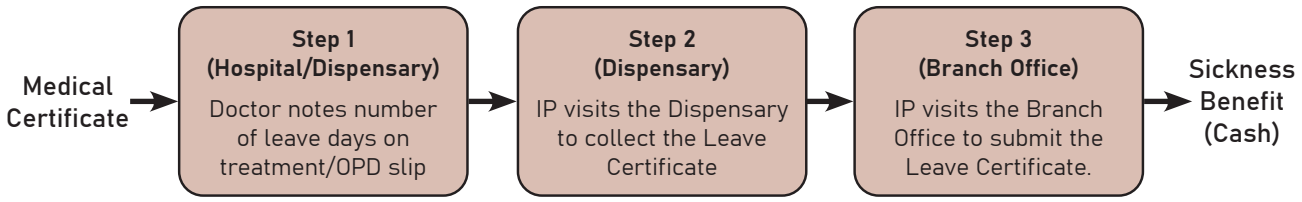


Figure 4.10: Current practical process for submitting a Sickness Benefits Claim in Person (ground reality)



Where the medical certificate is issued manually/physically, ESIC's IP Portal workflow provides for the IP to upload a scanned certificate and then submit the claim request online (certificate details + upload + claim period + declaration + submit).

However, in practice, in many locations, online submission is not prevalent, and insured persons still end up making multiple in-person trips and physically carrying/couriering papers between facilities. A practical exception we've seen is Faridabad, where the doctor provides the certificate immediately at the point of care, eliminating the separate dispensary visit otherwise required. This streamlining should be feasible more widely: if systems

can be digital for items like prescriptions, the same approach can be implemented for sickness certificates/leave certificates as well.

4.4.3 Medical Record Envelope now handled internally, eliminating an avoidable trip for Sickness Benefit claims. Positive change.

The Medical Record Envelope (MRE) is intended as an internal record-management document within the ESIC medical system. Treating the MRE as an internal workflow item (between the Dispensary/Hospital and the Branch Office/system) eliminates an avoidable in-person loop that, in practice in many locations, IPs were earlier required IPs to: visit the Branch Office to collect the MRE → take it to the dispensary → return to the Branch Office.

4.4.4 When IPs try the IP Portal, platform issues often prevent a successful submission

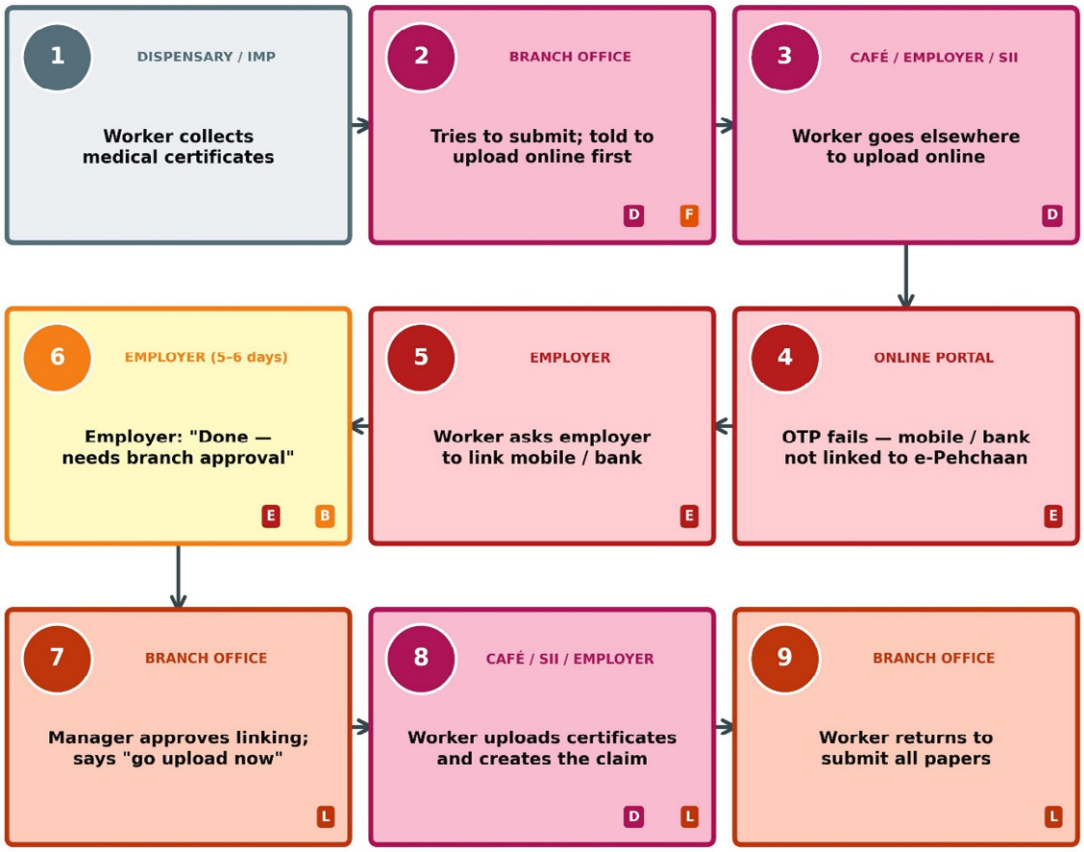
Where insured persons attempt to use the IP Portal for Sickness Benefit claim submission, many are unable to complete the process due to set-up and technical barriers. Common issues reported include:

- Mobile number (usually added by employer/contractor) not linked to the insurance record, blocking login/OTP and access.
- Biometric/eKYC not linked properly or not set up correctly, preventing authentication.
- Claim request fails to submit online due to technical errors (e.g., submission/validation failures, portal glitches, upload issues).

4.4.5 Online process for Medical Certificate submission still requires offline duplication, making it unnecessarily complicated

Although the IP Portal allows medical certificates to be uploaded online, this has *not* meaningfully simplified the process for many insured persons (IPs).

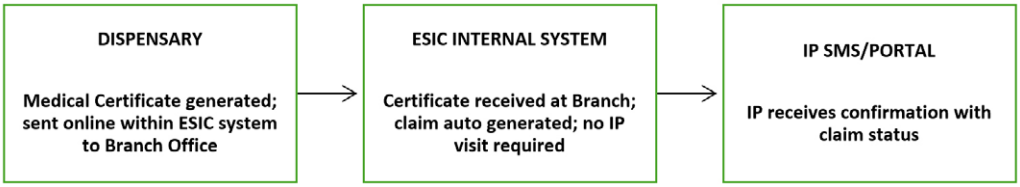
Figure 4.11: Complex Process to Submit a Medical Certificate: Avoidable Physical Processes in a Fully Automatable Process (ground reality)



In ESIS dispensaries, certificates may be generated in the system, yet IPs are often still given printed copies. IMPs (Insurance Medical Practitioners) typically provide only hard-copy certificates. In both situations, IPs are then required to carry the physical document to the Branch Office (BO), where it is uploaded again. Until this upload is completed, the claim is effectively not created, and the IP has no usable online trail. For online and offline submission processes to work, they should be separate and parallel processes (the online process should only have online steps, the offline process should only have offline steps).

Operational constraints further add friction. Power outages and unreliable internet, reported as particularly common in parts of Haryana, can prevent uploads at the BO, forcing the IP to either seek help from *paid* intermediaries for uploading or return to the BO on another day.

Figure 4.12: Recommended Process for Medical Certificate Submission



4.4.6 Delays due to pending Medical Referee Opinion (MRO)

In some cases, Sickness Benefit claims remain pending for extended periods because the Medical Referee Opinion (MRO), a written medical assessment by a Medical Referee (an independent ESIC-designated doctor), which is used when ESIC needs an additional medical verification beyond the routine medical certificate, remains pending for weeks and months, causing delays.

MR examination, provided/designed for specified circumstances, has been observed to be the default rather than the exception.

4.4.7 Delays when employers do not submit Form 10 (abstention verification)

Sickness Benefit processing is delayed when the employer does not provide Form 10 (abstention verification) in time. When it is not submitted or is submitted late, the claim remains pending, even if the IP has completed the medical certification and claim submission steps.

4.4.8 Lack of clear check lists and one-time full written communication undermines Sickness Benefit access

All IP participants in FGDs in Haryana (Gurugram) and Maharashtra (Pune) (January 2026) who availed Sickness Benefit (SB) reported not receiving a checklist. Most were not asked for all required documents in the first instance; additional document requests ranged from 1 to 3+. None reported receiving an acknowledgement/receipt upon submission, and participants reported zero written communication on status, delays, or any issues, leaving them without clarity on next steps.

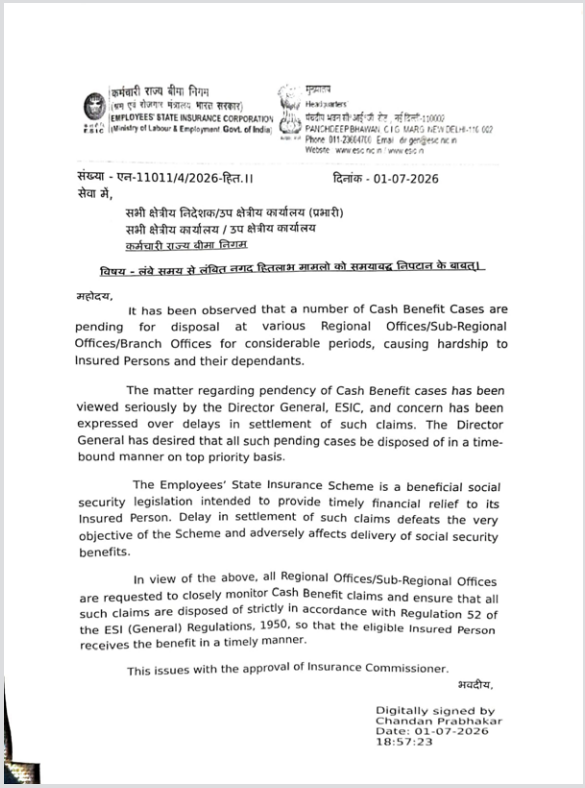
4.4.9 Mandatory physical presence of the sick worker at up to 3 locations on the same day

Some participants in FGDs in Haryana and Maharashtra (January 2026) who availed Sickness Benefit (MB) reported that the process required physical presence at the branch office for submitting certificates.

When a doctor prescribes sick leave, the patient must visit at least three separate locations the same day (hospital, dispensary, BO) to collect and submit the required Forms in person. If recovery takes longer, additional visits to the doctor are required, and extending leave means more trips to both the dispensary and the Branch Office.

In some ad hoc cases, depending on illness severity, the dispensary allows a family member to take the Form for the patient's signature, but only if they leave their identity card or similar important documents with them, *without acknowledgement*. With the heavy load of files, families worry as much about leaving these documents as about getting the patient to the office to sign.

ESIC Issued a Circular on Expeditious Disposal of Long-Pending Sickness Benefit Cases based on SII Recommendations on 01 July 2026



कर्मचारी राज्य बीमा निगम
(श्रम एवं रोजगार मंत्रालय, भारत सरकार)
EMPLOYEES' STATE INSURANCE CORPORATION
(Ministry of Labour & Employment Govt. of India)

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पंचदीप भवन, सी.आई.जी. मार्ग, नई दिल्ली-110002
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Phone: 011-23604700 Email: dir.gen@esic.nic.in
Website: www.esic.nic.in / www.esic.in

संख्या - एन-11011/4/2026-हित.II दिनांक - 01-07-2026

सेवा में,

सभी क्षेत्रीय निदेशक/उप क्षेत्रीय कार्यालय (प्रभारी)
सभी क्षेत्रीय कार्यालय / उप क्षेत्रीय कार्यालय
कर्मचारी राज्य बीमा निगम

विषय - लंबे समय से लंबित नगद हितलाभ मामलो को समयबद्ध निपटान के बाबत।

महोदय,

It has been observed that a number of Cash Benefit Cases are pending for disposal at various Regional Offices/Sub-Regional Offices/Branch Offices for considerable periods, causing hardship to Insured Persons and their dependants.

The matter regarding pendency of Cash Benefit cases has been viewed seriously by the Director General, ESIC, and concern has been expressed over delays in settlement of such claims. The Director General has desired that all such pending cases be disposed of in a time-bound manner on top priority basis.

The Employees' State Insurance Scheme is a beneficial social security legislation intended to provide timely financial relief to its Insured Person. Delay in settlement of such claims defeats the very objective of the Scheme and adversely affects delivery of social security benefits.

In view of the above, all Regional Offices/Sub-Regional Offices are requested to closely monitor Cash Benefit claims and ensure that all such claims are disposed of strictly in accordance with Regulation 52 of the ESI (General) Regulations, 1950, so that the eligible Insured Person receives the benefit in a timely manner.

This issues with the approval of Insurance Commissioner.

भवदीय,

Digitally signed by Chandan Prabhakar
Date: 01-07-2026 18:57:23

4.5 Recommendations

4.5.1 Re-engineer processes to improve turnaround time for IPs in line with ESIC's Citizens' Charter and define stepwise service standards for each stage of the Sickness Benefit application, including MRO (where applicable)

4.5.2 Allow proxy submission without ID surrender – Permit at least immediate family members to submit Forms for IPs who are unable to be present in person or not comfortable with online processes

4.5.3 Enable complete online processing, while retaining offline processing - Integrate the Branch Offices, dispensaries, IMPs, and ESIC HO processes to avoid duplication and the need for offline (hard) copies, where the IP is comfortable with online processing. Maintain two separate processes for online and offline submissions.

Automate the submission of Medical Leave Certificates from dispensary to Branch Office (currently carried physically by IPs).

IPs should be able to complete leave approval and certification at a single location (hospital or dispensary) for sick/injured workers, and avoid dispensary visits

4.5.4. Ensure on-time submission of Form 10 by employers (Abstention Verification), with clear accountability for process delays.

4.5.5 Raise awareness among IPs – Run multilingual, illustrated campaigns at workplaces and ESIC facilities on benefits, steps, and timelines.

4.5.6 A printed checklist of all necessary documents and steps for Sickness Benefits should be made available by the Branch Office.





CHAPTER 5

Complex Bill Reimbursement & Poor Process Around Referrals Drive Delays, Denials, and Worker Losses



The Employees' State Insurance Corporation (ESIC) allows reimbursement of out-of-pocket medical expenses when an Insured Person (IP) or their family cannot access necessary treatment through ESI facilities. This is provided for under Regulation 96-A, which covers cases where the required services are unavailable or insufficient in ESIC hospitals or clinics. This is an excellent provision for IPs.

Eligibility: IP must have a valid ESIC registration and have incurred expenses for treatment that ESIC facilities could not provide.

Claim submission period: Within one year from the date of the expense.

Modes of submission:

- Online – via the ESIC portal for faster processing.
- Offline – still used widely due to procedural preferences or local limitations of ESIC; useful for many IPs who aren't operating smartphones and other digital devices.

The reimbursable amount is determined according to ESIC's prescribed rates and guidelines, based on the nature of the treatment and the documentation provided. The State Government has the authority to approve reimbursement.

Reimbursement Cases under ESIC - These specific scenarios are explicitly listed in the ESIC Medical Manual as eligible under Regulation 96-A (Section 3.30, ESI Medical Manual):

1. Mobile dispensary van failure or off-hours* illness/injury.
2. Private treatment during ESI dispensary/emergency centre off-hours.
3. Purchase of prescribed medicines out of stock at the ESI dispensary/approved chemist.
4. Specialist-prescribed special medicines not provided by IMO/IMP and essential for treatment.
5. Purchase of prescribed special appliances (e.g., spinal supports, cervical collars, crutches).
6. Private treatment due to IMO/IMP failing to conduct a domiciliary visit when requested.
7. Emergency admission to a recognised hospital when the ESI identity is not immediately known**.
8. Admission to a non-recognised hospital in critical emergencies (e.g., heart attack, spinal fracture).
9. Admission elsewhere when all ESI-reserved beds at a recognised hospital are occupied.
10. Outpatient mental health therapy expenses (e.g., electroconvulsive therapy, ECT).
11. Specialist-recommended diagnostic tests unavailable in a recognised hospital.
12. Blood transfusion investigation costs.
13. Conveyance charges when an ESIC ambulance is unavailable and the patient is non-ambulatory.
14. Other meritorious cases approved on a case-by-case basis.

**sickness/injury arose at a time when the ESI dispensary/hospital was not functioning*

***Emergency, e.g., unconscious, accident case, with no card, no insurance number; where the hospital can't confirm entitlement at the counter, so it can't bill ESIC directly*

All medical treatment except Super Speciality Treatment (SST) is administered by the states; SST is reimbursed directly by ESIC through its bill-processing agency. All non-SST reimbursement to IPs is therefore disbursed by the state ESI (MB) directorate; the Superintendent for claims up to ₹1 lakh, the AMO above it. ESIC funds states on a per-capita basis: ₹3,000 per IP per annum (includes both delivery of medical benefits and reimbursements).

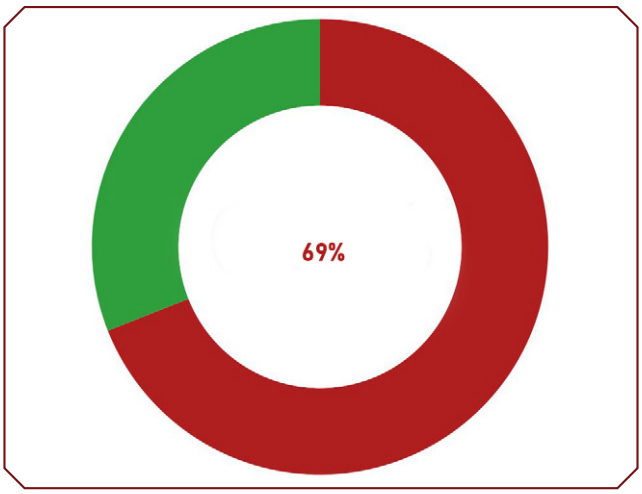
ESIC does not report reimbursements under Regulation 96-A as a separate line item; these expenses are included within the overall medical-benefit outlays, and *therefore, year-wise disbursal figures are not publicly available.*

The following analysis is based on SII's experiences of assisting injured workers in Haryana and Maharashtra, which do have some varying practices, but the key challenges are common and, in all likelihood, reflective of the process nationally.

5.1 69% IPs unaware about reimbursements, causing many IPs to miss benefits

Awareness of the reimbursement process and the documents required to submit a claim remains low among IPs. Across SII's community engagements, we have repeatedly found that many IPs are unaware of this benefit altogether.

Figure 5.1: Awareness of Reimbursements among FGD participants (IPs) in Haryana and Maharashtra (January 2026; n=48)

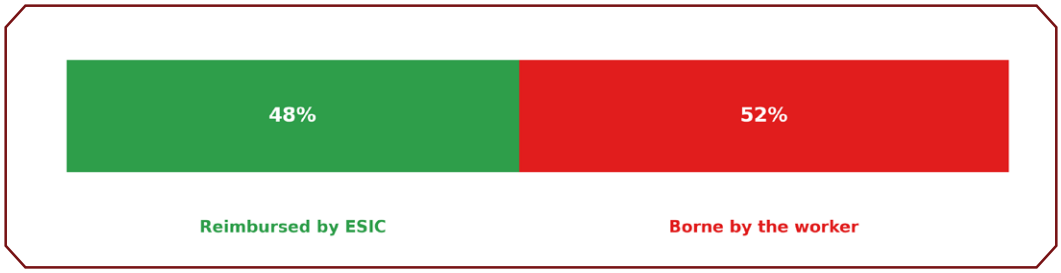


69% IPs unaware about reimbursements.

5.2 Average Reimbursement is Only 48% of the Bills

Where an IP is forced to take treatment outside an ESIC institution, reimbursement is capped at ESIC schedule rates, not the amount actually billed. The gap is borne by the worker. In a sample of 49 workers who claimed medical reimbursement, the mean recovery was 48% of the sum actually paid out of pocket; only 12% (6 of 49) were reimbursed in full.

Figure 5.2. Average Reimbursements (Haryana and Maharashtra- Sample Data)



The shortfall is concentrated in the highest-cost episodes, precisely the cases in which the family has the least capacity to absorb it.

Worker	Amount paid (₹)	Amount reimbursed (₹)	Recovered
Md. Zamir	3,70,849	1,60,000	43%
Pardeshi	2,09,000	87,000	42%

5.3 The Above Complex and Inefficient Processes and On-ground Challenges have led to 74% Bill Reimbursement claims not settled even after 6 months of submission.

5.3.1 ESIC's 2022 circular sets a 30-day turnaround for Reimbursements from the receipt of the bill

ESIC's Circular No. V-14/11/5/2012/Policy dated 25th April 2022 directed that medical reimbursements of IPs should be settled within 30 days from the receipt of the bill. This appears to be not applicable to the state governments, which process most reimbursements, but can be used as an indicative target.

5.3.2 Median IP assisted by SII received payments in 164 days (c.5.5 months) from the date of submission of bills

Figure 5.3. Time Taken for Reimbursements (Haryana and Maharashtra Data; Jan 2024-Dec 2025)

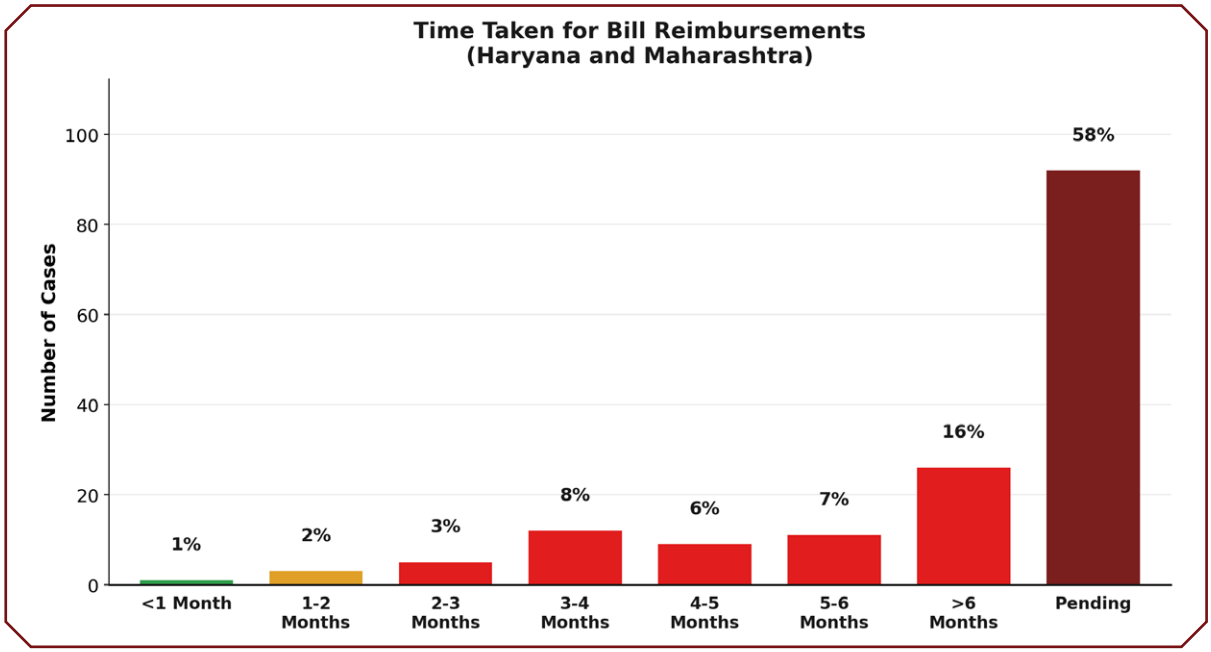
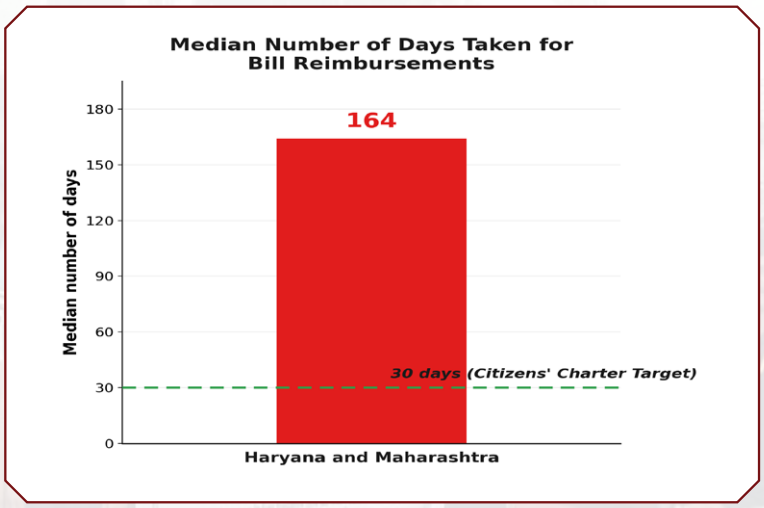


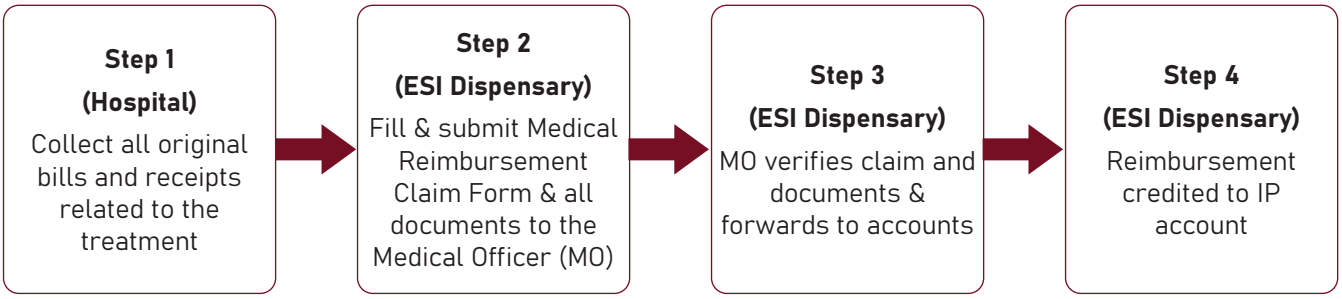
Figure 5.4. Median Number of Days Taken for Reimbursements (Haryana and Maharashtra Data) (only those reimbursed)



5.4 Procedural Complexity and Inadequate Documentation Practices Leading to Reimbursement Delays and Denials

5.4.1 Offline Submission Requires Dispensary Visits and Waiting, Causing Potential Wage Loss Regardless of Claim Size

Figure 5.5 Current defined process for submitting a Reimbursement request (Offline)



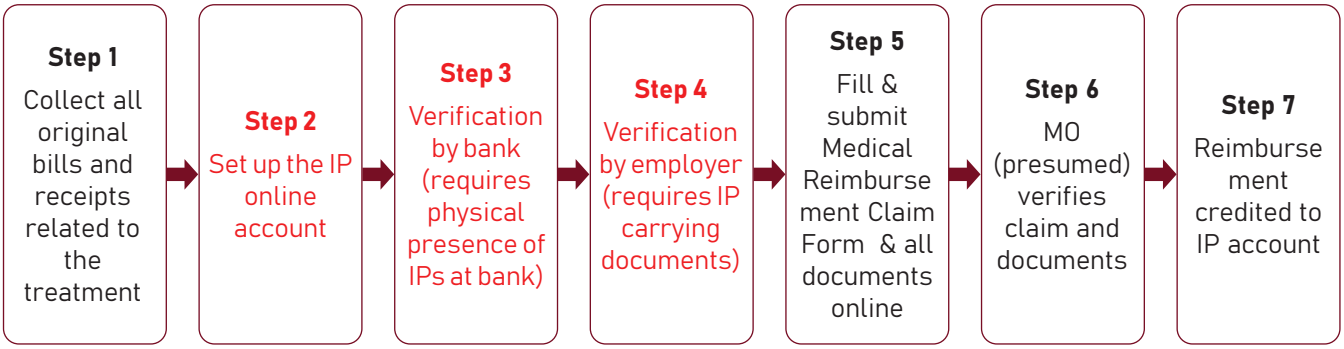
There are no visits to the BO for reimbursements, which makes the process less difficult for IPs,

c. 50% of workers supported by SII do not own a smartphone, making offline submission essential despite the availability of an online option.

Additionally, some dispensaries do not accept online applications from IPs. *The process requires IPs to visit ESIC dispensaries, wait in queues, and complete multiple manual steps, causing delays, inconvenience, and potential wage loss, especially for those living far from ESIC facilities.*

5.4.2 IPs have to go through a Complex Registration Process for First-Time Online Applications

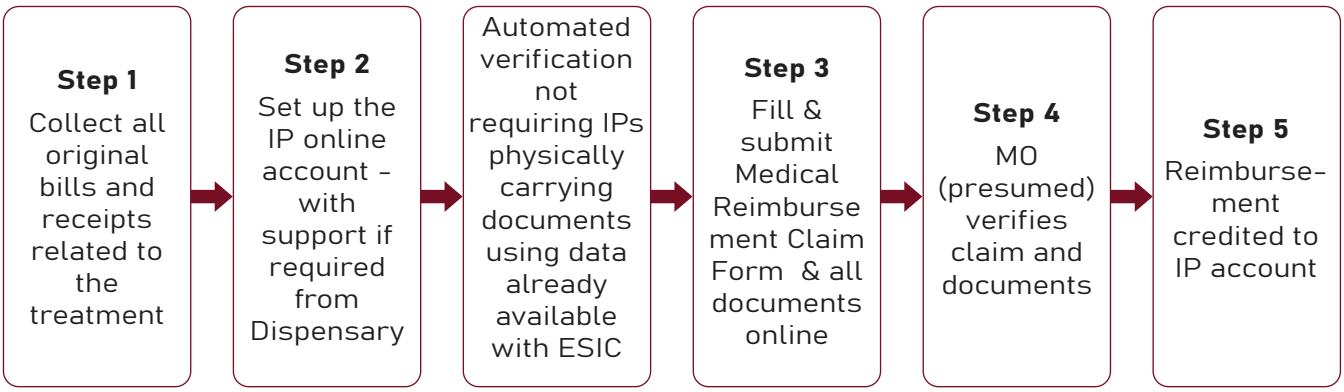
Figure 5.6 Current process for submitting a Reimbursement request (Online; First Time User)



In the online process, first-time applicants must set up their ESIC account by adding bank details and obtaining verification from both the bank and the employer, a time-consuming step requiring coordination among three parties. Once verified, bills can be uploaded, *but many IPs face barriers like poor internet access and limited ability to convert paper bills into a digital format (e.g., scanning).*



Figure 5.7 Recommended process for submitting a Reimbursement request (Online; First Time User)



5.4.3 Bank and Employer Verification Delays Online Registration

For first-time online reimbursement claims, the IP must register on the ESIC portal and link a bank account for payments (even though bank account linking is a step during registration). This also requires employer certification of the Account Number, a step that depends entirely on employer cooperation and can delay or stall the registration process for many.

5.4.4 Refusal by Employer to provide Accident Report halts IPD Claims Process

In In-Patient (IPD) cases of injury, the claim must include an Accident Report in addition to other documents. As this report is issued by the employer, refusal or inaction on their part can delay or completely prevent the IP from filing the claim.

See Chapters 2 and 11 for details on Accident Reports.

5.4.5 Sometimes Lack of Proper Referral Documentation from ESIC Doctors Leads to Claim Rejections

IPs often lack a valid "Not Available (N/A) Outpatient Department (OPD)" slip or "dispensary referral" slip, rendering their bill reimbursement claims ineligible. In many cases, ESIC doctors give verbal advice or write referrals on plain paper, and some referred facilities fail to return the official slip. Pressured to get timely treatment, IPs sometimes follow oral suggestions to use private hospitals, mistaking them for claimable referrals, which later end up in the "Non-Eligible" category.

5.4.6 Dispensaries use their own version of the Medical Reimbursement Claim Form instead of a Standard Form

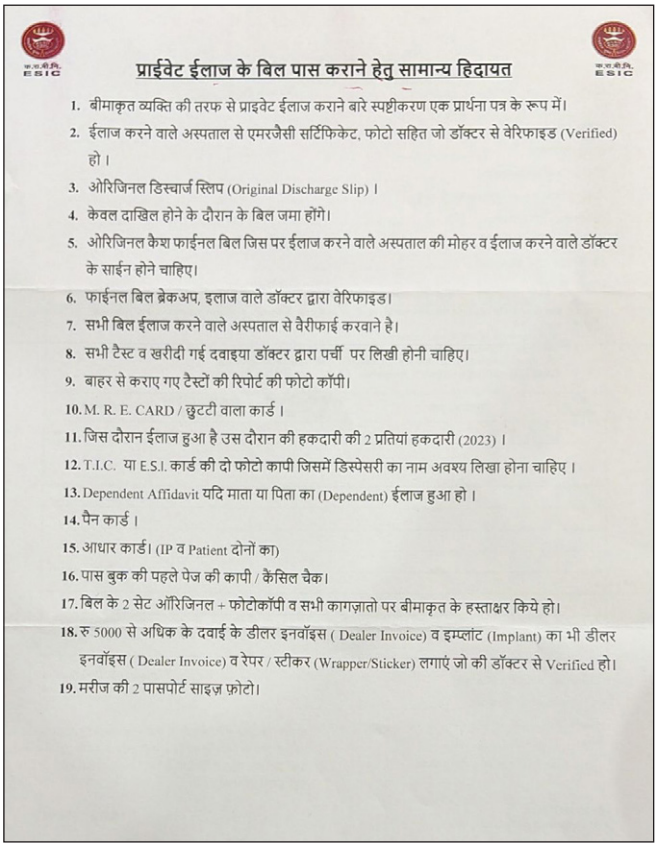
IPs have reported that some dispensaries insist on local, dispensary-specific forms and do not accept the standard forms available on the ESIC website. This lack of standardisation leads to duplicate form-filling, unnecessary back-and-forth, and avoidable rejections, raising time and cost burdens for IPs.

5.4.7 Reimbursement checklists are non-standardised across Branch Offices, run to 19 elements, and unreasonable demand documentation

Reimbursement checklists vary from one Branch Office to another: there is no single national list, and beneficiaries filing the same claim in two BOs face different documentary requirements. Every version we reviewed is long and procedurally demanding, up to 19 elements (forms and supporting documents) for inpatient reimbursement, and up to 12 for outpatient claims where medicines were unavailable at the dispensary.

Several requirements have no obvious diagnostic or audit purpose: among the more striking, beneficiaries are asked to submit the physical wrapper of the medicine as proof of purchase.

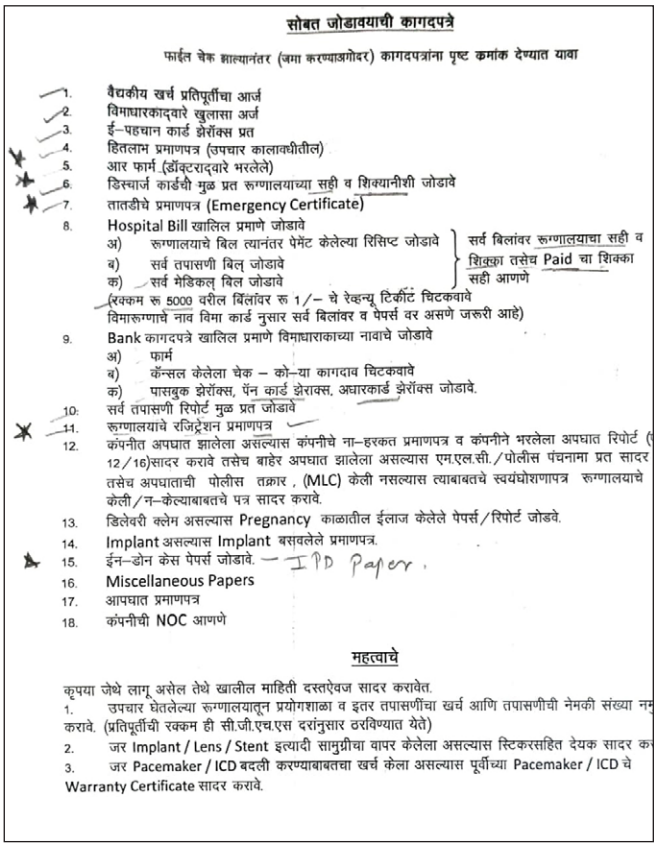
Image 5.1. Checklist for Hospitalisation (IPD) Reimbursement – Manesar Dispensary



प्राईवेट ईलाज के बिल पास कराने हेतु सामान्य हिदायत

1. बीमाकृत व्यक्ति की तरफ से प्राइवेट ईलाज कराने बारे स्पष्टीकरण एक प्रार्थना पत्र के रूप में।
2. ईलाज करने वाले अस्पताल से एमरजैंसी सर्टिफिकेट, फोटो सहित जो डॉक्टर से वेरिफाइड (Verified) हो।
3. ओरिजिनल डिस्चार्ज स्लिप (Original Discharge Slip)।
4. केवल दाखिल होने के दौरान के बिल जमा होंगे।
5. ओरिजिनल कैश फाईनल बिल जिस पर ईलाज करने वाले अस्पताल की मोहर व ईलाज करने वाले डॉक्टर के साईन होने चाहिए।
6. फाईनल बिल ब्रेकअप, इलाज वाले डॉक्टर द्वारा वेरिफाइड।
7. सभी बिल ईलाज करने वाले अस्पताल से वैरीफाई करवाने है।
8. सभी टैस्ट व खरीदी गई दवाइया डॉक्टर द्वारा पर्ची पर लिखी होनी चाहिए।
9. बाहर से कराए गए टैस्टों की रिपोर्ट की फोटो कॉपी।
10. M. R. E. CARD / छुटटी वाला कार्ड।
11. जिस दौरान ईलाज हुआ है उस दौरान की हकदारी की 2 प्रतियां हकदारी (2023)।
12. T.I.C. या E.S.I. कार्ड की दो फोटो कापी जिसमें डिस्पेसरी का नाम अवश्य लिखा होना चाहिए।
13. Dependent Affidavit यदि माता या पिता का (Dependent) ईलाज हुआ हो।
14. पैन कार्ड।
15. आधार कार्ड। (IP व Patient दोनों का)
16. पास बुक की पहले पेज की कापी / कैसिल चैक।
17. बिल के 2 सेट ऑरिजिनल + फोटोकॉपी व सभी कागज़ातो पर बीमाकृत के हस्ताक्षर किये हो।
18. रु 5000 से अधिक के दवाई के डीलर इनवॉइस (Dealer Invoice) व इम्प्लांट (Implant) का भी डीलर इनवॉइस (Dealer Invoice) व रेपर / स्टीकर (Wrapper/Sticker) लगाएं जो की डॉक्टर से Verified हो।
19. मरीज की 2 पासपोर्ट साइज़ फ़ोटो।

Image 5.2. Checklist for Hospitalisation (IPD) Reimbursement – Pune



सोबत जोडावयाची कागदपत्रे

फाईल चेक झाल्यानंतर (जमा करण्याअगोदर) कागदपत्रांना पृष्ट कमांक देण्यात यावा

1. वैद्यकीय खर्च प्रतिपूर्तीचा अर्ज
2. विमाधारकादवारे खुलासा अर्ज
3. ई–पहचान कार्ड झेरॉक्स प्रत
4. हितलाभ प्रमाणपत्र (उपचार कालावधीतील)
5. आर फार्म (डॉक्टरादवारे भरलेले)
6. डिस्चार्ज कार्डची मुळ प्रत रूग्णालयाच्या सही व शिक्यानीशी जोडावे
7. तातडीचे प्रमाणपत्र (Emergency Certificate)
8. Hospital Bill खालिल प्रमाणे जोडावे
   - अ) रूग्णालयाचे बिल त्यानंतर पेमेंट केलेल्या रिसिप्ट जोडावे
   - ब) सर्व तपासणी बिल जोडावे
   - क) सर्व मेडिकल बिल जोडावे

   } सर्व बिलांवर रूग्णालयाचा सही व शिक्का तसेच Paid चा शिक्का सही आणणे

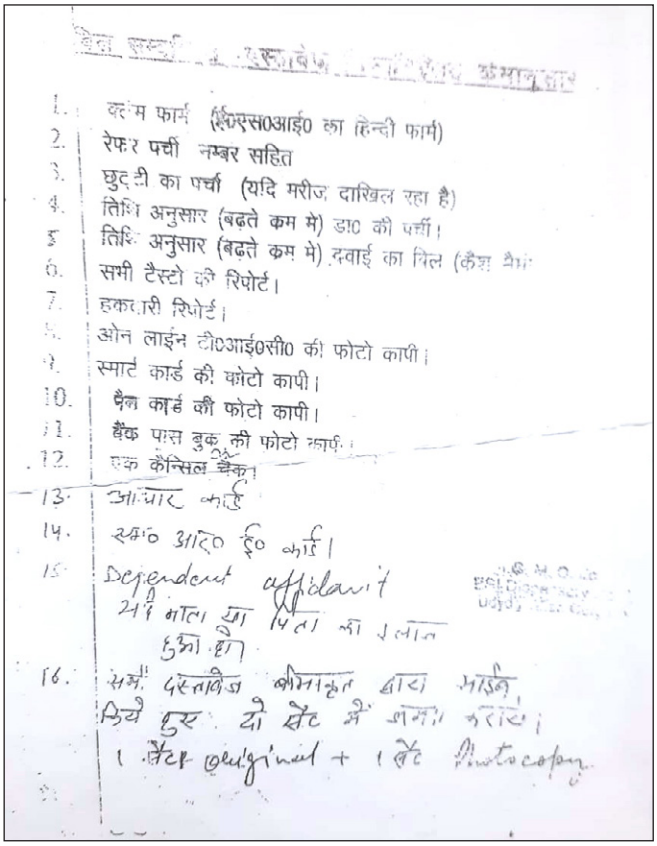
   (रक्कम रू 5000 वरील बिलांवर रू 1/– चे रेव्हन्यू टिकीट चिटकवावे
   विमारूग्णाचे नाव विमा कार्ड नुसार सर्व बिलांवर व पेपर्स वर असणे जरूरी आहे)
9. Bank कागदपत्रे खालिल प्रमाणे विमाधाराकाच्या नावाचे जोडावे
   - अ) फार्म
   - ब) कॅन्सल केलेला चेक – को–या कागदाव चिटकवावे
   - क) पासबुक झेरॉक्स, पॅन कार्ड झेरॉक्स, अधारकार्ड झेरॉक्स जोडावे.
10. सर्व तपासणी रिपोर्ट मुळ प्रत जोडावे
11. रूग्णालयाचे रजिट्रेशन प्रमाणपत्र
12. कंपनीत अपघात झालेला असल्यास कंपनीचे ना–हरकत प्रमाणपत्र व कंपनीने भरलेला अपघात रिपोर्ट (12/16)सादर करावे तसेच बाहेर अपघात आलेला असल्यास एम.एल.सी./पोलीस पंचनामा प्रत सादर तसेच अपघाताची पोलीस तक्रार, (MLC) केली नसल्यास त्याबाबतचे स्वयंघोशणापत्र रूग्णालयाचे केली/न–केल्याबाबतचे पत्र सादर करावे.
13. डिलेवरी क्लेम असल्यास Pregnancy काळातील ईलाज केलेले पेपर्स/रिपोर्ट जोडवे.
14. Implant असल्यास Implant बसवलेले प्रमाणपत्र.
15. ईन–डोन केस पेपर्स जोडावे. — IPD Paper.
16. Miscellaneous Papers
17. आपघात प्रमाणपत्र
18. कंपनीची NOC आणणे

महत्वाचे

कृपया जेथे लागू असेल तेथे खालील माहिती दस्तऐवज सादर करावेत.

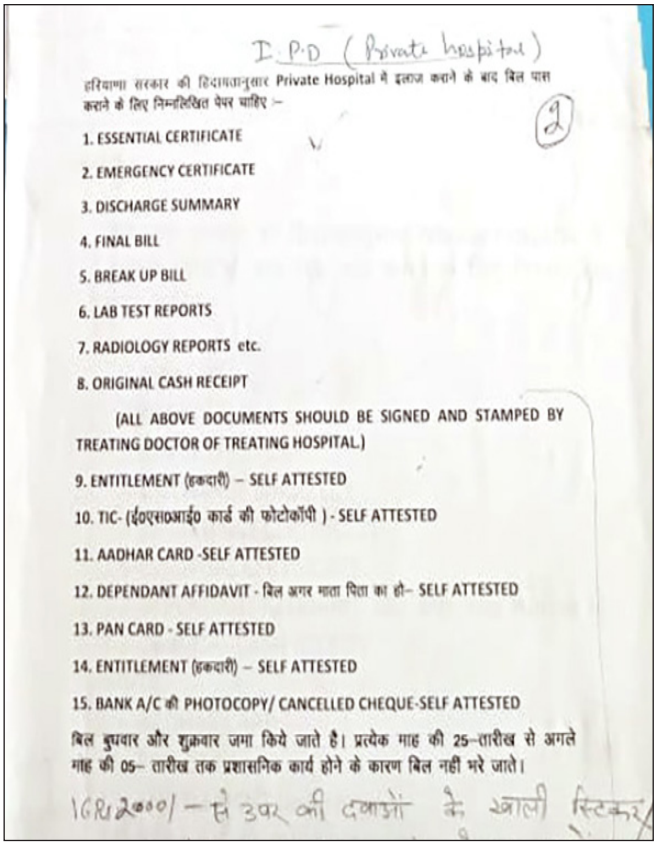
1. उपचार घेतलेल्या रूग्णालयातून प्रयोगशाळा व इतर तपासणींचा खर्च आणि तपासणीची नेमकी संख्या नम् करावे. (प्रतिपूर्तीची रक्कम ही सी.जी.एच.एस दरांनुसार ठरविण्यात येते)
2. जर Implant / Lens / Stent इत्यादी सामुग्रीचा वापर केलेला असल्यास स्टिकरसहित देयक सादर क
3. जर Pacemaker / ICD बदली करण्याबाबतचा खर्च केला असल्यास पूर्वीच्या Pacemaker / ICD चे Warranty Certificate सादर करावे.

Image 5.3. Checklist for Hospitalisation (IPD) Reimbursement – Udyog Vihar Dispensary, Gurugram



1. क्लेम फार्म (ई0एस0आई0 का हिन्दी फार्म)
2. रेफर पर्ची नम्बर सहित
3. छुट्टी का पर्चा (यदि मरीज दाखिल रहा है)
4. तिथि अनुसार (बढ़ते कम मे) डा0 की पर्ची।
5. तिथि अनुसार (बढ़ते कम मे) दवाई का बिल (कैश मैमो
6. सभी टैस्टो के रिपोर्ट।
7. हकदारी रिपोर्ट।
8. ओन लाईन टी0आई0सी0 की फोटो कापी।
9. स्मार्ट कार्ड की फोटो कापी।
10. पैन कार्ड की फोटो कापी।
11. बैंक पास बुक की फोटो कापी।
12. एक कैंसिल चैक।
13. आधार कार्ड
14. स्मा0 आई0 ई0 कार्ड।
15. Dependent affidavit
    यदि माता या पिता का क्लेम
    हुआ हो।
16. सभी दस्तावेज बीमाकृत द्वारा साईन किये हुए दो सैट में जमा कराये।
    1 सैट Original + 1 सैट Photocopy

Image 5.4. Checklist for Hospitalisation (IPD) Reimbursement – Sector 8, Faridabad



I.P.D (Private hospital)

हरियाणा सरकार की हिदायतानुसार Private Hospital से इलाज कराने के बाद बिल पास कराने के लिए निम्नलिखित पेपर चाहिए :–

1. ESSENTIAL CERTIFICATE
2. EMERGENCY CERTIFICATE
3. DISCHARGE SUMMARY
4. FINAL BILL
5. BREAK UP BILL
6. LAB TEST REPORTS
7. RADIOLOGY REPORTS etc.
8. ORIGINAL CASH RECEIPT

(ALL ABOVE DOCUMENTS SHOULD BE SIGNED AND STAMPED BY TREATING DOCTOR OF TREATING HOSPITAL.)

9. ENTITLEMENT (हकदारी) – SELF ATTESTED
10. TIC- (ई0एस0आई0 कार्ड की फोटोकॉपी) - SELF ATTESTED
11. AADHAR CARD -SELF ATTESTED
12. DEPENDANT AFFIDAVIT - बिल अगर माता पिता का हो– SELF ATTESTED
13. PAN CARD - SELF ATTESTED
14. ENTITLEMENT (हकदारी) – SELF ATTESTED
15. BANK A/C की PHOTOCOPY/ CANCELLED CHEQUE-SELF ATTESTED

बिल बुधवार और शुक्रवार जमा किये जाते है। प्रत्येक माह की 25–तारीख से अगले माह की 05– तारीख तक प्रशासनिक कार्य होने के कारण बिल नहीं भरे जाते।

16 से 2000/– से उपर की दवाओं के खाली स्टिकर

Image 5.5. Checklist for Medicines (OPD) Reimbursement – Sector 6 Dispensary, Faridabad

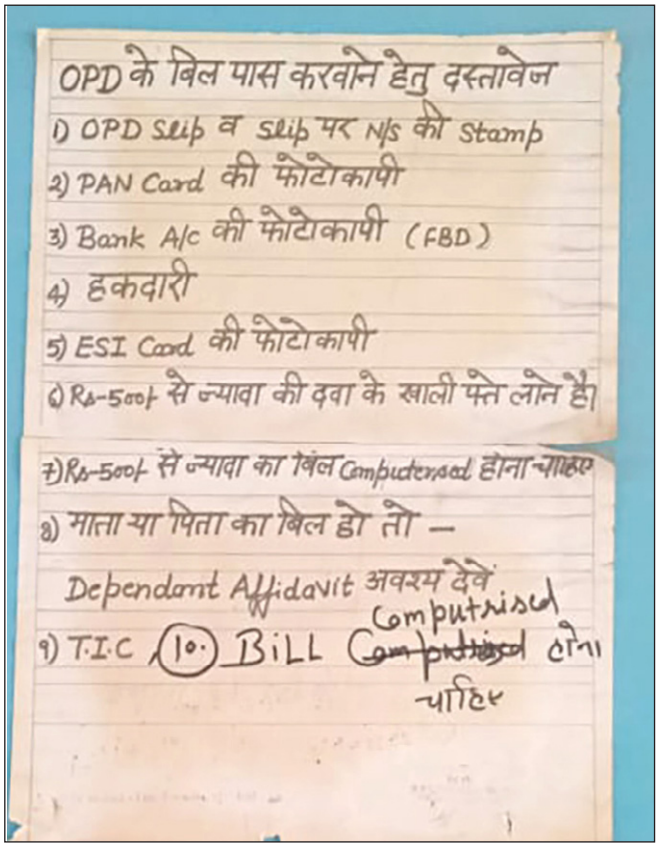


Image 5.6. Checklist for Medicines (OPD) Reimbursement – Sector 55 Dispensary, Faridabad

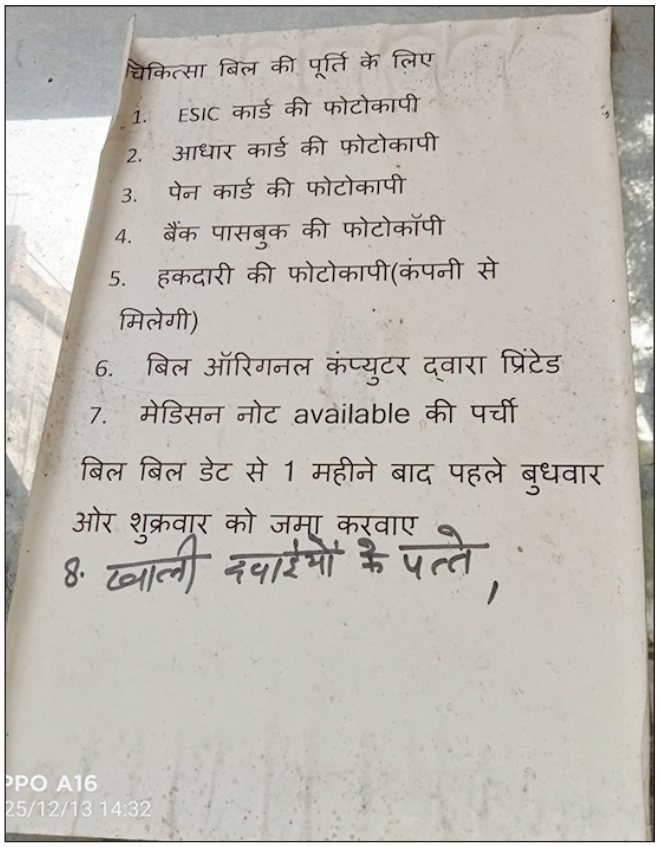


Image 5.7. Checklist for Medicines (OPD) Reimbursement – Sector 8, Faridabad

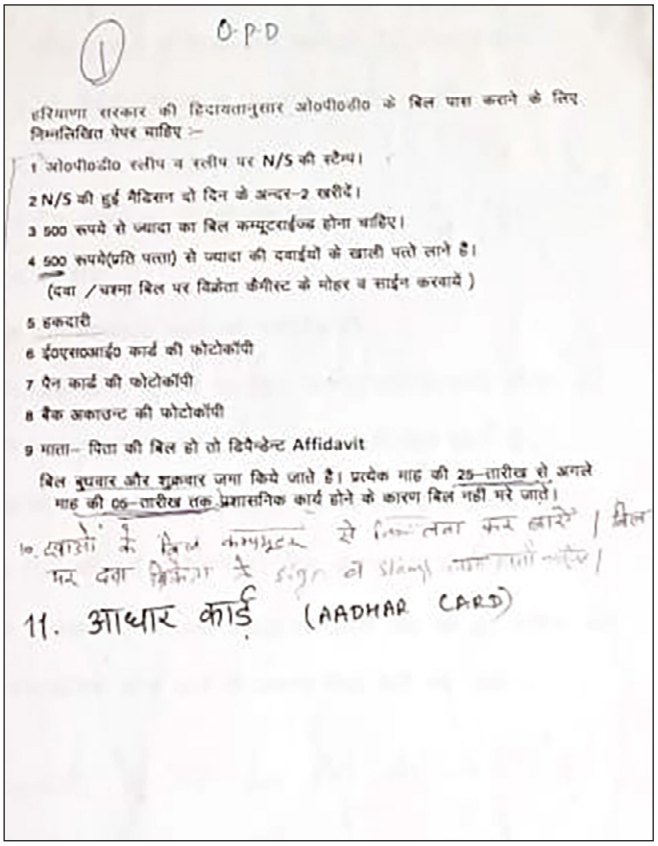
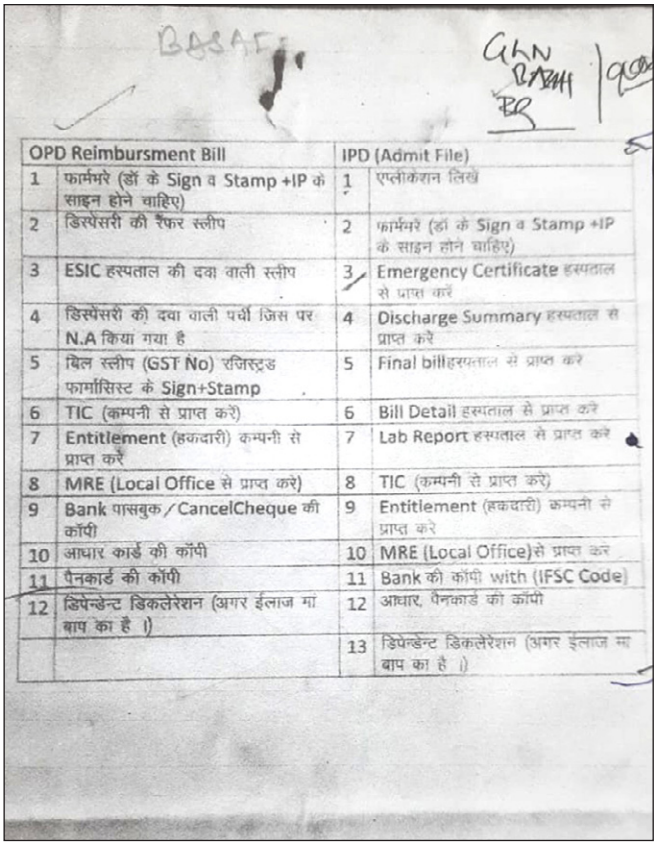
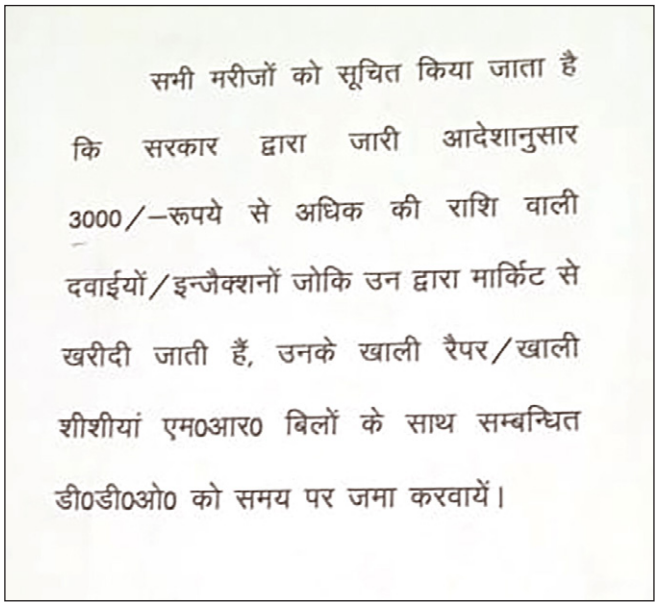


Image 5.8. Checklists for IPD & OPD Reimbursement – Basai Dispensary, Gurugram



OPD Reimbursment Bill		IPD (Admit File)	
1	फार्मभरे (डॉ के Sign व Stamp +IP के साइन होने चाहिए)	1	एप्लीकेशन लिखे
2	डिस्पेंसरी की रैफर स्लीप	2	फार्मभरे (डॉ के Sign व Stamp +IP के साइन होने चाहिए)
3	ESIC हस्पताल की दवा वाली स्लीप	3	Emergency Certificate हस्पताल से प्राप्त करें
4	डिस्पेंसरी की दवा वाली पर्ची जिस पर N.A किया गया है	4	Discharge Summary हस्पताल से प्राप्त करें
5	बिल स्लीप (GST No) रजिस्ट्रड फार्मासिस्ट के Sign+Stamp	5	Final billहस्पताल से प्राप्त करें
6	TIC (कम्पनी से प्राप्त करें)	6	Bill Detail हस्पताल से प्राप्त करें
7	Entitlement (हकदारी) कम्पनी से प्राप्त करें	7	Lab Report हस्पताल से प्राप्त करें
8	MRE (Local Office से प्राप्त करें)	8	TIC (कम्पनी से प्राप्त करें)
9	Bank पासबुक/CancelCheque की कॉपी	9	Entitlement (हकदारी) कम्पनी से प्राप्त करें
10	आधार कार्ड की कॉपी	10	MRE (Local Office)से प्राप्त करें
11	पैनकार्ड की कॉपी	11	Bank की कॉपी with (IFSC Code)
12	डिपेन्डेन्ट डिकलेरेशन (अगर ईलाज मां बाप का है ।)	12	आधार, पैनकार्ड की कॉपी
		13	डिपेन्डेन्ट डिकलेरेशन (अगर ईलाज मां बाप का है ।)

Image 5.9. Notice on Requirement of Medicine Wrappers for Reimbursements – No. 6 Dispensary, Faridabad



सभी मरीजों को सूचित किया जाता है कि सरकार द्वारा जारी आदेशानुसार 3000/–रूपये से अधिक की राशि वाली दवाईयों/इन्जैक्शनों जोकि उन द्वारा मार्किट से खरीदी जाती हैं, उनके खाली रैपर/खाली शीशीयां एम0आर0 बिलों के साथ सम्बन्धित डी0डी0ओ0 को समय पर जमा करवायें।

Delays in Reimbursements due to Reimbursements being primarily handled by State Governments

In the four states with an ESI Society (Maharashtra, Chhattisgarh, Tripura, J&K), ESIC transfers funds directly to the society's ring-fenced account, which disburses reimbursements autonomously.

Everywhere else, including Haryana, funds enter the state Consolidated Fund, and disbursement is gated by the state Finance Department's treasury, appropriation limits, fungibility with general revenue, year-end lapse, and cash-management holds.

In both models, reimbursements are delayed. Maharashtra reimburses faster than Haryana (median 144 vs 193 days), but both are well above the standards set for reimbursements.

The same bottleneck starves in-kind delivery: drugs, diagnostics, and staffing. Please refer to Chapter 6.

5.5 Recommendations

5.5.1 Improve turnaround time for IPs in line with ESIC's Citizens' Charter and extend service standards to reimbursements made by the State Government/ESIS

5.5.2 Re-engineer First-Time Online Registration and Bank Verification Process based on IP Experience

5.5.3 Introduce significant penal provisions for employers not submitting Accident Reports for reimbursement claims

5.5.4 Provide an online assistance facility to help IPs who are not digitally savvy with account setup, form filling, and submission.

5.5.5 Remove the step for adding bank verification for first-time online applicants where bank details are already available; use details collected during registration

5.5.6 Remove the step for verification by the employer for first-time online applicants

5.5.7 Ensure Proper Referral Documentation by ESI Doctors – Mandate that all referrals and Not Available (N/A) OPD slips be issued in both digital and hard copy formats (standardised) through the ESIC system, automatically stored in the IP's online account

5.5.8 Introduce a standardised 'Non-Availability Certificate' for cases where services such as medicines and diagnostic tests (e.g., ultrasound scans) cannot be provided. This certificate could be given to the IP, who can then attach it to the external provider's bill and submit for reimbursement.

5.5.9 Form ESI Societies in all states, to remove the treasury bottleneck for both reimbursement and delivery.

5.5.10 Sever the rate cap from the cases where ESIC was not able to deliver timely treatment.

Where an IP is treated outside because ESIC could not provide the care (emergency, facility closed, treatment or drug unavailable, or a referral out), reimburse the actual billed amount, subject to a certificate of non-availability/referral and a reasonableness check against a defined ceiling for the procedure at an empanelled hospital.

5.5.11 Branch Offices should issue a printed, standardised, and simplified reimbursement checklist.

Every Branch Office should hand beneficiaries a printed checklist setting out all the documents and steps required to file a reimbursement claim.

The checklist must be standardised nationally, and it must be simplified, pared down to what is genuinely needed to verify the claim, with the extraneous items presently demanded removed.

Dilip Kumar, from Siddharthnagar, Uttar Pradesh



Dilip Kumar works in the auto sector in Mahindra's supply chain.On 30 August 2023, he was seriously injured in a road accident, with hospital expenses of around ₹4,33,000. He handed all documents to his contractor to file for Benefit Reimbursement (BR) from ESIC. For over a year, the contractor claimed the file was "in progress." Eventually, he told Dilip that ESIC had rejected the claim and advised him to drop the matter. When SII took up the case, it emerged that the documents had never been submitted to the BR section at ESIC Hospital, Mohan Nagar. With repeated pressure, Dilip recovered the original file from the contractor's office. By then, ESIC Mohan Nagar refused to accept it, citing the two-year time bar. SII raised the case at a Suvidha Samagam, and on the BR section's advice, prepared a condonation request to the RO Commissioner, Mumbai. The file was resubmitted in October 2025 and accepted. On 5 March 2026, Dilip received ₹1,63,110 in BR benefit.

CHAPTER 6

ESI Medical Coverage: Infrastructure and service quality needs to keep pace with rising IP enrolments



Over the last decade, ESIC has brought millions more insured persons (IPs) and their families under its umbrella. The number of IPs nearly doubled (≈1.95×), from 1.96 Cr. in 2013–14 to 3.84 Cr. in 2024–25, while the number of beneficiaries went from 7.58 Cr. To 14.91 Cr.

When services are available, ESI hospitals offer among the lowest patient spend for admissions (details later in this chapter), the empanelled network helps plug super-speciality gaps, and there are pockets of high utilisation that show what's possible.

Yet the everyday experience of care has not improved commensurately: infrastructure limitations, staff gaps, and missing first-line diagnostics; hospital admissions are uneven, with super-speciality needs routinely pushed outside the network and "cashless" care often partial in practice. Stock-outs of essential medicines and tests force avoidable referrals and out-of-pocket spending, while facilities remain clustered in older industrial zones that no longer match where workers live and work.

This chapter takes a service-delivery lens: (1) OPD (dispensaries and hospital OP), (2) IPD (including super-speciality and referrals), (3) Diagnostics & Medicines (availability and purchasing), and (4) Access & Accountability enablers, so coverage translates into real, reliable care.

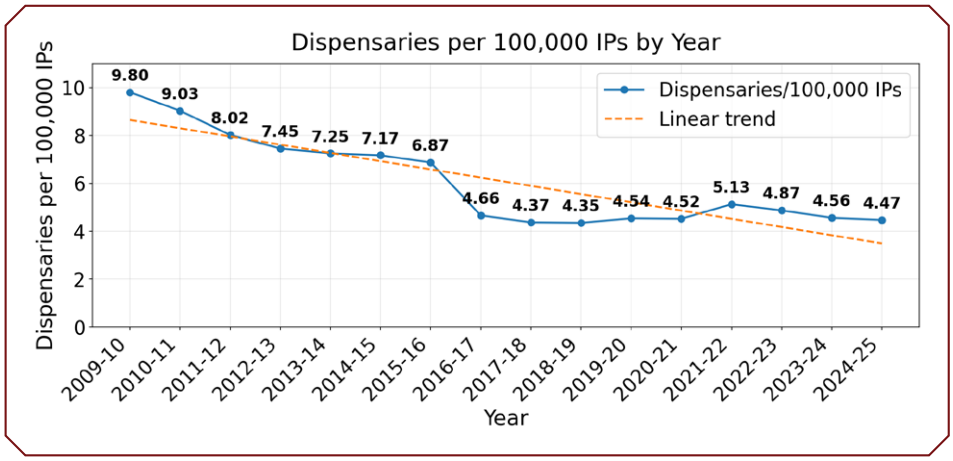
Note: Across this chapter, national data and data for the top 5 states (based on ESI enrolment) have been presented.

6.1 Dispensary facilities and staffing haven't kept pace with the increase in IP enrolment: leading to poorer dispensary experience and higher out-of-pocket expenses for IPs

6.1.1 The number of dispensaries has increased, but hasn't kept pace with the rise in IPs; drop from 9.80 to 4.47 dispensaries per 100,000 IPs over 15 years; half of ESIC's norm

The number of dispensaries increased from 1,402 to 1,719 (+23%) in the 15 years from 2009-10 to 2024-25, but the increase hasn't kept pace with the increase in the number of IPs. The national availability of ESIC dispensaries declined from 9.80 per 100,000 IPs in 2009–10 to 4.47 per 100,000 IPs in 2024–25. The trendline is downward over the last 15 years.

Figure 6.1: No. of dispensaries per 100,000 IPs from 2009-10 to 2024-25

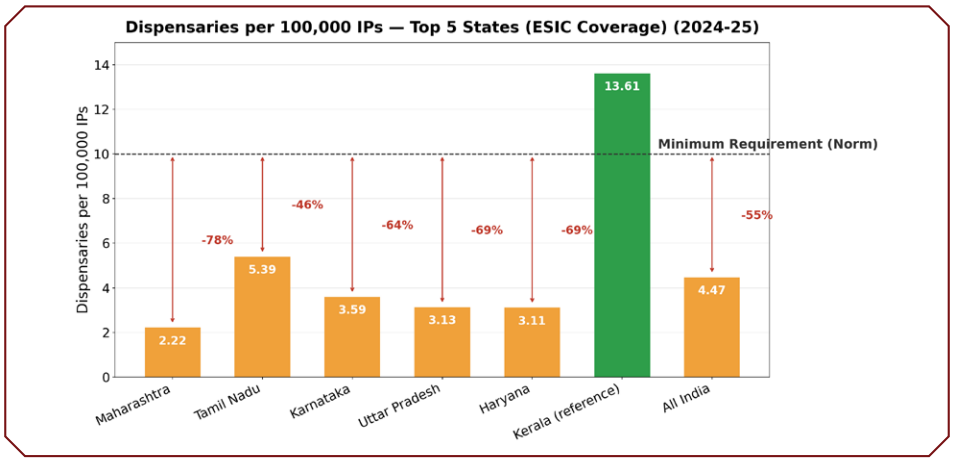


ESIC prescribes staffing thresholds per dispensary (e.g., a 2-doctor dispensary for 3,000 IPs; 3-doctor dispensary for 5,000 IPs; 5-doctor dispensary for 10,000 IPs). *Taking the most conservative threshold, i.e., 1 dispensary per 10,000 IPs, the implied requirement is 10 dispensaries per 100,000 IPs. Against this proxy (since ESIC has no standard for total dispensaries per IPs), the all-India level of 4.47; half of ESIC's own norm.*

There are pronounced state differences. Maharashtra, Haryana, Uttar Pradesh, and Karnataka are below the national average (4.47), while Tamil Nadu (5.39) is slightly above the national level.

Additionally, Maharashtra has 502 IMPs (Insurance Medical Practitioners), down from 530 in 2023-24, who are allowed to register up to 2000 IP family units.

Figure 6.2: No. of dispensaries per 100,000 IPs for Top 5 States (ESIC Coverage) (2024-25)



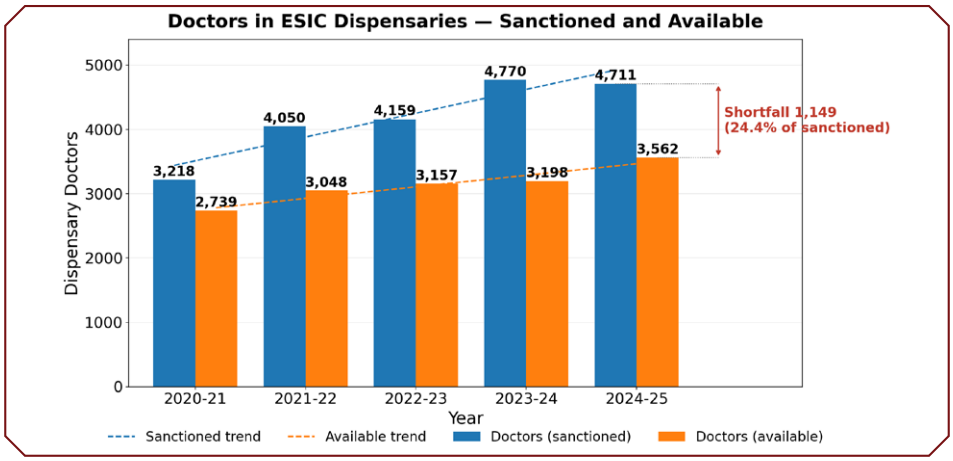
Note: Kerala is used as a reference across the chapter because it provides a feasible upper bound for ESIC service availability.

Estimated shortage of c.2100 dispensaries

6.1.2 Doctors in ESI dispensaries: sanctioned strength and hiring have increased, but the gap has widened

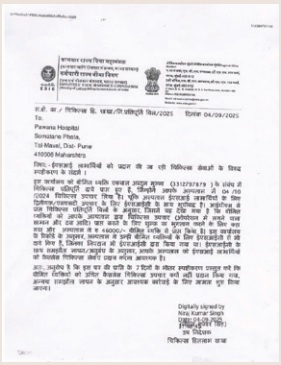
Sanctioned doctors per dispensary have improved across the five years for which data are available (rising from roughly 2.10 to 2.74), but on-the-ground availability has plateaued at two doctors per dispensary (≈2.07), limiting service capacity and, by extension, care quality. This is however a slight improvement over 2023-24 ((≈1.89)

Figure 6.3: Dispensary doctors – Sanctioned and Available (2020-21 to 2024-25)



Iqbal Mulla

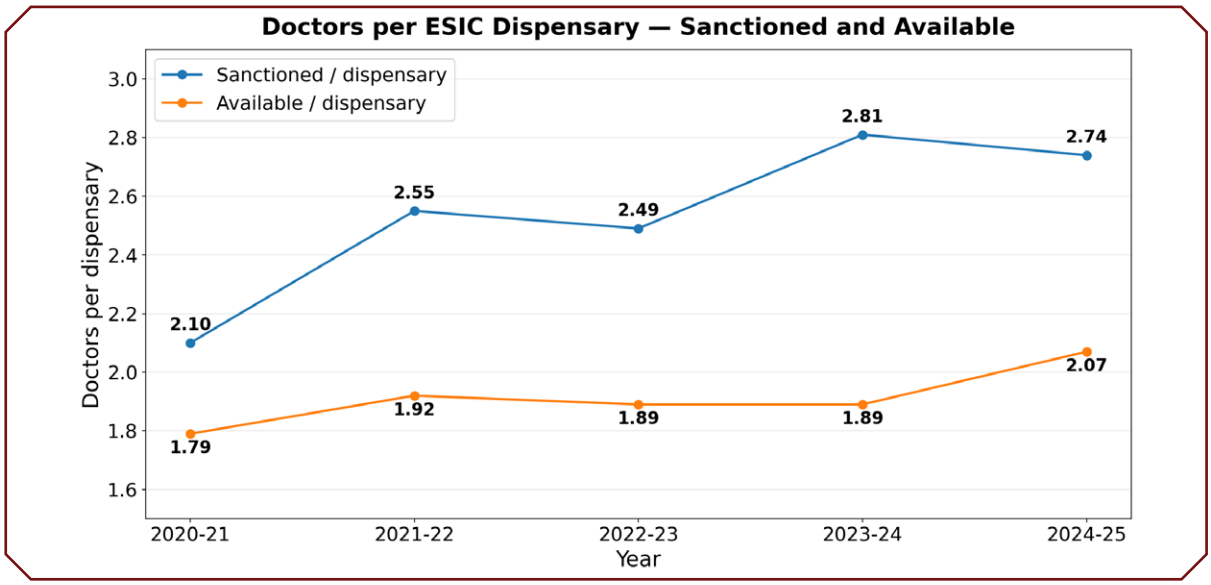




Iqbal Mulla underwent heart bypass surgery at Pawana Hospital, an ESIC panel hospital. As a panel hospital, Pawana should have provided the full treatment free of charge to an ESIC-insured worker. Instead, the hospital charged him ₹46,000 during the course of treatment.

SII took the matter to a Suvidha Samagam and subsequently filed a complaint on CPGRAMS. ESIC RO Mumbai has since issued a notice to the hospital.

Figure 6.4: Dispensary doctors – Sanctioned/Dispensary and Available/Dispensary (2020-21 to 2024-25)

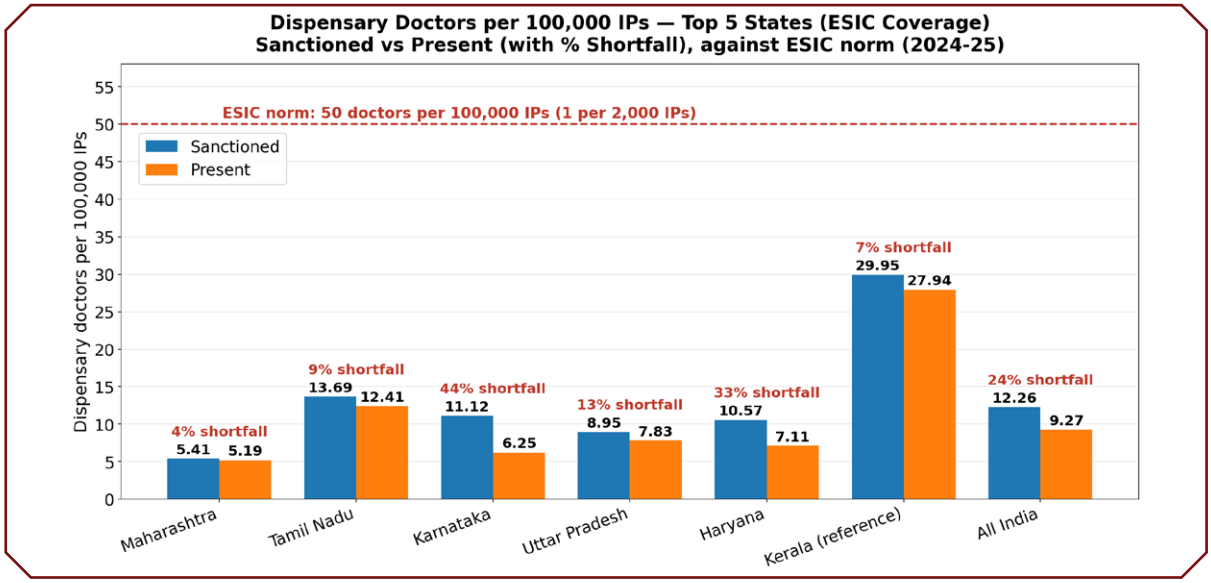


In 2024–25, the all-India ESI dispensary-doctor density stood at 9.27 available doctors vs 12.26 sanctioned doctors per 100,000 IPs, a 24% shortfall relative to sanctioned posts.

Using the conservative proxy (5 doctors per 10,000 IP dispensary and therefore, 50 doctors per 100,000 IPs), availability meets only 19% of need, and even sanctioned strength reaches just 25%.

Severe shortages persist in Karnataka (6.25), Haryana (7.11), and Uttar Pradesh (7.83); each <20% of this benchmark.

Figure 6.5: No. of dispensary doctors per 100,000 IPs (sanctioned and available) for Top 5 States (ESIC Coverage) (2024-25)



Shortfall indicated is the difference between doctors sanctioned and present.

Note: Including the 502 IMPs (not present in other states), Maharashtra will have 15.40 doctors per 100,000 IPs.

6.1.3 From 2013 to 2025: CAG-flagged ESIC dispensary issues persist

What CAG flagged (2013): The national auditor documented basic infrastructure gaps in multiple ESIC facilities, e.g., dispensaries in Chandigarh with inadequate space, and several Rajasthan dispensaries with unsafe buildings (defective wiring; broken walls/doors/windows). At ESIC Hospital, Noida, OPDs were being run from the small remaining portion of an old, partially demolished building because the new hospital block had no OPD provision, causing overcrowding.

Table 6.1. Infrastructure Issues from 10 Dispensaries across Haryana and Maharashtra – 9 out of 10 didn't have power backup.

Sl. No.	RO/SRO	Dispensary	Power Backup
1	Gurugram	Basai Road	No Power Backup
2	Gurugram	Khekhri Daula	No Power Backup
3	Gurugram	Dispensary No 1	No Power Backup
4	Gurugram	Daulatabad	No Power Backup
5	Gurugram	Manesar	Available
6	Faridabad	Jawahar Colony	No Power Backup
7	Faridabad	Sector 8	No Power Backup
8	Pune	Bhosari	No Power Backup
9	Pune	Chinchwad	No Power Backup
10	Pune	Chakan	No Power Backup

Based on information collected by the SII team from IPs.

2025 case study (Manesar) – Improvements since SII report: Safe in India's 2025 ESIC ki Baat Aapke Saath series report on the ESI Manesar dispensary highlights poor infrastructure and cleanliness, understaffing (often one doctor for 150–200 patients present), long registration queues, and frequent medicine shortages, indicating that core problems remain at the dispensary level. After the release of this report, significant improvements in infrastructure have thankfully been initiated at the Manesar dispensary. *Please check out the case study at the end of this chapter.*

6.1.4 ESI provides lowest out-of-pocket costs for outpatient IPs, compared to private and even other government facilities

ILO's 2022 survey shows that, nationally, fewer than half of insured persons' OP visits occur at ESI facilities, reflecting barriers of distance, doctor availability, wait times, and facility conditions, and patterns vary widely by state. (ILO 2022 Survey)

Figure 6.6. Utilisation of out-patient care by types of facilities across states (ILO 2022).

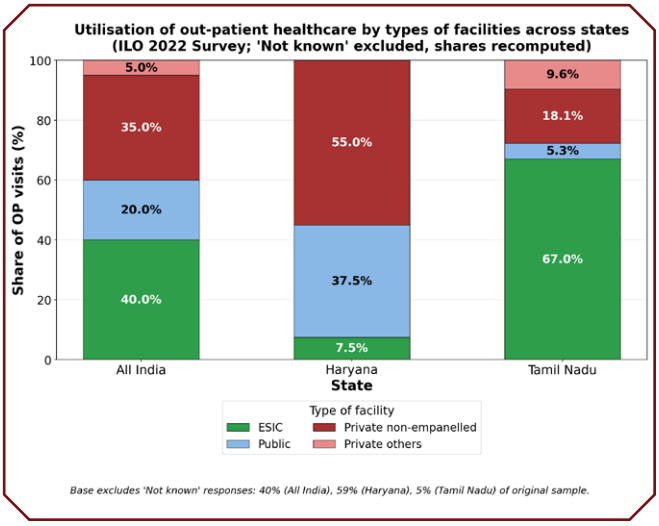
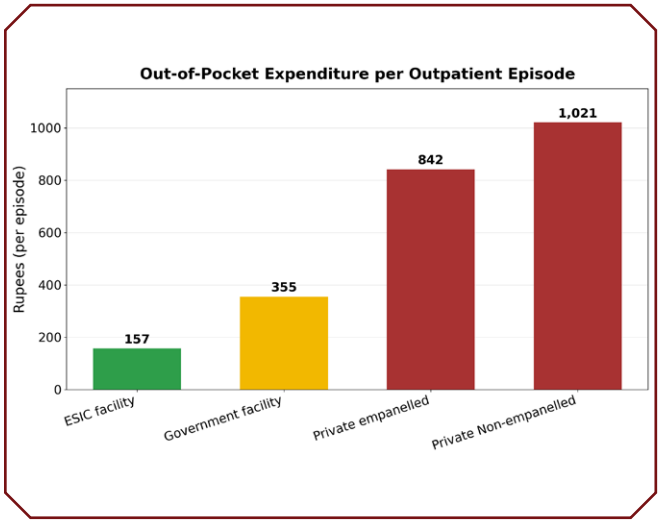


Figure 6.7: Out-of-pocket spending per OP episode



When ESI can't be used, out-of-pocket costs jump; private non-empanelled ≈6× (₹1,021) and private empanelled ≈5× (₹842) versus ESIC (₹157); even government facilities ≈2× (₹355).

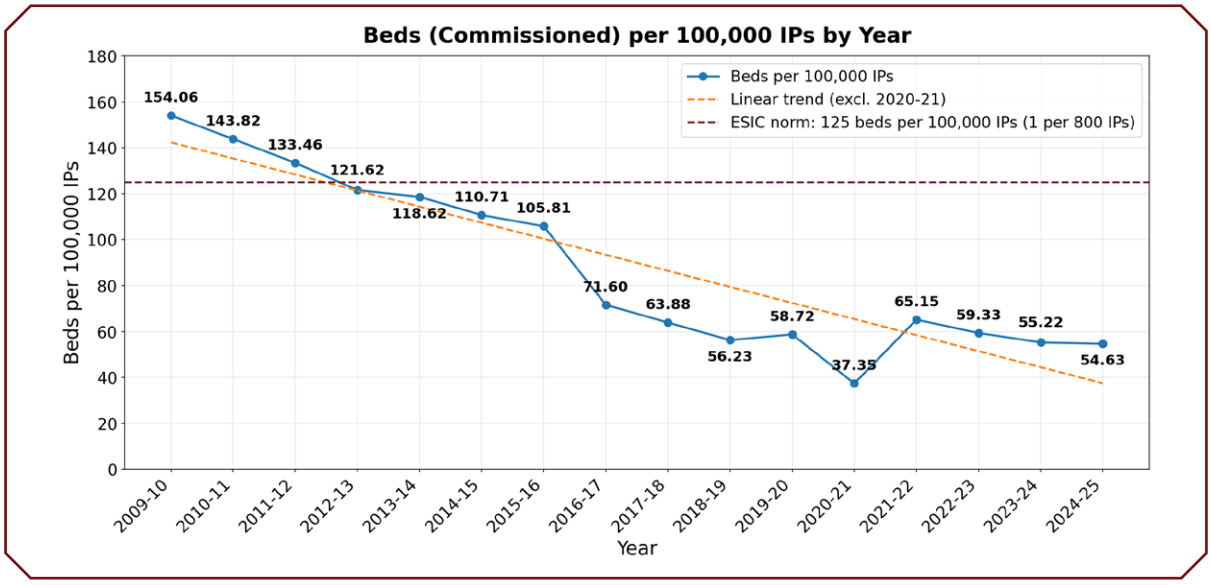
6.2 ESIC & ESIS hospitals: beds, staffing, and specialist service gaps persist

6.2.1: The number of hospital beds hasn't kept pace with the rise in IPs; Shortfall at 56% against norm – 125 beds per 100,000 IPs

Section 40 of the Social Security Code (Section 58 of the ESI Act earlier) places a duty on state governments (with ESIC support) to provide 'reasonable' medical treatment. The CAG (in 2013) had flagged widespread bed shortages in ESIC/ESIS hospitals. A decade later, the data shows that gaps persist.

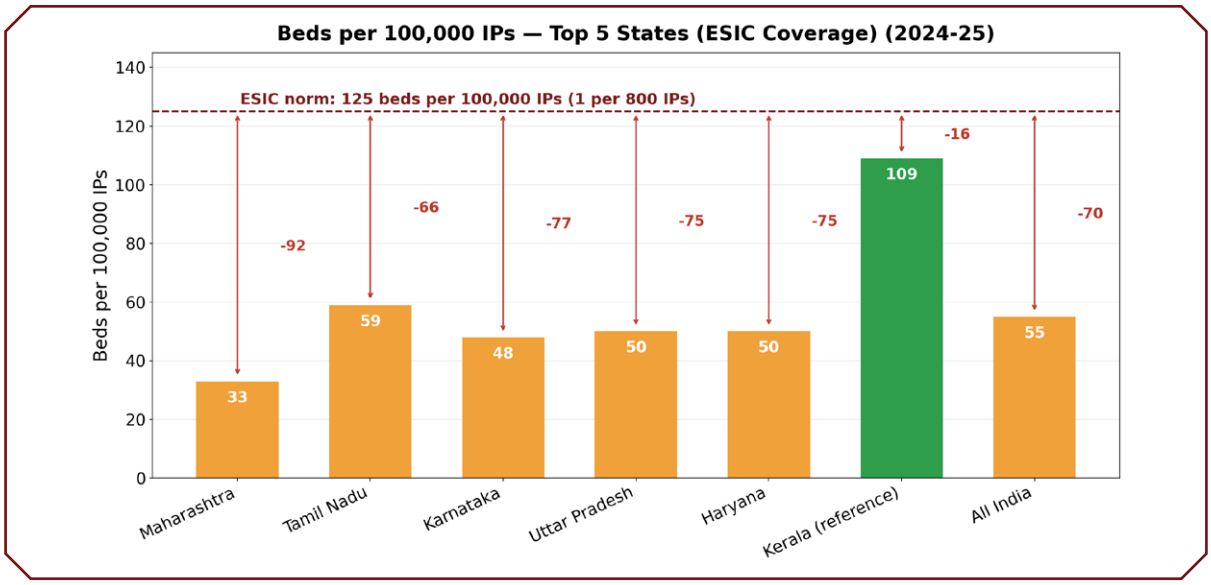
The national availability of commissioned beds in ESIC/ESIS hospitals declined from 154 per 100,000 IPs in 2009-10 to 55 in 2024–25. The trendline is downward over the last 15 years.

Figure 6.8: Commissioned beds in ESIC and ESIS hospitals per 100,000 IPs from 2009-10 to 2024-25



Against the conservative norm of 125 beds per 100,000 IPs (ESIC expresses hospital sizing as IP thresholds, e.g., 250 beds for 200,000 IPs. Taking the most conservative tier, the implied requirement is 125 beds per 100,000 IPs), the all-India level is at 44% of need (shortfall ≈ 70). Most large states remain far below the benchmark.

Figure 6.9: Commissioned beds in ESIC and ESIS hospitals per 100,000 IPs for Top 5 States (ESIC Coverage) (2024-25)



Estimated shortage of c.27000 hospital beds.

SII case study (Pune): Safe in India's case study on the ESIS hospital at Mohan Nagar, Pune, highlights poor infrastructure and lack of diagnostic equipment as an example of quality issues with ESI hospitals. Please check the box on the topic at the end of this chapter.

ESIC currently has 105 new hospitals in the pipeline (in-principle approvals), which, once commissioned, should materially expand capacity and help narrow the shortfall.

Much-awaited Sriperumbudur ESI Hospital opens in July 2026

Sriperumbudur ESI Hospital: In Sriperumbudur, an important automobile and industrial hub, there was no ESI hospital, and IPs often depended on ESI facilities in Chennai city for hospital care. The 100-bedded ESIC hospital at Sriperumbudur, inaugurated in July 2026, is therefore a significant step toward bringing care closer to the area where many workers are employed. This should help address part of the current access gap.



6.2.2: ESIC (centrally run) & ESIS (state run) doctors: increased by 8% and 17% respectively; availability still below sanctioned; reduction in sanctioned posts post 2022-23

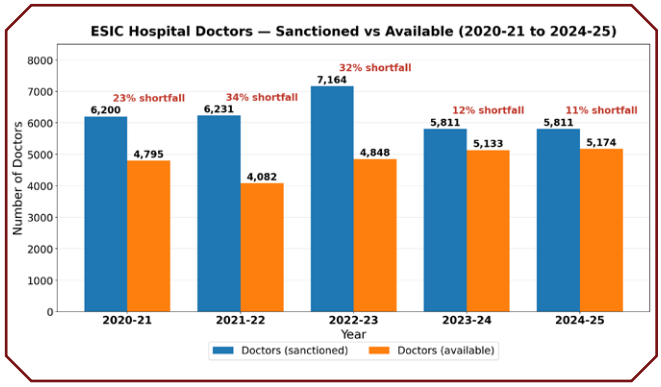
What CAG flagged (2013): The national auditor had highlighted that vacancies were substantial - 41% for specialists and 22% for GDMOs, contributing to referrals and service gaps.

The underlying availability gap remains.

In 2024–25, the shortfall of doctors was 11% in ESIC hospitals and 19% in ESIS hospitals. When availability (in 2024-25) is benchmarked to 2022-23's sanctioned strength, the gap is larger at 28% and 22%. The pattern holds across ESIC and ESIS systems and across several large states, indicating a persistent, system-wide constraint rather than an isolated issue.

In the last 5 years, sanctioned capacity in ESIC hospitals reduced by 6% although doctor availability did increase by 8%.

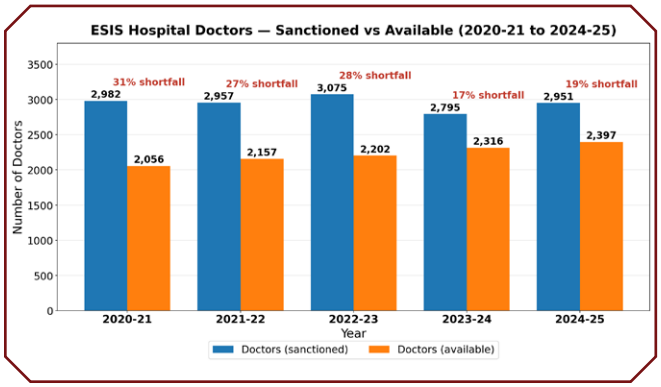
Figure 6.10: ESIC (Central) hospital doctors – Sanctioned and Available (2020-21 to 2024-25)



In 2024-25, doctor availability in ESIC hospitals was more than 80% in the top 5 states, but if 2022-23 values for sanctioned posts are considered, doctor availability is less than 75% in all these states.

In the last 5 years, sanctioned capacity in ESIS hospitals reduced by 1% while doctor availability increased by 17%.

Figure 6.11: ESIS (State) hospital doctors – Sanctioned and Available (2020-21 to 2024-25)



In 2024-25, doctor availability in ESIS hospitals was more than 60% in the top 5 states, but if 2022-23 values for sanctioned posts are considered, doctor availability percentage decreases for most states.

SII was unable to identify norms for the total number of doctors or specialists.

6.2.3: Specialist doctors shortfall highlighted by CAG reports in 2013 still exists; upwards of 50% in some states; however ESIC hospitals in Karnataka and ESIS hospitals in Tamil Nadu show good practice

The 2013 CAG performance audit (ESIC) had found large specialist doctor vacancies (~41% specialists). Critical units were non-functional. For example, at ESIC Noida (300 beds), two ICUs and one CCU lay idle for over two years, with costly equipment unutilised. Growing gaps pushed super-speciality referrals sharply upward.

The recent CAG compliance audit (Rajasthan, ESIS, 2021) also indicated similar issues with specialised treatment. The fifty-bed ESIS hospitals faced specialist shortages of ~38–60% vs norms (and ~10–54% vs sanctioned). At ESIS Jodhpur, no major orthopaedic surgeries occurred (2015–2019) because only 5 of 63 essential items were available. Obstetric emergencies were referred out due to the absence of a paediatrician. Physiotherapy cases were sent to the government medical college despite funds being available.

Figure 6.12: No. of ESIC (Central) specialist doctors (sanctioned and available) for Top 5 States (ESIC Coverage) (2022-23) (data not available since 2023-24)

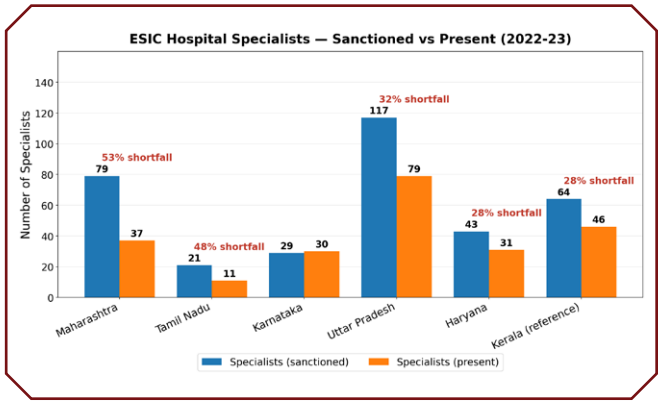
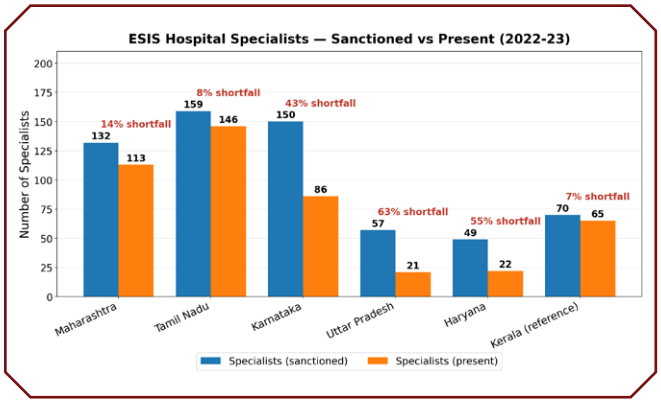


Figure 6.13: No. of ESIS (State) specialist doctors (sanctioned and available) Top 5 States (ESIC Coverage) (2022-23)



6.2.4: Under-occupancy in ESI hospital; likely driven by staffing and service-quality gaps; ESIC hospitals perform better than ESIS hospitals, but still show uneven utilisation.

The CAG (2013) had flagged under-utilisation in ESI hospitals, with ~35% of hospitals having <40% occupancy in 2012–13, with this being attributed to staffing and service-quality gaps.

The pattern persists in 2024–25, especially in ESIS hospitals; ESIC hospitals perform somewhat better but still show uneven utilisation.

Figure 6.14: Occupancy in ESIC (centrally run) hospitals for Top 5 States (ESIC Coverage) (2024-25)

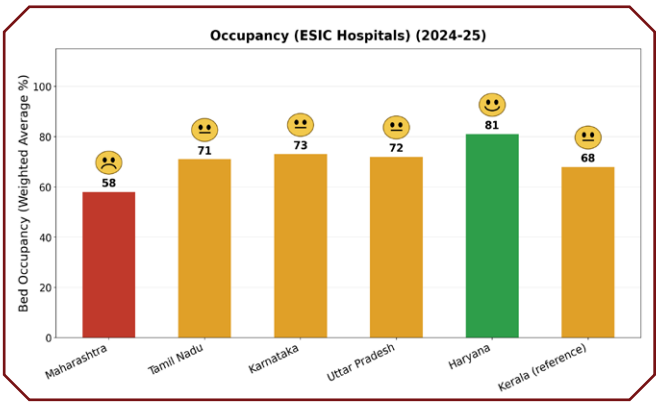


Figure 6.15: Occupancy in ESIS (state run) hospitals for Top 5 States (ESIC Coverage) (2024-25)

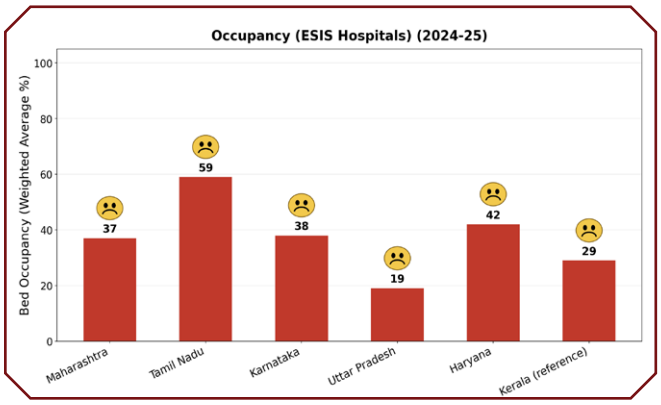


Table 6.2. Occupancy Rates for ESIS and ESIC hospitals in 2024-25

Occupancy rate in % in different ESI hospitals	0-20	21-40	41-60	61-80	81-100
No of State Govt (ESIS) run Hospitals	19	37	14	17	9
No of Centrally run (ESIC) Hospitals	3	5	13	27	7

The values represent the number of hospitals in each occupancy range. E.g., 19 ESIS hospitals had occupancy between 0 and 20%.
Note: Hospitals with 0 beds commissioned haven't been included.

6.2.5 Non-availability of ambulances and stretchers during emergencies pushes workers to private hospitals

In addition to the non-availability of doctors, the non-availability of ambulances during emergencies at the nearest ESIC/ESIS units delays time-critical care and pushes workers to private providers. These emergency-readiness gaps are a first-order access barrier and add to beneficiaries' out-of-pocket costs.

Table 6.3. Data from 5 Hospitals from Haryana and Maharashtra – 4 out of 5 face a shortage of ambulances and stretchers

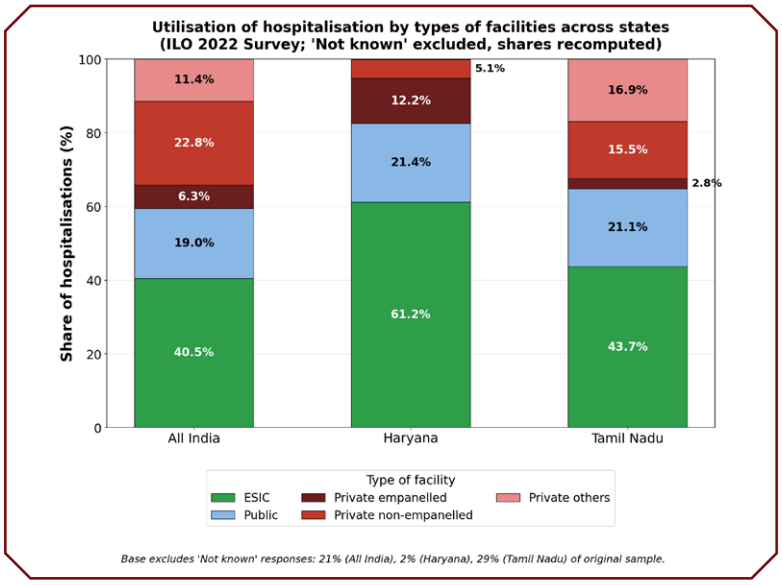
Sl. No.	RO/SRO	Hospital	Ambulances	Stretchers
1	Gurugram	ESIC Hospital, Sector 9-A, Gurugram	Limited number	Not Enough
2	Gurugram	ESIC Hospital, Sector 3, IMT Manesar	Available	Not Enough
3	Faridabad	ESIC Medical College & Hospital, NIT-3, Faridabad	Available	Available
4	Faridabad	ESI Hospital, Sector 8, Faridabad	Limited number	Not Enough
5	Pune	ESIS Hospital, Mohan Nagar, Chinchwad	Only General Ambulance is available; Cardiac Ambulance not available	Not Enough

Based on information collected by the SII team from IPs.

6.2.6: ESI hospitals provide IPs inpatient treatment at 1/14th the cost of private hospitals; Limited access to treatment at ESIC hospitals results in higher inpatient OOP

ILO's 2022 survey shows that, nationally, less than half the IPs' (insured persons') hospitalisations occur at ESIC hospitals

Figure 6.16: Utilisation of hospitalisation by types of facilities across states (ILO 2022 Survey)



When ESIC hospitals can't be used, inpatient OOP shoots up: about 14× at private non-empanelled and 5–6× at private empanelled facilities compared to ESIC; other government facilities are almost similar.

Figure 6.17: Out-of-Pocket Expenditure per Inpatient Episode

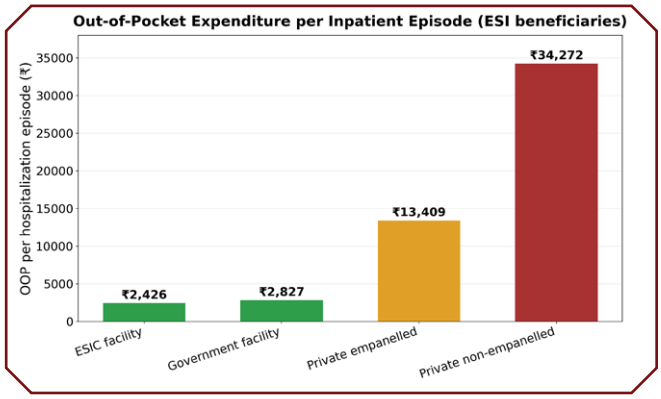
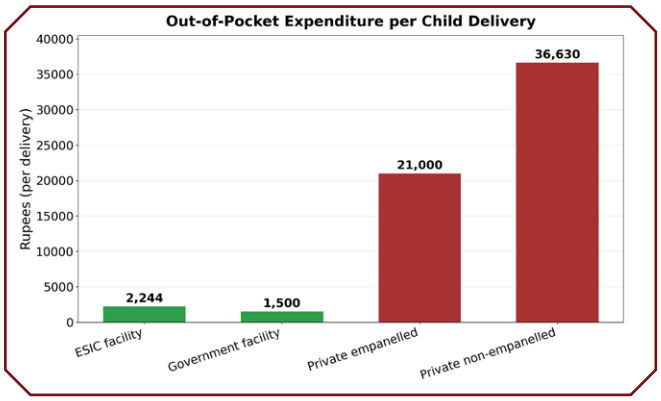


Figure 6.18: Out-of-Pocket Expenditure per child delivery



For deliveries (childbirth), private empanelled costs are roughly 9×, and private non-empanelled about 16×, compared to ESIC (government is lower than ESIC).

KK Nagar ESIC Hospital: what a well-run ESIC hospital looks like

The ESIC Model Hospital at KK Nagar, Chennai is among the better-run ESIC hospitals, with visibly strong institutional processes, a clear value system, and high observed care standards.







6.3 Medicines and diagnostics: shortages, staffing gaps, and higher OOP for IPs; Fixable by ESIC

6.3.1 Average IP spends ₹1,237 on medicines from their pocket even when treatment is at ESI hospitals (ILO 2022)

ESIC promises cashless medicines, yet drug non-availability remains common. The 2013 CAG audit flagged weak stock practices: re-order level kept at 1.5 months vs 3 months, leading to frequent stock-outs (e.g., 83 tablets, 75 injections, 14 syrups unavailable in March 2013).

The ILO 2022 study shows the problem endures: for in-patient episodes at ESIC hospitals, medicines account for 51% of medical OOP, averaging ₹1,237 per episode. In the same survey, 51% of IPs reported dissatisfaction with medicine availability.

Figure 6.19: 51% of IPs reported dissatisfaction with medicine availability (ILO Survey)

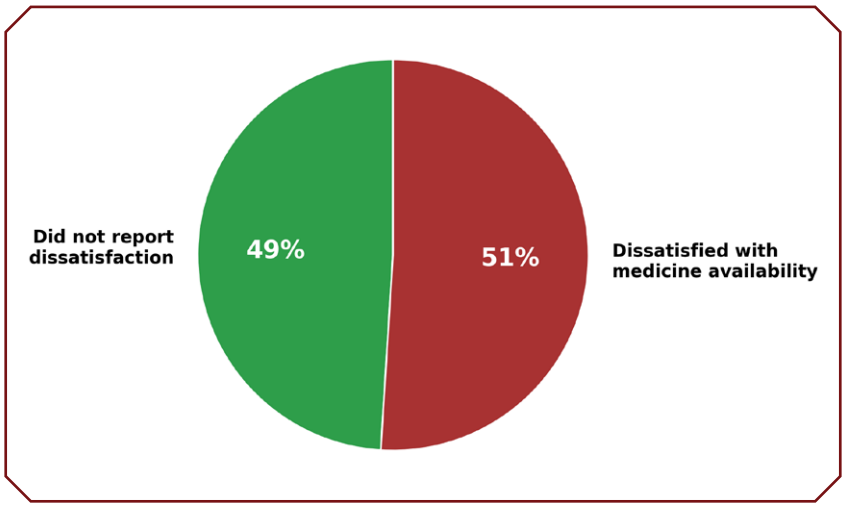


Table 6.4. Data from 10 Dispensaries across Haryana and Maharashtra – 8 out of 10 face a shortage of medicines and 4 out of 10 don't have a laboratory.

Sl. No.	RO/SRO	Dispensary	Medicines	Laboratory
1	Gurugram	Basai Road	Shortage of Essential Medicine	Available
2	Gurugram	Khekhri Daula	Shortage of Essential Medicine	Available
3	Gurugram	Dispensary No 1	Shortage of Essential Medicine	Available
4	Gurugram	Daulatabad	Shortage of Essential Medicine	Available
5	Gurugram	Manesar	Shortage of Essential Medicine	Available
6	Faridabad	Jawahar Colony	Shortage of Essential Medicine	Not Available
7	Faridabad	Sector 8	Shortage of Essential Medicine	Available
8	Pune	Bhosari	No Shortages Reported by IPs	Not Available
9	Pune	Chinchwad	No Shortages Reported by IPs	Not Available
10	Pune	Chakan	Shortage of Essential Medicine	Not Available

Based on information collected by the SII team from IPs.

Table 6.5. Data from 5 Hospitals from Haryana and Maharashtra – 4 out of 5 face a shortage of medicines and 4 out of 5 don't have a blood bank.

Sl. No.	RO/SRO	Hospital	Medicines	Blood Bank
1	Gurugram	ESIC Hospital, Sector 9-A, Gurugram	Shortage of Essential Medicine	Not Available
2	Manesar	ESIC Hospital, Sector 3, IMT Manesar	Available, but some medicines are not available sometimes	Not Available
3	Faridabad	ESIC Medical College & Hospital, NIT-3, Faridabad	Shortage of Essential Medicine	Available
4	Faridabad	ESI Hospital, Sector 8, Faridabad	Available, but some medicines are not available sometimes	Not Available
5	Pune	ESIS Hospital, Mohan Nagar, Chinchwad	Available	Not Available

Based on information collected by the SII team from IPs.

6.3.2 Private ultrasound costs ₹1,150, around 10% of an average IP's monthly salary; diagnostics are still in short supply or underutilised

Out-of-Pocket Diagnostics cost Inpatients ≈₹582 per episode - ILO Study: Although ESIC is meant to provide comprehensive, cashless diagnostics, beneficiaries continue to face non-availability of tests, driving significant out-of-pocket (OOP) spending. In the ILO 2022 study, diagnostics made up 24% of inpatient OOP (≈₹582 per episode).

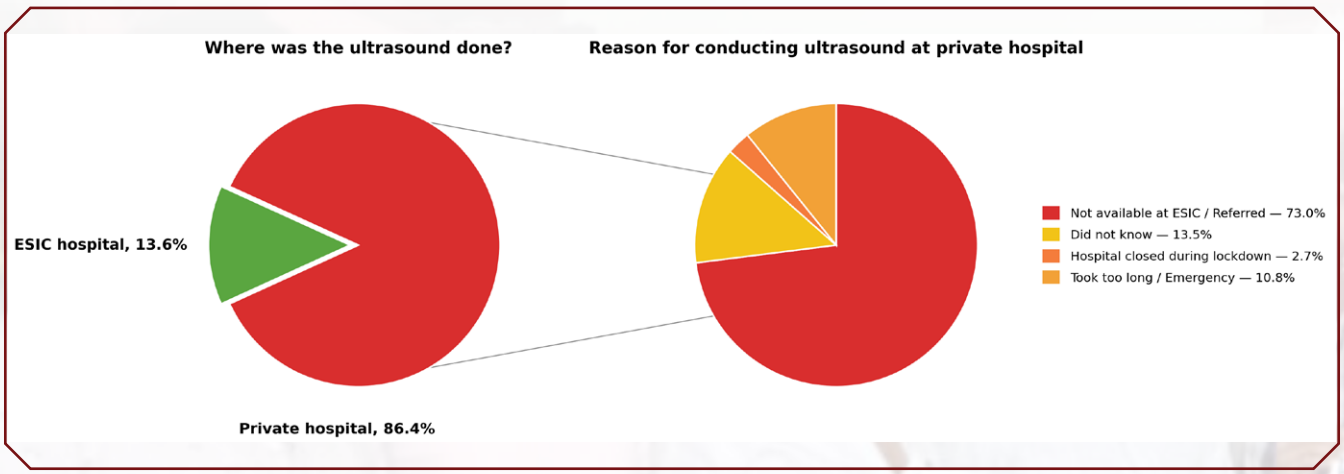
CAG's 2013 ESIC audit highlighted diagnostics shortages (historical, illustrative): The national auditor, CAG, documented systemic diagnostic gaps at the time: large hospitals (e.g., 300-bed Jhilmil, Delhi, and Noida, UP) operating without CT/MRI despite norms for ≥250-bed facilities; substantial avoidable referral spend on CT/MRI (≈₹4.32 crore in 2011–13); and widespread equipment under-use (e.g., 142 items worth ≈₹9.43 crore lying idle, ICU/CCU at Noida non-functional for >2 years with ≈₹8.16 crore of equipment unutilised, and 156 items at Joka commissioned 92–876 days late). These are older findings, cited here to show the pattern of issues that later audits and field evidence suggest has persisted in parts of the system.

CAG's recent ESIS Rajasthan compliance audit (2021) highlighted continuing diagnostics shortages: Ultrasound machines at ESIS Jodhpur (since Sep 2014) and Bhilwara (since Jan 2013) were non-functional and sealed; a 2020–21 proposal to buy four new machines was not cleared despite sufficient unspent funds, depriving IPs of essential diagnostics.

Dispensary labs still missing: Despite an ESIC directive (Nov 2015) that all state dispensaries must have a lab for basic investigations, a test check of 21 dispensaries found 7 had neither an in-house lab nor any tie-up as of Feb 2020.

Field evidence (Haryana, 2022): SII survey (≈70 IPs, Jun–Dec 2022): 86.4% got ultrasounds at private hospitals; 73% cited non-availability at ESIC Manesar (or referral) as the reason; *none received reimbursement* (more on reimbursements in Chapter 8).

Figure 6.20: IPs usage of private hospitals for Ultrasound tests (SII Haryana Survey)



Cost burden: The average private ultrasound cost was ₹1,150, roughly 10% of a typical monthly wage for these workers.

The diagnostics shortage results in "privatisation by stealth".

Table 6.6. Data from 5 Hospitals from Haryana and Maharashtra – 4 out of 5 do not have enough diagnostic facilities

Sl. No.	RO/SRO	Hospital	Ultrasound Facility	CT Scan and MRI facilities	X-ray Machine
1	Gurugram	ESIC Hospital, Sector 9-A, Gurugram	Not Available	Not Available	X-ray films are not provided. Patients are made to take a photo of the image using their mobile phone.
2	Gurugram	ESIC Hospital, Sector 3, IMT Manesar	Available	Not Available	Available
3	Faridabad	ESIC Medical College & Hospital, NIT-3, Faridabad	Not Available in the Labour Room	Available	Available
4	Faridabad	ESI Hospital, Sector 8, Faridabad	Not Available	Not Available	Available
5	Pune	ESIS Hospital, Mohan Nagar, Chinchwad	Available	Not Available	Available

Based on information collected by the SII team from IPs.



X-ray image of an injured IP taken on a mobile phone due to non-availability of X-ray films.

The IP didn't have a smartphone and had to depend on an SII team member's mobile phone.

From national audits (2013) to recent state reviews (2021) and field data (2022 & 2026), diagnostics remain a weak link: missing or non-functional machines, delayed installations, absent labs, and heavy reliance on private providers. These gaps directly translate into avoidable OOP, even for inpatient episodes that should be largely cashless under ESIC.

6.3.3 Understaffed labs and pharmacies: paramedical and pharmacist shortfalls across both ESIC & ESIS hospital; shortfall exceeds 50% in some cases

Audit evidence (Rajasthan, ESIS, 2021): Lab posts were far below norms: each hospital had only one laboratory technician and no laboratory assistants sanctioned (norm: 1 technician + 3 assistants per lab). No ECG technician posts were sanctioned at Jodhpur or Bhilwara despite ECG machines, *so ECGs were run by non-specialist staff.*

Pan-India picture: ESIC data indicate persistent paramedical shortfalls across major cadres, with wide interstate variation (see Figures 6.21 and 6.22).

The result is predictable: slower test turnaround, idle equipment, more referrals to the private sector, and added OOP for beneficiaries when diagnostics can't be provided in-house.

Figure 6.21: No. of ESIC (Central) paramedical staff (sanctioned and available) for Top 5 States (ESIC Coverage) (2022-23) (data not available for 2023-24 & 2024-25)

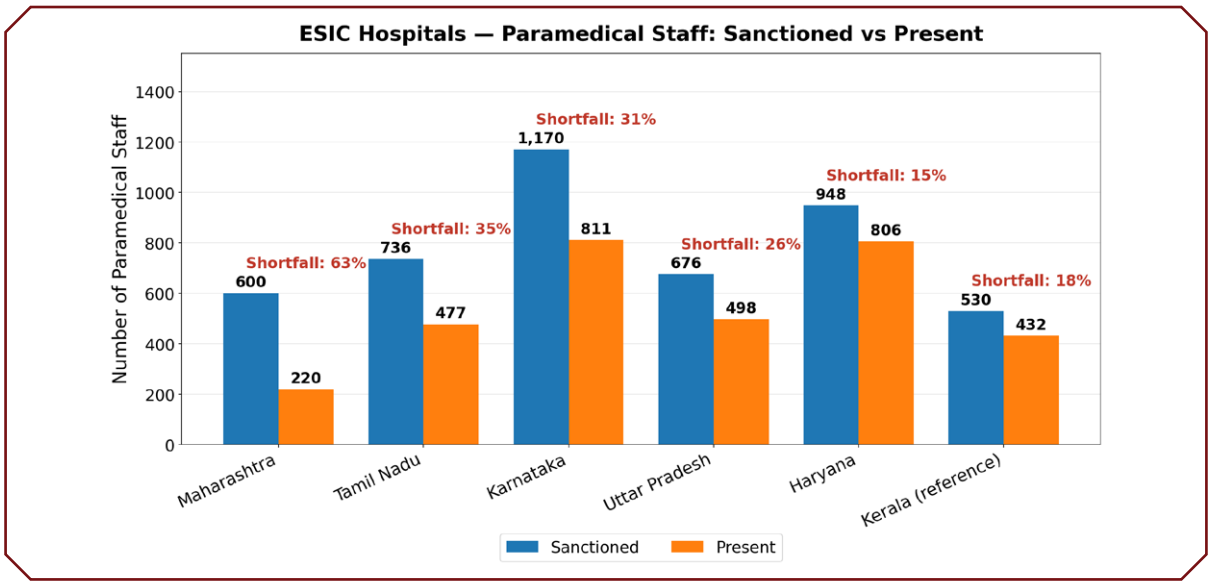
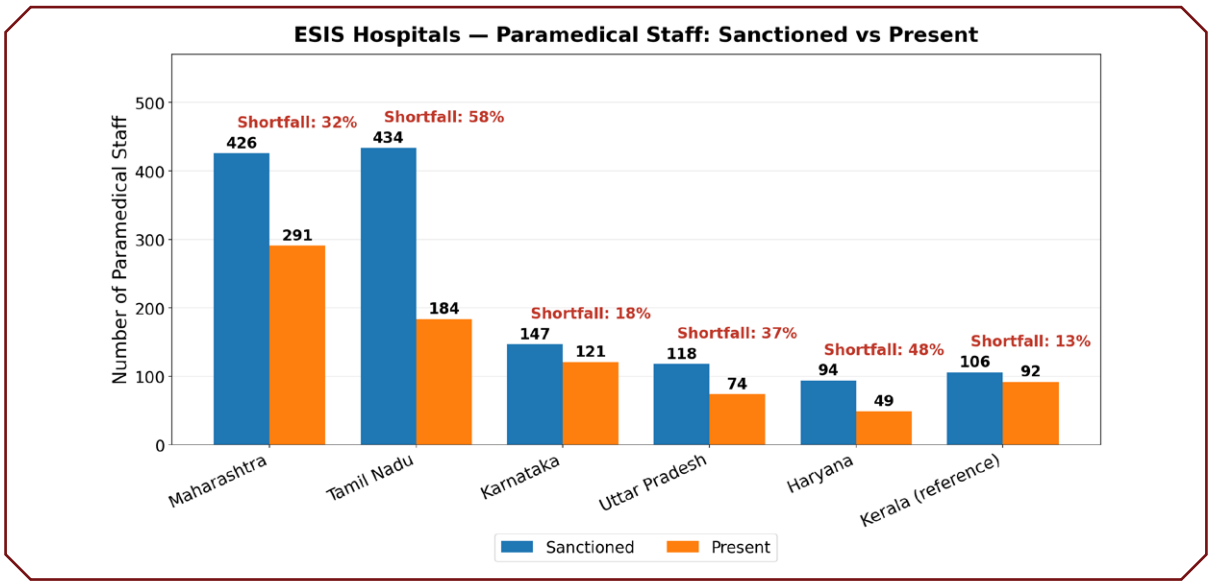


Figure 6.22: No. of ESIS (State) paramedical staff (sanctioned and available) for Top 5 States (ESIC Coverage) (2022-23)



ESIC's Human Resource Crisis: Systemic Shortage

There is a shortage of doctors, especially specialists, in ESIC dispensaries and smaller hospitals; contractual arrangements dominate, undermining quality and continuity of care. ESIC compensation, career progression, and posting terms compare unfavourably with private hospitals (with respect to location and pay) but are better than State health services, and comparable to AIIMS-linked institutions; therefore, contractual engagement dominating with not enough focus on permanent cadre entry, and therefore no long-horizon career progression, appears to be the main structural problem.

Recruitment cycles are slow. ESIC's own medical colleges and PG programmes, which should be a natural pipeline into ESIC service, feed the wider Indian medical market rather than ESIC's own facilities. ESIC's medical colleges do carry a compulsory bond service requirement, but the bond has been softened over time (including through court orders). Importantly, there is no evidence of a structured absorption mechanism: pass-outs from ESIC medical colleges and PGIMSRs are not preferentially or systematically recruited as permanent staff into ESIC hospitals and dispensaries.

6.4 ESI's specialised-care network lists 2,836 tie-up hospitals: expands access to treatment for IPs, but delays and out-of-pocket expenses persist; could result in increasing privatisation

Recent changes: ESIC is expanding speciality and super-speciality treatment (SST): in 2024, SST began in 25 hospitals and chemotherapy units were set up in 42 hospitals (Financial Estimates & Performance Budget 2025–26).

In parallel, ESIC now provides SST through 2,836 tie-up hospitals nationwide, which further broadens access. Considering the difficulty in hiring specialist doctors for public sector hospitals, this is a positive development for IPs from ESIC.

This provides much-needed support for IPs. But this also shifts focus towards privatisation from improving ESI's own infrastructure.

ESIC's referral spend for Super-Speciality Treatment (SST) and secondary tie-ups is substantial and increasing: ₹1,710 crore (Actual 2023–24), ₹2,100 crore (Revised Estimate, 2024–25), which is c.14% of total medical expense, and ₹2,328 crore (Budget Estimate, 2025–26). The reports don't break this out by SST vs. secondary.

The share of Medical Benefits through Tie-Up Hospitals has remained constant at around c.15% for the last 10 years (Please refer to graph in Chapter 13)

Referrals form a significant part of the IP journey. Referrals to empanelled hospitals are cashless for beneficiaries; claims are vetted by the Bill Processing Agency (BPA; UTIITSL/others) and paid directly to hospitals. That's positive, but OOP persists outside SST (medicines, diagnostics, emergency care), and ESIC has acknowledged delays/ issues in reimbursement processing (DG, 2017).

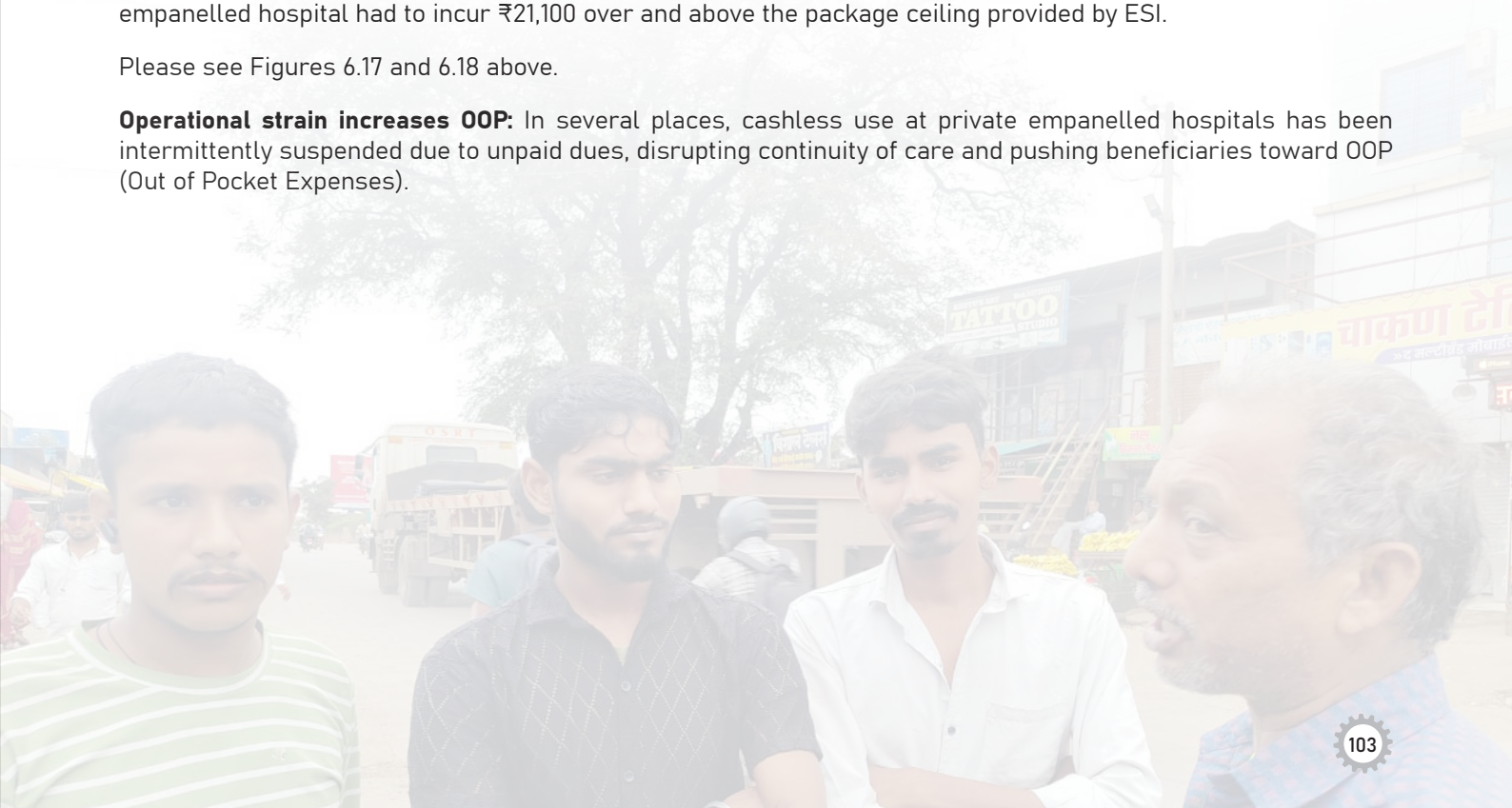
Field evidence (diagnostics access in Manesar and Pune): In the example cited earlier, none of the respondents who paid privately for ultrasound received reimbursement. Many were referred to ESIC/ESIS facilities that were distant or had long waits; in urgent cases, they paid privately and hoped to claim later. Knowledge and process frictions are material: ~65% did not claim due to lack of awareness; ~20% cited difficulties/unclear amounts.

At Pune's ESIS Mohan Nagar Hospital, diagnostics including MRI, CT, ECG, Ultrasound and other investigations are not available or functional and were referred to D Y Patil Hospital (tie up). Please refer to the Case Study at the end of this chapter.

User experience data (ILO 2022): Even for inpatient episodes at ESI hospitals, beneficiaries incurred some OOP; only 45% reported being satisfied with "no/limited delay" in reimbursement. For an episode of inpatient care at an ESI facility, beneficiaries still paid an average of ₹2,426 OOP. This cost rose to ₹13,409 in a private empanelled hospital and ₹34,372 in a private non-empanelled hospital. For child delivery services, a beneficiary in a private empanelled hospital had to incur ₹21,100 over and above the package ceiling provided by ESI.

Please see Figures 6.17 and 6.18 above.

Operational strain increases OOP: In several places, cashless use at private empanelled hospitals has been intermittently suspended due to unpaid dues, disrupting continuity of care and pushing beneficiaries toward OOP (Out of Pocket Expenses).



Arjun Bera, from West Bengal



Arjun Bera, a Bengali-speaking migrant worker in Gurugram, was injured on the job and required orthopaedic treatment at the ESIC hospital.

At the hospital, the X-ray department had no film available; only a mobile photo of the image could be taken to the doctor. The IPD slip staff were absent when he arrived. Because he spoke no Hindi, he could not communicate with the doctor, who diagnosed a fracture requiring surgery and a steel plate. He also did not know the location or process of his ESI Dispensary for obtaining a medical certificate.

Three days after the accident, his employer had still not filed an Accident Report.

SII's Field Executive walked him through the X-ray, plaster and IPD process, secured his medicines and a one-week Medical (Rest) certificate, and interpreted between him and the doctor across two hospital visits.

SII also visited the contractor's office, where the HR Manager initially refused to file the Accident Report on the grounds that three days had passed, and secured his agreement to file it.

His family in West Bengal was contacted so they could travel to Gurugram to support him through the surgery.

6.5 Tactical Recommendations

6.5.1 Dispensaries & Out-Patient Services

- **Expand access by an estimated c.2100 dispensaries** by adding dispensaries where density is lower than norms (1 dispensary per 100,000 IPs) and aligning locations to where insured persons live and work.
- **Close doctor gaps** with a sustained hiring plan, targeting **100%** of sanctioned posts filled and using short-term contracts only as a bridge, **by appointing c.1150 doctors.**
- **Standardise OPD operations**: minimum **8-hour** service with staggered shifts, tokenised queues, and a fast-track window for repeat prescriptions.
- **Provide core diagnostics on-site** at every dispensary: CBC, blood sugar, urine, pregnancy test, and ECG.
- **Explore new delivery mechanisms**, e.g., work-site-based sites (where work-force concentration is large enough), but with facilitation for families, MLHP (Mid-Level Health Provider) based centres on the lines of HWCs (Health and Wellness Centres), integration with functional AB-HWCs (Ayushman Bharat - Health and Wellness Centres).
- Provide an entitlement for an annual check-up with local PHC or ESI dispensary for IPs to be paid for by ESIC.

6.5.2 Hospitals, Beds & Specialists

- **Increase bed capacity by estimated c.27,000 hospital beds**, by commissioning the pipeline (100+) on time and adding new projects where gaps remain, based on current demand and catchment needs.
- **Achieve staffing parity**: keep **100%** of doctors and specialists posts filled; do not reduce sanctioned strength to mask vacancies **by appointing c.1200 doctors.**
- **Human resource overhaul** to solve for the chronic shortage of doctors, specialists, and nurses; with recruitment, retention, compensation, and career-path reform.
- **Keep critical units ready**: ensure ICUs, CCUs, and OTs meet standards.
- **Make super-speciality services reliable**: operationalise designated super-speciality and chemotherapy units and align specialist rosters to equipment availability.
- **Lift under-occupancy**: analyse causes site-by-site and fix staffing/equipment bottlenecks so hospitals below **40%** occupancy become **<10%** of the network (currently 58% in ESIS hospitals and 15% in ESIC hospitals).

6.5.3 Diagnostics & Medicines

- **Assure drug availability:** keep a rolling ≥**3-month buffer** for the top essential molecules
- **Make medicines effectively cashless:** dispense inpatient medicines at **zero point-of-care payment**; if a stock-out forces a purchase, **reimburse within 30 days** via a simplified claim.
- **Minimise out-of-pocket spend**: make OP and IP care effectively **cashless** at ESIC facilities; only allow exceptions with a clear, quick reimbursement pathway.
- **Ensure diagnostic capacity:** make ultrasound services available **on-site at all district-level units** or **through a nearby cashless tie-up**; repair or replace any non-functional machines **within 14 days**.
- **Staff labs to norms:** provide **technicians + assistants per lab as per norms**, and post **ECG technicians** wherever ECG machines exist.

6.5.4 Claims & Reimbursements Linked to Medical Care

- **Guarantee cashless treatment:** keep empanelled hospitals live and prevent tie-up suspensions; if a provider is paused, auto-route patients to an alternate cashless facility and notify them immediately.
- **Fast-track small claims when ESIC is unavailable:** approve low-value medical claims (e.g., diagnostics/ medicines) on the treating doctor's prescription/referral alone; reimburse within a short, stated timeline (30-days).
- **Track inpatient OOP and fix leaks:** publish simple, hospital-wise monthly OOP metrics for ESIC-treated episodes; investigate outliers and implement corrective actions.

6.5.5 Ease of Access

- IPs should not need to register themselves at the dispensary/IMPs to be able to be referred to an ESIC hospital, as practised in some ROs.
- Tokens to manage queues/waiting time should be introduced at all locations with a long waiting time.



A Case for National Dispensary Improvement Potential





The Manesar ESIC dispensary revealed systemic failures that reflect healthcare challenges for thousands of insured workers using ESI dispensaries nationwide.

Despite clear ESIC and Health Ministry norms, patients faced unhygienic facilities, overcrowding, medicine shortages, and indifferent grievance handling.

Infrastructure was broken; non-functional washrooms, no drinking water, poor ventilation, and exposed medical waste damaged dignity and morale for both patients and staff.

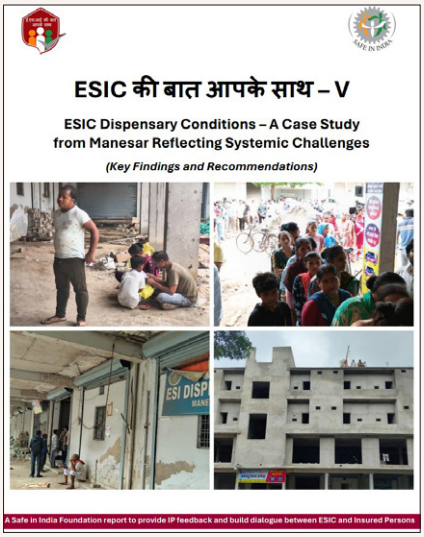
Registration is chaotic; one counter for hundreds of patients, no token system, and long hours-long waits in extreme heat.

Staffing is inadequate; one doctor for 150–200 patients daily, with the pharmacist and medical officer overburdened by both care and administration.

Medicines for chronic illnesses are frequently out of stock, forcing patients to buy them at their own cost.

Grievance systems are invisible; workers have no clear channel to raise issues or learn their rights.

Dignity is compromised; patients report being ignored or shouted at, while exhausted staff lack the support to provide respectful care.



This case study reflected a systemic neglect that calls for immediate, well-funded, and accountable reforms. Across ESI dispensaries, there is a need to restore trust, upgrade infrastructure, expand staff, ensure medicine availability, and make dignity and fairness non-negotiable in every dispensary.

Changes Post SII Report Submitted to the Medical Commissioner (August 2025)

After the submission of the report to Dr R Srinivasan, Medical Commissioner, ESIC in August 2025, and his subsequent visit, the infrastructure at the dispensary has been significantly improved.

SII thanks ESIC for the infrastructure improvements made at the Manesar dispensary.

SII will report on the final status of the dispensary by September 2026 (1 Year after the first report).







Poor ESIS (State Government-managed) Hospital Conditions due to Shortage of Funding – A Case Study from Mohan Nagar (Chinchwad), Pune, Maharashtra

The ESIS Mohan Nagar Hospital reveals systemic gaps that undermine healthcare access for insured workers in a major industrial belt. With only 100 beds, it is one of just two ESI hospitals serving c.17 lakh insured persons across Pune and surrounding industrial areas (versus the norm of 125 beds per 100,000 workers, which would require c.2100 beds).



Diagnostics are failing; MRI and CT are non-functional in-house. Since August 2025, an interim tie-up with D Y Patil Hospital has provided MRI/CT/ECG/Ultrasound and other investigations free of cost (tie-up), a useful relief, but not a permanent solution. Dependence on external providers persists, and referrals add friction for injured and ill workers.

Example of OOP Expenses for IPs: IPs referred to external providers by doctors at ESIS Mohan Nagar Hospital spent Rs. 2006 for an MRI and Rs. 1150 for a 2D Echo. The interim tie-up temporarily solves this problem.

Critical care is constrained; there are insufficient ICU/HDU beds for surgery (Norm=10 beds for a 100-bed hospital) and post-operative patients, and even a newly built ICU remains non-operational due to a lack of skilled staff.

Ward-level monitoring is weak; wards do not have dedicated advanced ECG machines and bedside monitoring capacity. Workers needing ECG/monitoring are referred outside, including under the interim tie-up.

Example of OOP Expenses for IPs: An IP invoice showed a charge of Rs. 800 for a monitoring procedure (ECG) for an insured person referred externally.

Mobility and safe transfers are compromised; inadequate wheelchairs hinder safe movement from the ambulance bay to wards, affecting both safety and dignity.

Basic amenities are missing; several wards lack functional drinking-water coolers, reducing comfort for patients and staff.

Several doctors have advised SII that the hospital management is trying hard to resolve these issues but is unable to do so due to a lack of funding.

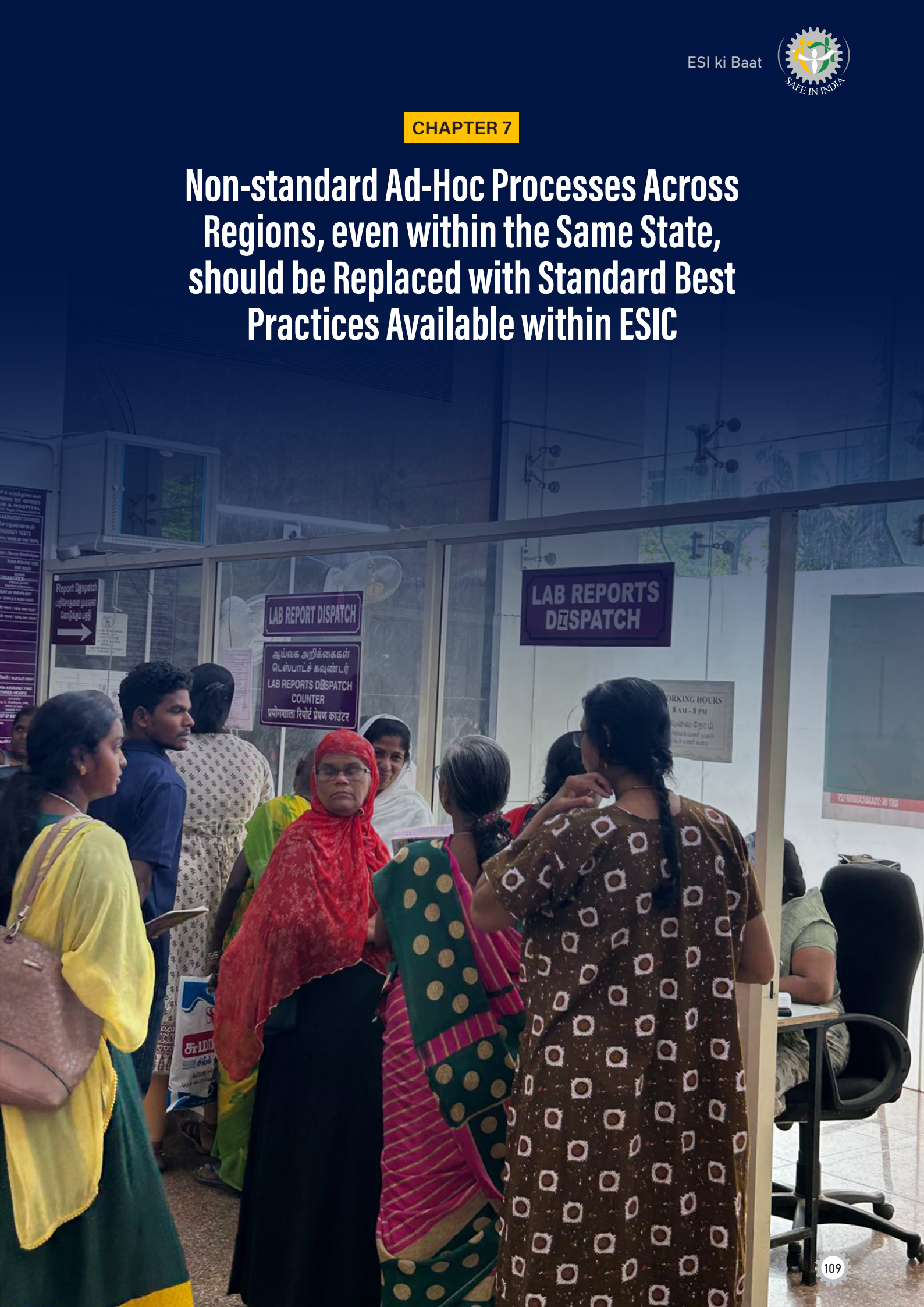
Please refer to Chapter 13 for a discussion on the role of ESIC and state governments in funding medical care.

This case study reflects under-resourcing in ESIS hospitals that should provide dignified, reliable care in-house at scale.



CHAPTER 7

Non-standard Ad-Hoc Processes Across Regions, even within the Same State, should be Replaced with Standard Best Practices Available within ESIC



Despite the common framework of the ESI scheme, significant variations exist in its implementation across different regions, even within the same state. These inconsistencies often arise from local practices, additional documentation demands, or differing interpretations of procedures, which not only create inefficiencies but also burden Insured Persons (IPs).

Drawing from SII's experiences across its five Worker Assistance Centres (WACs) in two states, this chapter highlights such non-standard practices, grades them using the R-A-G model based on IPs' qualitative feedback, and recommends adopting standardised best practices. Standardisation would not only improve efficiency but also enable fair comparison of performance across locations while ensuring a more consistent and equitable experience for IPs.

7.1 How Payment (Cash) Benefits Process Differ for IPs Across Locations

The table below highlights how processes linked to some of the main payment benefits under the ESI scheme differ across locations, often leading to inconsistent experiences for IPs.

Sl. No.	Topic	Question	Gurugram, HR	Manesar, HR	Faridabad, HR	Pune, MH
1	Payment Benefits (All) – Documents Checklist	Is a **printed copy of the checklist** of all the necessary documents provided by the branch office?	No	No	No	Yes
2	Payment Benefits (Sickness & TDB) – Fitness Certificate	When IPs are declared fit, does the BO (Branch Office) **fill up the Form to meet the Medical Referee**?	Mostly yes	Mostly yes	Mostly yes	No. IPs are made to fill a form.
3	Temporary Disability Benefit	Is TDB payment started **immediately once the disability is known**, i.e., before fitness?	No	No	No	Yes. (except Bhosari BO)
4	Permanent Disability Benefit – Medical Board	How do IPs **receive information** about the Medical Board?	Letter, SMS and phone (from SRO)	Letter, SMS and phone (from SRO)	Letter, SMS and phone (from SRO)	Phone (from BO)
5	Permanent Disability Benefit – Medical Board	How often does the **Medical Board convene**?	Once a month	Once a month	Once a month	Twice a month
6	Permanent Disability Benefit – Medical Board	When is Form -142 for **payment of travelling expenses** for Medical Boards provided to the IP?	Along with the intimation letter	Along with the intimation letter	During the medical board. Asked to submit it to the branch office.	During the medical board. Asked to submit it to the branch office.
7	Permanent Disability Benefit – Decision Letter	Is a copy of the Decision Letter (ESIC 154) **sent to IP by post** at his given address after the Medical Board?	Yes	Yes	No. They have to visit the branch office and RO.	No. They have to visit the branch office and RO.

Sl. No.	Topic	Question	Gurugram, HR	Manesar, HR	Faridabad, HR	Pune, MH
8	Permanent Disability Benefit	Do IPs **receive a call** from the Branch Office about the start of their pension (PDB), after the medical board?	No	No	Yes	Yes
9	Permanent Disability Benefit	After the Medical Board, do the IPs have to **visit** the Branch Office to get their pension (PDB) released?	Yes	Yes	No	No
10	Life Certificate	Are **all formats of the Life Certificate** (Form 23) that cover all the elements accepted at the branch office?	No. Only ESIC's standard format is accepted.	No. Only ESIC's standard format is accepted.	ESIC's standard format and other format are accepted.	ESIC's standard format and own designed format are accepted.
11	Suvidha Samagam	From ESIC, who are present for the **Suvidha Samagams?**	Director/ In-Charge Director, Branch Managers, Medical Superintendents of all branch offices.	Director/ In-Charge Director, Branch Managers, Medical Superintendents of all branch offices.	Director/ In-Charge Director, Branch Managers, Medical Superintendents of all branch offices.	Director/In-charge, Medical Superintendent are present, but Branch Office manager does not attend.
12	Suvidha Samagam	Are **employers informed about the Suvidha Samagam**s through WhatsApp?	No	No	No	Employers are informed through WhatsApp before the Suvidha Samagams

7.2 How Medical Benefits Process Differ for IPs Across Locations:

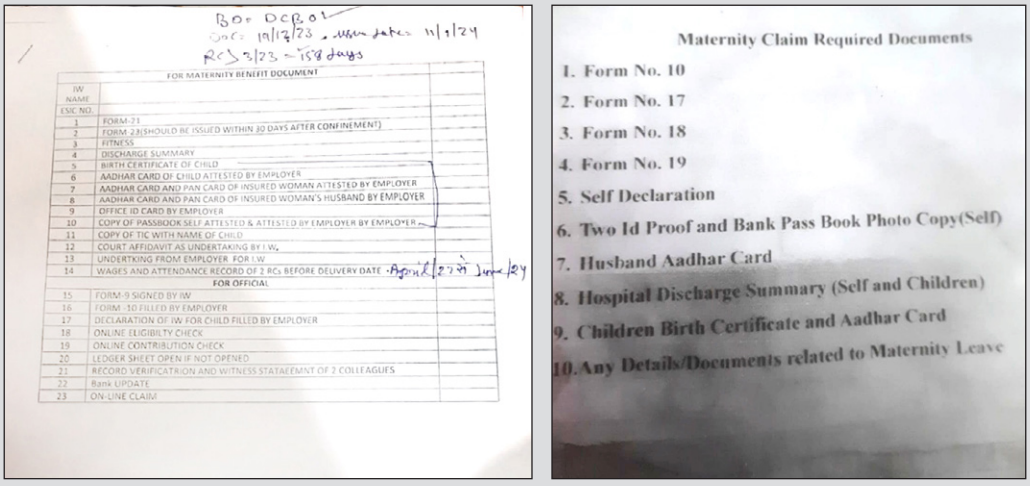
The table below shows variations in medical benefit processes at dispensaries and hospitals, highlighting how non-standard practices affect the ease and consistency of access for IPs.

Sl. No.	Topic	Question	Gurugram, HR	Manesar, HR	Faridabad, HR	Pune, MH
1	Registration at Dispensary	Do IPs have to **register themselves at the dispensary** to be able to be referred to an ESIC hospital? ESI Norm: Not required. Coverage starts from day 1 after online registration, and doesn't require registration at dispensary	No	No	No	Yes. By submitting Form MED 7A (dispensaries) and ESIC-MED 7A &7B / ESIC MED 37 (at IMPs)

Sl. No.	Topic	Question	Gurugram, HR	Manesar, HR	Faridabad, HR	Pune, MH
2	OPD Tokens	Is a system of **tokens** for OPDs present?	Yes	No	Yes. But a finite number of tokens results in IPs not receiving treatment on the same day.	No. Not required (short waiting time)
3	Medical Record Envelope	Where is the MRE (**Medical Record Envelope**) issued?	Branch Office	Dispensary	Dispensary	Dispensary (but also retained at the dispensary)
4	Medical/Rest slip	Is the **Medical/Rest slip submitted to the MTS** in the branch office, and does the MTS put the ledger number on the IP's E-identity card?	Yes	Yes	Yes	No (deposited in the slip in the box outside the branch office). No
5	Medical/Rest slip	How is the **Medical/ Rest slip provided** to the IPs at the dispensary?	Online	Online	Online	Offline (by printing the online slip)

Regional Variation in Checklists

Image 7.1. Regional Variation in Maternity Benefit Checklists – Faridabad (Left) and Gurugram (Right)



Similar variations observed for Bill Reimbursements (see Chapter 5)

7.3 Recommendations

Adopt standardised best practices across ROs/BOs. Standardisation will improve efficiency and ensure a more consistent and equitable experience for IPs and employers.

The specific recommendations focused on standardising processes related to cash benefits and medical benefits are provided as part of the respective chapters (Chapters 2 to 6 and 8).

CHAPTER 8

Grievance Redressal in ESIC: Welcome Increased Accountability through Rising Filings, but Access & Quality need Improvement



"Efforts for qualitative and speedy redressal" of grievances is a stated aim of the Employees' State Insurance Corporation (ESIC). At ESIC, grievances can be submitted both online and offline, ensuring accessibility for all stakeholders.

Offline modes of grievance submission include:

- **Facilitation Centres** located in all Regional Offices, Sub-Regional Offices, ESIC Hospitals, and Model Hospitals.

SII has seen no evidence of the existence of Facilitation Centres.

- **Suvidha Samagam sessions**, held on the second Wednesday of every month at ESIC Regional and Sub-Regional Offices, and on the second Friday of every month at DCBOs/BOs. These are designed as one-stop platforms for redressal of all issues, including those related to medical services.
- **Employees' Insurance Court**

Unfortunately, IPs are often not able to meet the person responsible, who knows their case

Online modes for filing complaints include:

- The **Central Toll-Free (24x7) Helpline**: 1800-11-2526 (general); 1800-11-3839 (medical helpline).
- The Centralised Public Grievance Redressal and Monitoring System (**CPGRAMS**)
- **Emails** sent to pg-hqrs@esic.nic.in

In this chapter, we examine the major grievance redressal mechanisms- CPGRAMS, the Helpline, and Suvidha Samagam, as well as a new tactical collaborative initiative between SII and ESIC in Haryana and Maharashtra: Project "Hazaron Khwahishen", which aims to resolve 1000+ long-pending ESIC benefit cases.

8.1 CPGRAMS: Increase in Accountability, Grievances; Timely Closures; Quality-of-Redressal Mixed

8.1.1 Post-CPGRAMS Adoption: In 10 Years, ~4× Rise in Grievances Raised

ESIC had adopted the Central Government's CPGRAMS from FY 2014–15; additionally, ESIC launched its own Public Grievance (PG) module aligned to CPGRAMS on 13 Aug 2015 (public from 15 Aug 2015).

In 2024–25, ESIC received 19,063 grievances on CPGRAMS alone, about four times the 4,655 grievances recorded from all sources combined in 2013–14.

This reflects not only greater public use of digital grievance systems but also strengthened accountability mechanisms within ESIC.

The data show an upward trend in the number of grievances lodged through CPGRAMS over the past decade (Figure 8.1), rising from 653 cases in 2014–15 to 19,063 in 2024–25.

MD Naseem, 35 years, Jaunpur, Uttar Pradesh



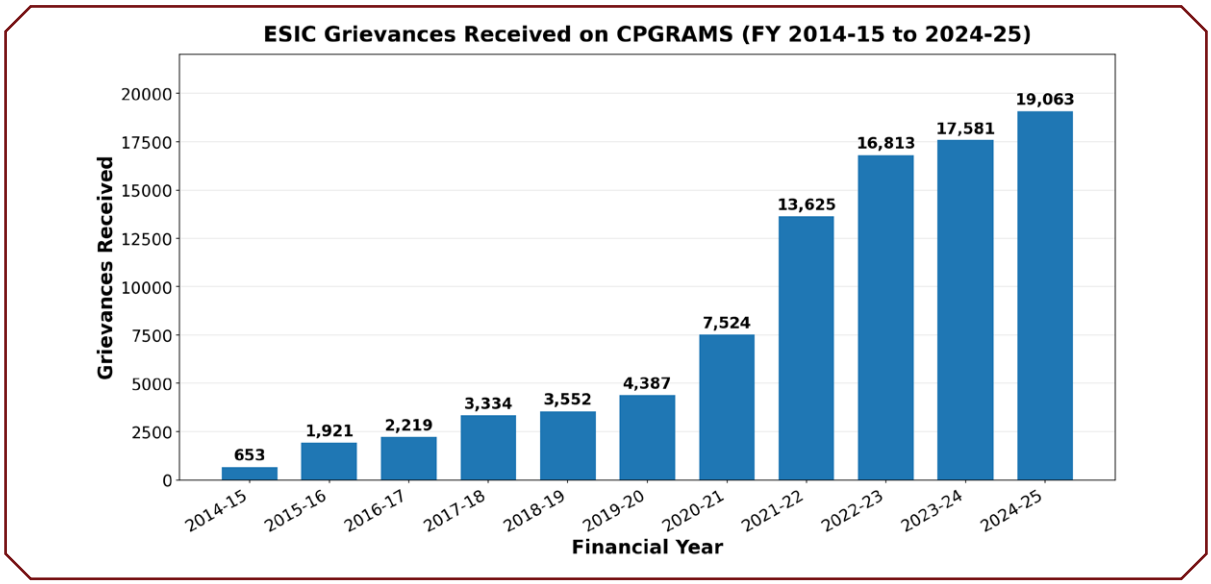
MD Naseem was seriously injured in a workplace accident on 23 November 2024, losing two and a half fingers.

He received no proper ESIC support in the initial period. With no one to care for him in Pune, he returned to his village for treatment and only came back in May 2025 to resume his struggle for ESIC benefits. By then, his financial stress, the trauma of the injury, and the delay in benefits had left him completely worn down.

When SII took up his case, he had no Leave Certificates; he only had a fitness slip, the initial treatment slip, and a discharge card. SII asked him to obtain a medical certificate from the doctor at his village, then pursued the case with the Bhosari Branch and raised it at the SRO's Suvidha Samagam meeting.

The first TDB arrear of ₹4,000 was credited in December 2025 a full year after his accident.

Figure 8.1. ESIC Grievances Received on CPGRAMS (FY 2014-15 to 2024-25)

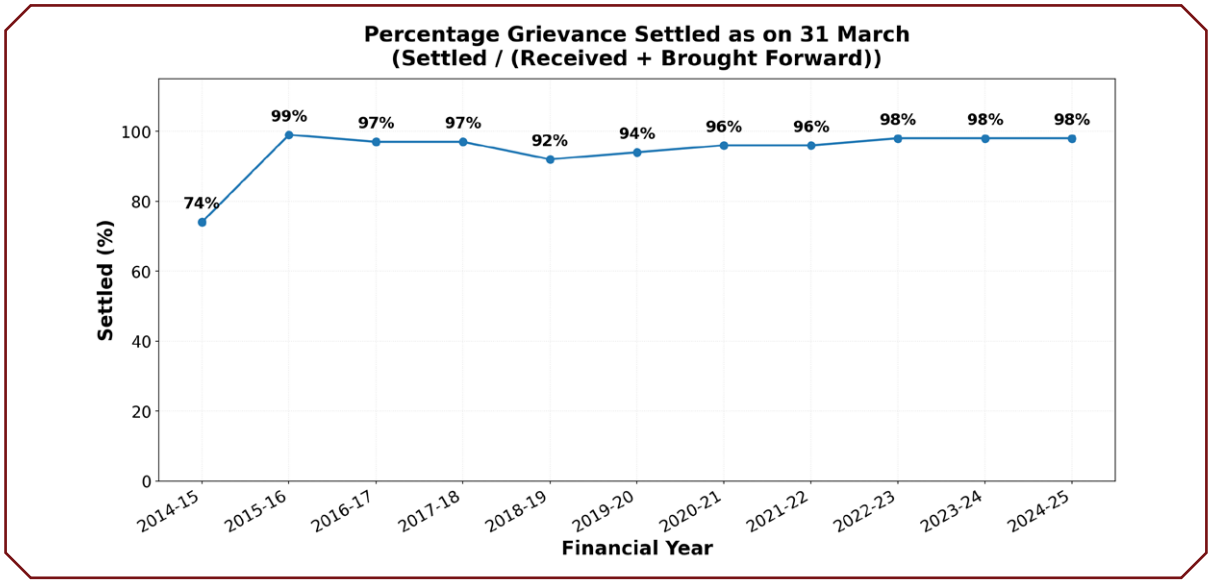


8.1.2 ESIC "Settles" Almost 100% of Cases Within 21 Days

As per ESIC/DARPG guidance, grievances should ordinarily be resolved within 21 days (reduced from 30; earlier 45). If delay is unavoidable, an interim reply is required.

As of 31 March 2025, 98% of grievances received during the year had been settled (Settled / (Received + Brought/ Forward)). The small 2% remaining are largely cases received in the last 30 days of March, implying an effective 100% within-time resolution for the year's inflow.

Figure 8.2: Percentage of grievances settled as on 31 March (FY 2014–15 to 2024–25).



This is a strong outcome against the prescribed 21-day operational standard.

8.1.3 However, "Disposed" is not always "Meaningfully Resolved"

On CPGRAMS-linked portals, a grievance is typically marked "disposed/redressed" once a formal reply or action is recorded, *not necessarily when the complainant's problem is actually solved.*

Example: A worker reports non-payment of a benefit; the reply "Claim under process - contact local branch office" registers as disposed, even though no payment has been received.

Therefore, 100% disposal does not equal 100% meaningful resolution.

Indicative evidence of this gap appears in MoLE-level CPGRAMS caller feedback, where non-satisfaction is 48% (Oct 2023–Apr 2024); a ministry aggregate, not ESIC-specific, but directionally relevant to how "disposal" is experienced by users (Figure 8.5).

Worker feedback to SII echoes this: cases are often closed without notification or remedy.

Figure 8.3: MoLE CPGRAMS non-satisfaction rate (Jan 2024–Nov 2024): 48%.

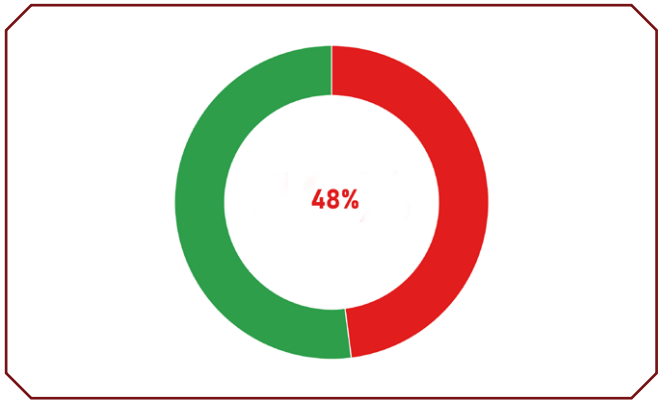
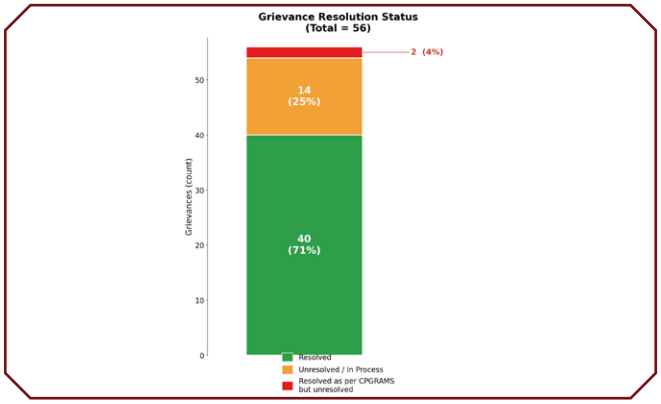


Figure 8.4: ESIC CPGRAMS resolution rate (IPs supported by SII)



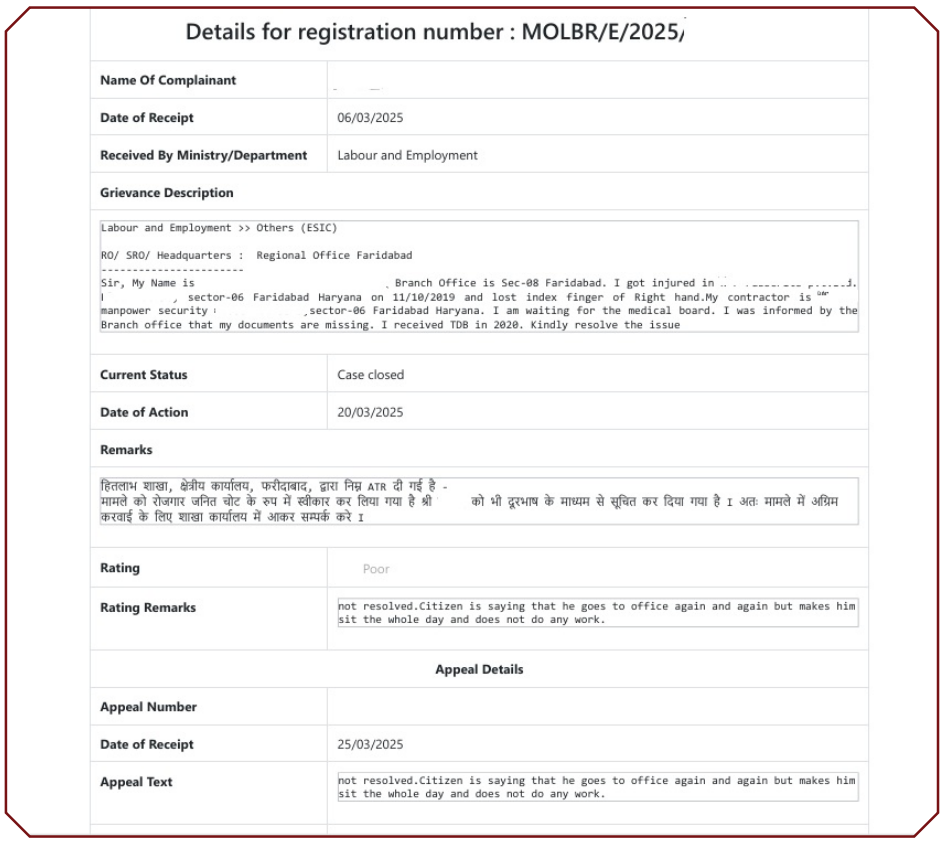
This was last reported in November 2024. This is a good initiative and needs to be restarted.

Separate data for ESIC wasn't published.

Among 56 IPs supported by SII, who used CPGRAMS, 71% of cases were resolved, while 25% cases were unresolved or in process.

There were 2 cases which were disposed of but not resolved as per the IPs.

Image 8.1. Sample case which were disposed of on CPGRAMS but not resolved as per the IPs



Details for registration number : MOLBR/E/2025/

Name Of Complainant	
Date of Receipt	06/03/2025
Received By Ministry/Department	Labour and Employment
Grievance Description	

Labour and Employment >> Others (ESIC)

RO/ SRO/ Headquarters : Regional Office Faridabad

Sir, My Name is , Branch Office is Sec-08 Faridabad. I got injured in ... sector-06 Faridabad Haryana on 11/10/2019 and lost index finger of Right hand.My contractor is manpower security , sector-06 Faridabad Haryana. I am waiting for the medical board. I was informed by the Branch office that my documents are missing. I received TDB in 2020. Kindly resolve the issue

Current Status	Case closed
Date of Action	20/03/2025
Remarks	

हितलाभ शाखा, क्षेत्रीय कार्यालय, फरीदाबाद, द्वारा निम्न ATR दी गई है - मामले को रोजगार जनित चोट के रूप में स्वीकार कर लिया गया है श्री को भी दूरभाष के माध्यम से सूचित कर दिया गया है I अतः मामले में अग्रिम करवाई के लिए शाखा कार्यालय में आकर सम्पर्क करे I

Rating	Poor
Rating Remarks	not resolved.Citizen is saying that he goes to office again and again but makes him sit the whole day and does not do any work.

Appeal Details

Appeal Number	
Date of Receipt	25/03/2025
Appeal Text	not resolved.Citizen is saying that he goes to office again and again but makes him sit the whole day and does not do any work.

8.1.4 Technical difficulties of CPGRAMS; Separate Registration required; Offline process still critical

Centralised online grievance filing can exclude workers without smartphones, email access, or usable email IDs.

Many insured persons (IPs) are not digitally confident, and CPGRAMS filing adds another layer of complexity. In practice, IPs typically cannot use their ESIC IP Portal credentials to raise a CPGRAMS grievance. Instead, CPGRAMS requires a separate registration with a new user ID and password. This creates friction for workers who may have limited smartphone access (SII FGDs show only c.50% smart access), low digital literacy, or difficulty managing multiple logins. Further, the "AAA" app does not offer a simple in-app CPGRAMS integration, so IPs cannot smoothly move from the ESIC service interface to grievance filing.

CPGRAMS is available via the UMANG app.

Evidence (SII survey, July 2021; n=108):

- 87% were not aware of the ESIC website, so they do not use the IP Portal on their own.
- 84% did not know ESIC falls under the Ministry of Labour & Employment, a field they must complete to submit a complaint.
- 72% lacked a usable email ID (did not have/forgot/didn't know), another mandatory requirement to register on CPGRAMS.

Implication: Design and process choices (mandatory ministry selection, email requirement) create a technology/knowledge gap that keeps many IPs from accessing formal grievance channels.

8.2 Suvidha Samagam: Extremely Useful Offline Forum; Makes a Huge Difference to IPs, when and where it works

8.2.1 Over Half of Injured IPs Report Resolution After Suvidha Samagam

In a Focus Group Discussion (SII, March 2023; n=44 injured workers), Insured Persons (IPs) reported that over 50% of issues raised at Suvidha Samagam were eventually resolved. Several participants noted, however, that resolution still took 2–3 months in some cases, indicating that while the forum can trigger action, time-to-closure varies.

8.2.2 Irregular Sessions and Limited Access Reduce Effectiveness

Although Suvidha Samagams are scheduled monthly on fixed days at RO/SRO and DCBO/BO (2nd Wed/2nd Fri), participants reported that sessions were sometimes not held or the venue/notice wasn't adequately publicised, causing IPs to miss opportunities to raise concerns.

Table 8.1: Regularity of Suvidha Samagams – Haryana and Maharashtra

	RO/SRO	Branch
Haryana	Regular	Never
Maharashtra	Regular	Some Branches

Unfortunately, no written response is provided to IPs. No minutes of the Suvidha Samagams are put in the public domain.

NGO Representatives are not allowed to accompany IPs to Suvidha Samagams in some regions

SII field team members also report that, in some locations, they were not permitted to accompany workers into the venue. Where cases were not fully resolved on the spot, this led to information gaps between what was said in the forum and what the worker later understood, making follow-up actions harder to determine.

8.2.3 Low Employer Participation

As observed by SII across the last 10 years, employer participation in Suvidha Samagams remains negligible. This is a critical gap because several key roadblocks in benefit processing sit at the employer end, e.g., submission of required forms/documents like Accident Reports.

Employers who default repeatedly on the submission of forms/documents should be summoned to the Suvidha Samagams for better compliance.

Two of three Suvidha Samagams revived/regularised following SII advocacy in Haryana and Maharashtra have been discontinued

Safe In India Foundation's advocacy has contributed to the starting, restarting, or making regular Suvidha Samagams in the following locations:

- Sector 8, Faridabad (Discontinued)
- Sector 23, Faridabad (Discontinued)
- Bhosari, Pune

These Suvidha Samagams had been useful in resolving insured persons' (IPs) issues by providing a structured forum for on-the-spot troubleshooting, document checks, and follow-ups with ESIC officials.

SII thanks SRO Pune for these improvements and requests SRO Faridabad to restart Suvidha Samagams at BOs.

8.3 Outsourced ESIC Helplines: Difficulty Connecting, Advice Often Redirects, Metrics Unpublished – a Cautionary Case for Privatisation

ESIC does not appear to publicly publish helpline call-performance or user-satisfaction metrics. It provides toll-free grievance helplines and other grievance channels, but the current service model and performance standards are not transparently reported in the public documents reviewed.

8.3.1 IPs Struggle to Get Through to Privatised Helpline Support

Finding (SII survey): In a field survey of 96 Insured Persons (IPs) who attempted calling ESIC helpline numbers during April–May 2021, 45% reported they could not speak to anyone.

Implication: Nearly 1 in 2 callers failed to reach an agent, indicating a significant accessibility constraint for helpline-based grievance redressal in the period surveyed.

Figure 8.5: Helpline Access - IPs Unable to Reach Support (SII, Apr–May 2021; n=96).

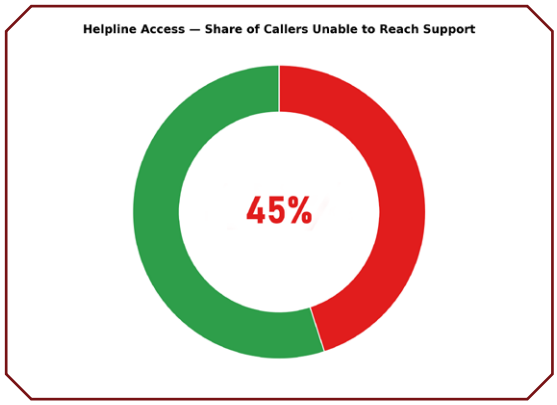
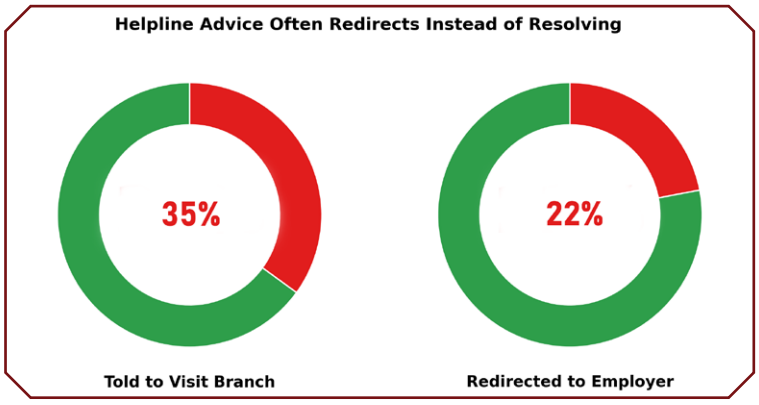


Figure 8.6: Unhelpful helpline suggested solutions among IPs who received advice(SII, Apr–May 2021).



8.3.2 Service Quality: Offered Solutions Often Don't Solve

Among IPs who actually received a suggested solution from the helpline:

- 35% found it not helpful because they were simply told to visit the branch office.
- 22% were redirected to their employer, rather than receiving actionable support.

8.4 Low Awareness and Accessibility of Grievance Redressal Mechanisms (SII Surveys)

8.4.1 Worker Voice: Low Awareness, Preference for In-Person Complaints

Most IPs aren't fully aware of formal grievance options; most default to visiting the Branch Office and speaking to multiple officials without filing a formal complaint.

CPGRAMS (online portal):

SII FGD (Mar 2023; n=44 injured IPs struggling with ESI processes): 0% had ever filed on CPGRAMS.

Helpline (telephonic):

SII survey (May 2021; n=117): 87% not aware of the ESIC helpline number; among them, 64% didn't know where to find it.

Suvidha Samagam (offline forum):

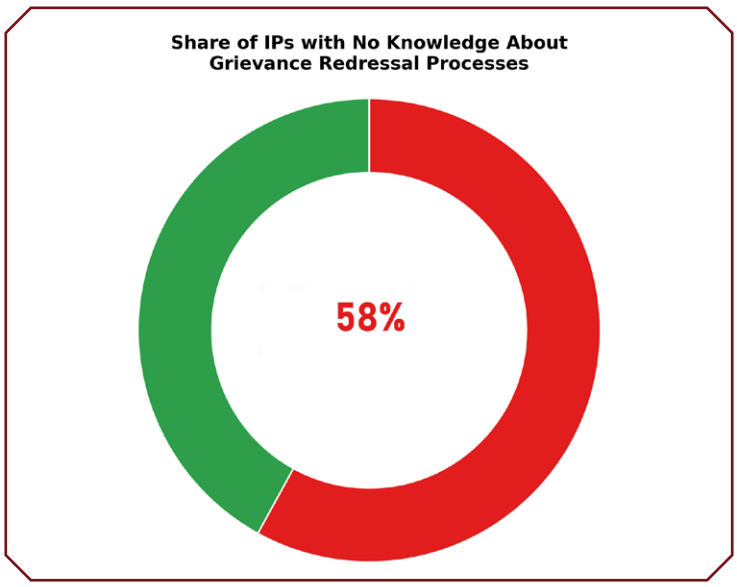
ILO employer survey (2022): Only ~1 in 3 employers are aware of Suvidha Samagam.

Overall awareness of mechanisms:

ILO employer survey (2022): Only ~50% employers aware of available grievance redressal mechanisms.

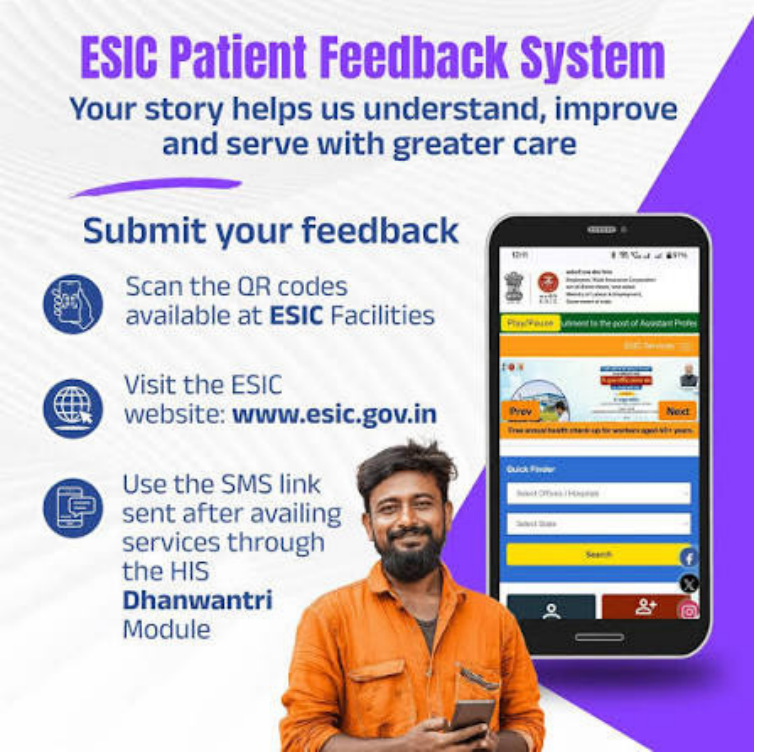
SII survey (July 2021; n=108): 58% of IPs did not know how to raise a complaint by any means.

Figure 8.7: Share of IPs reporting they did not know how to file a grievance by any means (July 2021; n=108)



8.5 ESIC's new Feedback System for Dispensaries & Hospitals, launched in July 2026

A new Feedback system by ESIC with questions on cleanliness, doctor/staff behaviour, waiting time, and medicine availability.



Through a direct feedback link via SMS after availing services through the ESIC HIS (Dhanwantri) Module; QR codes on multilingual posters at OPDs; and direct submission through the ESIC website.

Critical issues are automatically flagged when service ratings fall below 3.

SII will report on workers feedback on the Feedback system.

8.6 Recommendations

8.5.1 Measure satisfaction across all channels; For CPGRAMS - change reporting from "disposed" to satisfactorily resolved.

Publish both metrics (sample reporting for "resolved" to start with).

Run a uniform post-closure survey for CPGRAMS, helplines, and Suvidha Samagam. Publish the satisfaction score.

8.5.2 Improve Response Quality (Across Channels)

Target clear, actionable responses, and fewer reopens of grievances

Train the helpline teams for better first-time resolution and keep the helpline technically robust so IPs do not have to call multiple times to connect.

8.5.3 Integrate CPGRAMS into the ESIC IP Portal/ESIC app via single sign-on (no separate registration) and enable a one-click "Raise Grievance" flow with key IP details auto-filled.

8.5.4 Make Suvidha Samagams more IP-centric and effective

- Hold sessions as scheduled; Identify failing RO/SROs and DCBO/BOs and enforce monthly sessions.
- Publicise dates/venues in advance to IPs.
- Additionally, inform employers.

- Use multiple channels for communication (Phone calls, Messages, WhatsApp, and Letters)
- Branch Office (BO) managers should be present for the Suvidha Samagams
- Suvidha Samagams are currently designed as a closed-door meeting. They should be designed as a Jan Sunwais with the IP being allowed to take help from NGOs/civil society and trade unions.
- Follow-through: Issue an Action Sheet at Samagam and track closure to completion and publish status publicly; Every IP with a case raised in Suvidha Samagam should leave with a written Action Sheet (paper + digital) assigning an owner, steps, and dates, and should be tracked to closure.

8.5.5 Awareness: Boost user guidance (both on availability of grievance mechanisms and usage)

i. A simple how-to guide

ii. Assisted filing

iii. Multilingual materials

Print ESIC helpline numbers on e-Pehchan cards, OPD tickets and slips

Project Hazaron Khwahishen – SII's Collaborative Initiative with ESIC to Resolve 1000+ Long-Pending ESIC Benefit Cases; Early Progress

Under Hazaron Khwahishen, launched in July 2025, SII is taking up and following up 1000+ long-pending TDB/PDB cases in Haryana and Maharashtra on behalf of IPs, and is sharing consolidated case lists with the concerned ESIC offices for targeted action. ESIC thankfully acknowledges the issue and indicates support for coordinated follow-up on the flagged cases.

The delays are arising from non/late accident reports, procedural complexity, low worker awareness, and documentation lags by employers/contractors, factors that are keeping eligible claims pending and are prolonging hardship for injured workers and families. All factors are explained in Chapter 2 and other chapters.

SII is providing case details, is supplying available documents, and is aligning next steps with ESIC (e.g., Accident Report submission, wage verification, payment processing) to secure the timely settlement of the pending claims.

Figure 8.8: Project Hazaron Khwahishen – Case Status – 32% Cases Progressed (by 11th August 2026)





CHAPTER 9

Common Process Issues Across Various ESIC Benefits: A Case for Process Re-Engineering



9.1. Responsibility and risk are pushed to IPs (workers) instead of employers

Fragmented responsibility, weak compliance by employers, and inadequate ESIC follow-up result in delays, which can stall claims, and the IP bears the burden.

Example (TDB/PDB): Case creation and TDB start hinge on the Employer Accident Report (Form 12); when it is late or incomplete, processing stalls and IPs repeatedly follow up. c.40% of Accident Reports are either not submitted or submitted late by employers.

Example (Sickness Benefit): Payments can remain pending even after medical certification when the employer does not submit Form 10 (abstention verification) promptly.

Example (Reimbursement): Employer-dependent documents (e.g., Accident Report for IPD reimbursement) can delay or block filing when employers are unresponsive.

Example (Maternity Benefit): Employer-dependent documents (e.g., employer affidavits demanded in some MB checklists) can delay or block filing when employers are unresponsive.

9.2. Incomplete end to end digitisation results in online processes dropping into offline steps

Online and offline processes work best as separate and parallel steps. For some processes, IPs have to apply through online steps without removing some of the offline work; IPs end up doing both.

Example (Sickness Benefit): IPs may receive printed certificates and still need to carry them to the Branch Office for upload; until the BO upload happens, the claim is effectively not created.

Example (Disablement Benefits): In practice, in many locations, IPs physically courier RM-3/BI-1(a) and related papers between the BO & the dispensary, and BO then re-uploads them online.

Example (Reimbursements): Online reimbursement adds bank + employer verification and bill uploads, while the underlying paperwork and visits still persist.

9.3. Manual processes persist even where automation is feasible

Manual process residues remain even where automation is feasible, creating avoidable trips and queues.

Example (Medicine Availability at Dispensaries and Hospitals): Manual processes result in medicine unavailability, stock-outs, repeated shortages, and abnormal patterns (including leakages), where existing automated processes could be used instead to resolve shortages.

Example (Sickness Benefit): Digital systems exist for prescriptions, but sick-leave certificates are not consistently created/submitted digitally, leading to repeat visits and paper movement.

Example (Facility data not used): Even for ESIC-hospital deliveries, the Maternity Benefit claim steps aren't automated and still demand the IP's physical presence, duplicating data the hospital already holds.

Example (Internal forms become IP couriered forms): In Disablement Benefits, RM-3 / BI-1(a) are intended as internal inter-office documents, but in practice, IPs are often made to physically courier them between centres.

9.4. Low visibility and unpredictable communication force IPs into repeated visits to "find out"

Low visibility and weak communication push IPs to keep returning to check status, because they have no independent way of knowing where their claim sits in the pipeline.

Example (Disablement Benefits): After a file moves from BO to SRO for Medical Board processing/approval, IPs often lack tracking, acknowledgement of completeness, and clear next-step communication.

Example (Decision Letters): Decision Letters and intimations are not reliably delivered, pushing many IPs to collect in person and delaying first credit/arrears.

Example (Sickness Benefit): Portal and eKYC/linking issues can prevent submission or confirmation; IPs cannot tell whether the claim is in the system, and need repeated visits.

9.5. No acknowledgement of receipt or completeness of a process across IP journeys

IPs receive no acknowledgement at the point of document submissions for benefits: no receipt confirming that documents were accepted, no confirmation of completeness, and no unique reference against which to follow up.

Example: Across payment benefits, IPs aren't provided acknowledgements.

Draft ESI Regulations 2026 include the following (Regulation 29): "The claim for any benefit shall be acknowledged electronically or otherwise."

Shalini Doke



Shalini Doke received a minor injury while working at a supplier factory in Pune. The doctor handed her a seven-day medical (rest) certificate.

When she went to submit the certificate at the ESIC branch office, she was told it would first have to be uploaded online, but no one explained how. She then went to ESIC Hospital, Mohan Nagar, for help, but received none there either.

On her way home, a security guard at the gate told her about the SII office nearby. SII uploaded her certificate online.

9.6. Non-standardisation results in local "checklist risk" and avoidable rejections

Non-standardisation creates 'checklist risk'; requirements vary by office, increasing rework and discretion.

Example (Maternity Benefit): Different BOs use different MB checklists (e.g., an 18-item list in Faridabad that was later reduced) and demands like marriage certificates can persist unevenly across locations.

Example (Reimbursements): Some dispensaries insist on local reimbursement formats rather than standard forms, causing duplicate form-filling and avoidable back-and-forth.

Example (Life Certificate): Lack of a clear, public list of authorised signatories leads to inconsistent acceptance and repeat submissions.

9.7. Processes need to be reengineered for low digital access, outages, illness, pregnancy, mobility constraints

Process design often assumes time, mobility, stable internet, and digital access—exactly what many IPs lack when sick, injured, or postpartum.

Example (Reimbursements): With many workers lacking smartphones (c.50% of IPs supported by SII), online-first steps can exclude; offline submission then means queues, wage loss risk, and multiple visits.

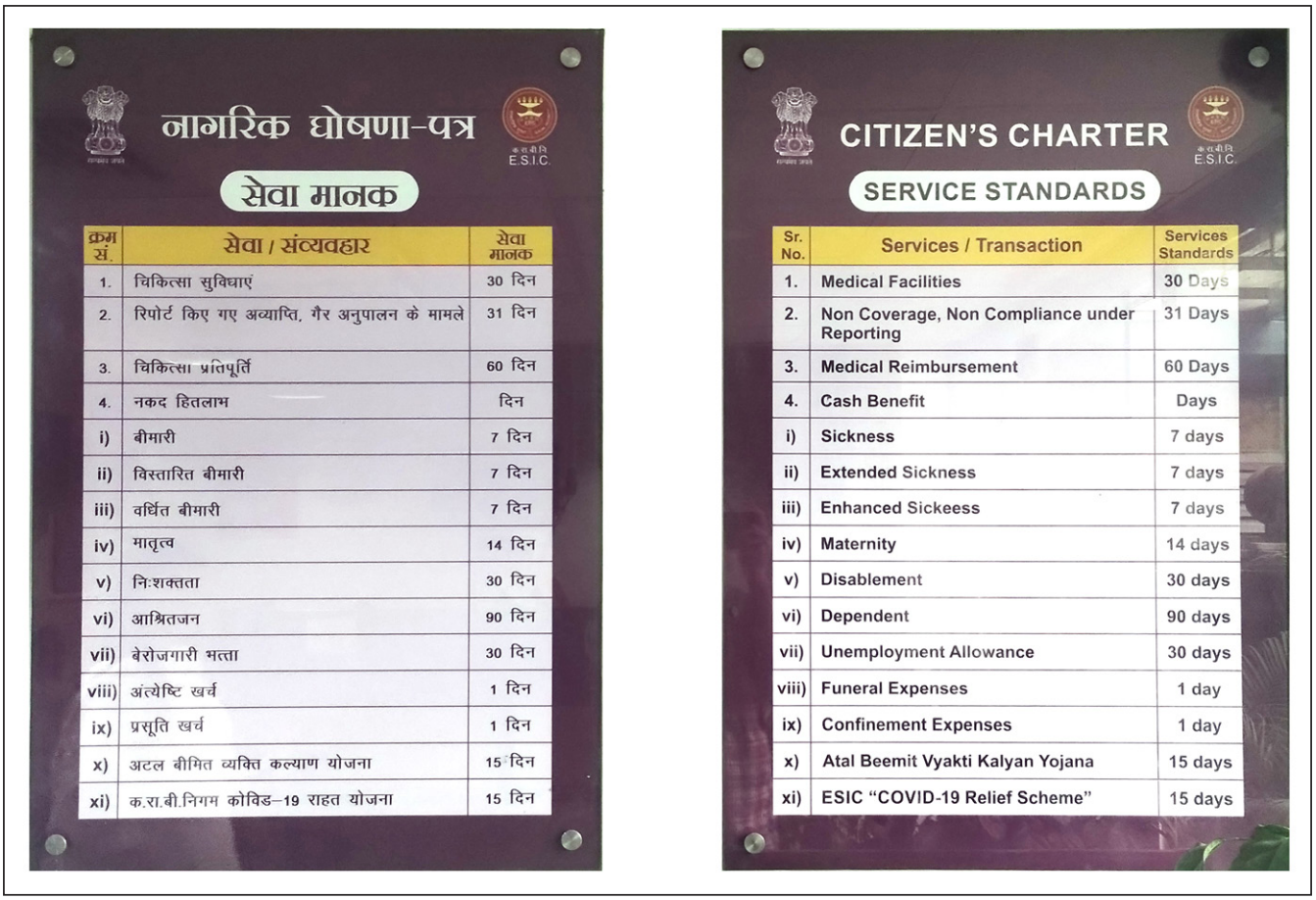
Example (Sickness Benefit): Journeys can require multiple locations in a day; proxy submission may require leaving identity documents, and outages/internet failures block uploads.

Example (Maternity Benefit): Neonatal mothers are required to physically visit within 30 days post-delivery to obtain Form 18; even for ESIC-hospital deliveries, there is no simplified 'zero-touch' pathway.

Please refer to Chapter 21 for SII's recommendations on Re-engineering.

9.8 Impact of Process Issues: Citizens' Charter's Service Standards not met

The Citizens' Charter is ESIC's public-facing service commitment pledge to IPs and their families about what services ESIC will deliver, to what standard, and within what timeframes.



नागरिक घोषणा-पत्र

सेवा मानक

क्रम सं.	सेवा / संव्यवहार	सेवा मानक
1.	चिकित्सा सुविधाएं	30 दिन
2.	रिपोर्ट किए गए अव्याप्ति, गैर अनुपालन के मामले	31 दिन
3.	चिकित्सा प्रतिपूर्ति	60 दिन
4.	नकद हितलाभ	दिन
i)	बीमारी	7 दिन
ii)	विस्तारित बीमारी	7 दिन
iii)	वर्धित बीमारी	7 दिन
iv)	मातृत्व	14 दिन
v)	निःशक्तता	30 दिन
vi)	आश्रितजन	90 दिन
vii)	बेरोजगारी भत्ता	30 दिन
viii)	अंत्येष्टि खर्च	1 दिन
ix)	प्रसूति खर्च	1 दिन
x)	अटल बीमित व्यक्ति कल्याण योजना	15 दिन
xi)	क.रा.बी.निगम कोविड–19 राहत योजना	15 दिन

CITIZEN'S CHARTER

SERVICE STANDARDS

Sr. No.	Services / Transaction	Services Standards
1.	Medical Facilities	30 Days
2.	Non Coverage, Non Compliance under Reporting	31 Days
3.	Medical Reimbursement	60 Days
4.	Cash Benefit	Days
i)	Sickness	7 days
ii)	Extended Sickness	7 days
iii)	Enhanced Sickeess	7 days
iv)	Maternity	14 days
v)	Disablement	30 days
vi)	Dependent	90 days
vii)	Unemployment Allowance	30 days
viii)	Funeral Expenses	1 day
ix)	Confinement Expenses	1 day
x)	Atal Beemit Vyakti Kalyan Yojana	15 days
xi)	ESIC "COVID-19 Relief Scheme"	15 days

Citizens' Charter displayed at an ESIC Office

But based on the experience of IPs supported by SII, the Citizens' Charter commitments aren't met.

Sl. No.	Benefit	Service Standard (Citizens' Charter)	Median Turnaround Time
1	TDB	30 days	187 days (from Accident)
2	PDB	30 days	470 days (from Accident); 144 days from TDB to Medical Board and 69 days from Medical Board to Decision Letter
3	Maternity Benefit	14 days	165 days
4	Sickness Benefit	7 days	58 days
5	Reimbursements	30 days (ESIC)	164 days (State Govts)

Service standards are not defined for the different steps involved in each benefit's process.

CHAPTER 10

ESIC's Digital Systems and AI: Uneven Adoption; Future Opportunities



ESIC has moved meaningfully toward digitisation, but not yet toward a consistently digital user experience. Across registration, benefits, medical services, and dashboards, ESIC has introduced important systems and tools. Yet many core processes still remain fragmented, partly manual, and difficult for workers to navigate. The challenge, therefore, is to make existing systems simpler, more integrated, more visible, and more reliable in practice, along with introducing more technology.

10.1 Key Principles of ESIC IT Reform (the "big picture")

ESIC needs to become a predictable, trackable service where an insured person (IP) can register, access care, and receive cash benefits with minimal visits, minimal dependence on employer action, and full transparency on status and timelines. Therefore, SII proposes a set of 9 Principles for ESIC IT reform:

Principle 1: Worker-first service design

Design journeys around the worker's reality (low time, low digital literacy, high dependency), not internal ESIC departments.

Principle 2: Reduce dependence on the employer & local discretion

Give workers more direct ability to view/correct/track core records; reduce errors created by employer-entry and manual selection.

Principle 3: End-to-end digitisation (not just digital submission)

A process is not "digital" if an IP must carry papers between offices, or if internal papers move physically.

Principle 4: Once-only data + verified data at source

Capture core identity/address/employer linkage once, verify early, reuse everywhere; prevent errors at the start.

Principle 5: Default transparency and measure accountability (clear performance indicators)

Every service journey must have acknowledgement of receipts, visible status, timelines, pending actions, next steps and measurable service standards (for IP and employer). Transparency reduces visits and corruption risk.

Principle 6: Adoption is a program, not a feature

Training, incentives, workflow enforcement, and monitoring must be built into reform, especially across 2,000+ locations.

Principle 7: One front door, modular services behind the scenes

Create a single, coherent worker-facing front end, with APIs and modules behind it. Avoid channel duplication.

Principle 8: AI as bottleneck management, not optics

AI should diagnose delays and defects, detect fraud, predict workload, triage issues, and trigger proactive communications.

Principle 9: Privacy, security, fraud detection, and resilience by design

Given ESIC's scale and sensitive data, role-based access, audit trails, uptime targets, and DR drills are non-negotiable.

10.2 Registration and enrolment: improved digital architecture, but still too dependent on employer actions

For registration and enrolment, ESIC has a reasonably clear digital architecture: employer-side registration, worker-side access through the IP portal, and a backend system that holds the record and enables later access/edit access.

10.2.1 Recent reforms give IPs a greater role, but the system remains employer-dependent

The registration layer still depends heavily on employer action. Initial onboarding, key employee particulars, and much of the accuracy of the worker record continue to be dependent on the employer, resulting in non-registration, no cards and therefore no access, missing or incorrect details, and non-payment of dues by employers. *Please check out Chapter 12 for data on these issues.*

Some of the structural factors leading to the above issues are:

i. **Employer power is too high:** employer control over registration, card delivery, and corrections leaves the worker with little fallback when the employer delays or evades.

ii. **Registration is not being treated as a compulsory joining step**; it is still functioning like a back-office activity that can be delayed.

iii. There is institutional resistance to empowering workers directly, with **control still designed to sit mainly with employers or intermediaries**.

iv. **Contractor/principal employer responsibility is blurred,** which weakens accountability at the point of onboarding.

v. **Awareness is low** among both workers and employers, including on registration, e-Pehchaan, family addition, and actual benefit use.

vi. The **quality of ESIC consultants/facilitators is uneven**, and many do not adequately understand, explain, or push benefit access.

More recent technology changes that allow IPs to initiate updates to personal or family details are a clear improvement, but they do not fully change this basic dependence, since employer verification and Branch Office approval still remain part of the workflow.

10.2.2 Employer mistakes (intentional and unintentional) create later benefit frictions for IPs

When employers enter weak or incorrect data, the problems often surface much later, when IPs try to access benefits. In cases of IPs supported by SII, employers often fail to record complete, verified, and accurate addresses, provide incorrect telephone numbers (e.g., Contractor instead of IP), omit family members, and even register some IPs under nicknames. These errors weaken record reliability and create downstream problems for communication, document delivery and benefit access. Corrections come too late and remain too employer-dependent.

Indrapal Saket



Indrapal Saket works in a small auto-parts unit in Pune with only six workers on the floor. On 28 October 2025, a heavy component fell on his foot at work. The unit had no safety shoes, gloves, masks, or even a first-aid kit for its workers. In his words: "Sir, there are only six workers in our company, and there is only one safety shoe. How will everyone get it?"

The injury initially looked minor. After a few days of rest, the contractor asked him to resume work without full treatment. The injury worsened, and his toe was severely damaged, an outcome a basic safety shoe would likely have prevented.

His TDB file then ran into an administrative tangle. His branch was Akurdi, but the contractor submitted his online file to another branch. Because of the “sub-code system”, the case was admitted online at Bhosari branch while the physical documents remained at Akurdi, invisible on the portal to other officials.

In the next two months, he was told he had been removed from work, that no accident report had been submitted, and that he would receive no benefits, despite the fact that he was carrying a copy of the accident report, which no one bothered to verify.

After SII's intervention and a visit to the Akurdi branch, the Branch Manager accepted the pending documents and assured that the benefit amount would be credited within eight days.

10.2.3 Aadhaar seeding is a strong improvement, but it is still not universal and not a complete solution.

Aadhaar seeding is one of the strongest recent improvements for ESIC registration. ESIC was formally allowed to seed and authenticate Aadhaar for the identification of beneficiaries on a voluntary basis in January 2023. ESIC's standard note reported that about 48.76 lakh beneficiaries (c.3%) had been Aadhaar-seeded as on 1 January 2024. Recent data is not available. Aadhaar seeding is now available through multiple channels, including the app, IP Portal, Employer Portal and staff login.

Aadhaar clearly helps with de-duplication and improves accuracy in fields such as name and date of birth. But it is not a one-stop solution. Aadhaar-based registration is mandatory but not fully enforced, and even where Aadhaar is used, address details may remain incomplete or unverified. Aadhaar can clean up part of the record, but it does not by itself fix weak address capture, wrong facility mapping, or broader enrolment-quality problems.

Wrong dispensary mapping creates avoidable hardship.

A practical issue seen in the field is dispensary allocation at the time of enrolment. Even within a digital system, the selected dispensary may not always be the nearest or most suitable one. In practice, employers or data-entry operators may simply select the dispensary that appears first for the district, rather than the one closest to the worker's actual residence or workplace. Where such a wrong or default selection is made, the worker later faces difficulty in accessing routine care, medical certification, and other services. In many cases, the IP is first told to get the dispensary corrected and only then approach the correct dispensary, creating extra visits and delay.

This is exactly the kind of simple, easily corrected, problem technology should solve better. Dispensary allocation should be automatically guided by verified address, work location and geographic proximity, with the system automatically surfacing the nearest and most relevant options, rather than leaving the choice to error-prone manual selection. Further improvements would be AI-driven, linked with the latest information, closer to real time.

10.3 Front-end access tools: ESIC Health Connect/AAA+ and related digital tools show real promise, but awareness and use remain extremely low

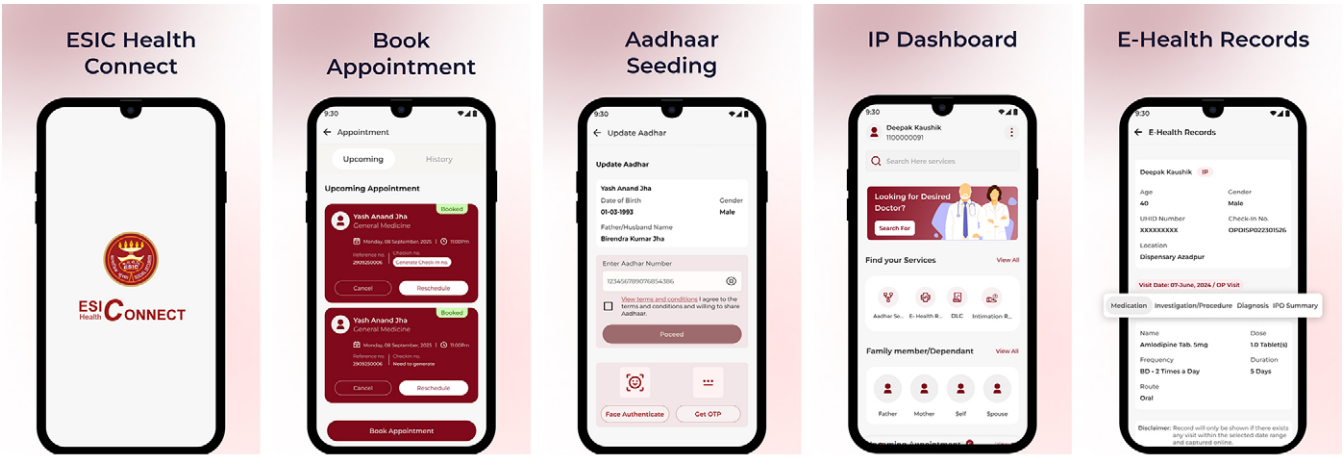
ESIC's main worker-facing digital access layer is now the AAA+ app, recently revamped as ESIC Health Connect. AAA+ was originally launched 7 years back on 10 April 2017 for prior OPD appointments; the app has expanded beyond appointment booking. It now includes self-check-in, viewing personal details, tracking update requests, checking benefit eligibility, downloading e-Pehchan, viewing contribution details, claim-intimation status, home sample collection requests, Aadhaar seeding, and ABHA generation.

ESIC also provides access through other channels, such as UMANG, but AAA+/Health Connect appears to be its main dedicated beneficiary-facing app.

10.3.1 The front-end digital layer has improved significantly

The expansion of AAA+ into ESIC Health Connect (January-February 2026) is a step forward. ESIC's 2025 standard note mentions that the app was fortified with new beneficiary-facing features, and that the number of online appointments increased by 177% from 2023 to 2024. The app already showed 1M+ downloads on Google Play, indicating meaningful reach at least in terms of installations. Taken together, this suggests that ESIC has moved beyond a narrow appointment tool toward a broader service-access interface.

Image 1: Screens from ESIC Health Connect App



10.3.2 Awareness and actual use remain very low among workers

Despite these improvements, data from SII's FGDs show that awareness and real use remain weak. Among FGD participants in Haryana and Maharashtra in January 2026 (n=48), only 25% were aware of the AAA+ app, and only 15% were aware of the UMANG app, despite SII efforts at awareness. *More strikingly, only 8% reported using digital tools/apps for accessing ESIC benefits.*

Figure 10.1: Awareness of the AAA+ app and Umang app among FGD participants (IPs) in Haryana and Maharashtra (January 2026; n=48)

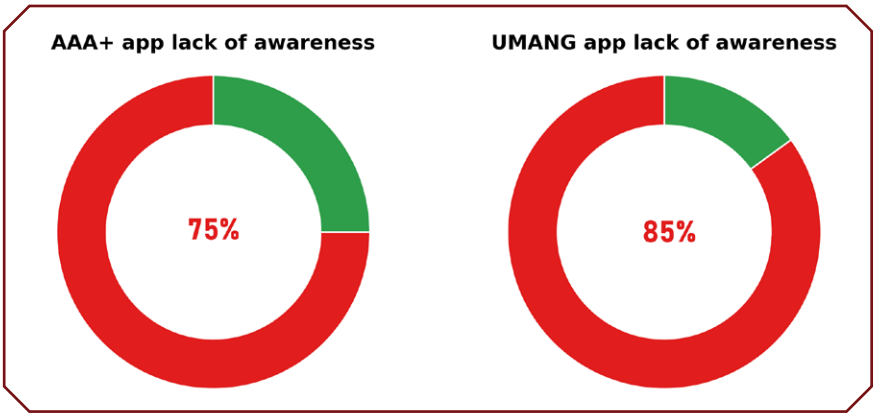
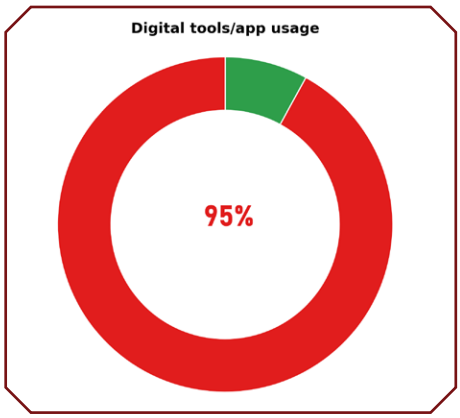


Figure 10.2: Usage of digital solutions for accessing ESIC benefits among FGD participants (IPs) in Haryana and Maharashtra (January 2026; n=48)



10.4 Digital layer has been added on top of legacy systems and processes; only a limited improvement to IP journeys

10.4.1 Cash-benefit digital journeys: online pathways exist, but end-to-end digitisation remains weak

On paper, digital pathways exist for major cash benefits such as Sickness Benefit and Maternity Benefit, and parts of the disablement-benefit journey are also digitised. For PDB, some processes such as the Life Certificate have moved online. But the overall journey is still far from truly end-to-end digital for most IPs.

In practice, *IPs are still often required to print, carry and submit papers in person.* There is also little visibility on file movement or status.

(Please check chapters 2 to 5, 7, 8 and 9 for details)

10.4.2 Medical Benefit technology: the digital front end is expanding, but service quality still depends on last-mile execution

On paper, ESIC's medical-technology stack now spans appointments, OPD e-check-in, tele-consultation, home delivery of medicines, e-prescriptions, hospital information systems, e-claims for cashless referrals, and ABHA-linked digital records. This is a meaningful shift. Even one change, i.e., moving from a paper trail to digital medical records, can make the patient journey more traceable and far easier to manage. At the same time, *the real value of this technology still depends on whether it is actually used well at facilities and backed by reliable staffing, diagnostics, medicine stocks and referral systems.*

ESIC's official app now supports OPD booking/rescheduling and digital check-in. Tele-consultation through eSanjeevani can help where in-person visits are difficult. Eligible IPs can receive up to 90 days of medicines at home, hospitals are increasingly using digital prescriptions, and the Bill Processing Agency enables e-claims and direct payment to empanelled hospitals for cashless referrals. There is also an ABDM/ABHA push, with early pilots showing digital health records and online prescriptions.

ESIC also says that the Dhanwantri module is being used more widely in hospitals and dispensaries, with a 50% growth in adoption since the beginning of 2024.

Adoption on the ground remains uneven:

At some dispensaries and facilities, digital systems (e.g., e-prescriptions) appear underused, while staff and patients continue with older manual methods.

What is needed now is stronger adoption: clearer workflows, better training and skilling of doctors and frontline staff, and regular worker awareness efforts so that the digital systems already introduced are actually used in day-to-day care.

10.4.3 Panchdeep: legacy design still limits performance

Panchdeep is ESIC's core digital backbone. It was conceived in 2009 and went live in 2011, and even though ESIC has upgraded it repeatedly, it still appears to operate as a legacy system under continuous repair rather than as a clean modern rebuild. ESIC's older official note says it covers 2300+ locations. A new system integrator, ECIL, took over in 2023 for a 3-year period. ESIC's own recent note highlights major upgrades to infrastructure, software and connectivity, which suggests that reliability and usability remain live concerns.

Examples: IPs supported by SII have reported that:

i. After the Accident Report is submitted, they or their employers are sometimes unable to upload supporting documents through the system. From their perspective, this appears to be due to a back-end technology issue, after which the process shifts back to physical submission.

ii. The system hangs/crashes during peak hours, an issue which severely impacts dispensary operations.

10.5 Dashboards and monitoring: ESIC has expanded management dashboards, but still lacks a public/IP-facing dashboard

10.5.1 ESIC already has a significant management dashboard layer

ESIC already uses dashboards for internal monitoring and senior management. By 2021-22, it was reporting a Performance Dashboard and a Management Dashboard for top management. By 2025, the management dashboard menu had widened to include Hospital, Construction, Medical Equipment, Vacancy, Analytics and Patient Feedback dashboards.

ESIC also says that during 2024–25 it added newer dashboards for DO letters, audit paras and CCTV surveillance of medical colleges and hospitals.

10.5.2 What is still missing is a simple, public IP and employer-facing performance dashboard

What ESIC still does not appear to publish in a simple and regular way is a dashboard of the indicators that matter most to IPs: e.g., application-to-decision time, decision-to-credit time, pendency, overdue cases, acceptance and rework rates, grievance redressal data and branch-wise performance.

This matters because ESIC already has time-bound service commitments through its Citizen's Charter and related service standards. A public dashboard against these indicators would make those commitments visible, reduce repeat enquiry visits, and help identify bottlenecks faster.

Image 2: Sample Public Facing Dashboard – NHS England

Provider	Elective proportion waiting within 18 weeks ▲ Rank out of 118 May 2026	Elective proportion waiting over 52 weeks Rank out of 118 May 2026	Cancer faster diagnosis Rank out of 118 May 2026	Cancer 31-day treatment Rank out of 117 May 2026	Cancer 62-day combined Rank out of 117 May 2026	Diagnostics proportion waiting over 6 weeks Rank out of 118 May 2026	A&E 4-hour performance Rank out of 118 Jun 2026	A&E 12-hour performan Rank out of 1 Jun 2026
NHS Foundation Trust	**83.1%** 1	0.1% 14	86.0% 9	92.9% 83	77.2% 27	18.3% 61	78.1% 27	4.6% 20
Northumbria Healthcare NHS Foundation Trust	**83.0%** 2	0.0% 1	83.1% 29	97.2% 31	80.6% 13	0.7% 1	91.2% 1	0.1% 1
Gateshead Health NHS Foundation Trust	**78.4%** 3	0.1% 12	45.0% 118	100.0% 1	65.2% 85	7.8% 20	77.7% 32	1.8% 8
Tameside And Glossop Integrated Care NHS Foundation Trust	**77.6%** 4	0.0% 1	82.6% 31	96.5% 46	78.7% 20	1.2% 3	62.8% 113	10.3% 59

10.6 ESIC and AI: current use is limited, but the potential for service improvement and fraud detection is huge

At present, ESIC's publicly visible AI use appears narrow.

Some ideas/early suggestions for AI use given below.

10.6.1 ESIC already has a chatbot layer, but it does not appear to function

The clearest official example of AI use by ESIC is the AI-based chatbot / virtual assistant on the ESIC website. ESIC was already talking about implementing an AI chatbot in January 2023, later public material in 2023 described a first chatbot/virtual assistant for scheme queries, and ESIC issued a fresh procurement for an AI-based chatbot in September 2024 with multilingual text and audio capability and website/WhatsApp deployment in scope.

But it does not appear to be functioning as a robust, dependable first-line support channel for users

10.6.2 AI for cash-benefit operations: identifying where delays occur, and why

ESIC already has a large digital workflow and transaction data through Panchdeep and related systems; AI can be used, e.g., to identify where files are getting stuck.

It can flag which BOs/ROs/SROs are taking unusually long for steps such as:

- Accident Report submission
- Certification
- Medical Referee review
- Medical Board scheduling
- Decision Letter issue
- First payment

It can also help classify likely causes:

- staffing shortages
- missing employer inputs
- repeated document defects
- backlog spikes
- system outages
- weak scheduling discipline

This would help ESIC move from passive file processing to active bottleneck management.

10.6.3 AI for medical benefits: identifying shortages, referral stress, and service gaps earlier

AI can sit on top of existing medical data from Dhanwantri, e-prescriptions, booking systems and referral records to identify recurring service gaps earlier. This is an inference from ESIC's stated digital medical stack and chatbot/data ambitions.

It can help identify, e.g.,

- medicine stock-out risk
- facilities repeatedly giving shorter-than-intended medicine supply
- abnormal referral outflow from specific dispensaries
- repeated diagnostics non-availability
- specialist shortages
- machine downtime patterns

This would make AI useful not only for answering questions but also for improving medical service quality and facility readiness.

10.6.4 AI for assisted service delivery: guidance, document checks, and proactive communication

AI can make ESIC much easier to use for workers and employers without changing legal entitlements.

- high-value uses include:
- multilingual guidance in simple Hindi and regional languages
- assisted form filling
- document check before submission
- reminders for missing steps
- nudges for Life Certificate, Medical Board dates, bank mismatch, family linking
- routing users to the right BO, dispensary or hospital

This is also where the chatbot should evolve: from a basic FAQ tool into a real digital assistant.

10.6.5 AI for preventive action: using ESIC data to spot recurring risk and weak compliance

ESIC can use AI not just for service delivery, but for prevention and management. It can help identify:

- injury hotspots
- repeat-defaulter establishments
- branches with chronic delays
- geographies with unusual claim drop-offs
- facilities with repeated medicine shortages or referral overload

That would help ESIC use its own data more strategically, not only to process claims after problems arise, but also to detect patterns early and respond faster.

Please refer to Chapter 22 for a detailed chapter on leveraging ESI data.

10.6.6 AI for fraud detection: catching leakage on the employer, provider and claim side

Anomaly-detection models on ESIC's data can surface likely fraud earlier across stakeholders:

Employer-side: e.g., under-reporting of wages, headcount, or contribution days; contributions collected from workers but not remitted to ESIC.

Tie-up hospital/provider-side: e.g., billing pattern inconsistencies; unusually high SST utilisation from specific geographies; procedure–diagnosis mismatches; repeat readmissions that may indicate padded billing; costs consistently at the upper end of package rates, etc.

Claim-side: duplicate registrations; clustered claims; unlikely combinations; fake dependants etc.

Cross-linkage: employer + hospital combinations that recur across suspicious claims; IP–employer–provider triangles that suggest manufactured episodes.

10.7 Recommendations

10.7.1 Re-engineer registration and enrolment to reduce employer dependence and improve record accuracy

ESIC should redesign registration so that more key fields are validated at the start, while giving IPs greater ability to view, correct and track their own records. Family enrolment, address correction and other changes should not remain overly dependent on employer action after the initial stage.

10.7.2 Use Aadhaar seeding more effectively, while retaining non-Aadhaar access

Aadhaar seeding should continue to be expanded because it improves de-duplication and record accuracy. At the same time, ESIC should recognise that Aadhaar is not a complete solution: address verification, family linking, and facility mapping still require separate process improvements, and non-Aadhaar access routes should remain available.

10.7.3 Automate dispensary and facility allocation based on verified geography

Dispensary and facility allocation should be guided by verified address, work location and proximity, with the system automatically surfacing the nearest and most relevant options. This would reduce wrong mapping, later correction requests, and avoidable hardship for IPs.

10.7.4 Complete end-to-end digitisation of cash-benefit workflows, not just front-end submission

ESIC should ensure digital upload, internal movement and status visibility for all major cash-benefit workflows, including Accident Reports and documents such as RM-3 and BI-1A, so that IPs are no longer made to carry papers between offices in practice, in many locations.

10.7.5 Introduce live status tracking and proactive communication for IPs and employers

ESIC should provide proactive SMS and WhatsApp updates on missing documents, acceptance, pendency, Medical Board dates, Decision Letters, Life Certificates, bank mismatch, and payment release, so that users do not have to make repeated visits just to ask what is happening.

10.7.6 Use technology for inventory management of medicines

Replace ESIC's current periodic medicine-supply model with a technology-based inventory management system; with real-time stock visibility across dispensaries and hospitals, auto-triggered reorder against consumption data, and Dhanwantri-linked prescription flows.

Batch-level tracking also enables expiry management and reduces wastage.

10.7.7 Integrate AAA+/ESIC Health Connect and UMANG into a simpler worker-facing front end

ESIC should integrate AAA+/Health Connect and UMANG more effectively for OPD booking, tele-consultation, e-prescriptions, medicine delivery, claim tracking and record viewing. The aim should be a simpler and more coherent user experience rather than multiple partially overlapping channels.

10.7.8 Focus on adoption, not only on launching more digital features

ESIC should set clear adoption targets for the use of digital tools at hospitals, dispensaries and branch offices. Doctors, frontline staff and administrators need better training and skilling so that systems such as e-prescriptions, digital records, online submissions and tele-consultation are used consistently in day-to-day service delivery.

10.7.9 Make the chatbot a real multilingual digital assistant

The chatbot should be made functional and worker-friendly, with support in simple Hindi and major regional languages. It should move beyond basic FAQs to provide guided help on eligibility, required documents, location/facility routing, and live status support for common service requests.

10.7.10 Use AI and ESIC's own data to identify bottlenecks and service gaps earlier

Please refer to Chapter 22 which covers this recommendation in detail.

10.7.11 Publish a public dashboard of user-facing indicators and branch-level performance

ESIC should publish application-to-decision time, decision-to-credit time, pendency, overdue cases, acceptance and rework rates, grievance outcomes, grievance redressal data, and branch-wise performance on a small set of key user-facing indicators. This would make service standards more visible, reduce repeated enquiry visits, and help both ESIC and users identify bottlenecks faster.



CHAPTER 11

The Employer Perspective: Improved Specific Awareness of ESIC Benefits, especially Cash Benefits, will Increase Adoption

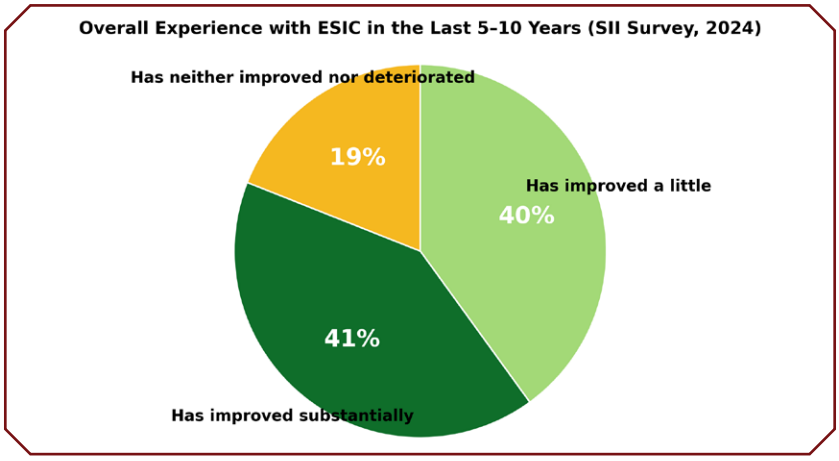


This chapter examines how employers understand and experience ESIC in their routine interactions, distinct from the non-compliance pathways covered in Chapter 12. It focuses on four everyday interfaces: (i) registration and contributions, (ii) medical benefit, (iii) cash ("payment") benefits, and (iv) grievance and help channels. Across these areas, the analysis highlights what employers are aware of, how they perceive processes and services, and what they typically do in practice. However, the depth of evidence varies by interface.

Evidence draws on two employer surveys conducted by SII in March–April 2022 (244 employers in Pune from the manufacturing sector; direct suppliers of a single manufacturing company in Maharashtra) and March–April 2024 (52 employers across multiple sectors), alongside ILO's 2022 survey, Accessing medical benefits under ESI Scheme: A demand-side perspective (553 employers across 4 states and multiple sectors).

Findings from the 2024 SII survey point to marked improvement in employer experiences with ESIC. Four out of five employers (81%) reported that their overall experience had improved over the last 5-10 years, with none reporting deterioration.

Figure 11.1: Overall Experience with ESIC in the Last 5-10 Years (SII Survey, 2024)



11.1 Registration & contributions: High general awareness, but enrolment actions remain uneven, and payment steps remain complex.

11.1.1 Employer awareness is high (90%) on ESIC registration procedures, but weaker on details of enrolment and payment rules

ILO's 2022 employer survey shows strong headline awareness, but there are awareness gaps on specifics. Nine in ten employers (90%) know the registration procedure, yet only around two-thirds know that registration is mandatory (63%) or the salary threshold for enrolment (69%).

Figure 11.2: Employer awareness of ESIC registration and enrolment (ILO Survey, 2022)

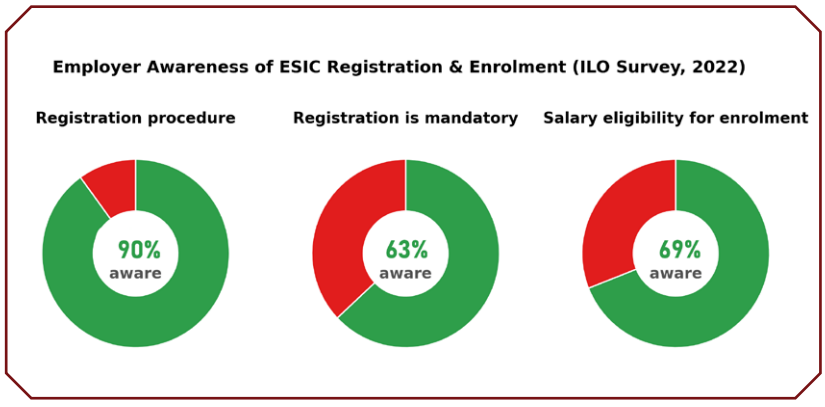
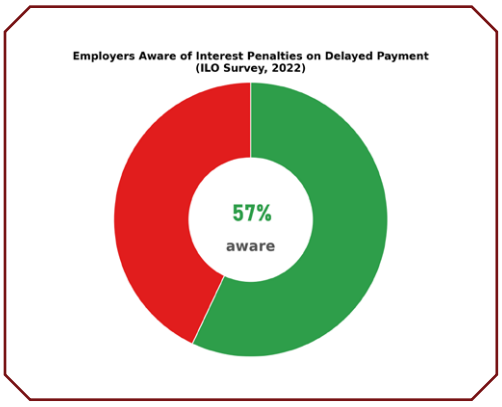


Figure 11.3: Employers aware of interest penalties on delayed payment (ILO Survey, 2022)



On payments, just 57% know that interest is levied on delayed remittances, and roughly two in three can correctly state the employer contribution rate (under 4% of wages) and the due date (by the 15th of the following month).

11.1.2 ILO's 2022 survey found that around half the employers perceived payment steps as complex; SII's 2024 survey shows >20% employees not satisfied with ESIC Processes

ILO's 2022 multi-state survey found that about half of employers viewed the contribution payment process as complicated (Figure 11.4).

A 2024 SII survey of 52 employers reports broadly positive experiences across routine portal tasks, i.e., registration, enrolment, e-Challan payment, and downloading documents (Figure 11.5). But more than 20% respondents were not satisfied.

Together, the sources indicate a perception of complexity around processes.

Figure 11.4: 47% Employers find the payment contribution process complicated (ILO Survey, 2022)

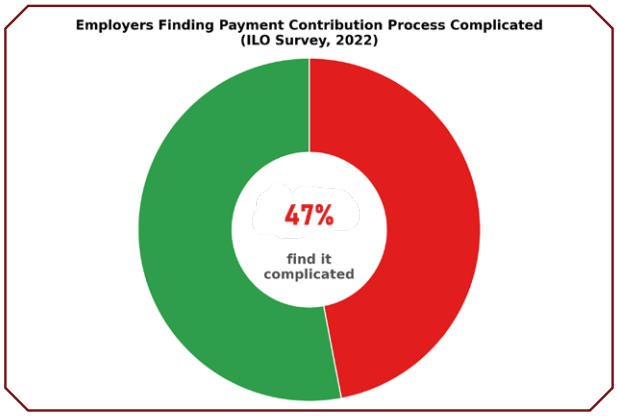
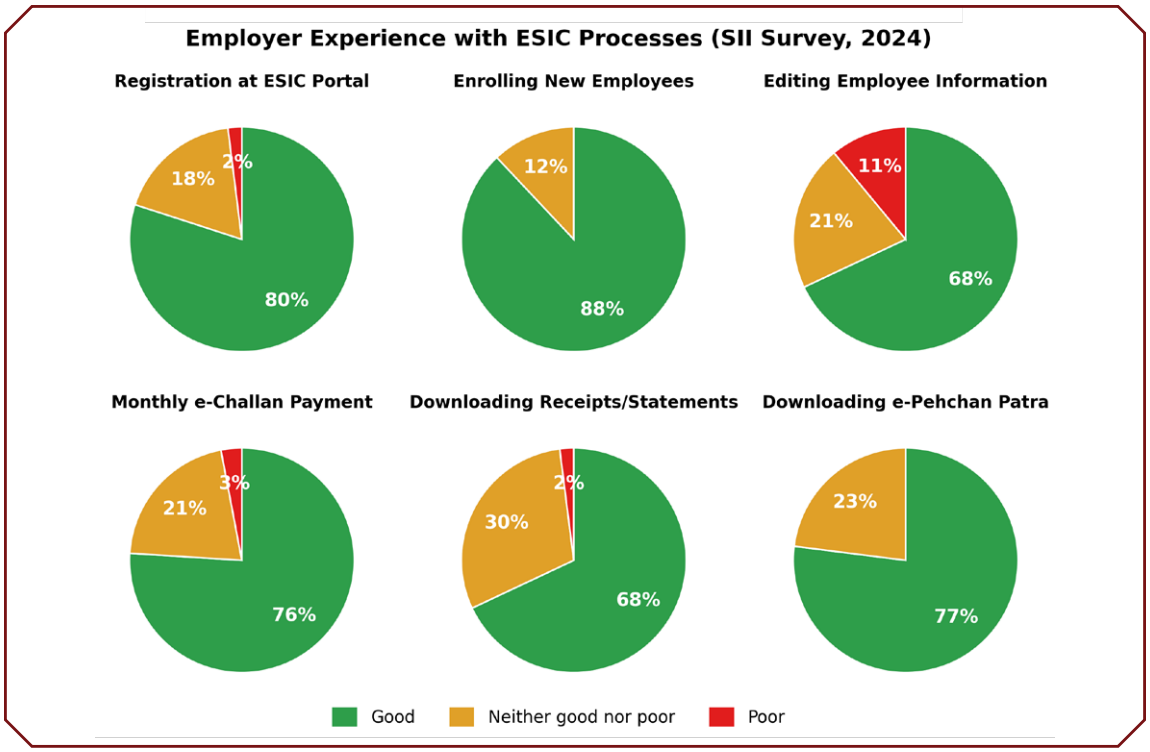


Figure 11.5: Employer experience with ESIC processes (SII Survey, 2024)



11.1.3 Employers state 15% workers not enrolled and that 34% of workers did not have an e-Pehchan card.

ILO's 2022 survey reports employer-stated enrolment of insured persons at 85% (Fig. 11.6) and families at 78%. The IP enrolment number aligns with Chapter 12 evidence that about 16% of injured-worker cases were post-accident registrations (PARs).

Figure 11.6: Employer-reported enrolment of insured persons (IPs) and families (ILO Survey, 2022)

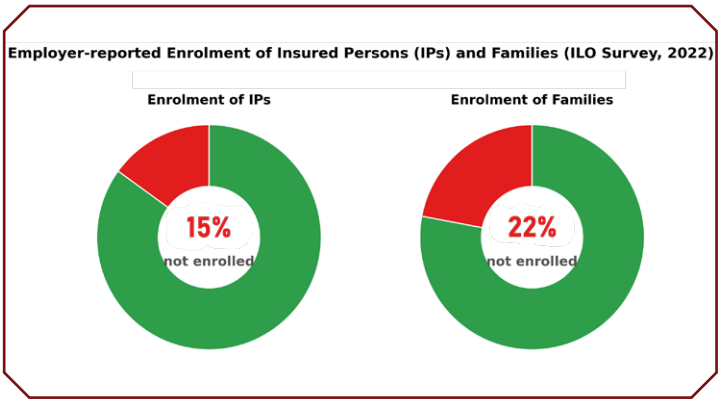
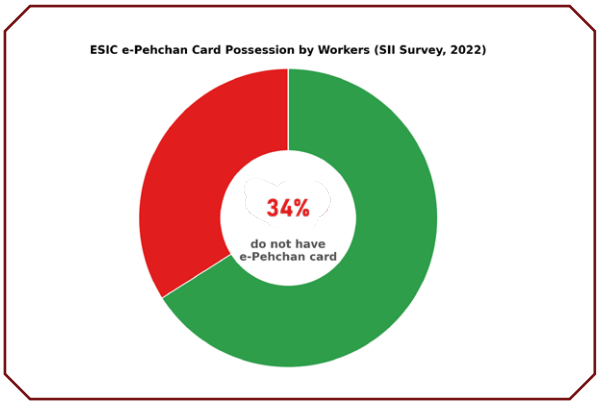


Figure 11.7: Workers with ESIC e-Pehchan card as reported by employers (SII Survey, 2022)



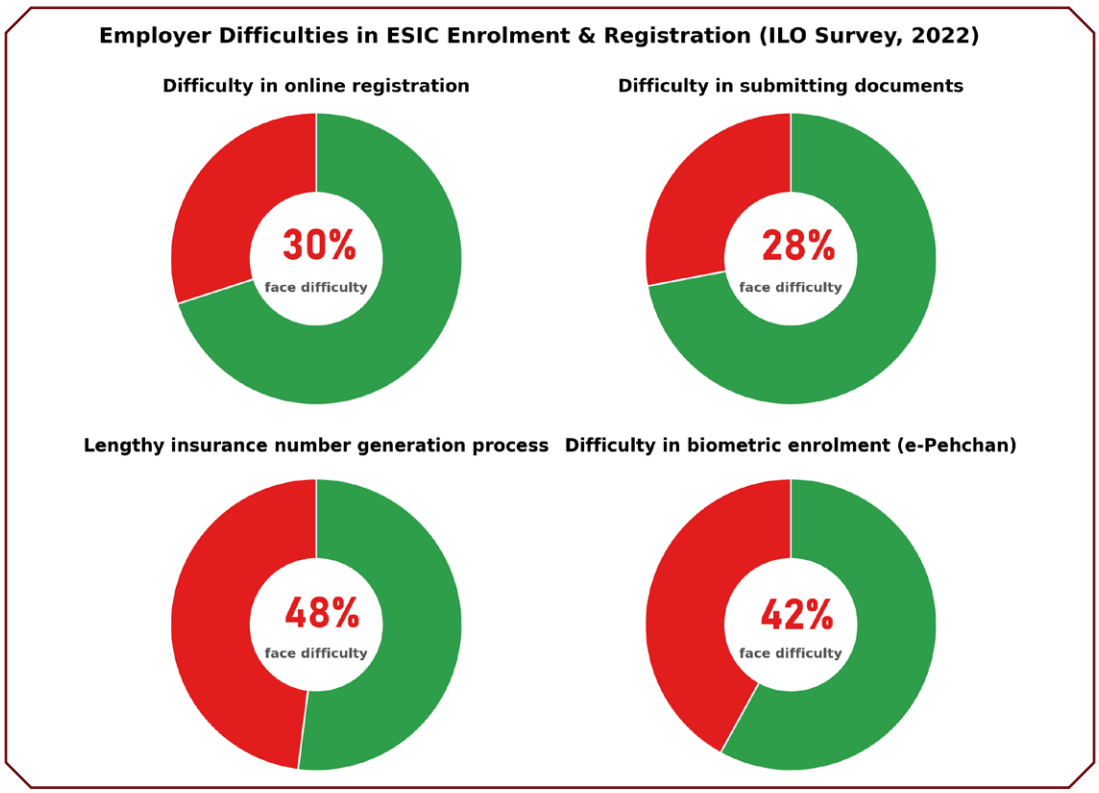
In SII 2022, employers said around one-third of workers did not have an e-Pehchan card, which would translate to an estimated 1.3 Crore IPs without an e-Pehchan card (Fig. 11.7).

But SII data from injured workers (Chapter 12) shows a much higher number, i.e., about 63% of injured workers received the card only after the accident, suggesting baseline possession is likely lower than employer reports indicate.

11.1.4 Persistent difficulties in enrolment steps, including delays in insurance number generation and biometric e-Pehchan.

While the 2024 SII survey shows that employers generally find portal-based tasks such as registration, enrolment, payments, and downloads straightforward (see Fig. 11.5 earlier), the ILO's 2022 survey documents several process-related challenges. Employers most often pointed to delays in generating insurance numbers (48%) and difficulties in biometric enrolment for the e-Pehchan card (42%), followed by challenges in online registration (30%) and document submission (28%) (Fig. 11.8). These findings suggest that while recent feedback on routine digital tasks is positive, process complexity and delays remain a notable barrier for many employers.

Figure 11.8: Employer difficulties in ESIC enrolment and registration (ILO Survey, 2022)



11.2 Medical Benefits: General Awareness is high and perceptions are favourable, but use of specific ESIC facilities is patchy, especially in emergencies.

11.2.1 High general awareness of ESIC medical benefits, but knowledge of specific features is thinner among employers.

In both ILO and SII surveys, employers report strong awareness of ESIC's medical benefits.

However, 2024 SII survey shows awareness drops for specific items like specialist/super-specialist consultations and bill reimbursement (Fig. 11.10).

Figure 11.9: Employers aware of ESIC medical benefits (ILO Survey, 2022)

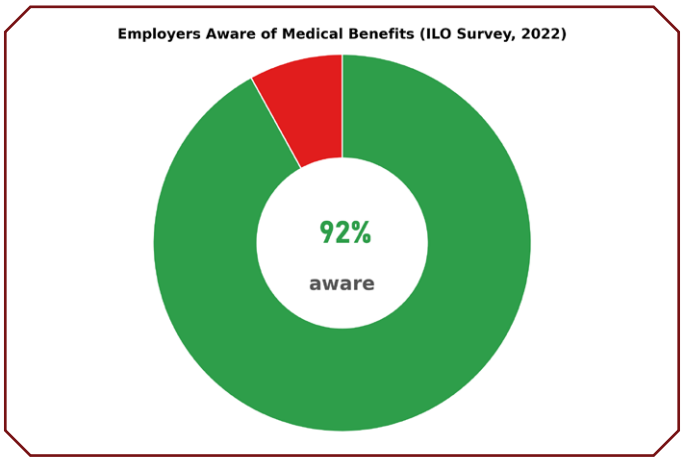
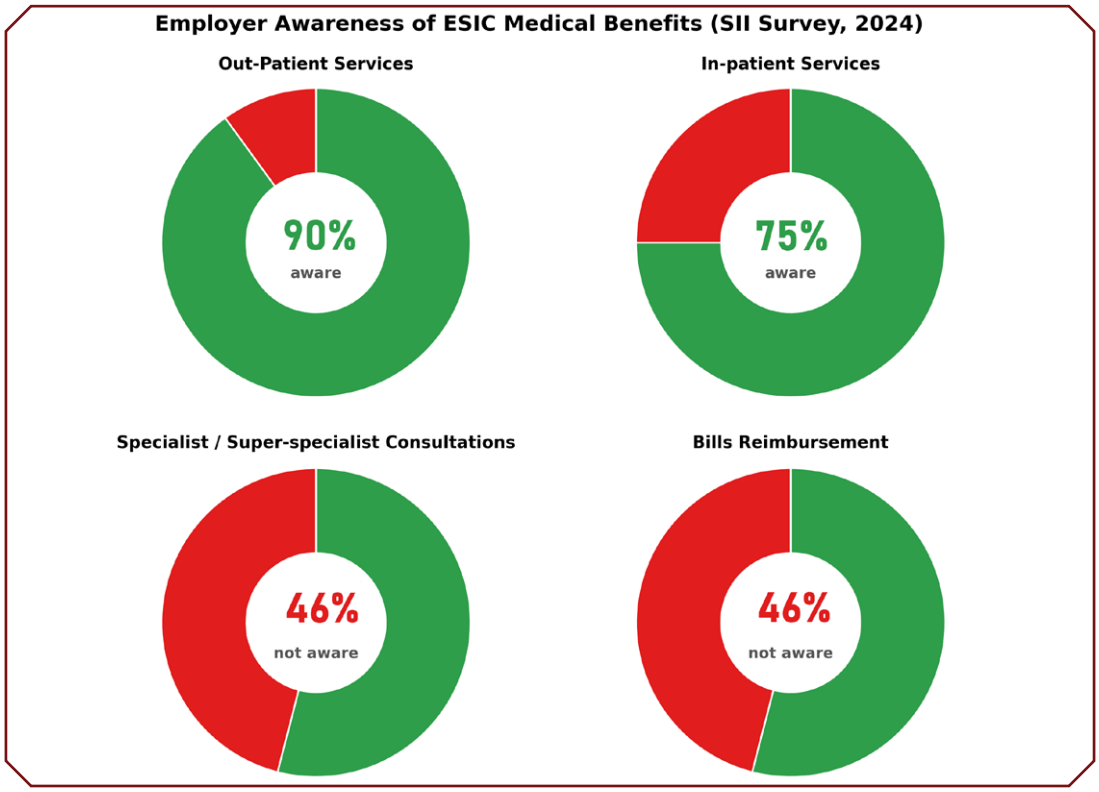


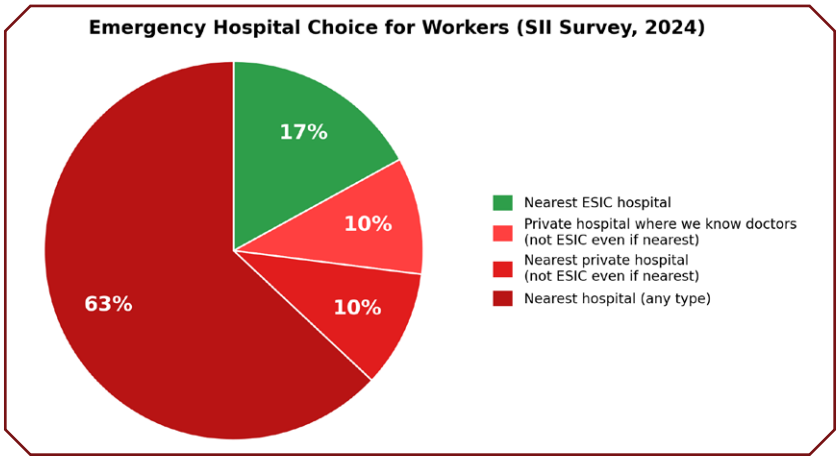
Figure 11.10: Employer awareness of ESIC medical benefits by service type (SII Survey, 2024)



11.2.2 Despite high General Awareness and favourable views, use of ESIC facilities remains limited, especially in emergencies.

In emergencies, many employers say that they mostly send workers to the nearest hospital rather than prioritising the nearest ESIC facility, and about one-fifth say they would choose a private hospital even if an ESIC hospital is closer (i.e., they would never prioritise ESIC) (Fig. 11.11).

Figure 11.11: Employer-reported emergency hospital choice for workers (SII Survey, 2024)



This is consistent with data from injured workers (Chapter 12); 46% of injured workers were first taken to a private hospital, rather than an ESIC hospital. The reasons for not preferring an ESIC hospital point to systemic gaps: employer failure and low employer trust in ESIC.

Consistent with this, many employers say workers and families have never used ESIC medical benefits (Fig. 11.12), and substantial non-use of ESIC hospitals is reported both for routine sickness and for serious illness or injury (Fig. 11.13). Together, these patterns point to a gap between awareness/perceptions and actual use of ESIC medical services.

Figure 11.12: Employer-reported share of workers/families who have never used ESIC medical benefits (SII Survey, 2022)

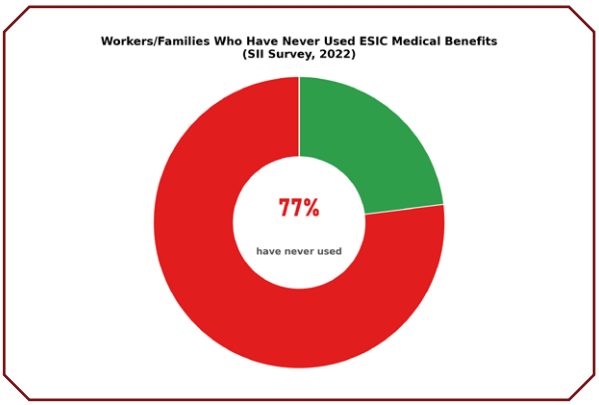
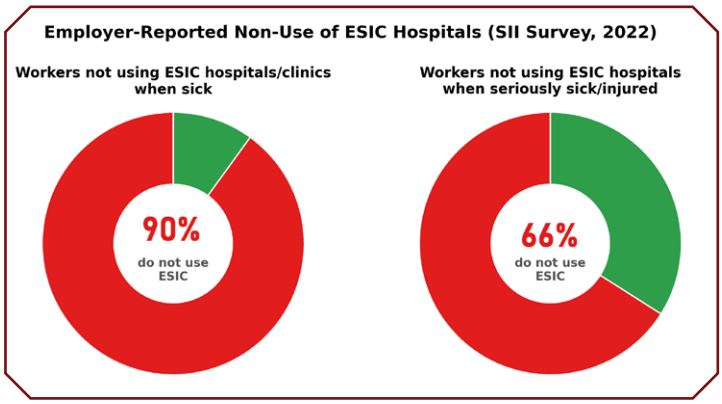


Figure 11.13: Employer-reported non-use of ESIC hospitals (SII Survey, 2022)



11.3 Payment (cash) benefits: Awareness is worse than Medical Benefits; specific schemes are less known, and experiences with facilitating claims are mixed.

11.3.1 Awareness of ESIC cash benefits is uneven – stronger for disability/maternity, thinner for dependants', funeral, and unemployment benefits, despite SII's efforts.

Across sources, knowledge of payment (cash) benefits trails medical benefits. ILO's 2022 survey records uneven awareness, with unemployment and funeral benefits least known (Fig. 11.14 and Fig 11.15). The 2024 SII survey similarly shows higher recognition for disability and maternity benefits, with lower recall for dependants' and funeral support (Fig. 11.16).

Figure 11.14: Employer awareness of ESIC payment (cash) benefits (ILO Survey, 2022)

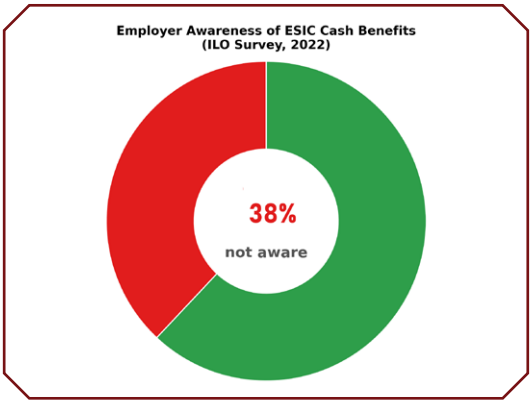


Figure 11.15: Employer awareness of specific ESIC payment (cash) benefits (ILO Survey, 2022)

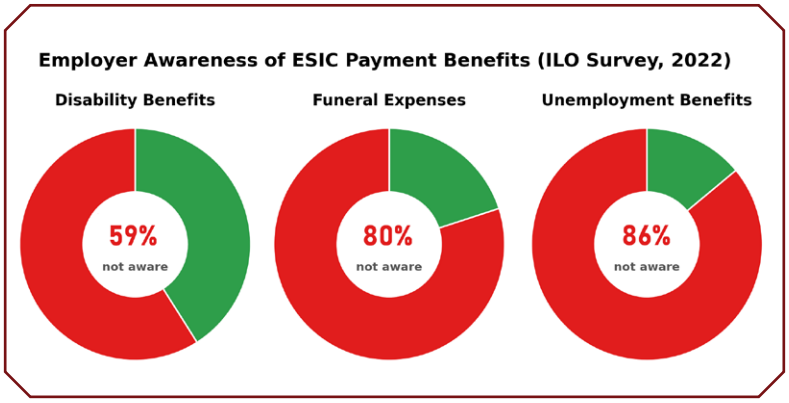
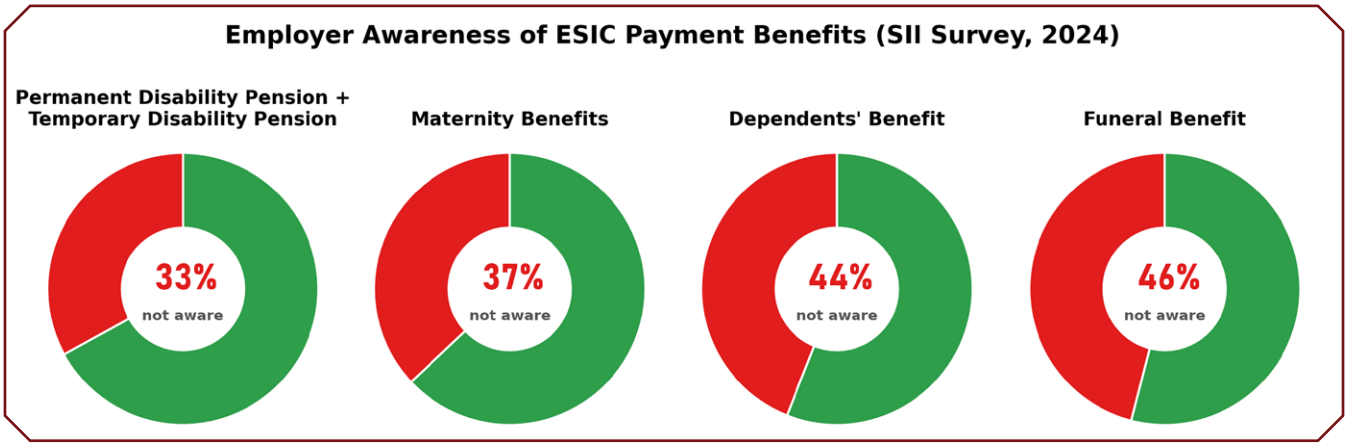


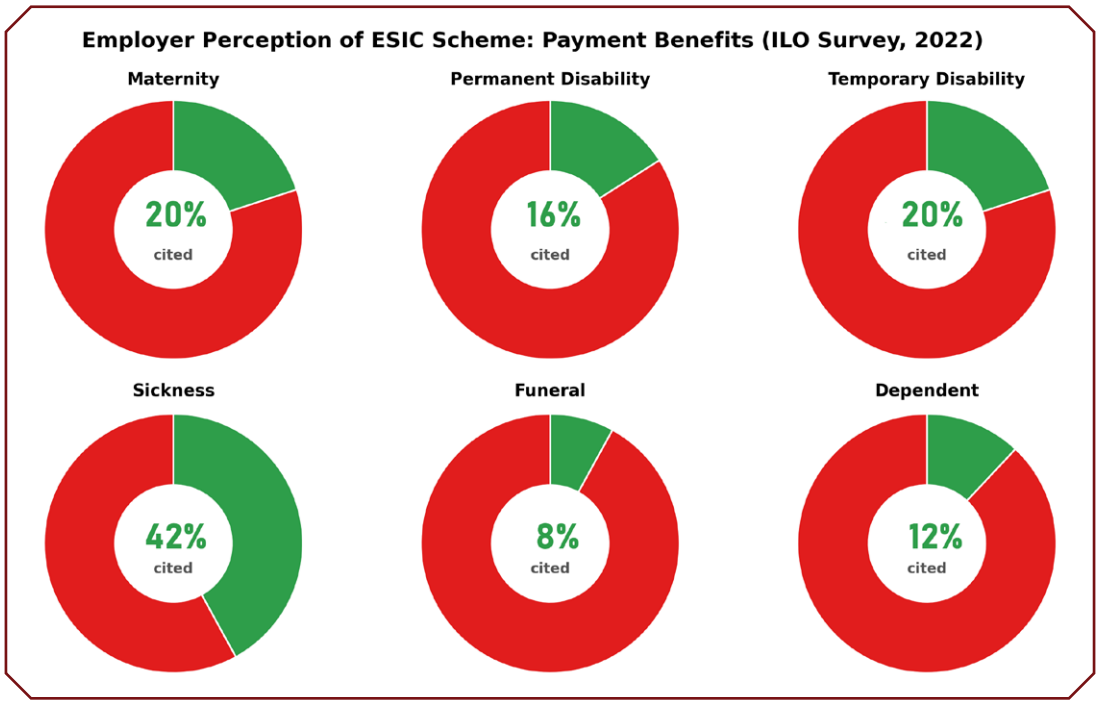
Figure 11.16: Employer awareness of ESIC payment (cash) benefits by type (SII Survey, 2024)



11.3.2 Specific schemes are rarely understood

When asked to list positives of ESIC, employers most often mentioned sickness benefits, with far fewer spontaneous mentions of disability, dependants' or funeral benefits (Fig. 11.17). This is a missed opportunity.

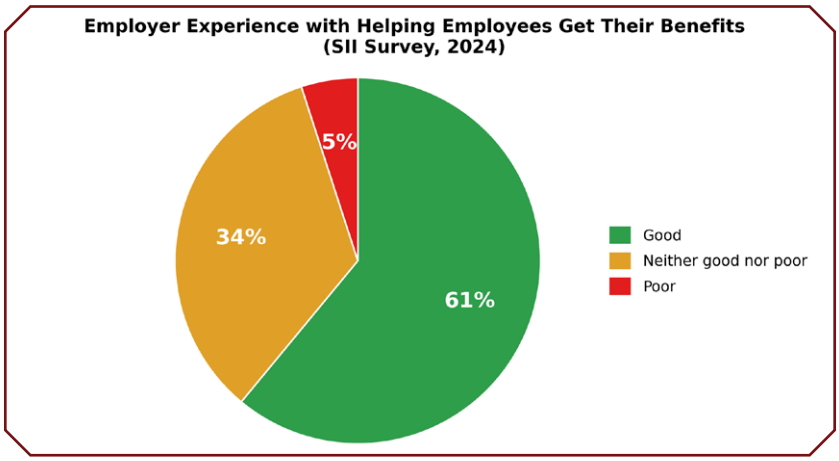
Figure 11.17: Employer-reported positives of ESIC: cash benefit types cited (ILO Survey, 2022)



11.3.3 A significant share (39%) of employers were not fully satisfied with the cash benefit process

In 2024, employers who helped workers pursue cash benefits reported a mix of outcomes, many "good," alongside a sizeable neutral share and some "poor" (Fig. 11.18).

Figure 11.18: Employer experience when helping employees obtain ESIC cash benefits (SII Survey, 2024)



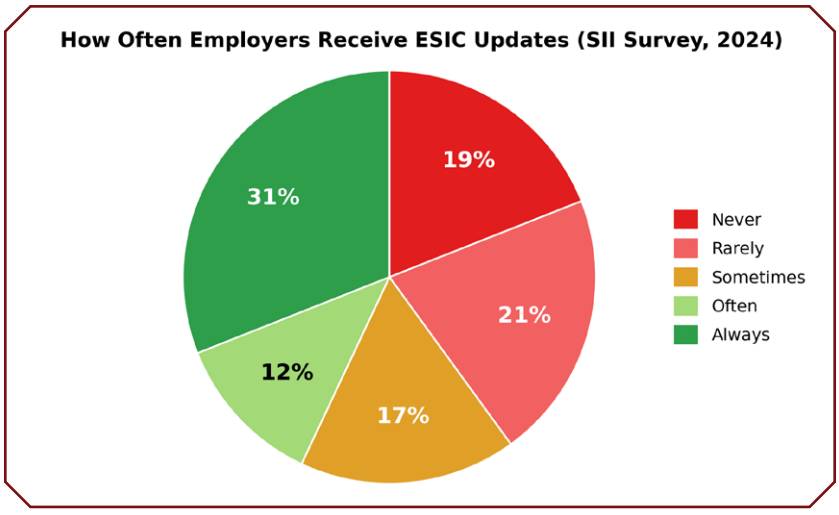
Note: Patterns of actual use and claims outcomes are discussed in Chapter 12 and elsewhere in this report.

11.4 Partial awareness of grievance options; ESIC updates reach only about one third and inconsistently.

Grievance/help: In ILO's 2022 survey, about half of employers knew ESIC offers grievance-redress mechanisms, but only around one-third specifically knew of Suvidha Samagam, the most effective grievance mechanism of ESIC.

Information flow: In SII's 2024 survey, only one-third said they always receive ESIC updates, while a sizable share reported getting them rarely or never; the rest receive updates intermittently (Fig. 11.19).

Figure 11.19: 40% employers reported poor frequency of receiving ESIC updates (SII Survey, 2024)



Employers are not wholly disconnected from ESIC: broad awareness is fairly high, perceptions are often positive, and many report that their experience with the system has improved in recent years. But awareness remains uneven on specifics.

More importantly, awareness does not consistently translate into practice. Enrolment remains incomplete, e-Pehchan provision is not universal, employers still report friction in registration and contribution processes, and use of ESIC medical facilities remains patchy, especially in emergencies.

11.5 Recommendations

11.5.1 Conduct regular employer satisfaction surveys

11.5.2 Increase employer awareness, especially on cash benefit specifics, not just general ESIC familiarity.

This should be done through regular communication campaigns, simple multilingual guidance materials, workshops, employer-facing help sessions, and practical orientation through local offices and employer associations.

11.5.3 Build a more reliable employer grievance-and-update system.

ESIC should create a more dependable system for employer support and information flow through regular portal alerts, SMS/WhatsApp/email, social media updates, clearer help channels with videos, and better-publicised grievance and assistance mechanisms.




सेफ इन इंडिया फाउंडेशन
इंडसइंड बैंक
IndusInd Bank
ईएसआईसी जागरूकता कार्यक्रम
न्याय और समानता,

CHAPTER 12

Impact of Employer Non-Compliance on IPs: Before, During, and After Workplace Accidents/Disability



Effective access to ESIC's payment benefits, especially Disability Benefits, depends on employers meeting basic obligations. They must:

1. Register every eligible worker on time and deposit contributions
2. When an accident occurs, report it truthfully, and immediately, and take the worker without delay to an ESIC hospital or a properly referred facility; and
3. After the accident, cooperate fully on paperwork and verification, including wage records, accident reports, and identity details, so claims can be processed.

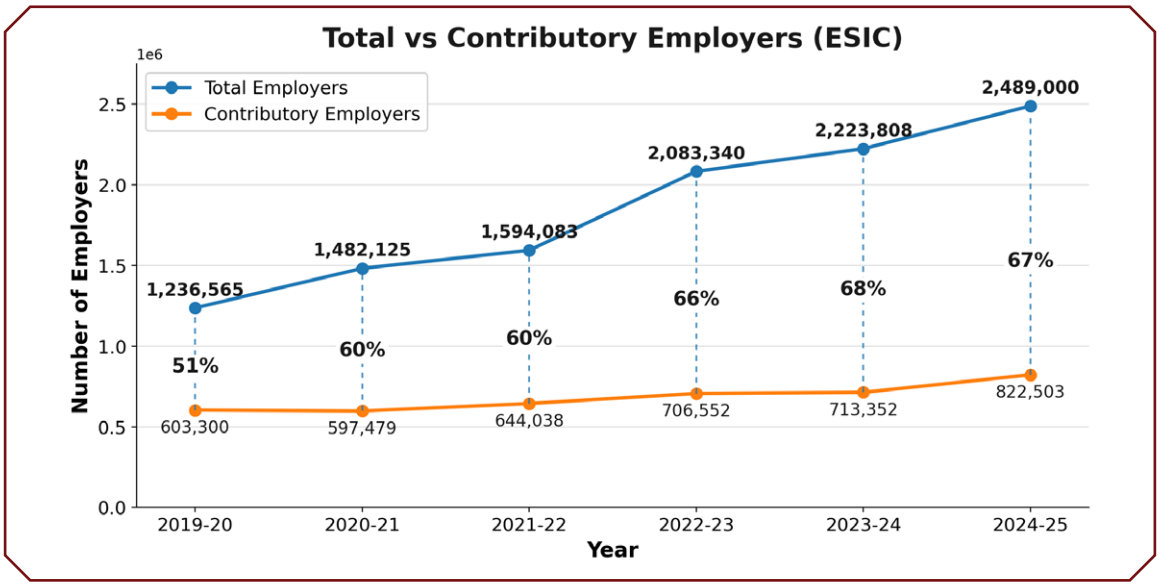
When employers do not adhere to these requirements, whether through apathy, inefficiency or evasion, the chain breaks and benefits slow or stop, with tragic consequences for workers and their families. This chapter maps the non-compliance across three moments: pre-accident, during/immediate post-accident, and later post-accident, and shows how these failures compound an already weak system, leaving insured workers without the protections they are promised.

12.1 Employer Non-Registration & Withheld ESIC (e-Pehchaan) Cards – A Missed Formalisation Opportunity: IPs and Families Lose Benefits, ESIC Loses Revenue and incurs Higher Cost of Processing Claims

12.1.1 Non-Payment of Dues and Under-Reporting by Registered Employers; 67% of Employers are Non-Contributory.

Since 2019–20 (the first year ESIC annual reports that cover data on contributory employers), a majority of registered employers have been non-contributory, and this share has increased each year. The shrinking proportion that pays in is a strong signal of widespread non-registration/under-registration of workers.

Figure 12.1: Total Employers vs. Contributory Employers

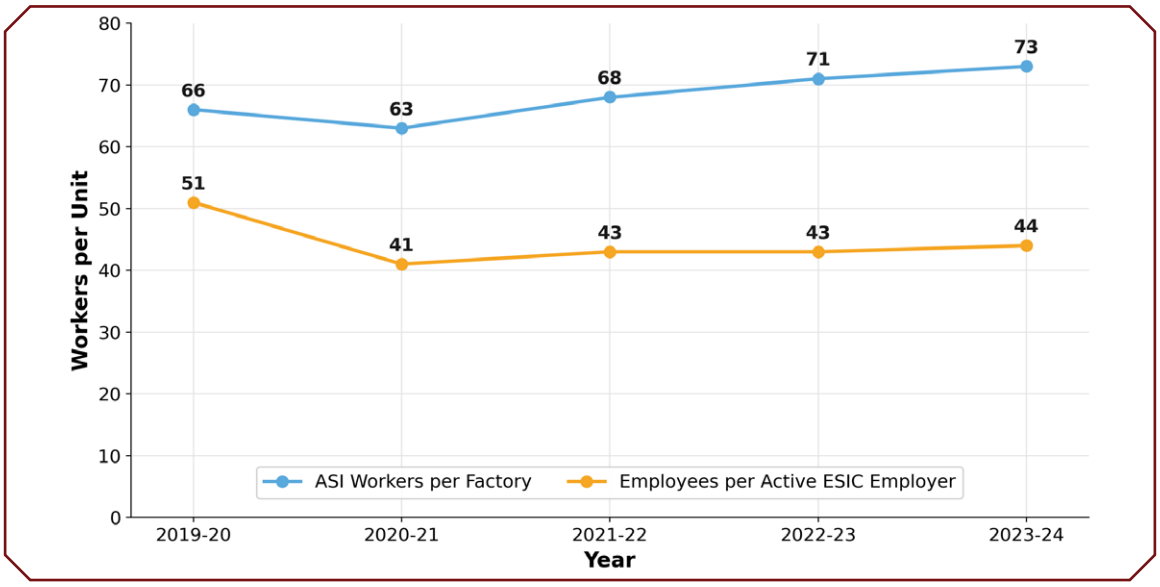


Additionally, as of 31 March 2025, unpaid ESIC contributions total ₹6,183 crore, approximately 30% of the year's contribution income (₹20,512 crore). This persistently high arrears load suggests that employers are registering but not remitting dues and delaying benefits for workers.

Even among active (contributing) employers, there appears to be non-compliance. The ESIC average of about 44 covered employees per active employer in 2023–24 is well below ASI's factory benchmark of ~73 workers per factory in 2023–24 (latest year for which data is available). While the figures aren't directly comparable (different coverage and definitions), the persistent gap is consistent with under-declaration of workers to ESIC, especially in manufacturing.

Compliance is also a formalisation lever: every worker brought correctly onto ESIC rolls shifts an eligible informal job toward formal protection. Today's arrears and under-declaration, therefore, represent a missed formalisation opportunity

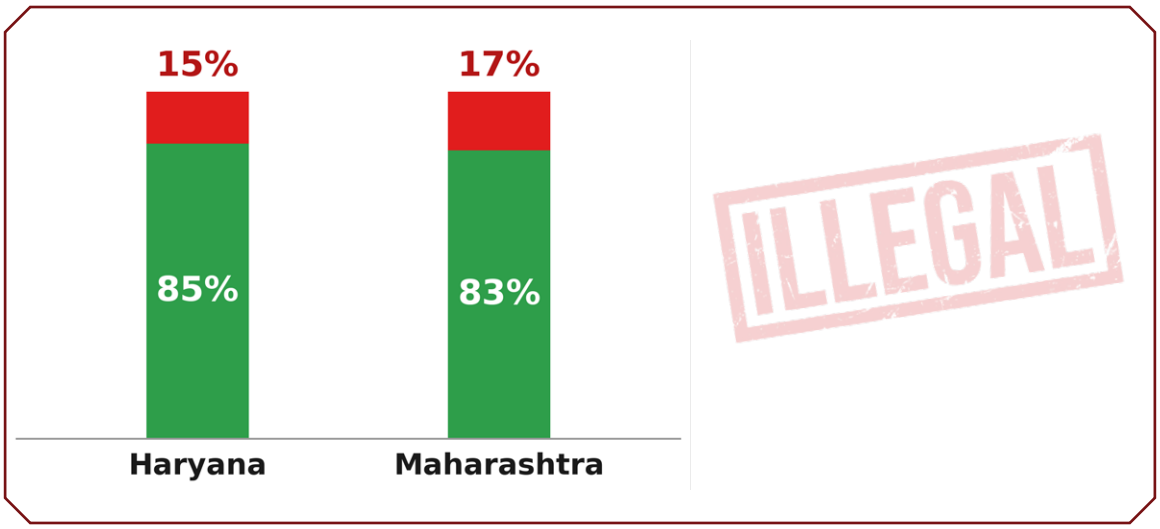
Figure 12.2: Employees per Contributory Employer is far below Workers Per Factory (ASI data)



12.1.2 SII Case Data Corroborates Non-Registration: 15–17% Post-Accident ESIC Registration (PAR) (Haryana & Maharashtra) (ad-hoc non-standard decline letters from ESIC and misery for IPs)

About one-sixth of SII-supported injured workers in Haryana and Maharashtra were Post-Accident Registration (PAR) cases, i.e., their ESIC registration date is after the accident date, indicating pre-injury non-registration by employers.

Figure 12.3: Post Accident Registration for Workers Assisted by SII (Haryana & Maharashtra)

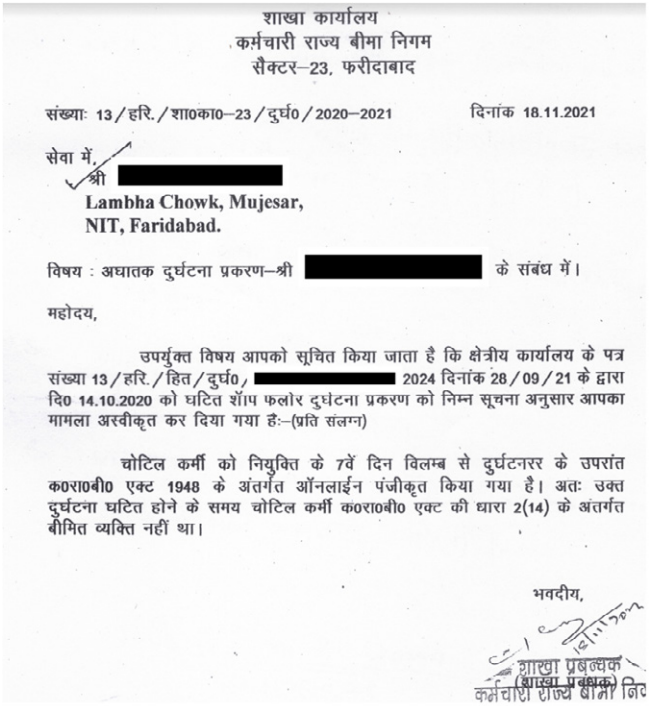


Post-Accident Registration (PAR) delays claim disbursement and, in some cases, leads to outright denial.

During discussions with SII, ESIC officials have acknowledged the scale of PAR but ESIC does not maintain a central, actionable tracker to monitor it or trigger enforcement. When compensation is declined in PAR cases, injured IPs typically receive an ad hoc decline letter that is non-standard, causing issuance delays, and insufficiently reasoned, omitting clear grounds, appeal routes, and what to obtain from the employer.

The absence of a standard, reasoned notice prolongs disputes and leaves workers without a clear path to remedy. See below for specimen PAR decline letters currently being issued; the format is non-standard and often lacks clear grounds, appeal routes, and employer obligations, which prolongs disputes. A standardised, reasoned template would shorten resolution time.

Non-Standard PAR Decline Letter v/s Recommended PAR Letter



शाखा कार्यालय
कर्मचारी राज्य बीमा निगम
सैक्टर–23, फरीदाबाद

संख्याः 13/हरि./शा0का0–23/दुर्घ0/2020–2021 दिनांक 18.11.2021

सेवा में,
श्री [redacted]
Lambha Chowk, Mujesar,
NIT, Faridabad.

विषय : अघातक दुर्घटना प्रकरण–श्री [redacted] के संबंध में।

महोदय,

उपर्युक्त विषय आपको सूचित किया जाता है कि क्षेत्रीय कार्यालय के पत्र संख्या 13/हरि./हित/दुर्घ0/ [redacted] 2024 दिनांक 28/09/21 के द्वारा दि0 14.10.2020 को घटित शॉप फ्लोर दुर्घटना प्रकरण को निम्न सूचना अनुसार आपका मामला अस्वीकृत कर दिया गया है:–(प्रति संलग्न)

चोटिल कर्मी को नियुक्ति के 7वें दिन विलम्ब से दुर्घटनरर के उपरांत क0रा0बी0 एक्ट 1948 के अंतर्गत ऑनलाईन पंजीकृत किया गया है। अतः उक्त दुर्घटना घटित होने के समय चोटिल कर्मी क0रा0बी0 एक्ट की धारा 2(14) के अंतर्गत बीमित व्यक्ति नहीं था।

भवदीय,

शाखा प्रबन्धक
(शाखा प्रबंधक)
कर्मचारी राज्य बीमा निगम

[ESIC BRANCH OFFICE LETTERHEAD]

Ref: Date: [DD-MM-YYYY]

To, [Worker's full name], IP No. [____] [Address]

Subject: Decision on your employment-injury claim - accident dated [DD-MM-YYYY] at [factory/establishment name]

Dear [Name],

1. Our decision. We regret that ESIC is unable to sanction disablement benefit on your claim from the accident of [date] at **[principal employer/factory name, address]**. Reason: your employer registered you with ESIC on [registration date], which is *after* your accident (a post-accident registration). On this ground, benefit cannot be sanctioned under the present rules.

2. What you would have received, had your employer registered you on time (as the law required, from day one of your employment):

- Injury: [describe — e.g., amputation, loss of fingers, etc.]
- Last drawn average daily wage: ₹[___]
- Loss of earning capacity, assessed by an ESIC Medical Board: approximately **[__] %**
- **Permanent Disablement Benefit (PDB):** ~90% of your average daily wage × [LEC]% ≈ **₹[]/day (₹[]/month), payable for life,** with effect from [date].
- [If applicable] Temporary Disablement Benefit for your period off work: ~90% of wages from [date] to [date].

3. You may claim equivalent compensation directly from **[employer name]** under Chapter VII of the Social Security Code.

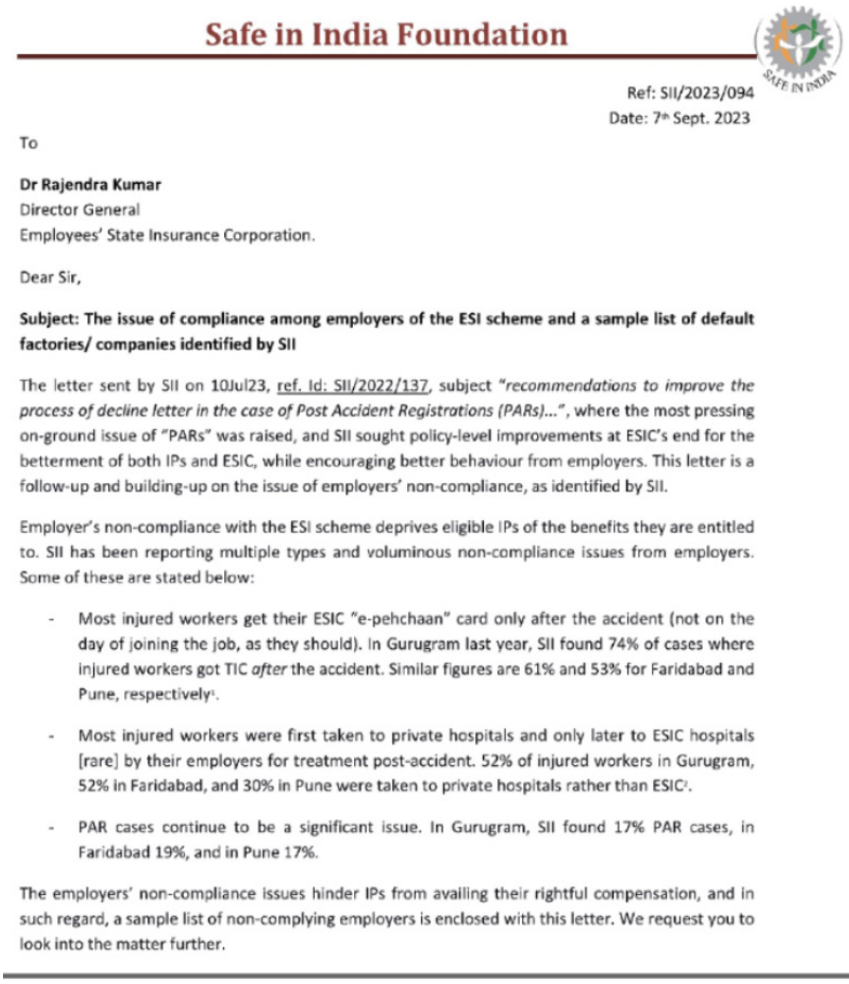
4. If you disagree (appeal). You may challenge this decision before the **Employees' Insurance Court**, within [limitation period] of this letter.

5. Help available. Branch Office: [contact/helpline]. Next Suvidha Samagam: [date]. You may also seek free assistance from [SII Worker Assistance Centre contact].

Yours faithfully, [Name, Designation], [Branch Office] *Encl.: accident report copy; notional Medical Board assessment; Claim guidance sheet.*

Please check out the box at the end of this chapter for the clearer version of the recommended standard PAR refusal letter, which was shared by SII with ESIC in June 2026.

SII Letter to DG ESIC on PAR (Sep 2023)



Safe in India Foundation

Ref: SII/2023/094
Date: 7th Sept. 2023

To

Dr Rajendra Kumar
Director General
Employees' State Insurance Corporation.

Dear Sir,

Subject: The issue of compliance among employers of the ESI scheme and a sample list of default factories/ companies identified by SII

The letter sent by SII on 10Jul23, ref. Id: SII/2022/137, subject *"recommendations to improve the process of decline letter in the case of Post Accident Registrations (PARs)..."*, where the most pressing on-ground issue of "PARs" was raised, and SII sought policy-level improvements at ESIC's end for the betterment of both IPs and ESIC, while encouraging better behaviour from employers. This letter is a follow-up and building-up on the issue of employers' non-compliance, as identified by SII.

Employer's non-compliance with the ESI scheme deprives eligible IPs of the benefits they are entitled to. SII has been reporting multiple types and voluminous non-compliance issues from employers. Some of these are stated below:

- Most injured workers get their ESIC "e-pehchaan" card only after the accident (not on the day of joining the job, as they should). In Gurugram last year, SII found 74% of cases where injured workers got TIC *after* the accident. Similar figures are 61% and 53% for Faridabad and Pune, respectively[1].
- Most injured workers were first taken to private hospitals and only later to ESIC hospitals [rare] by their employers for treatment post-accident. 52% of injured workers in Gurugram, 52% in Faridabad, and 30% in Pune were taken to private hospitals rather than ESIC[2].
- PAR cases continue to be a significant issue. In Gurugram, SII found 17% PAR cases, in Faridabad 19%, and in Pune 17%.

The employers' non-compliance issues hinder IPs from availing their rightful compensation, and in such regard, a sample list of non-complying employers is enclosed with this letter. We request you to look into the matter further.

What does the law say? Section 42 (Social Security Code) entitles ESIC to recover from the employer the lifetime "capitalised value of the benefit paid to the employee", materially larger than the ESI Act's old "twice the contribution" (section 68).

SII has not come across a single case of Section 68 under the ESI Act being implemented, in support of workers assisted by SII.

Raju Sahu



Raju Sahu worked as a contract worker in Pune for six years before being injured.

Post-injury, he received medical (leave) certificates from the ESI doctor, but neither his employer nor anyone at ESI informed him that this had to be submitted online to receive cash benefit (TDB).

The contractor had entered the wrong mobile number on his ESIC card, and so he couldn't receive any updates or OTPs. When he asked the contractor to fix it, he was refused.

SII helped him get his mobile number corrected and submitted his four pending certificates online, resulting in Raju being eligible for TDB payment.

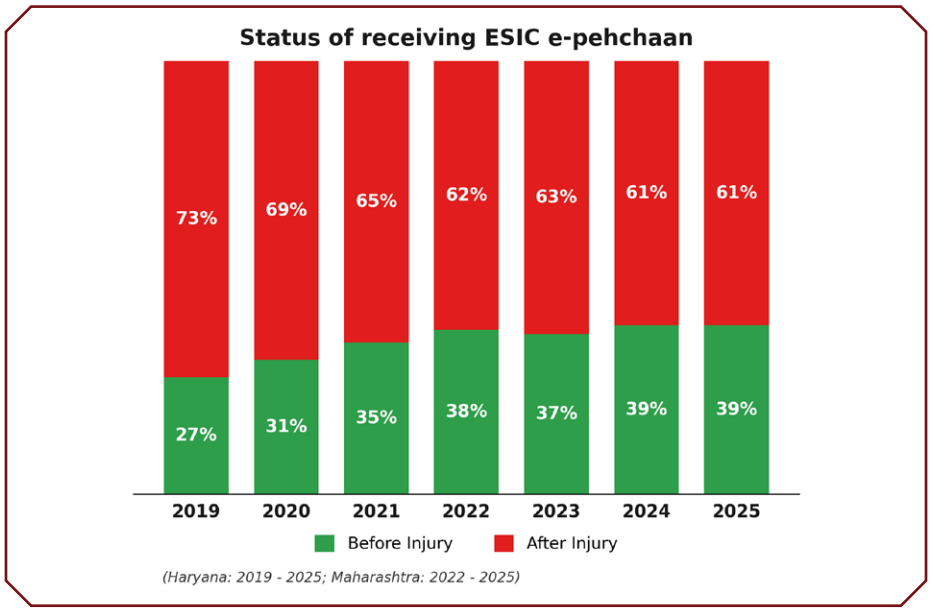
12.1.3 Even When Registered, Benefits Don't Start: Most Injured Workers Receive Their ESIC e-Pehchaan Cards Only After the Accident; Delayed e-Pehchaan cards cut families off ESI Benefits for years; Improvement since SII started assisting IPs

The ESIC e-Pehchaan (identity) card is a crucial document that allows workers and their eligible dependents (families) to access a range of ESIC benefits, including primary, secondary, and tertiary healthcare, as well as compensation for sickness, injuries, unemployment, childbirth, and death. However, the majority of injured workers advised SII that they received their ESIC e-Pehchaan card only after their accident (and not on their first day of employment, as mandated by ESIC regulations).

These lapses not only affect injury compensation; late registration and delayed e-Pehchaan cut families off from sickness, maternity and unemployment protections precisely when they are needed most. In short, non-compliance weakens ESIC's role as social insurance, not merely claims administration.

This has not improved significantly over the years.

Figure 12.4 Annual Trend – 60%+ Workers Receive ESIC e-Pehchaan Card After Injury



This issue exists in both Haryana and Maharashtra, and is higher for Maharashtra. Overall, c.63% of injured workers received an E-Pehchaan card after the accident. This proportion was c.58% for Haryana and higher for Maharashtra at c.79%.

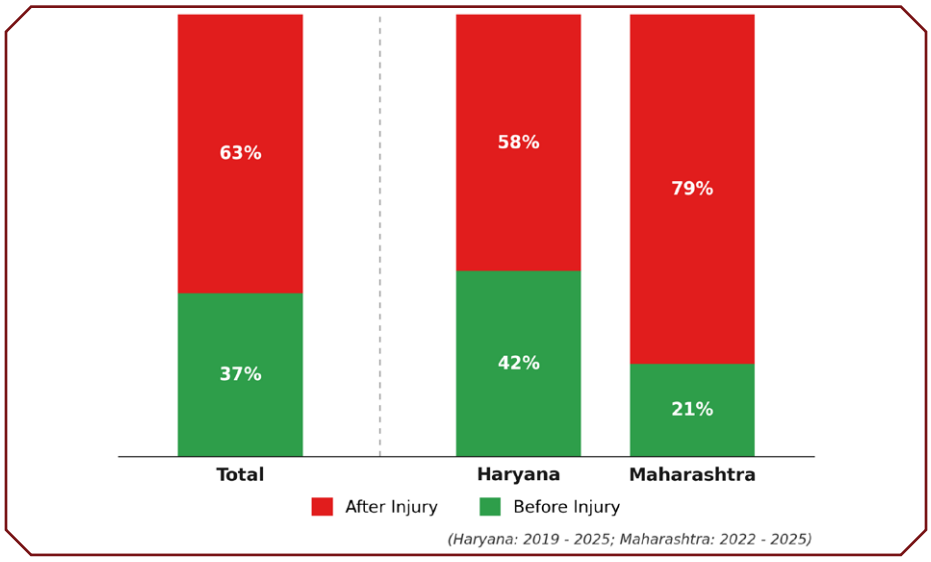
Mukesh Tiwari, Field Executive Cum Community Mobiliser, Safe In India



मैंने इतने सालों से ई एस आई सी के मुददे पे काम करते हुए ये पाया है कि इप्पलायर समय से ई पहचान कार्ड या **TIC** समय से किसी भी वर्कर को नहीं देते हैं जो कि रूल के हिसाब से जॉब स्टार्ट करने के सिंगल डे ही मिलना चाहिए ये आंकड़ा मेरे हिसाब से **99.9%** से भी ज्यादा हो सकता है।

Over so many years of working on ESIC-related issues, I have found that employers do not give the e-Pehchaan card or the TIC (Temporary Identity Certificate) to any worker on time, which, as per the rules, should be provided on the very first day the job starts. In my estimation, this figure could be even higher than 99.9%.

Figure 12.5 63% of Workers receive ESIC e-Pehchaan Card After Injury



And over the years, this proportion for Haryana appears to be improving, while for Maharashtra it is deteriorating.

Although SII has not fully investigated the reason, the following are some of the possible reasons for PAR and the non-issuance of ESIC cards

1. Ignorance/lack of awareness – both employers and workers
2. The factories are hiding these workers from their payrolls until the accident/injury.
3. The workers are registered ahead of accidents, but they are not issued their ESIC cards for reasons of apathy and/or saving on administration cost, however marginal, or to avoid workers being empowered by coverage of ESIC, e.g., their rights of sickness benefits, leave, maternity benefits, etc.
4. Employers not putting in the effort to understand the importance of and their role in registering workers; registration is not being treated as a compulsory joining step
5. Employer power is too high and there is institutional resistance to empowering workers directly
6. Contractor/principal employer responsibility is blurred, which weakens accountability at the point of onboarding.
7. The quality of ESIC consultants/facilitators is uneven, and many do not adequately understand, explain, or push benefit access.

Why this persists: no penalties in practice; therefore, the expected cost of non-compliance is low. On paper, there is a 12% interest, up to 25% p.a. damages, recovery, and even imprisonment for serious defaults; in practice, hearings, waivers, and lengthy proceedings make the expected cost of non-compliance insignificant. So, some employers delay registration, under-declare workers, or pay only when forced.

Mandatory linking of ESIC IP number to Aadhaar could help develop a system where the IP himself/herself could know his/her registration status online by just entering Aadhaar and the authentication OTP received on the linked mobile number.

The Unregulated ESIC Consultant Ecosystem

A visible, openly advertised paid consultant industry serves employers with ESIC registration and monthly compliance, with standard pricing of ₹2,000 to 4,000 for registration, ~₹1,000/month for filing, and ~₹300 per employee enrolment. They often operate under no professional accountability at all.

Many consultants do not understand ESIC well enough to file employer records correctly. Errors arise from a mix of genuine ignorance, carelessness, and in some cases deliberate under-reporting of wages or headcount at the employer's instruction. The cost of these errors is often borne by the worker (IP): incorrectly recorded contact details, wage details, dependent entries, etc. result in delayed claims when the IP tries to claim benefits, often after an injury.

The need for community health workers (like ASHAs/Arogya Mitras)

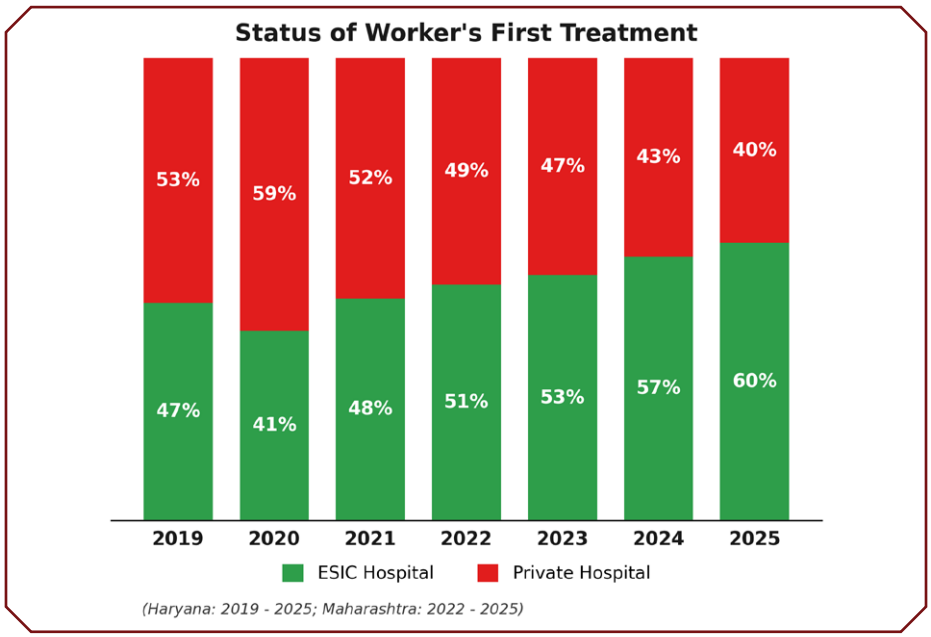
ESIC's wage ceiling of ₹21,000/month means this is a low-income, often migrant workforce. IPs do not know what they are entitled to, how to claim it, or where to go.

India has proven that this kind of gap can be closed. The ASHA programme, launched in 2005, deployed approximately 10 lakh community health workers as a bridge between communities and the public health system, resulting in institutional deliveries rising from 39% in 2005-06 to 89% by 2019-21. Under Ayushman Bharat, the Pradhan Mantri Arogya Mitra (PMAM) followed the same logic with Arogya Mitras.

12.2 Immediate Post-Accident Care Often in Private Hospitals, Not ESIC (Thankfully Improving but still Widespread)

Despite ESIC coverage, many injured workers are still taken first to private hospitals rather than ESIC facilities, albeit only for initial treatment. The pattern has persisted across SII caseloads, though it is gradually improving, and it matters because the first hour ("golden hour") often determines clinical outcomes and later benefit access.

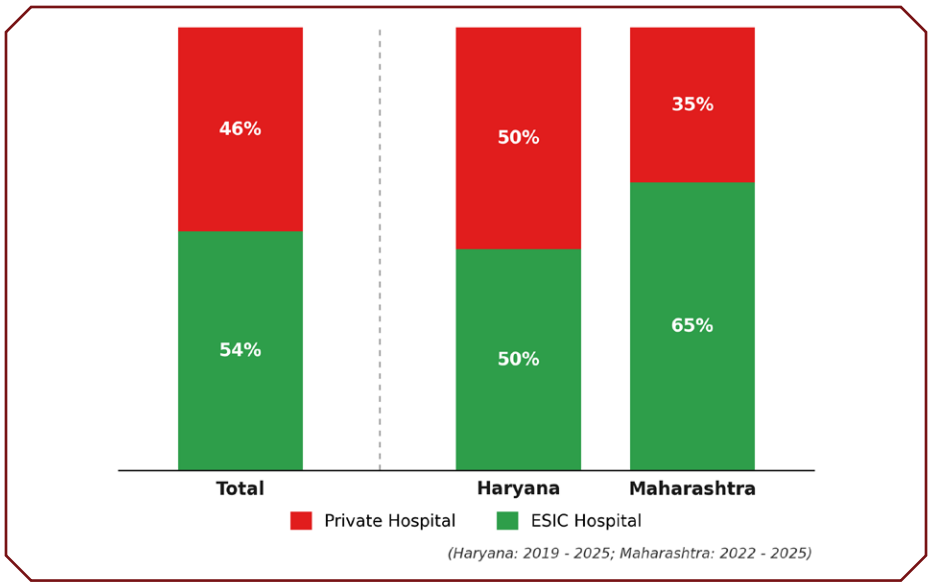
Figure 12.6 Annual Trend – Status of Injured Workers Receiving First Treatment at Private vs ESIC Hospitals



In c.46% of the injury cases, workers are taken to a private hospital for their immediate treatment instead of an ESIC Hospital.

In Haryana, c.50% are first taken to a private hospital instead of the ESIC hospital. The situation appears to be better in Maharashtra, where c.35% of injured workers go to private hospitals.

Figure 12.7 Status of Injured Workers Receiving First Treatment Hospital at Pvt vs ESIC Hospital



Thankfully, this trend appears to be marginally improving for both Maharashtra and Haryana.

Why does this happen? (Based on our experience)

Employer non-compliance and "paper-setting": A significant share of cases involve Post-Accident Registration (PAR) (≈15–17% above) or other compliance gaps; employers delay ESIC hospital referral while they regularise records (registration, contributions, identity/card).

Documentation irregularities: Mismatched joining/registration dates, unpaid contributions, or missing e-Pehchaan cards push employers to route workers privately first, then to ESIC later.

Access and confidence barriers: Distance to ESIC hospitals and low confidence in ESIC care also contribute in some cases.

SII's view is that employer non-compliance is the primary driver of private-first treatment, as this is usually combined with providing ESIC cards post-accident and treatment.

These delays can forfeit the golden hour, worsen disability, and complicate or slow ESIC claims (retro-referrals, additional scrutiny, and higher out-of-pocket costs) for injured workers.

12.3 "Human Error" stated instead of Machine/OSH Failures: Employers Misrepresent Cause of Accidents to Potentially Evade Liability

In SII's review of Accident Reports from Gurugram and Faridabad, 2 in 5 employers falsely reported accident/injury data; 65% of those employers had 100+ employees, showing this is not confined to small units.

Why does this happen: SII believes that this is to evade legal responsibility and prosecution for OSH lapses.

Typical misrepresentations:

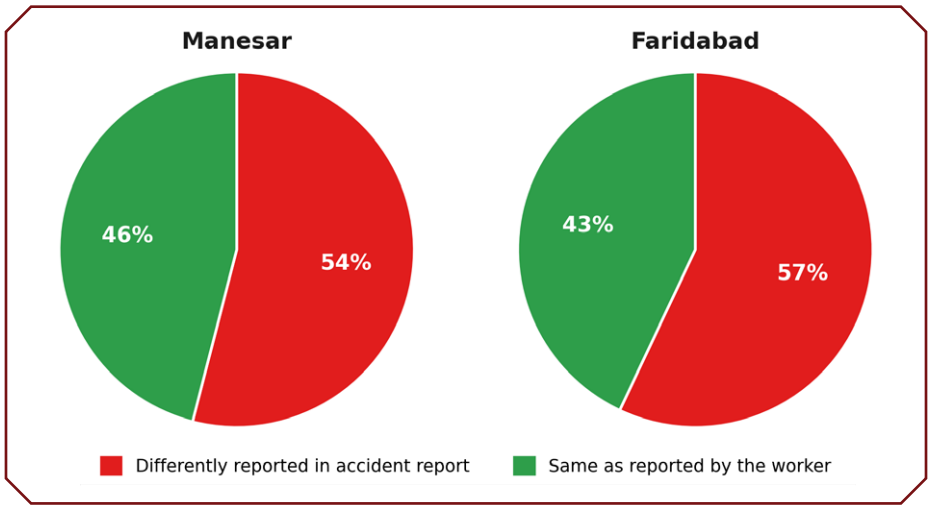
1. **Misrepresenting the cause of accident:** Machine/OSH faults recast as "human error," despite injured workers frequently attributing incidents to faulty machinery or unsafe conditions.

Table 12.1 Reason for Accident – variations in Accident Report and IPs version

Injured worker	The reason of the accident according to the "Accident Report"	The reason for the accident, as advised by the injured worker to SII
Rahul Chipa, 27, Rajasthan — lost one finger on a CNC machine while making parts for JCB	"He was cleaning the machine. During cleaning, *he did not shut down the machine.* He lost his attention and his left hand's first finger moved inside the tool and got injured."	"The worker was [checking] repairing the CNC machine because *the maintenance person refused to repair it.* The worker was checking the machine when the finger came inside the machine, due to which the accident occurred."
Mahesh, 30, Uttar Pradesh — lost both hands on a power press machine while making parts for Maruti	"He was working on a press shop machine, suddenly *he [got] distract[ed] from work* and got injured in both hands. All fingers are damaged."	The worker was a helper. "He ran the machine for the first time. When he was taking out pieces from the power press machine, *suddenly the pressure went down, due to which the machine came down directly*, and the accident occurred."
Rakesh, 33, Bihar — lost two fingers on a power press machine while making parts for Maruti	"When the injured person was cleaning the press machine, *suddenly his hand touched the start button* resulting [in] the machine start and his right-hand fingers came into press machine, resulting his right-hand small finger cut and rest finger crushed."	"While taking out pieces from the power press machine, the *machine double stroked."*

2. **Misrepresenting the Time of accident:** In c. 50% of cases, factories misstate accident time, possibly to muddy shift/overtime records and create paperwork conflicts.

Figure 12.8 Proportion of cases where accident time reported differently in Accident Report (Haryana)



Impact on workers' cases: Accident Reports (ARs) are the official basis for employment-injury recognition and trigger the TDB→PDB path. When cause/time are manipulated, workers face conflicting versions, extra documentation/approvals, and payment delays, undermining the purpose of ESIC compensation and compromising injured workers' rights.

12.4 Excessive Dependence on Employers' Paperwork for Disability Benefits Makes a Disabled Worker's Life Immensely Worse

The most striking example of this is in the pathway for availing disability benefits: the employer is the critical source and conduit for core documents; when these are delayed or incomplete, claims stall for an injured and often disabled worker.

List of documents that the IP depends on the employer for:

1. Accident Report (Form 12)
2. Abstention Verification (Form 10)
3. Wage/Contributory Record for Disablement Benefit (Form 32)
4. Further particulars of accident (In case of demand from BO)
5. Accident Book entry (Form 11)

Even though the responsibility to obtain these documents is on ESIC, in reality, the disabled worker ends up being responsible for obtaining these documents.

Many employers withhold or delay ARs, wage records and abstention confirmations; IPs must chase documents that should flow promptly. Beyond process delay, withholding or slow release of ARs, wage records and identity details are sometimes used to *deter injured workers from lodging criminal complaints*. SII has intervened in multiple cases to secure documents in the face of such pressure.

In contract case of workers, irregular ESIC deposits and manipulated joining/registration dates trigger eligibility disputes and denials are common.

The result is a long tail of delay. Many *(43%) disabled workers receive PDB more than 24 months* after injury, far beyond ESIC's own timelines once papers are "complete."

Please refer to Chapter 2 for more details on Employer Non-Compliance related to Accident Reports.

Masking Non-Compliance – Under-Reporting of days worked to ESIC

In some industries, under-reporting of days worked to ESIC may be used to mask non-compliance with minimum-wage requirements. Since eligibility for Sickness Benefit requires only 78 days of reported employment in a six-month contribution period, workers may still qualify even where wage and attendance reporting is inaccurate. The benefit-calculation method, designed with daily-wage workers in mind, may in some cases produce a benefit amount that is higher than the worker's actual current earnings. This can create an incentive for misuse through false sickness claims, potentially delaying return to work, prolonging vacancies, and increasing employer costs through rehiring and retraining.

12.5 Recommendations

Registrations and ESIC e-Pehchaan Cards:

12.5.1 Integrate ESIC onboarding with the day-1 appointment letter; Share more power directly with workers for registration, e-Pehchaan access, family addition, and correction of basic data fields

- Trigger ESIC registration off the Labour Code's mandatory day-1 appointment letter.
- Deliver the IP number and login credentials directly to the worker's own mobile at registration, not through the employer, so the worker can self-download the e-Pehchaan.
- Give workers Aadhaar-authenticated self-service on worker-owned fields (mobile, address, bank, dispensary, family), Aadhaar-match self-correction on identity fields (name, DOB), and full visibility with a dispute route on employer-controlled fields (wages, employment dates).
- To make this operational, ESIC must share updated Insured Person lists with (i) state ESIS authorities, (ii) the Directorate of Public Health and the PHC covering the IP's residence, (iii) the designated ESI dispensary, and (iv) trade unions and civil society organisations willing to support outreach.

12.5.2 Create at least a periodic self-certification requirement for employers that they have given ESIC cards/access details to all eligible workers from day 1.

12.5.3 Create an escalation window at BO for workers who are injured or very sick, so that they can be registered or activated based on evidence of employment in an ESIC-registered business

They can be checked on ESIC portals, such as a salary slip, accident form, wage record, or similar documents; the exact protocol can be thought through.

12.5.4 Improve principal-employer visibility over contractor compliance: responsibility should be clearer, and visibility stronger, where contractors are involved.

A system for Principal Employers to check the compliance status of their contractors regarding ESIC, with details of each compliance/reporting/filing/contribution submission aspect of workers working in their factories

Require joint & several liability, right to pay-and-recover, and set-off clauses so Principal Employer can settle ESIC dues with ESIC and deduct from contractor bills.

12.5.5 ESIC should introduce a voluntary certification for ESIC consultants, with a basic knowledge test, a published code of conduct, and a delisting mechanism for verified complaints

Employment Injury Response:

12.5.6 To prevent Accident Form manipulation, in cause/time conflicts, default to independent medical/technical assessment; where employer filings are late/inconsistent, give presumptive weight to clinical records/IP statements.

12.5.7 Introduce system-led verification for TDB, PDB and other benefits: auto-pull contribution/ wage data from ESIC/EPFO; allow IP self-declaration (post-audit) if employer data is missing.

12.5.8 Standardise PAR denials with a reasoned template (clear grounds, appeal route, & employer obligations); please refer to SII's recommended template.

In PAR cases, reporting of ineligible accident benefit cases to the designated compensation commissioner of the state government by ESIC should be made a norm instead of an exception to ensure that the workers' rights are protected even if no benefit is payable by ESIC.

12.5.9 For employment-injury cases, ESIC should investigate data on sample cases where the first point of care wasn't a nearby ESIC hospital/dispensary or empanelled facility, where available.

Systems:

12.5.10 Create a central compliance and exception dashboard for late registration, PAR, no-card, wrong dispensary, unpaid contribution, and contractor-linked or primary employer- linked non-compliance, with action, alerts, and escalation.

12.5.11 Fix accountability for delay and error/increase penalty

For late registration, non-handover of cards, incomplete family addition, and unresolved correction requests should attract visible accountability, follow-up, and enforce penalties as per new Labour Codes.

Penalties for late/false filings (Form-12 cause/time fields, abstention, wage particulars), with prosecution for repeated or wilful misstatement.

12.5.12 Strengthen worker and employer awareness, and improve the quality of ESIC facilitation/ support

Deploy community health workers (like ASHAs/Arogya Mitras); e.g., one per 1,000 IPs; to activate demand-side access to benefits and invest in worker awareness tasked with assisting beneficiary in filing claims, ensuring renewal of certification as required , communication about benefits and how and where to access medical care, and provide a minimum package of health education, health promotion and preventive healthcare benefits.

SPREE 2025: "clean-slate" ESIC registration drive with high uptake – 1 Crore + employees; now increase penalties for non-compliance

SPREE 2025 was ESIC's Scheme to Promote Registration of Employers/Employees (SPREE), which offered a one-time window for eligible but unregistered establishments/workers to come under ESI, from 1 July 2025 to 31 December 2025, extended to 31 January 2026.

Key assurances included no demand for past contributions, no inspection/scrutiny of past records, and no requirement of prior records for the pre-registration period, encouraging voluntary compliance.

As of 11 January 2026, ~1.17 lakh employers and ~1.03 crore employees were registered/enrolled under SPREE.

On the flip side, somehow, such repeated schemes assure the employer of no penalty if you evade for a certain period without getting caught. The impact of previous such exercises and what led to this repeated cleaning of the slate needs to be studied and understood.

The last such exercise was conducted in 2016, which saw the registration of ~1.02 crore employees

SPREE was also discussed by SII in its employer awareness engagements in Pune in 2025–26, including sessions with Forbes Marshall's supply-chain companies' employers.

Draft PAR Decline Letter

[ESIC BRANCH OFFICE LETTERHEAD]

Ref: Date: [DD-MM-YYYY]

To, [Worker's full name], IP No. [____] [Address]

Subject: Decision on your employment-injury claim - accident dated [DD-MM-YYYY] at [factory/establishment name]

Dear [Name],

1. Our decision. We regret that ESIC is unable to sanction disablement benefit on your claim from the accident of [date] at **[principal employer/factory name, address]**. Reason: your employer registered you with ESIC on [registration date], which is *after* your accident (a post-accident registration). On this ground, benefit cannot be sanctioned under the present rules.

2. What you would have received, had your employer registered you on time (as the law required, from day one of your employment):

- Injury: [describe — e.g., amputation, loss of fingers, etc.]
- Last drawn average daily wage: ₹[___]
- Loss of earning capacity, assessed by an ESIC Medical Board: approximately **[__] %**
- **Permanent Disablement Benefit (PDB):** ~90% of your average daily wage × [LEC]% ≈ **₹[]/day (₹[]/month), payable for life**, with effect from [date].
- [If applicable] Temporary Disablement Benefit for your period off work: ~90% of wages from [date] to [date].

3. You may claim equivalent compensation directly from **[employer name]** under Chapter VII of the Social Security Code.

4. If you disagree (appeal). You may challenge this decision before the **Employees' Insurance Court**, within [limitation period] of this letter.

5. Help available. Branch Office: [contact/helpline]. Next Suvidha Samagam: [date]. You may also seek free assistance from [SII Worker Assistance Centre contact].

Yours faithfully, [Name, Designation], [Branch Office] *Encl.: accident report copy; notional Medical Board assessment; Claim guidance sheet.*

Bharuch's Chemical Industry: Employer Non-Compliance and Uneven ESIC Coverage Leads to Denial of ESI Services to High-Risk Workers (Aajeevika Bureau Case Study)

Bharuch district is a major hub for migrant industrial work and is widely regarded as a high-risk cluster for occupational safety and health (OSH). The district's core industries include chemical, petrochemical, pharmaceutical, and agro-based manufacturing, spread across multiple Gujarat Industrial Development Corporation (GIDC) estates, such as Ankleshwar, Panoli, Jhagadiya, Vagra, Vilayat, Saykha and Dahej, with additional activity in SEZ areas that have expanded in recent years. Yet ESIC coverage remains uneven: only the GIDCs in Ankleshwar and Bholav (and some nearby villages) are notified under the Act, while several other industrial estates, including the large Dahej region (with two GIDCs and two SEZs), remain outside the notified ambit of ESIC.

Against this backdrop, ESIC officials indicated that Bharuch district has a steady IP base of around 60,000. **ESI registration appears to have limited reach among casual and contract workers, who are often part of the migrant workforce.** The dispensary in Ankleshwar also does not currently cover Panoli or Jhagadiya GIDC, both located about 10 km away. Over the last couple of years, advocacy for extending service coverage to these estates has reportedly been met with the response that the Social Security Code will address the issue by extending ESI coverage to all eligible establishments (10 or more workers), irrespective of notified areas/districts.

In a randomised survey of 62 workers from some of the **larger chemical factories in Ankleshwar, over 75% of eligible workers reported not having ESIC coverage. A further 15% reported salary deductions towards ESIC but said they did not have any ESIC details or card number.** Only two workers reported having received their ESIC card; even among them, awareness of ESIC benefits was limited.

Awareness gaps also appear systemic, reflecting weak employer and state-led efforts to inform workers about ESIC coverage and entitlements.

In one case from the region, a social-security workshop was conducted at a multinational company manufacturing textile dyes and pigments for export, covering ESI and PF benefits and addressing worker queries. During this session, the company's HR team mentioned that a worker had died of natural causes the previous month and that the family was unaware of any ESIC-related entitlements. With Aajeevika Bureau's support, the family filed a claim for funeral expenses and ₹15,000 was credited to the widow's account within two days.

While the amount is modest relative to the loss of a primary breadwinner, the episode is instructive: the family had no awareness of the benefit, and even a large company employing over 1,000 workers did not appear fully informed about the range of ESIC entitlements. This raises concerns about what information reaches workers at the lowest rungs of the workforce.

In a hazardous industrial corridor like Bharuch, the priority cannot be limited to registration alone. Strengthening employer and state accountability for both coverage and effective benefit uptake is essential to ensure ESIC functions as meaningful social protection for workers.



CHAPTER 13

Big-Picture Service Delivery: Expansion Significant; Per-IP Capacity & Governance Needs to Catch Up



The Comptroller and Auditor General of India (CAG), through its performance audits of the Employees' State Insurance Corporation (ESIC) in 2006 and 2014, had highlighted critical gaps in ESIC service delivery across the country. While both audits documented major deficiencies in the quality, capacity, and accessibility of ESIC's medical and claims services, many of these concerns persist. There have been some improvements over time. The 2006 CAG Report underscored infrastructural and operational challenges, including poor bed occupancy, staff shortages, inefficient procurement of medicines, and inappropriate hospital siting. The 2014 Performance Audit (covering 2008–09 to 2012–13) reiterated concerns over the quality of claims services, hospital and dispensary care, beneficiary awareness, and claim management.

Although several corrective actions have reportedly been undertaken since then, serious service quality issues continue to affect insured persons. Moreover, the national-level audit of ESIC has remained pending since 2014, with only one state-level audit thereafter: Rajasthan in 2021 (covering up to FY 2019–20; as part of a larger state government audit); and the implementation of earlier recommendations appears uneven and incomplete, leaving substantial room for improvement in the effectiveness, equity, and responsiveness of ESIC's service delivery systems.

This chapter takes a system-level view of ESIC service delivery: availability, accessibility, quality, and efficiency, drawing on CAG audit findings and secondary data from ESIC Annual Reports. Detailed diagnostics, metrics, and process-flow issues are covered in the thematic chapters: Cash Benefits (claims timeliness, adjudication quality, grievance resolution, payments integrity) and Medical Benefits (facility capacity and readiness, referral patterns, medicine procurement and availability, quality of care). Readers seeking program-specific evidence, state-level variations, and case studies should refer to those chapters for granularity.

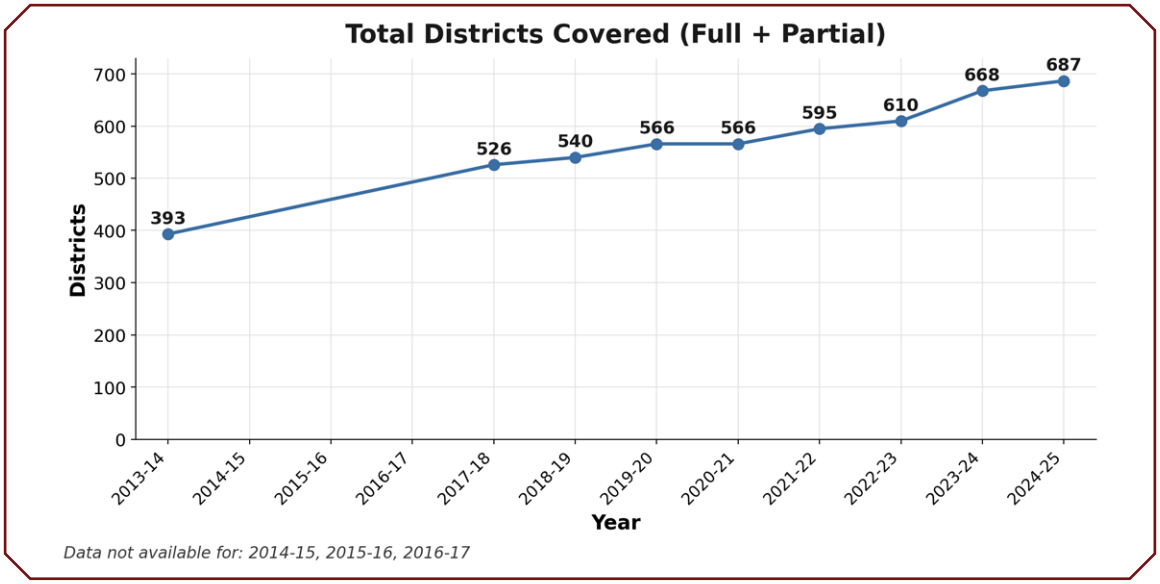
13.1 ESIC's Decadal Picture: Wider Coverage, Higher Enrolment, Rapid Employer Registration

13.1.1 ESIC coverage widened by 294 districts in a decade, covering 687 of India's 778 districts by 2024–25

ESIC's geographic coverage increased from 393 districts (2013–14) to 687 (2024–25), a net rise of 294 districts. As of 2024–25, ESIC reports 584 fully and 103 partially notified districts (total 687), implying roughly 91 districts remain of India's 778 districts.

Over the same period, State/UT coverage expanded from 31 (2013–14) to 36.

Figure 13.1: ESIC district coverage, 2013–14 to 2024–25



Pre 2013-14, ESIC's annual reports reported "implemented centres", and not district coverage

13.1.2 Insured Persons up 2.7× in 15 years to 3.84 crore; women IPs grow faster 3.2× to 0.83 crore; beneficiary figures use a fixed multiplier (×3.88) and therefore unclear

Total insured persons (IPs) rose from 1.43 crore (2009–10) to 3.84 crore (2024–25), with a temporary pandemic dip before recovery. Women IPs increased from 0.26 crore to 0.83 crore; women's share is now ~22% (up from ~18% in 2009–10).

Figure 13.2: Total Insured Persons (IPs), 2009–10 to 2024–25 (lakh)

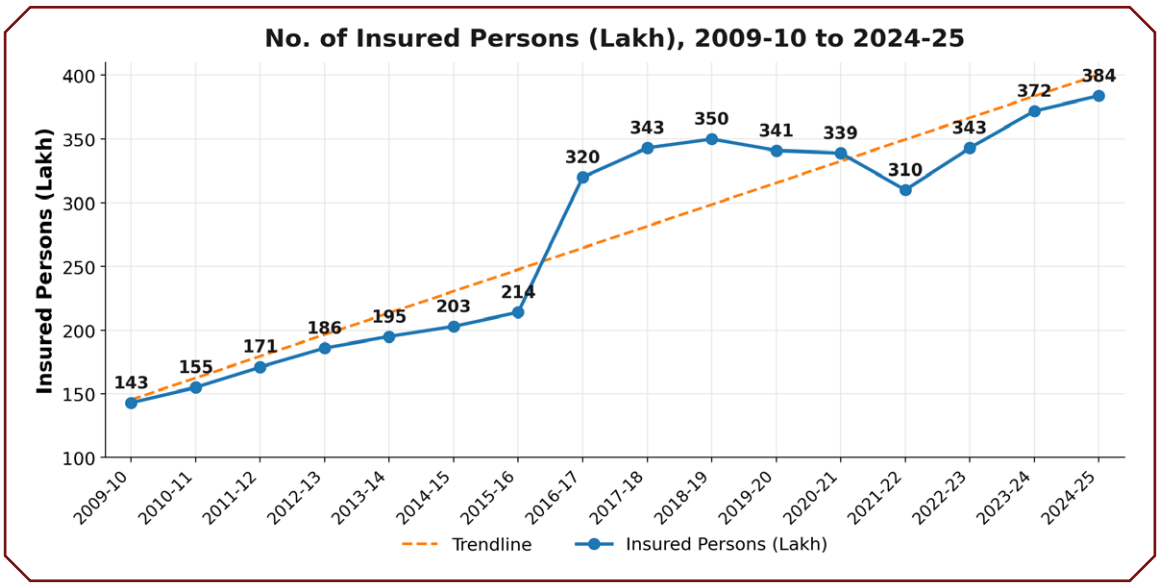
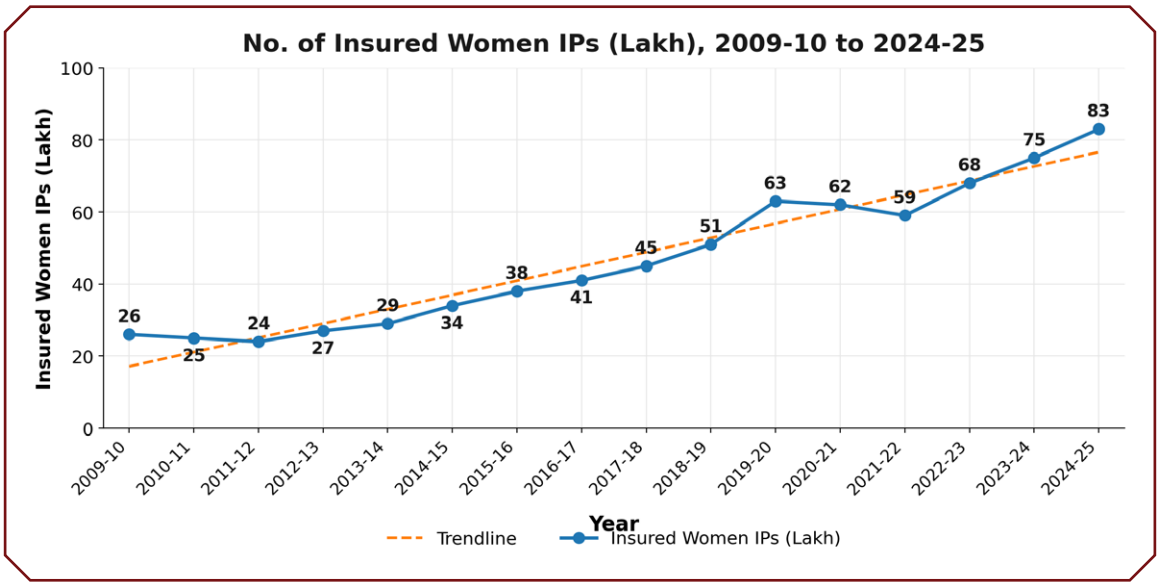


Figure 13.3: Insured Women IPs, 2009–10 to 2024–25 (lakh)

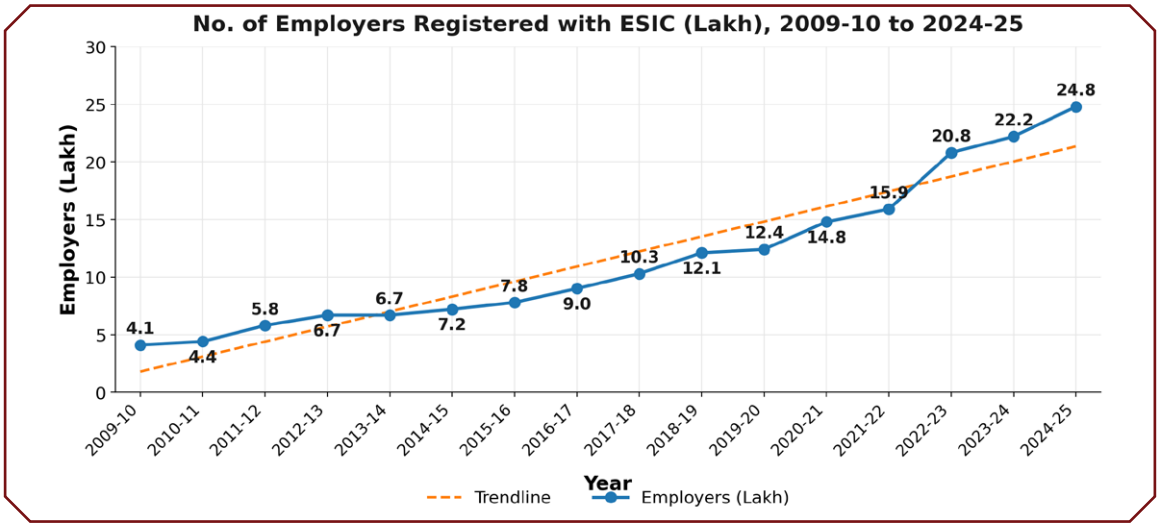


Data caveat: Beneficiary figures reported in ESIC Annual Reports mirror IP counts using a fixed multiplier (×3.88 of the number of IPs). Accordingly, this report does not use beneficiary data for analysis.

13.1.3 Registered employers up 6x to 24.8 lakh; sharp additions post-2021–22

Employers registered with ESIC increased from 4.1 lakh (2009–10) to 24.8 lakh (2024–25); a ~6x growth (net gain 20.7 lakh). Growth was steady through 2019–20, then accelerated after the pandemic:

Figure 13.4: Registered Employers with ESIC, 2009–10 to 2024–25 (lakh)

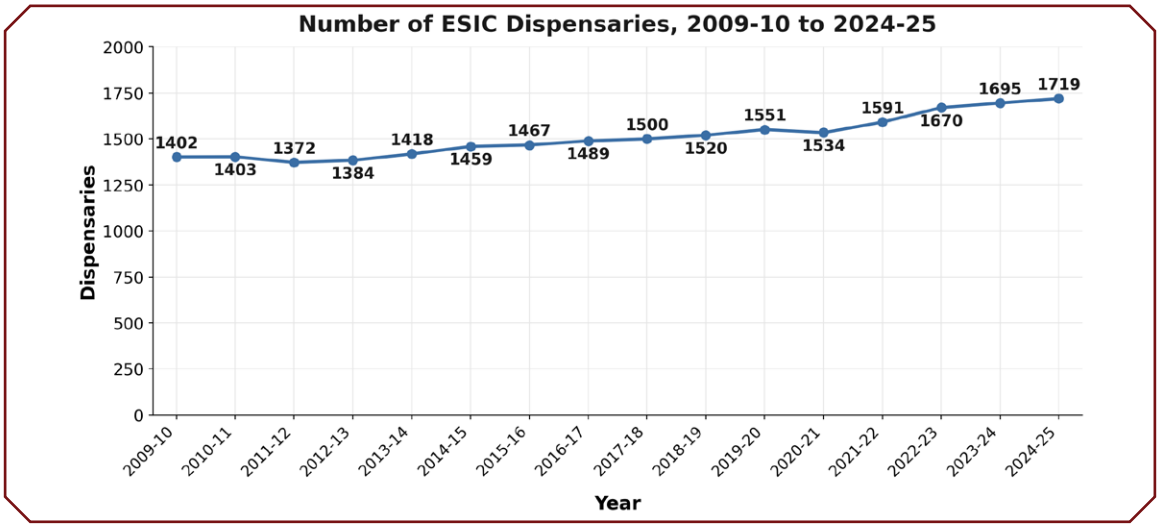


13.2 Medical Benefits: Modest Infra Growth; Capacity per IP Down

13.2.1 Medical infrastructure expanded modestly; capacity per IP fell as enrolment nearly tripled in 15 years

Dispensaries increased from 1,402 to 1,719 (+23%). Hospitals rose 144 to 165 (+15%). Commissioned beds, however, decreased from 22,030 to 20,999 (-5%). Over the same period, IPs increased 1.43 Cr. to 3.84 Cr. (+269%), so capacity per IP has declined significantly.

Figure 13.5: Number of ESIC Dispensaries, 2009–10 to 2024–25



Sarita Devi



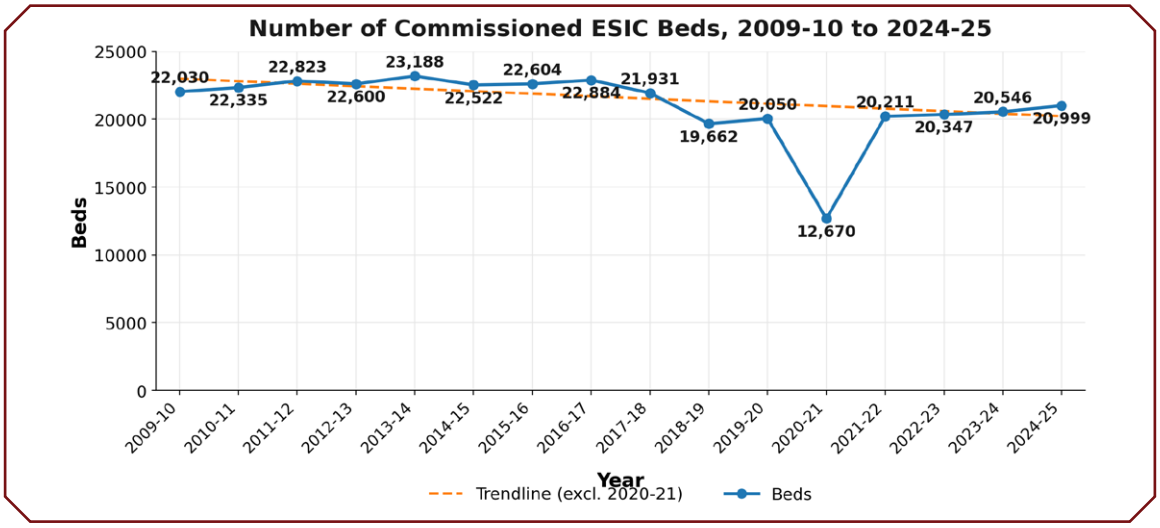
Sarita Devi was injured while working at a factory in Hero's supply chain in Manesar.

When she asked for her Accident Report to be filed to access disability benefits, the factory management and the contractor told her flatly that they do not file accident reports when women workers are injured.

She had to go back and forth between HR and the contractor, each insisting the other was responsible for filing her accident report and issuing her ESIC card, with neither actually doing it.

After months of sustained follow-up by SII, her accident report was finally filed.

Figure 13.6: Commissioned ESIC Hospital Beds, 2009–10 to 2024–25



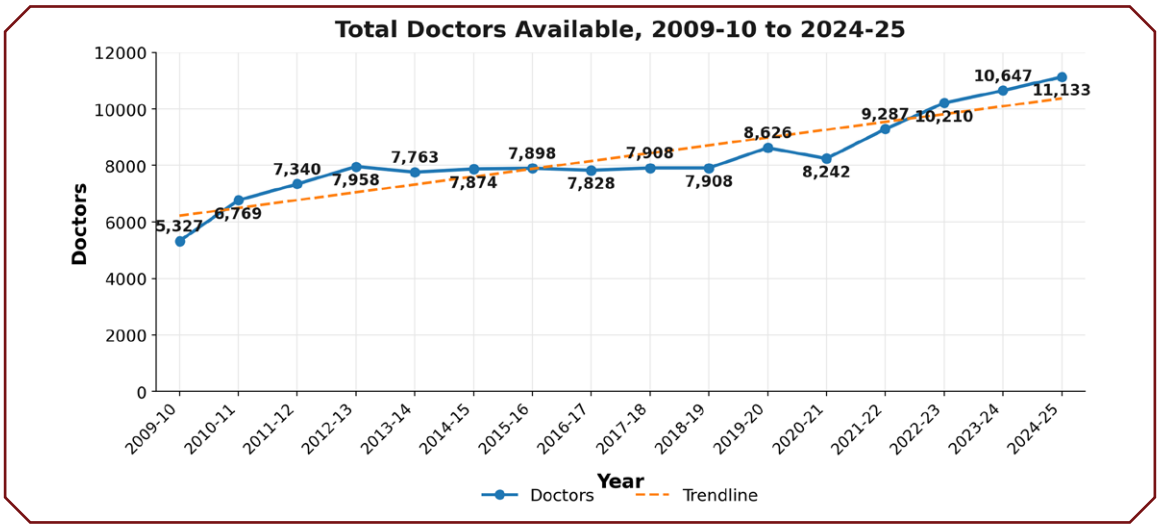
The dip in 2020-21 appears to be a COVID-19 reallocation. SII was unable to find an explanation for the general downward trend.

Detailed utilisation and readiness metrics are analysed in the Medical Benefits chapter (Chapter 6).

13.2.2 Doctor availability impressively doubled in 15 years; but doctors per IP declined as enrolment rose

Total doctors available with ESIC (including dispensaries and hospitals – ESIC and ESIS) doubled from 5,327 (2009–10) to 11,133 (2024–25); an increase of 109%. *However, with IPs rising to 3.84 crore, doctors per lakh IPs fell by ~23%*

Figure 13.7: Total Doctors Available (Dispensaries and Hospitals) 2009–10 to 2024–25



Detailed staffing ratios and vacancy patterns are analysed in the Medical Benefits chapter (Chapter 6).

13.2.3 Medical Benefits spend up ~3.8× in 15 years despite stable internal capacity; real per-IP spend plateaued; Share of Medical Benefits through tie-up hospitals stayed constant at c.15%

Total outlay: ESIC expenditure on Medical Benefits rose 3.8× from ₹4.08K Crores to ₹15.52K Crores (2009–10 to 2024–25).

Per-IP Expenditure (inflation-adjusted to 2024–25 prices): ~42% increase in 15 years; As enrolment rose ~2.7×, real spending per insured person has plateaued in the last 10 years (2013-14 to 2024-25). This could be a result of the following:

i. improved efficiency due to economies of scale

ii. new IP base yet to start claiming medical benefits due to lack of facilities (dispensaries or hospitals) near their location

iii. new IP base yet to start claiming due to a lack of awareness.

Figure 13.8: Medical Benefits (Real ₹, inflation-adjusted to 2024–25 Rupees)

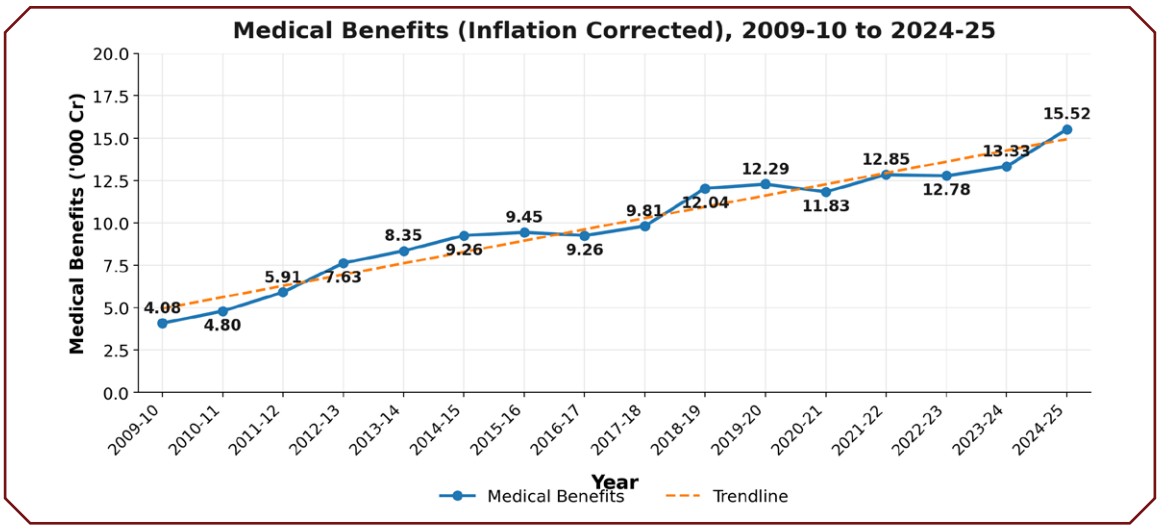
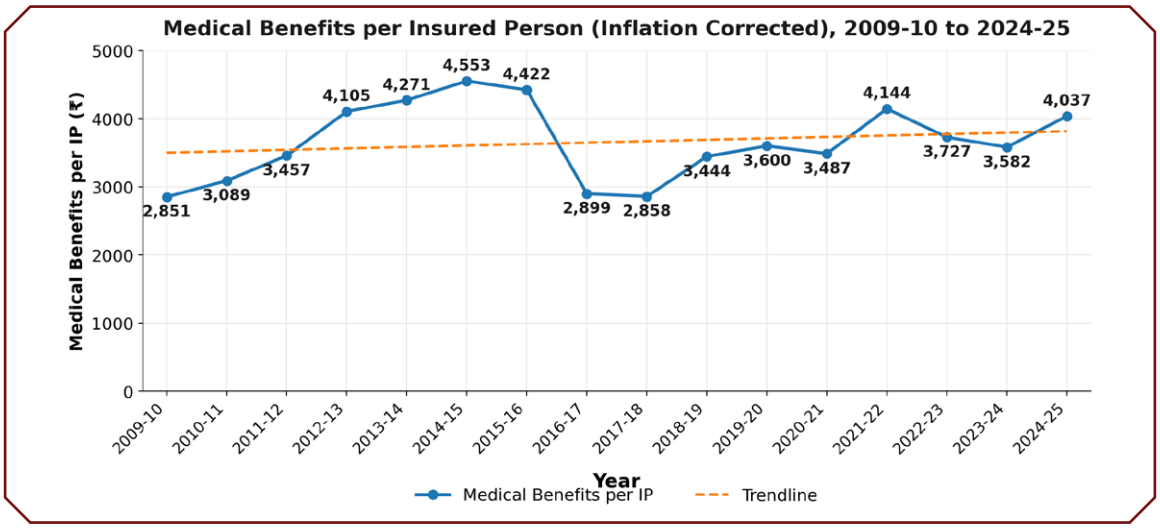


Figure 13.9: Medical Benefits per IP (Real ₹, inflation-adjusted to 2024–25 Rupees)

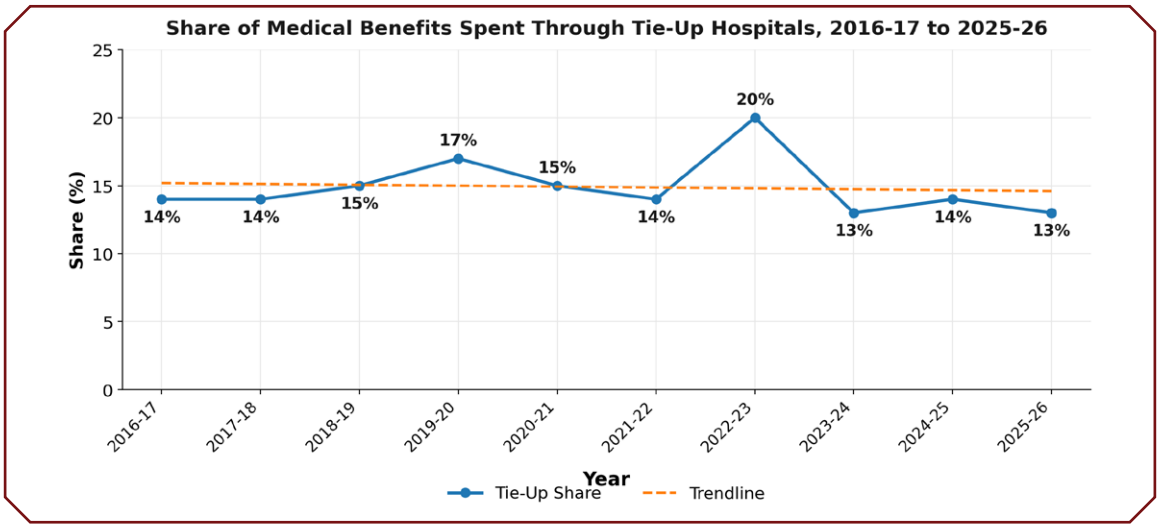


Note: Values are inflation-adjusted to 2024–25 prices (real).

The sharp dip between 2015–16 and 2016–17 occurred alongside a sharp increase in IP enrolment over the same period (Figure 13.2).

Across a ten year period from 2016-17 to 2025-26, in spite of tie-ups with hospitals nationwide, the share of expenses for medical benefits through Tie-Up hospitals has remained broadly consistent.

Figure 13.10: Share of Medical Benefits through Super Speciality Treatment & Secondary Care (Tie-Up Hospitals) (Real ₹, inflation-adjusted to 2024–25 Rupees)



For 2024-25 and 2025-26, Revised Estimates and Budget Estimates were used for Super Speciality Treatment & Secondary Care (Tie-Up Hospitals) expenses. For 2025-26, Budget Estimates used for Total Medical Benefits.

"Secondary Care" was explicitly added to the title post 2020.

13.3 Cash Benefits: Decreased Payments per IPs, Higher Real Per-IP Spend

13.3.1 Total cash benefit payments increased slightly, but not in line with IP growth

Total cash benefit payments rose 26% from 34.26 lakh (2009–10) to 43.24 lakh (2024–25), peaking again in 2024-25, after peaking post-pandemic in 2022–23 before easing. However, payments per 1,000 insured persons fell from ~240 to ~112 (~53% decline) over the 15 years, indicating that growth in claims paid has not kept pace with enrolment expansion.

Possible reasons for this decline include

i. expansion into geographies or industries with lower injury or sickness incidence

ii. persistent gaps in worker awareness and access

iii. newer IPs, who typically are less claims-prone.

Figure 13.11: Total Number of Cash Benefit Payments (Lakh), 2009–10 to 2024–25

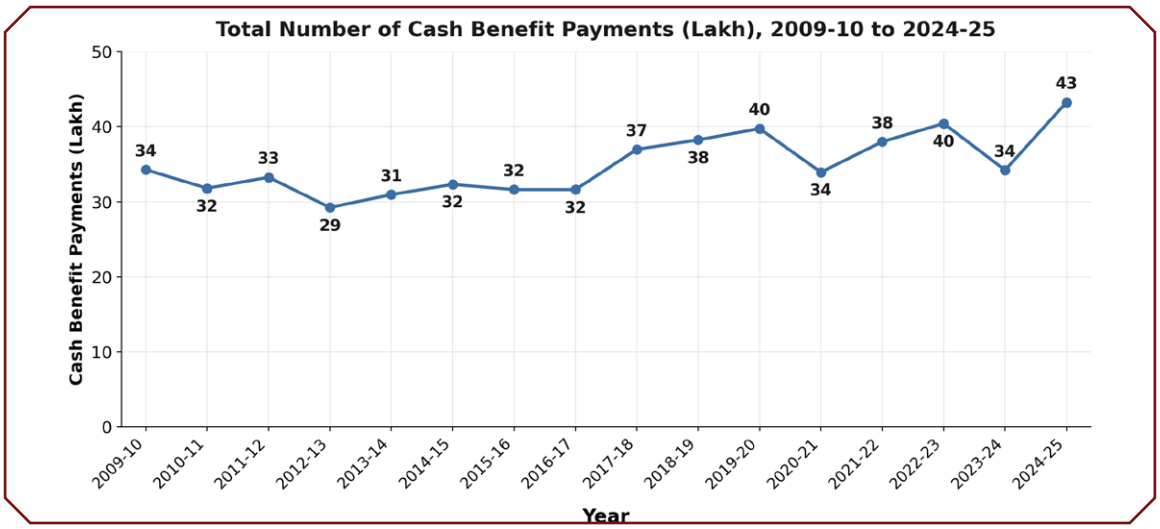
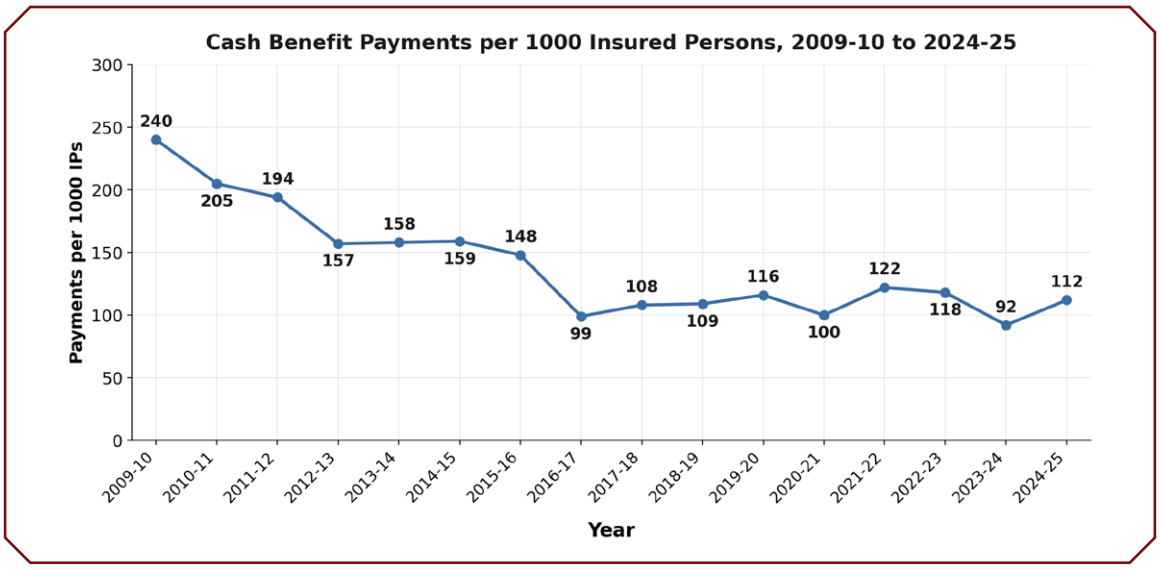


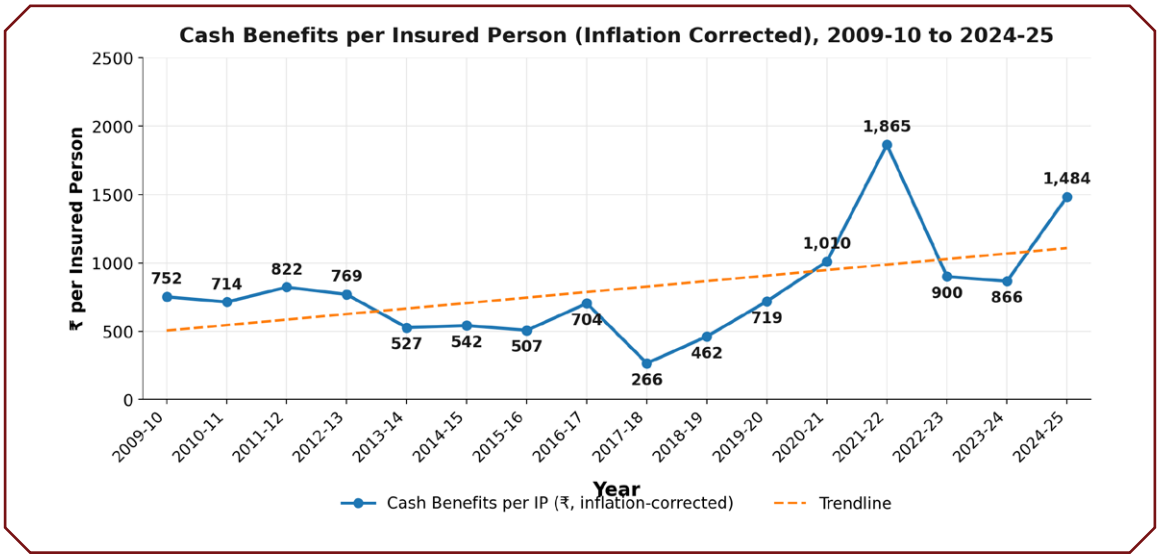
Figure 13.12: Number of Cash Benefit Payments per 1,000 IPs, 2009–10 to 2024–25



13.3.2 Cash benefits per IP have increased steadily; trends are uneven across benefits

Overall (Figure 13.12): Inflation-adjusted cash benefits per IP rose over the 15 years, peaking during the pandemic in 2021–22 and again in 2024-25. Gains are positive, but year-to-year variability persists.

Figure 13.13: Cash Benefits per IP (Real ₹, 2024–25 prices)



Note: Values are inflation-adjusted to 2024–25 prices (real).

By component (Figures 13.14 to 13.18):

Sickness Benefit (per IP): Downward trend across the 15 years.

Maternity Benefit (per woman IP): Upward trend but on a decline post-2018-19.

Temporary Disablement Benefit (per IP): Declining long-run pattern.

Permanent Disablement Benefit (Capitalised Value per IP): Mixed, with a slight downward drift.

Dependents' Benefit (Capitalised Value per IP): Upward trend with a sharp COVID-19 spike in 2021–22, followed by normalisation.

Figure 13.14: Cash Benefits by Component per IP (Real ₹): Sickness Benefits

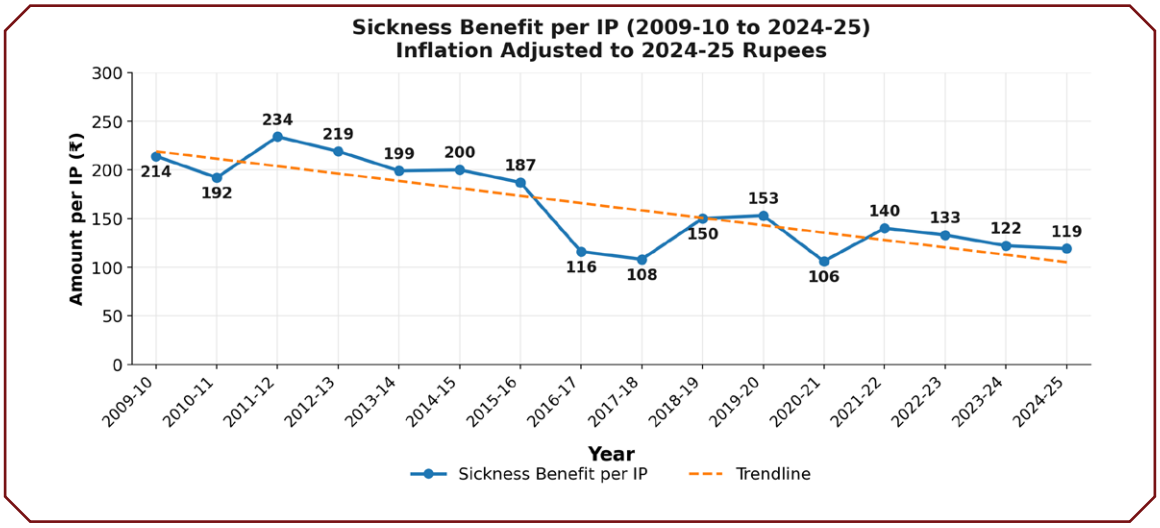


Figure 13.15: Cash Benefits by Component per IP (Real ₹): Maternity (per Insured Woman - IW)

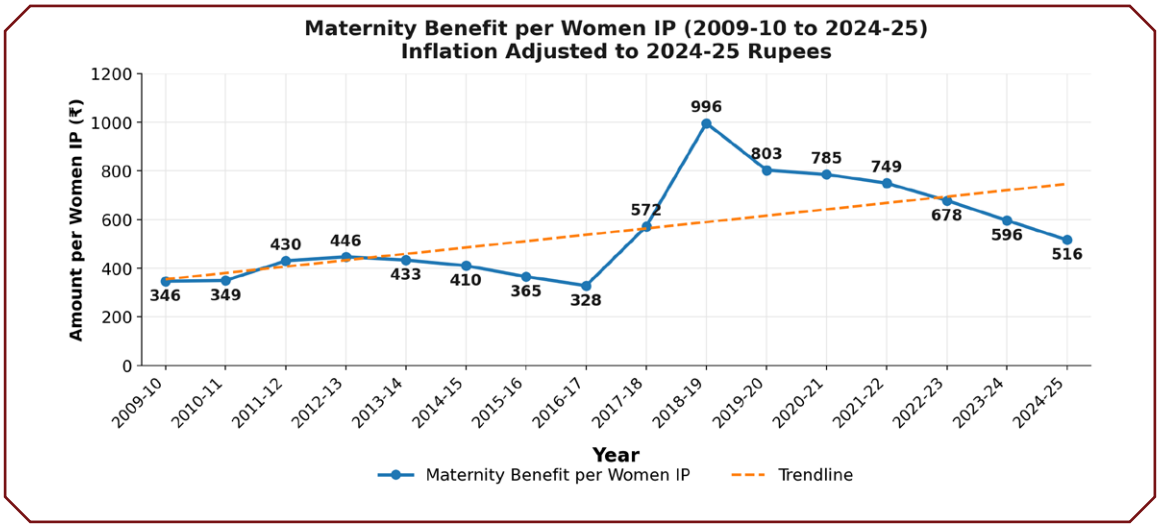


Figure 13.16: Cash Benefits by Component per IP (Real ₹): Temporary Disablement (TDB)

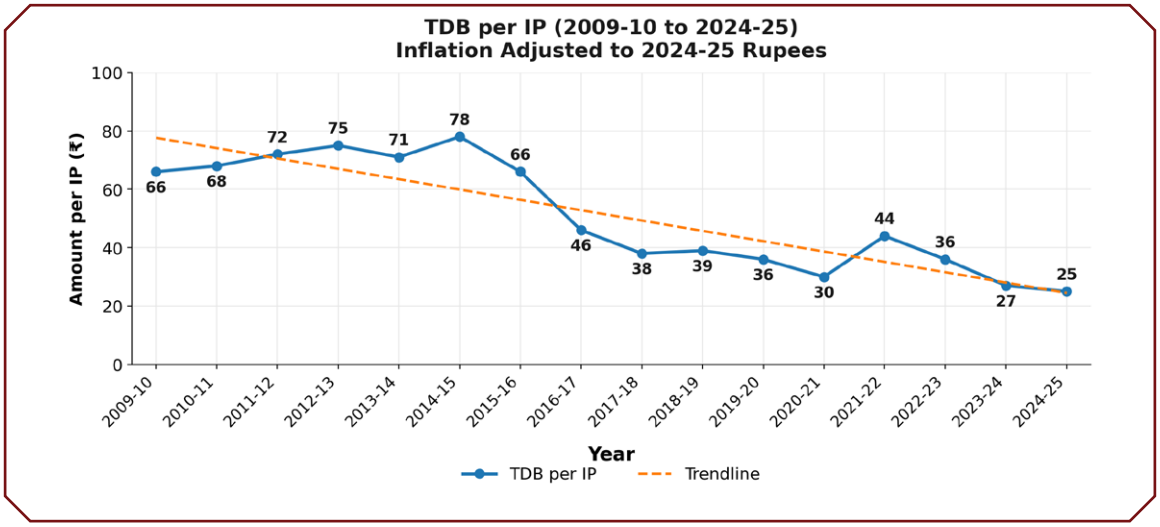


Figure 13.17: Cash Benefits by Component per IP (Real ₹): Permanent Disablement (PDB, capitalised value)

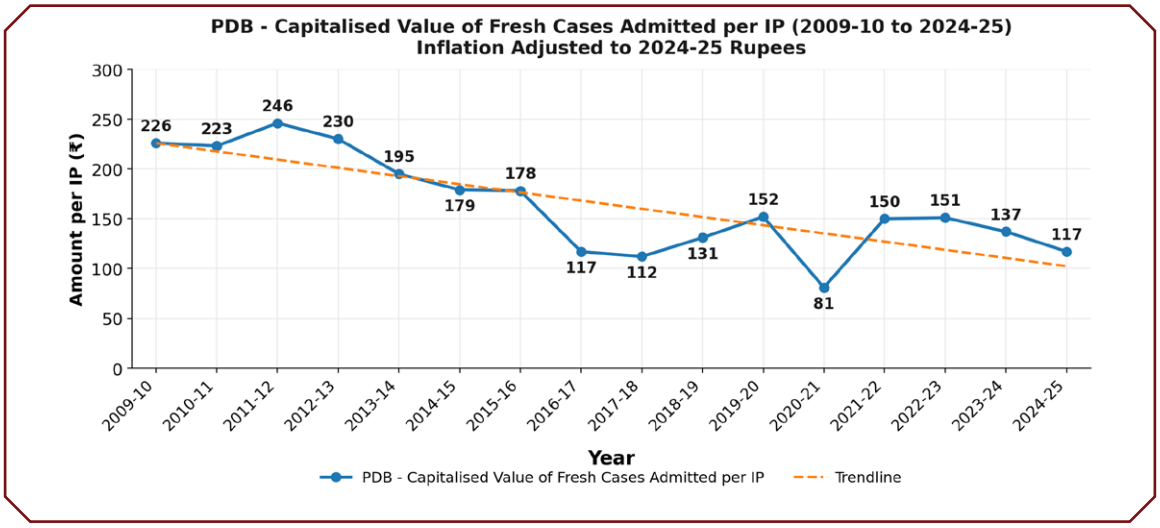
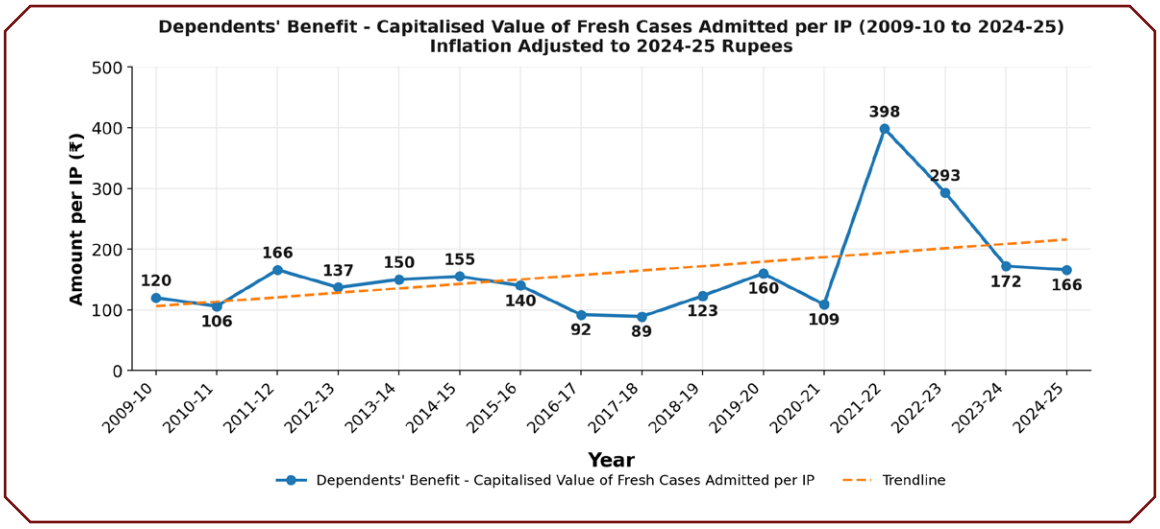


Figure 13.18: Cash Benefits by Component per IP (Real ₹): Dependents' Benefits (capitalised value)



Note: Values are inflation-adjusted to 2024–25 prices (real).

Details, definitions, and state patterns are covered in Chapters 2 to 4.

13.4 Governance: Partly Improved but Infrequent Committees; Inspections and Surveys Down Sharply, no CAG report since 2014 to confirm

The CAG's audits of ESIC in 2006 and 2014 highlighted significant administrative and governance shortcomings. Subsequent actions appear to have improved select parameters, but multiple gaps persist in compliance, transparency, and operational accountability. This section summarises the big-picture governance patterns; detailed diagnostics are covered in the relevant thematic chapters.

Leadership tenure and continuity: DG ESIC and Labour Secretary; Average tenure of last 5 ESIC DGs: ~14 months

The ESI Act (as well as the Code on Social Security, 2020) allows the ESIC Director General to hold office for a period "not exceeding five years".

In practice, tenures are far shorter (indicative, based on SII compilation):

DG ESIC: average tenure c.14 months (last 5 DG terms); c.21 months (last 10 DG terms).

MoLE Secretary: average tenure c.12 months (last 5); c.16 months (last 10).

Neither the ESI Act, nor the Social Security Code prescribes a minimum tenure; they only set a ceiling. But short, fast-cycling tenures potentially limit continuity for multi-year reforms, especially on policy follow-through, digital systems, medical governance, and service-delivery improvements.

13.4.1 Only four states have the much-needed ESI Society; Mixed Fund routing elsewhere throttles care delivery and reimbursements

Funding of medical benefits: ESIC transfers funds to states on a per-capita basis at ₹3,000 per IP per annum. Ninety per cent is released up-front against annual estimates (indexed to IP count); the residual 10% follows AG-audited final settlement. The pooled grant is intended to cover the full running cost of ESIS dispensaries and hospitals, IP reimbursements, and drug and diagnostic supply, through a state-held revolving corpus. All medical treatment except Super Speciality Treatment (SST) is state administered.

Two funding routes; one works better: In four states, Maharashtra, Chhattisgarh, Tripura, and Himachal Pradesh, an ESI Society receives ESIC transfers into a ring-fenced account and disburses autonomously (as per ESIC's Standard Note).

In every other state, including Haryana, funds enter the state Consolidated Fund and disbursement is gated by the Finance Department's treasury operations: appropriation limits, fungibility with general revenue, year-end lapse, and cash-management holds all apply.

The consequence is chronic under-delivery across drugs, diagnostics, staffing, and IP reimbursements, a bottleneck for want of timely cash release

13.4.2 ESIC is governed through a bulky 59-member Corporation (effectively the Board); Regional Boards are inactive; Local Committees are non-functional

ESIC Corporation: ESIC's current Corporation under Section 4 comprises 59 members, with 39 government-linked members (Central Government nominees, state representatives, MPs, DG), and just 10 employer and 8 employee representatives, almost all from national unions, with no contract worker representation, and 2 medical professionals. There are zero independent experts.

The workers whose contributions fund the system are underrepresented, and the contract workers who make up the majority of ESIC's insured population have no voice at all.

Regional Board (State/UT): has powers to recommend changes to the Code, Rules, Regulations, and Schemes, extending the scheme to new areas/families, improving benefits, special measures for local conditions and arrange rehabilitation for permanently disabled persons, employers' compliance, advise on improvements, promote health/safety, and check abuses like lax certification, IP & employer grievances and complaints etc.

Constituted in the past, but with limited functioning; rarely met (highlighted by CAG); no recent data

Local Committees (District usually): has powers to discuss local problems and make recommendations, refer general complaints to the Regional Director, and medical-related complaints to the State Government

Some instances of being constituted in the past (c. 2016-17), but practically inactive

13.4.3 Governance – Committee Meetings: CAG-flagged (2013–14) committee meeting shortfalls continue even now (2019–25)

CAG (2014) found major committee meeting shortfalls for 2008–13: Standing Committee ~20% short, Medical Benefit Council ~50% short, Regional Boards ~78% short, and Hospital Development Committees ~70% short.

2019-25 shows a similar pattern for some of the committees: the Medical Benefit Council met 4 of 12 times (2 times * 6 years) required, i.e., ~67% shortfall, and the Standing Committee met 22 of 24 times (4 times * 6 years), with statutory shortfalls in 5 of 6 and 3 of 6 years, respectively.

Figure 13.19: Infrequent meetings of ESIC Medical Benefit Council (Actual vs statutory minimum, 2019–20 to 2024–25)

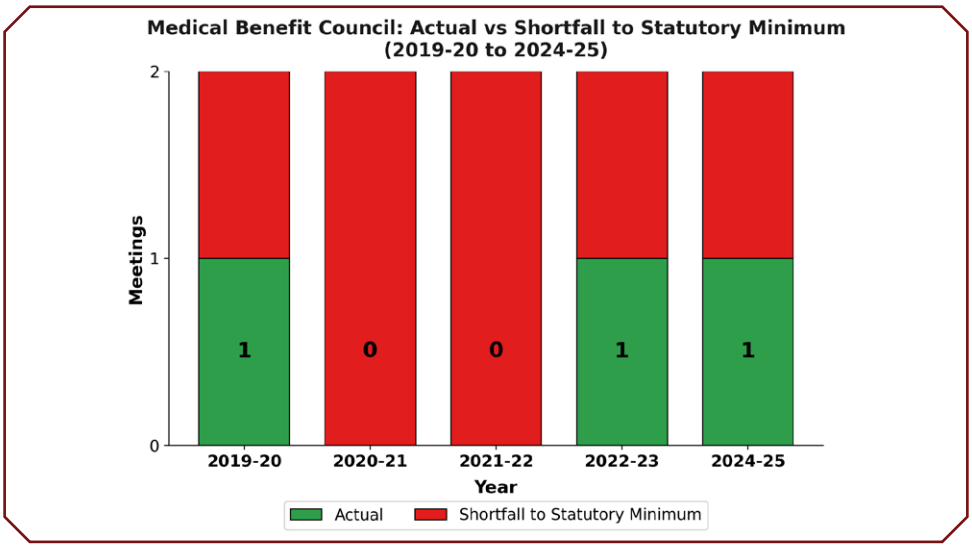
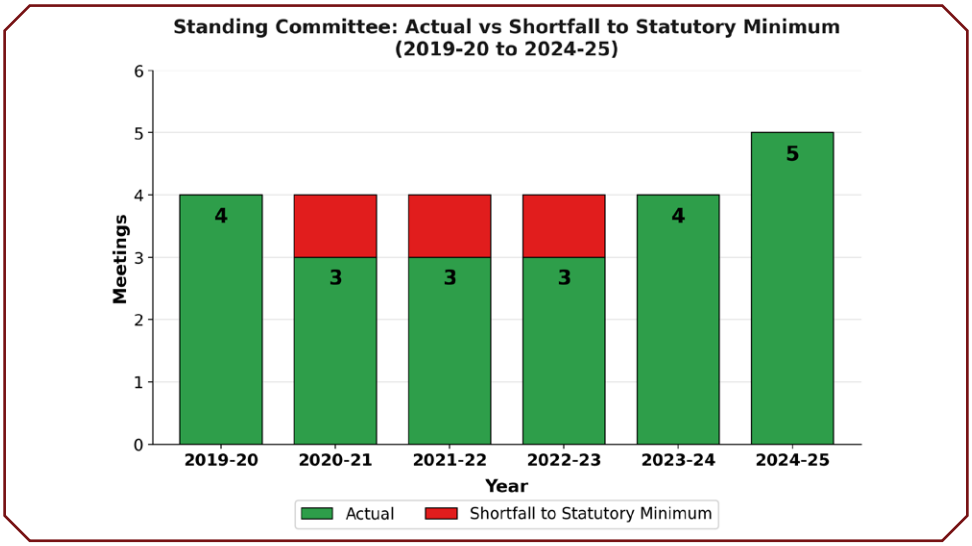


Figure 13.20: Infrequent meetings of ESIC Standing Committees (Actual vs statutory minimum, 2019–20 to 2024–25)



There is no Payment Benefits Council. The new Draft ESIC Regulations 2026 includes a provision for Committees to assist the Corporation (Reg 8); an open-ended power for the Corporation to constitute committees. This can be used to constitute a quality-of-claims / payment-benefit committee.

13.4.4 Inspections & Surveys - Benchmarks vs Reality: ~96–98% Shortfalls

Benchmarks & roles: ESIC's inspection policy sets operational targets per SSO of roughly one inspection and one survey per working day (≈ 20 inspections and 20 surveys per month), with regional annual plans. Surveys identify newly coverable establishments; inspections verify compliance in already covered units. Under Section 45 of the ESI Act (Section 123 in the new Social Security Code), SSOs can examine employment/wage records and conduct investigations; test inspections by Regional/Joint Directors provide oversight.

Audit context: CAG (2006) reported severe survey shortfalls versus ESIC's own benchmarks, i.e., ~72% on average, up to ~93% in some test-checked states; CAG (2014) again flagged persistent shortfalls.

What the last decade shows: Annual inspections and surveys have further declined (see Fig. 13.21 and 13.22):

Estimated shortfall (order-of-magnitude): Using the policy benchmark (~20/month) and the in-position SSO strength = 1,632 (31-03-2024):

Required per year (each): 1,632 × 240 ≈ 391,680

Actual 2023–24: 16,435 inspections; 6,474 surveys

Shortfall: ~96% (inspections) and ~98% (surveys)

Actual 2024–25: 15,600 inspections; 33,560 surveys

Shortfall: ~96% (inspections) and ~91% (surveys)

Notes: This estimation uses the latest SSO strength as a proxy (historic series unavailable) and assumes uniform target applicability; it is indicative of execution gaps, not of any deficiency in legal mandate.

Figure 13.21: ESIC Inspections (2009–10 to 2024–25)

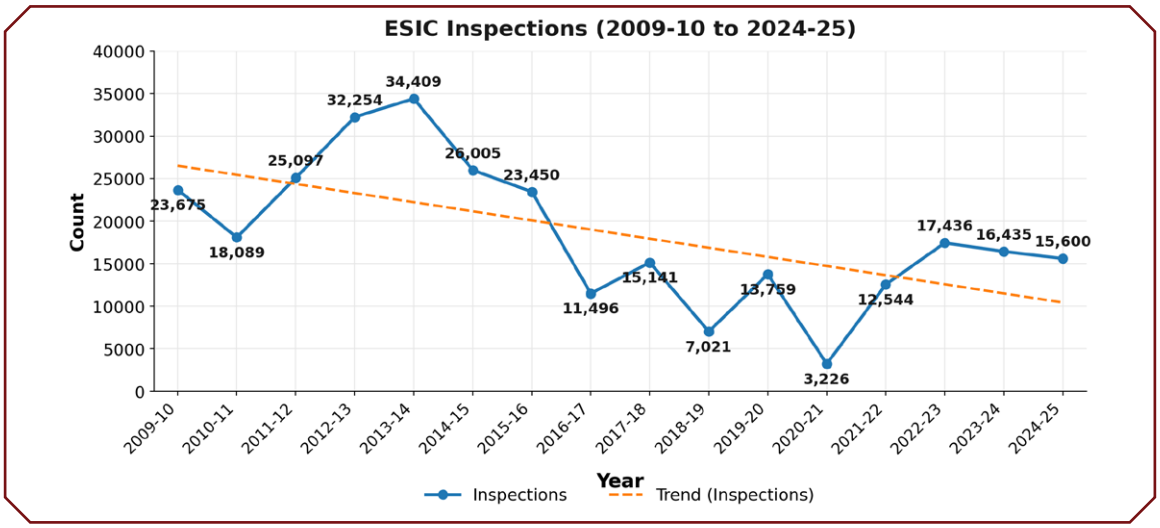
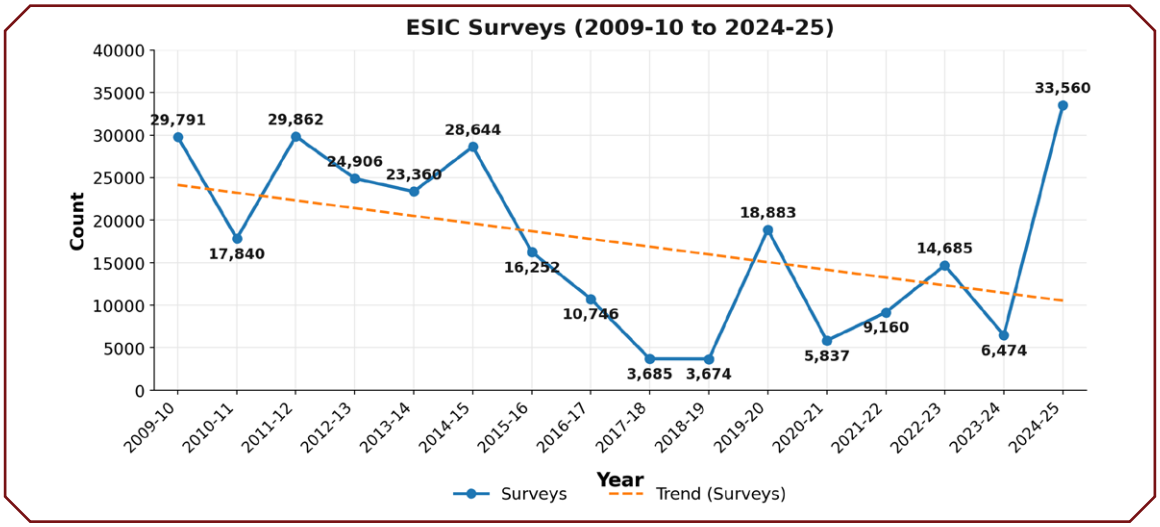


Figure 13.22: ESIC Surveys (2009–10 to 2024–25)

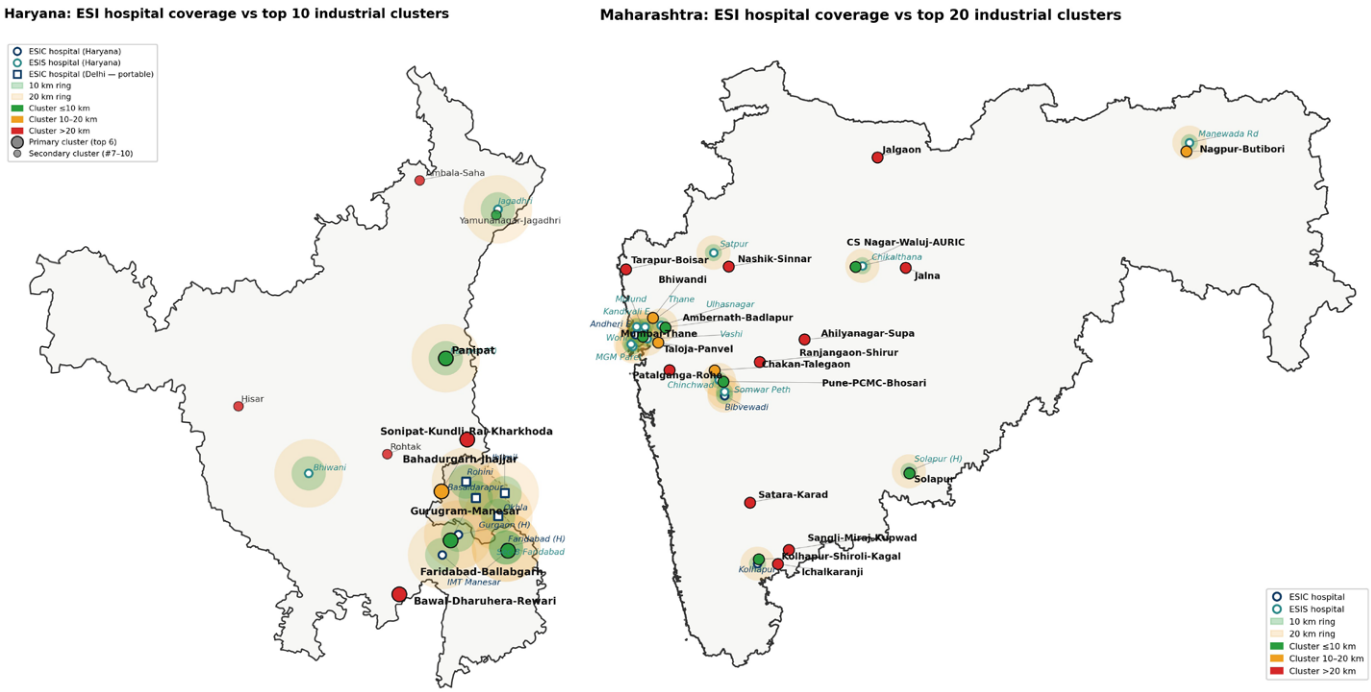


Positive: 33,560 surveys in 2024-25 (5x 2023-24 numbers) reported.

Field insight (Haryana & Maharashtra): In SII's limited experience, branch offices conduct hardly any surveys, primarily due to time and resource constraints as advised by ESIC staff. This has implications for the IP's social security and working conditions of workers (SII's data indicates a linkage between ESIC compliance and worker injuries – please refer to CRUSHED 2025 for details)

ESI hospital network and industrial clusters: mapping gaps in hospital access

Coverage is concentrated around Haryana's and Maharashtra's older industrial cores (Mumbai, Pune, Faridabad and Gurugram), while several major industrial corridors, including Chakan-Talegaon, Bawal-Dharuhera-Rewari, Sonipat-Kundli and Rohtak, fall outside the mapped access radius.



Methodology and Caveats:

- The above maps are indicative. They illustrate patterns of coverage mismatch, not a precise coverage audit.
- Hospitals shown: operational ESIC and state ESIS hospitals per esic.gov.in (Aug 2026). Excludes under-construction, sanctioned, dispensaries, IMPs, EUDs, and tie-up/empanelled private hospitals; this map excludes tie-up hospitals to focus on directly provided care. Delhi hospitals are shown for the Haryana map; they are accessible to Haryana IPs under ESIC portability. Other states' ESIS facilities are not portable and are excluded.
- Cluster selection is based on domain judgment, not a systematic worker-count ranking. Refinement using Udyam Registration data is a recommended next step.
- Cluster centroids are approximate for corridors spanning 15–25 km (Chakan-Talegaon, Sonipat-Kundli-Rai-Kharkhoda, Panipat); coverage at corridor edges would be worse than shown.
- Distances are straight-line (haversine); road distances are greater. The 10 km green ring reflects the ESIC beneficiary-access threshold; the 20 km amber ring is illustrative.
- AI assistance (Anthropic's Claude and OpenAI's ChatGPT) used for cluster shortlisting, geocoding, distance computation, and rendering. Hospital and cluster selections reviewed; accuracy is street/suburb-level, not ground-verified.

13.5 Recommendations

13.5.1 Restructure ESIC Corporation by improving its constitution

Restructure the Corporation (effectively the board) towards balanced representation: 25% each of government, employers, workers (including contract workers), and truly independent experts, with equal power, creating a board with the professional capability and stakeholder balance to govern an institution covering 14.91 crore beneficiaries.

13.5.2 Activate the Regional Boards and Local Committees

Amend the Regional Board and Local Committee composition to include representatives of contract and non-permanent workers, who can be IPs themselves and representatives of NGOs/Civil Society.

13.5.3 Use Regulation 8 to constitute a quality-of-claims/payment-benefit committee.

13.5.4 Constitute ESI Societies in all states

Ring-fenced Society accounts will remove the state treasury as a gating step for in-kind delivery (drugs, diagnostics, staffing) and IP reimbursements, converting ESIC's per-capita transfer into a dedicated, contributory-funded pool disbursed at the point of need (ESIC's Standard Note).

13.5.5 Ensure all committee meetings happen on schedule

13.5.6 Institute regular, independent performance and social audits

13.5.7 ESIC should be routinely and publicly accountable on both its performance and its costs through

Public Accountability Reporting: regular, structured, public reporting on ESIC's performance against its own commitments; including turnaround times against Citizen's Charter standards, grievance closure rates, benefit disbursal timeliness, hospital occupancy, vacancy rates against sanctioned strength, published quarterly by BO/RO/state

Public Costs Reporting: standardised, publicly disclosed financial reporting framework; including details on states' expenditure on medical benefits. (Please see Chapter 15 for details)

13.5.8 Replace the current random/rotational selection for both inspections and coverage surveys with a risk-based algorithm.

Please refer to Chapter 22.



Uncovered Silicosis in Gujarat's Ceramic Clusters (Morbi/Thangadh) (PTRC Case Study)

Peoples Training & Research Centre (PTRC) has been identifying silicosis-affected workers in Morbi, one of Gujarat's most industrialised ceramic hubs, and in Thangadh, a major sanitary-ware centre. These are long-notified ESIC areas: Morbi was notified under the ESI Act in 1967, the predominantly industrial Mahendranagar belt in 1993, and Thangadh much earlier than the present study period as well. Yet, despite this legal coverage, PTRC's work suggests **that many ceramic workers in these high-risk clusters remain outside effective ESIC protection**. Exposure to respirable silica arises across departments such as bharai, glazing and finishing, and an older NIOH study reportedly found **around 15% silicosis incidence in the ceramic industry**, with no recent re-estimation available.

In 2018, PTRC surveyed 1,000 ceramic workers in Thangadh. Of these, 984 reported that no ESI contribution was being deducted, despite appearing to meet the three basic statutory conditions for coverage: working in a notified area, being employed in units with 10 or more workers, and earning ₹21,000 per month or less. PTRC's continuing tracking in Morbi has identified 51 silicosis cases, of whom 14 had died at the time of reporting. Of these 51 workers, 27 had worked in ESI-notified factories employing at least 10 workers, and only one worker reportedly earned above the wage ceiling; yet only one patient was actually covered by ESIC. The wider PTRC Morbi survey of 2,000 workers across 290 units found similarly weak implementation: 92.65% said ESI contribution was not deducted, even though all surveyed workers were in notified areas, in units with 10 or more workers, and within the wage ceiling.

PTRC also used RTI to test what the administrative record showed. **RTI replies from ESIC offices in Morbi, Wankaner and Ahmedabad raised further concerns. For January 2023 to August 2024, Morbi reported zero cases of Temporary Disablement Benefit and zero cases of Permanent Disablement Benefit for occupational diseases. Wankaner reported zero TDB cases and only two PDB cases for occupational diseases over the same period. In a cluster with extensive silica exposure and active field identification of silicosis, these figures appear strikingly low.** PTRC's RTIs also revealed inconsistent counts of registered units and declining new registrations and OPD use at the Morbi ESIS dispensary, alongside vacant medical-officer posts.

Silicosis often strikes workers early, when they still have many earning years ahead. In Morbi's ceramic industry, piece-rate work, long hours without weekly rest, lack of ID cards or written contracts, and weak proof of employment reduce workers' bargaining power and make access to statutory social security even harder. The PTRC case shows that in high-risk industrial clusters, the problem is not only disease detection; it is also the large gap between statutory ESIC coverage on paper and actual coverage in practice.






Surat's Power-Loom Cluster: Reduced ESIC Reach and Worker Protection (Aajeevika Bureau Case Study)

Over 20% of Gujarat's MSMEs are registered in Surat, the state's textile and diamond hub. The district has over 2.55 Lakh MSMEs, predominantly micro enterprises, and, until 2020, these units alone employed around 15 lakh workers across industries (a conservative estimate). Against this scale, ESIC data indicates roughly 3 lakh insured persons in Surat. Surat district was only partially notified, covering industrial areas such as Sachin, Pandesara, Udhna, Limbayat, Dindoli and Katargam, among others.

Decreasing facilities: Less than a decade ago, the district reportedly had more than 15 functioning ESI dispensaries; today, *only seven are said to be operational*, with limited resources, and only two reportedly provide services for a few hours each day. Not all treatments and services are available at these dispensaries, forcing workers to seek care elsewhere. *Meanwhile, a 300-bed ESIC hospital has been under construction for over six years*, even as contributions have continued to be collected regularly. In a further example of weak administrative follow-through, two dispensaries were shifted to Sita Hospital, but lease/rent issues reportedly led to services being shut for a prolonged period, despite repeated public demands for restoration.

Case Story - Non-registration by businesses: Surat's power-loom sector is widely characterised by informality, which undermines workers' access to basic labour rights and social security. Pravasi Shramik Suraksha Manch, a registered trade union working with migrant loom workers for around a decade, initiated a campaign with the ESIC department in Surat in 2023. The union consolidated details of over 100 units located in notified areas and across industrial clusters such as Katargam, Unn, Limbayat and Udhna, and submitted this list to the department, flagging non-implementation of ESIC in eligible units.

A typical loom unit operates in two shifts and often employs more than 10 workers, suggesting that a substantial share of Surat's units should fall within ESIC's coverage threshold. However, workers' access to ESIC is reportedly constrained by non-registration, questionable documentation, and informal wage payments.

Following the submission, the campaign reportedly received a favourable initial response, but did not translate into meaningful enforcement. ESIC officials reportedly stated that, during inquiry, some units were shown as having only 2 to 3 workers, even where the unit had around 20 loom machines and multiple roles (e.g., warping, bobbin making, supervision, cleaning, beam handling) operating on the shopfloor, highlighting the extent of under-reporting encountered in practice.

Institutional Indifference: A workshop with loom owners and the ESIC Department in Surat was organised last year to discuss ESI implementation and on-ground challenges. Yet field accounts suggest that these deliberations have not translated into consistent enforcement. In one disturbing incident, the team persuaded a loom owner to register under ESIC and accompanied him to the department; *an official reportedly asked the owner why he was being "brainwashed" into registering.* In a risk-prone industry with frequent fatal and non-fatal accidents, this kind of response raises serious concerns about institutional seriousness in protecting workers' rights and ensuring compliance.



CHAPTER 14

Status of Occupational Diseases under ESIC: Strong Expertise; An Opportunity for Better Disease Tracking



14.1 ESIC has Increased OD Capacity, with a Nodal Institute for Occupational Health and 6 Zonal Centres

ESIC has also "set up one IOHER Centre at Basaidarapur & six Zonal Occupational Disease centres for providing early detection & prompt treatment, apart from taking steps for preventive & promotive aspects pertaining to occupational health".

14.1.1 ESIC has ODCs, an ICMR–NIOH MoU, and clinician training; although the impact remains unclear

Institutional capacity (latest publicly available data):

Network in place: One IOHER hub (Basaidarapur, New Delhi) + six Zonal ODCs (Chennai–K.K. Nagar; Joka–Kolkata; Andheri–Mumbai; Indore–M.P.; Alwar–Rajasthan; Bihta–Patna).

The recent placement of ODCs at Alwar (Rajasthan) and Bihta–Patna (Bihar) is strategically sensible for OD detection and care: Alwar sits within Rajasthan's known sandstone/silica belt, repeatedly flagged for silicosis risk.

Technical collaboration: MoU/working arrangement with ICMR–NIOH (Ahmedabad). Doctors are being trained through this technical collaboration. The latest publicly available data states 973 doctors trained for ODC work (Lok Sabha Standing Committee, Sept 30, 2023)

Unclear Effectiveness: ESIC does not publish centre-wise caseloads, disease-wise diagnoses, outcomes, timelines, spend, or any link from diagnosis to benefits. Without this coverage, conversion to PDB/DB, and effectiveness across states/industries can't be judged.

What's needed: a simple, consistent ODC dashboard/reporting released every year. Until that exists, the impact of ODCs remains unclear despite the infrastructure and training already in place.

14.2 Inadequate reporting and limited support for IPs with Occupational Diseases (ODs)

This chapter summarises how occupational diseases (ODs) are addressed within ESIC's legal and service-delivery framework, and what the public data do, and do not, reveal. The ESI Act provided for OD benefits (Sec. 52A; Sch. III). The new Code on Social Security, 2020 provides for OD benefits under Section 36. The Factories Act made listed ODs notifiable to authorities and had listed 29 ODs (Sections 89 & 90; Third Schedule). This is now required for all establishments under Section 12 of the OSH Code, 2020.

ESIC has some of India's deepest expertise in occupational diseases, e.g., on Silicosis.

14.2.1 27 of 29 notifiable ODs aren't tracked in ESIC stats; only Pneumoconiosis (includes silicosis & asbestosis) is visible.

From the list of 29 occupational diseases (Schedule III of the ESI Act and Schedule IV of the Code on Social Security lists the complete set of occupational diseases), ESIC's public morbidity tables (Appendix III-D) show an OD explicitly only as "Pneumoconiosis" (which medically includes silicosis, asbestosis, coal-workers' pneumoconiosis, mixed-dust pneumoconiosis). In 2023–24 it appears as Cause-group #170 in Appendix III-D. No state/industry splits are provided in Appendix III-D; the table is "for the country as a whole."

Other ODs may be lost inside broad, non-occupational buckets without any attribution to work cause, for example:

- Noise-induced hearing loss; listed only as "Hearing loss" (no "occupational" tag)
- Occupational/contact dermatitis, oil-acne; folded into "Other diseases of the skin and subcutaneous tissue."
- Occupational skin cancers may appear under generic skin neoplasm lines, not flagged as occupational.

Note that employers may be responsible for many occupational diseases (ODs), and preventive action is possible when diseases are related to occupations.

14.2.2 Only Pneumoconiosis is trackable in ESIC morbidity data; incidence trends down, absolute caseload roughly flat; families affected at scale and need proactive solutions

ESIC Annual Reports publish a single OD line, i.e., Pneumoconiosis (reported earlier as "Silicosis and Occupational Pulmonary Fibrosis" up to 2012–13). The per-1,000 incidence reported shows a gradual decline over 15 years. However, this fall could partly reflect mix effects (e.g., newly added areas with little/no exposure diluting the rate). A firmer interpretation requires state/industry-wise cuts, which ESIC does not publish.

When converted to absolute numbers, the estimated annual caseload is broadly stable with only a mild decrease: ~8,000 IP cases/year and ~26,000 family cases/year on average (families computed excluding the 2019–20 outlier). This suggests a persistent burden, not a disappearing one. The higher burden among family members, for a disease fundamentally linked to workplace exposure, warrants review to find out the sources of exposure to the pollutants.

Figure 14.1: Pneumoconiosis – New cases ('000), Insured Persons (ESIC), 2009–10 to 2024–25

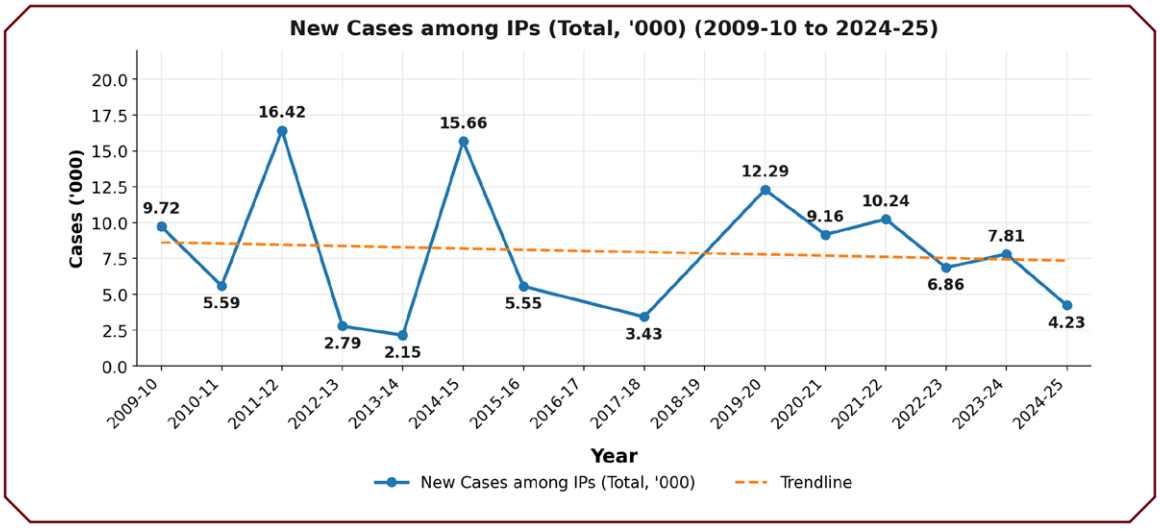
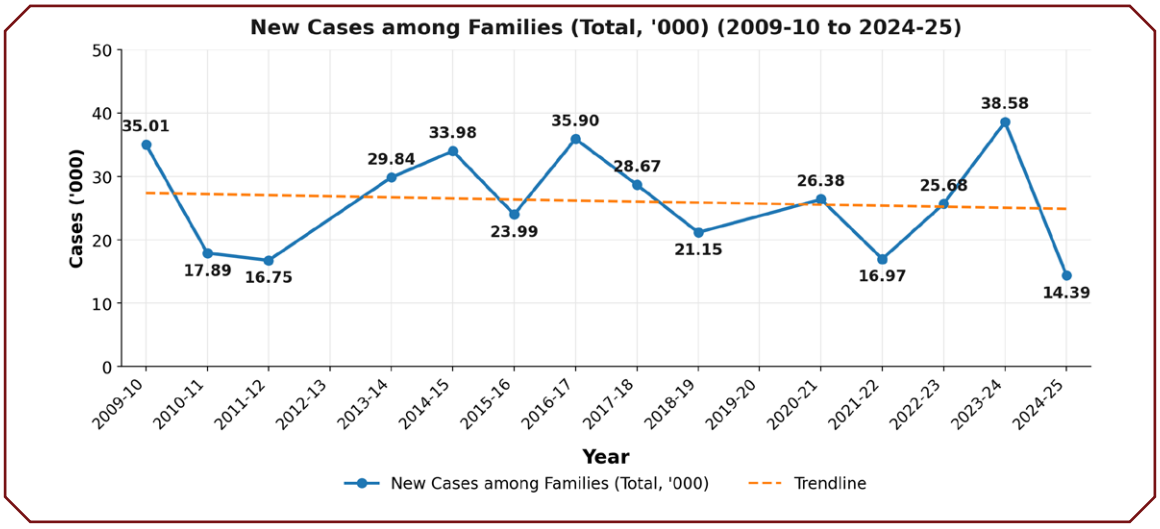


Figure 14.2: Pneumoconiosis – New cases ('000), ESIC Beneficiary Families, 2009–10 to 2024–25 (excludes 2019–20 outlier)



Note on 2019–20 (families): The families series shows a one-year spike in 2019–20 that is implausible for a work-exposure disease and is likely a data/coding/aggregation error. Accordingly, 2019–20 is excluded from trendlines (and from average calculations) and, in some charts, the point is omitted while the year label is retained for continuity.

14.2.3 Disease-linked ESIC benefit data for occupational diseases, currently not publicly available, can help prevent ODs

ESIC's published reports provide only annual aggregates for Permanent Disablement Benefit (PDB) and Dependent Benefit (DB), i.e., counts and amounts, without breaking them down by disease or linking them to morbidity entries (e.g., pneumoconiosis/silicosis). There are no state or centre-wise splits, and no table tracing the path from diagnosed case to statutory notification to sanctioned PDB/DB. As a result, SII cannot analyse how many of the sanctioned PDB/DB cases are due to occupational diseases versus employment injuries, nor how many pneumoconiosis/silicosis cases (or any other OD) actually converted to disability benefits.

Illustrative RO experience (Rajasthan), where ESIC took Positive Action:

ESIC RO Jaipur publicly reported 219 PDB approvals and 37 DB approvals for silicosis-affected workers (cash disbursements of ~₹14.29 lakh/month for PDB and ~₹3.17 lakh/month for DB) in December 2023, showing that OD claims do sometimes translate into benefits in practice.

ODs are dissimilar to accidents and require a separate mechanism: As indicated in Aajeevika Bureau's Pindwara & Sagwara case study (at the end of this chapter) covering the same geography, of ~360 silicosis-related ESIC claims filed in Pindwara, ~300 were sanctioned; the remainder were rejected over employer record-keeping problems or misdiagnosis of silicosis as TB. *This case study highlights systemic hurdles: dependence on employer-filed Accident Reports (ill-suited to chronic ODs)*, lack of a worker-initiated trigger, long Medical Board delays, and misclassification of silicosis as short-term sickness.

Coverage gaps in high-risk clusters: These issues are compounded by non-coverage of units with high OD risk under ESIC, as highlighted in Aajeevika Bureau's Pindwara & Sagwara study and PTRC's Morbi case study (at the end of the previous chapter).

Link to PDB chapter: The same problems noted in the Disability Benefits chapter apply here: employer-dependent reporting and opaque case tracking; Medical Board delays; misclassification of OD as ordinary sickness and administrative/documentation barriers.

14.3 Recommendations to Improve ESIC's Occupational Diseases Capacity and Reporting

14.3.1 Publish OD data by state and by disease and link it to the corresponding benefits

This should include all notifiable ODs, with state-wise and industry-wise splits

14.3.2 Different form for OD to replace Accident Reports

Accident Reports, designed for occupational injuries, are ill-suited for occupational diseases; an OD-specific equivalent form needs to be designed

14.3.3 Create a non-Accident-Report route for ODs

Occupational diseases should not depend on the standard Accident Report pathway, which is poorly suited to diseases that emerge over time. ESIC should create a separate OD trigger that can be initiated by an ESIC doctor, ODC/IOHER specialist, hospital, or the IP directly, with employer input sought later where needed.

14.3.4. Protect ex-IP access in long-latency ODs

ESIC should create a clearer framework for ex-IPs and former workers whose occupational disease is diagnosed after they leave covered employment. Claims should be allowed on the basis of prior covered work and medical evidence of occupational exposure, with faster timelines for OD-related medical board and benefit decisions.

14.3.5. Publish an annual ODC/IOHER performance report

Publish a simple annual report on screenings, diagnoses, referrals, benefit conversions, timelines and major industry clusters served. This would help assess whether the OD infrastructure is actually working.

300 Silicosis-Affected Stone Carvers in Pindwara and Sagwara Received ESIC Pensions (Aajeevika Bureau Case Study)

Across southern Rajasthan's Pindwara and Sagwara blocks, the stone-carving industry employs thousands of workers engaged in cutting and polishing sandstone for construction markets across India. In Pindwara alone, there are roughly 248 units employing around 15,000 workers, while Sagwara hosts another four major units with 500–600 workers. Yet ESIC and PF **coverage remains marginal**: only 14-15 large units, covering about 3,000-3,500 workers, are even partially linked to social protection schemes, and among those, many workers are not formally registered.

To avoid statutory obligations, over the course of time, **many employers have fragmented large workshops into multiple small units and are not reporting the actual workforce, to place them below ESIC's coverage threshold**. As a result, the majority of workers, especially those affected by silicosis, a fatal occupational disease, remain excluded from ESIC's intended safety net.

For silicosis-affected workers and their families, access to disability or family pensions under ESIC has been riddled with administrative hurdles. **In Pindwara, around 360 claims were filed with Aajeevika Bureau's support. Of these, 300 were successfully sanctioned, while others were rejected due to employer malpractice in attendance and wage records or due to misdiagnosis of silicosis as tuberculosis.** The pension amount ranged from ₹2,500 to ₹15,000 per month, with family pensions reaching up to ₹18,000.

For an ESIC benefit to be sanctioned, the employer must first file an accident report, but silicosis develops over years, without a single visible "injury." Most employers fail to acknowledge this responsibility, and without a submitted report, ESIC takes no action. Workers have no mechanism to verify whether the employer has submitted the form, either online or offline. Aajeevika Bureau has advocated for the creation of a worker-initiated Accident Report to trigger the process directly and reduce procedural delays.

Even where cases progress, medical board delays are chronic. For accidents, the boards have to be constituted and meet every three to four months, but for occupational diseases like silicosis, the interval even stretches up to a year, often leading to the death of claimants before decisions are finalised. Families then wait years for benefits, trapped in paperwork and medical ambiguity.

At Pindwara's ESIC-designated private facility, doctors classify silicosis merely as a short-term sickness, granting a 91-day sickness benefit instead of the 2-year extended sickness benefit at 80% of wages. This reclassification effectively denies workers their rightful compensation. Field accounts also point to shortages of medicines and staff, compounding distrust.

The experience of Rajasthan's stone carvers exposes ESIC's systemic failure to adapt its framework to occupational diseases. Without independent verification mechanisms, faster medical board timelines, and greater transparency in employer reporting, the promise of social security remains a distant reality for the workers.



CHAPTER 15

ESIC's finances: improved payouts, but worsening arrears risk ESIC's financial health; potential to use non-earmarked surplus for improving capacity



This chapter presents a limited big-picture view of ESIC's finances: how benefit outgo compares with contribution income on a per-IP basis; how administrative expenses have behaved (a pressure point flagged by CAG in earlier audits); the scale and ageing of arrears and recoveries (also highlighted by CAG); and the size and role of ESIC's reserves/corpus.

15.1 Post 2019 premium cut, the gap between benefits and contributions has decreased; and now risks ESIC's financial health

The CAG audit (FY2008–09 to FY2012–13) found ESIC's collections were "consistently and significantly higher" than its service expenditures; spending on core benefits (medical + cash) was only 33–46% of total income.

This has improved in recent years.

A key driver was the 2019–20 contribution rate cut from 6.5% to 4%. In the six years before the cut (FY2013–14 to FY2018–19), the benefits-to-income ratio averaged 0.50; in the five years after (FY2019–20 to FY2024–25), it averaged 0.89, comparable to private insurers' claims-to-premium ratios (IRDAI).

That said, COVID-19 likely distorted both revenue and utilisation in the post-2019 period, so a few more steady-state years will be needed to confirm the trend.

Figure 15.1: ESIC: Total Benefits vs Total Contributions, 2009-10 to 2024-25

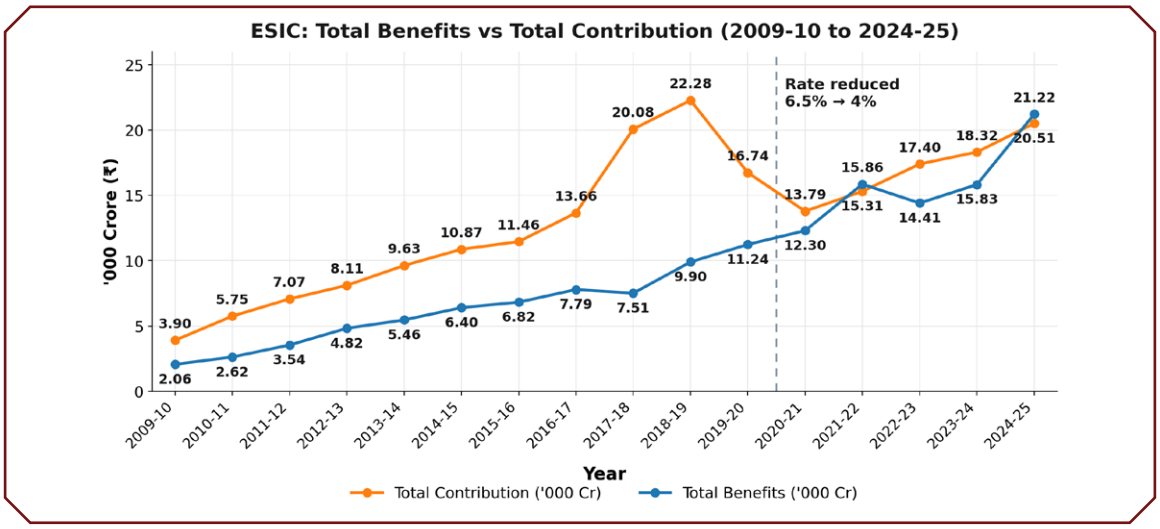
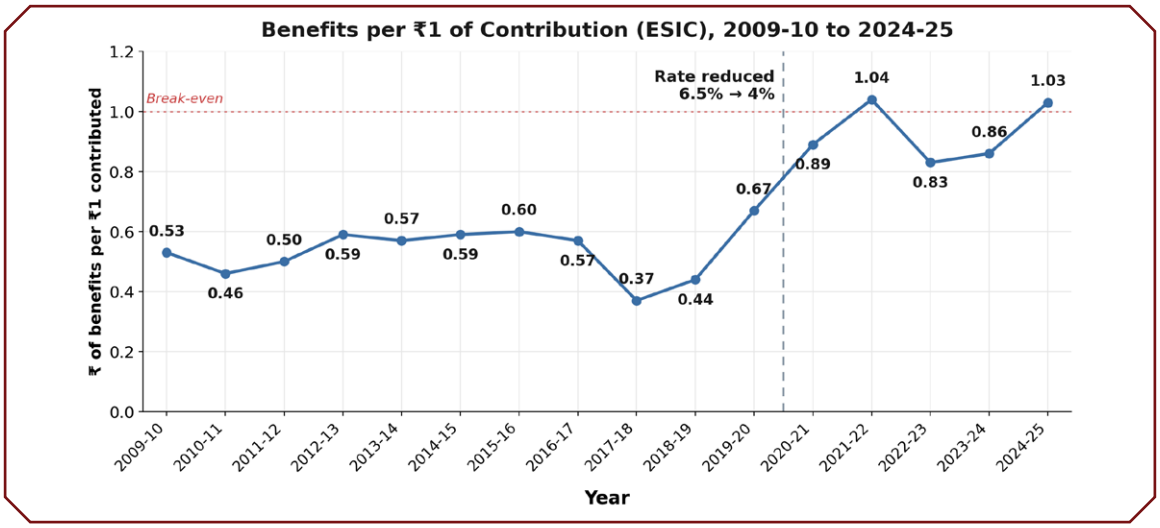
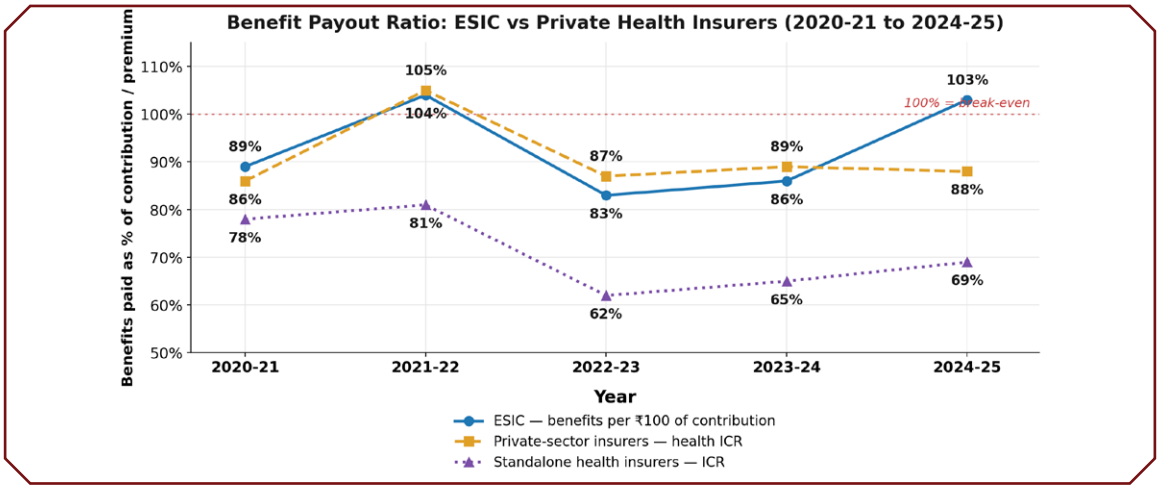


Figure 15.2: ESIC: Benefits per ₹1 of Contribution, 2009–10–2024–25



In 2021-22 and 2024-25, ESIC provided more benefits than contributions collected; this is concerning for ESIC's long-term financial health.

Figure 15.3: ESIC Payout Ratio v/s Incurred Claims Ratio under Health Insurance Business of General and Health Insurers (IRDAI data), 2020–21–2024–25



The insurer rows are health-segment ICR (net incurred claims ÷ net earned premium); ESIC is benefit expenditure ÷ contribution income. The two aren't computed identically but are comparable.

After the contribution rate was reduced from 6.5% to 4%, ESIC benefit payments have been broadly at or above contribution income. The benefit-to-contribution ratio averaged around 93% from 2020–21 to 2024–25 (ESIC Annual Reports,2020–21 to 2024–25). For comparison, in private health insurance, the 2024–25 incurred claims ratio for the most recent 5-year period was 88% for private-sector general insurers and 69% for standalone health insurers who deal exclusively with health insurance (IRDAI Annual Report)[1].

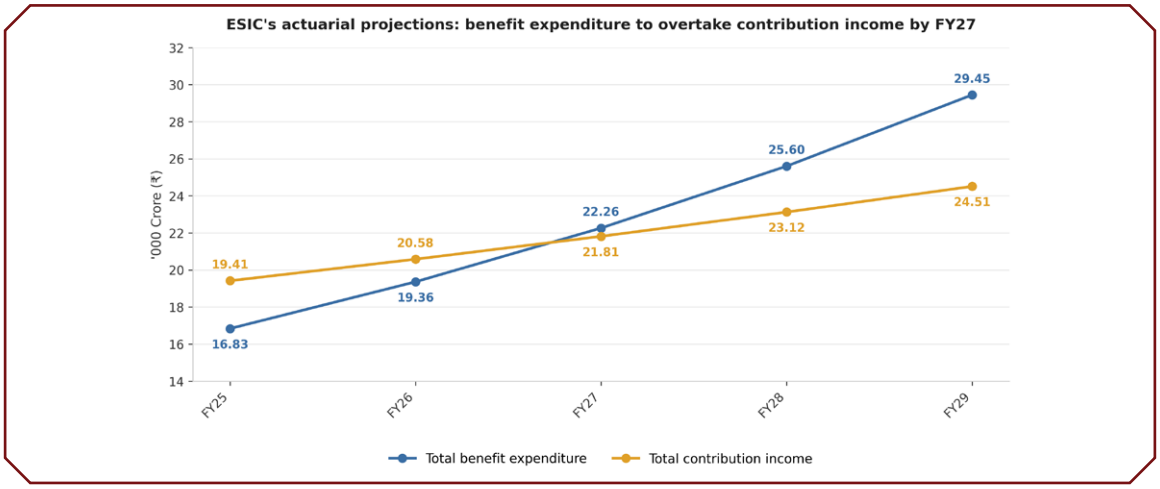
Long-term financial trajectory: ESIC's actuarial projections point to an eroding fiscal cushion

The actuarial projections placed before the ESI Corporation, reviewed by *Business Standard* (17 August 2026)[2], project the scheme's fiscal position through FY29, with serious implications for long-term stability.

Contribution income is projected to grow at 6 per cent per annum. Benefit expenditure, however, is projected to grow at much higher rates across most categories: medical care at 15 per cent, maternity benefit at 25 per cent, dependants' benefit at 17.25 per cent, funeral expenses at 8.75 per cent, and temporary disablement benefit at 3 per cent. The implied blended growth rate for total benefit expenditure, from the FY25 and FY29 anchor values disclosed, works out to approximately 15 per cent per annum, two and a half times the growth rate of contribution income.

At these rates, benefit expenditure exceeds contribution income from FY26 onwards, and the gap widens each year (graph below).

Figure 15.4: ESIC: Total Benefits vs Total Contributions (Actuarial Projections, 2024–25 to 2028–29)

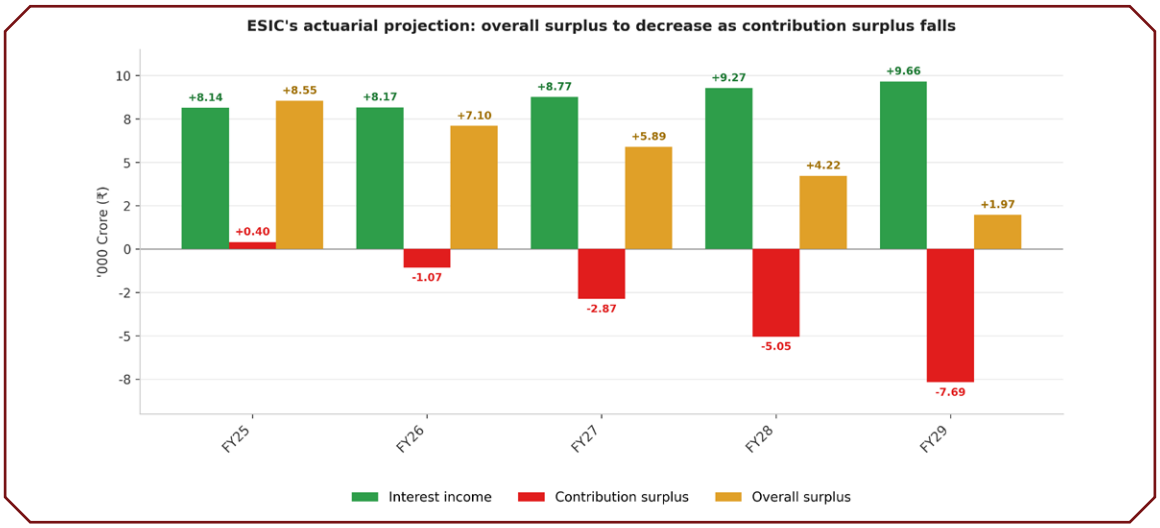


[1] IRDAI Annual Report 2024-25; Table I.27, Incurred Claims Ratio under Health Insurance Business of General and Health Insurers

[2] Actuarial projections placed before the ESI Corporation, as reported in Mukherjee, A., "ESIC contribution cushion seen thinning on rise in benefit costs", Business Standard, 17 August 2026.

The contribution surplus (what remains after benefits and administrative expenses are met from contribution income alone) falls from ₹404 crore in FY25 to a deficit of ₹7,686 crore by FY29. The scheme continues to record an overall surplus income only because of interest earned on its accumulated corpus.

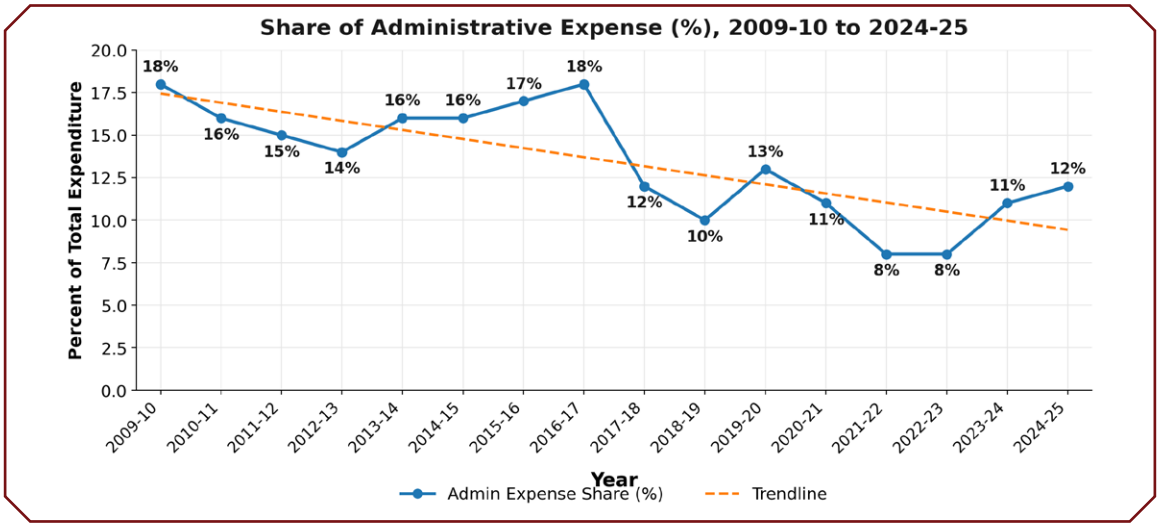
Figure 15.5: ESIC Surplus (Actuarial Projections, 2024-25 to 2028-29)



15.2 Administrative overhead declines over the decade and remains around 10% of expenditure, within the 15% ceiling

The CAG (2014) noted that administrative expenditure for running the ESIC scheme ranged between 12 and 20 per cent of total expenditure, which appeared high, though it remained within the statutory limit of 15 per cent. ESIC's administrative expense share declined over the decade, dipped below 10% in 2021–23, but rose above 10% again in 2023–24 and 2024-25

Figure 15.6: Share of Administrative Expense (%), 2009-10 to 2024–25



These administrative-cost figures should be read with caution: the classification boundary between administrative and medical-benefit costs is not clear, especially in states. The comparisons below are indicative of broad magnitude rather than exact.

For comparison, for standalone health insurers in 2024-25, IRDAI shows operating expenses of c.18% (as a share of total expenses) (IRDAI Annual Report 2024-25).

But ESIC should be benchmarked against efficient public social-insurance systems, not private commercial insurers. Bismarck-style social health insurance systems, which are closest to ESIC in design, average about 3.5%

of health spending on administration and governance in OECD countries[3] [4]. Administrative overhead, therefore, remains well above the international benchmark for social insurance systems.

Rahul



Rahul was employed at an auto supplier running four plants in IMT Manesar, but only one of the four plants is registered with ESIC. The other three run without registration, signboards, or company identification.

Accidents at these unregistered plants go unrecorded: the company neither files accident reports with ESIC nor issues ESIC cards to workers. In Rahul's words: "There is no audit, no officer ever visits."

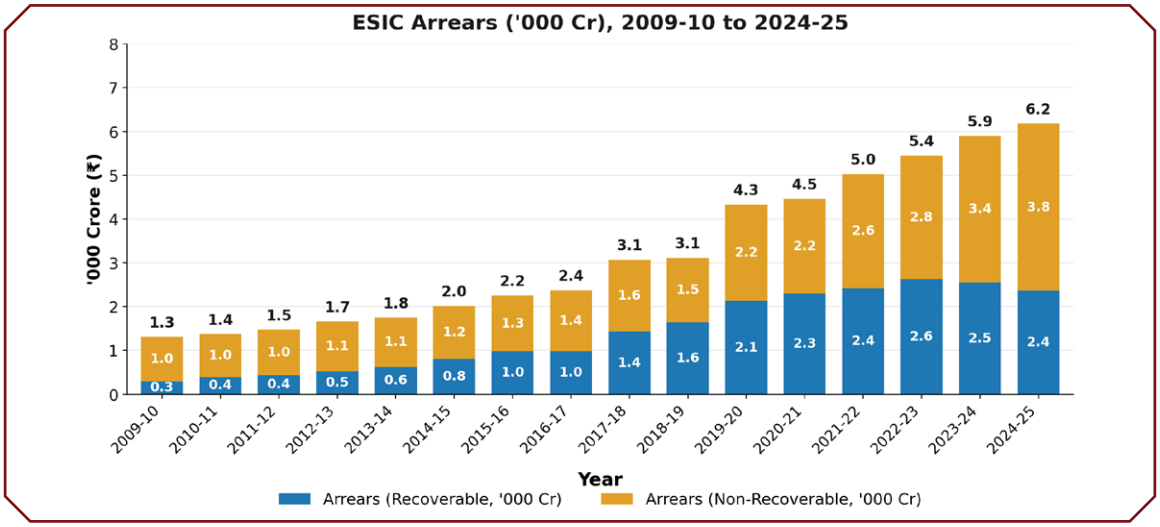
As a result, his ESIC card shows a different company and address from the one where he actually works and was injured.

15.3 Employer contribution arrears keep rising; the non-recoverable share has (mostly) stayed above 50%

The CAG's 2014 audit had flagged growing arrears in employer contributions, rising from ₹1,267 crore in 2008-09 to ₹1,655 crore in 2012-13, and warned that a significant portion was unlikely to be recovered due to litigation, closure of establishments, or untraceable employers.

Over the subsequent decade, the problem has worsened materially. Arrears climbed from ₹1,750 crore in 2013-14 to ₹6,183 crore in 2024-25. Of this, ₹3,818 crore (62%) is now categorised as non-recoverable (reasons include court cases, employer whereabouts not known/establishments closed, and cases becoming time-barred due to non-initiation of timely action), while only ₹2,364 crore remains recoverable. This means that more than half of all arrears are effectively lost, underscoring persistent weaknesses in ESIC's contribution recovery and enforcement systems.

Figure 15.7: ESIC Arrears (₹ '000 Crore), 2009-10 to 2024-25



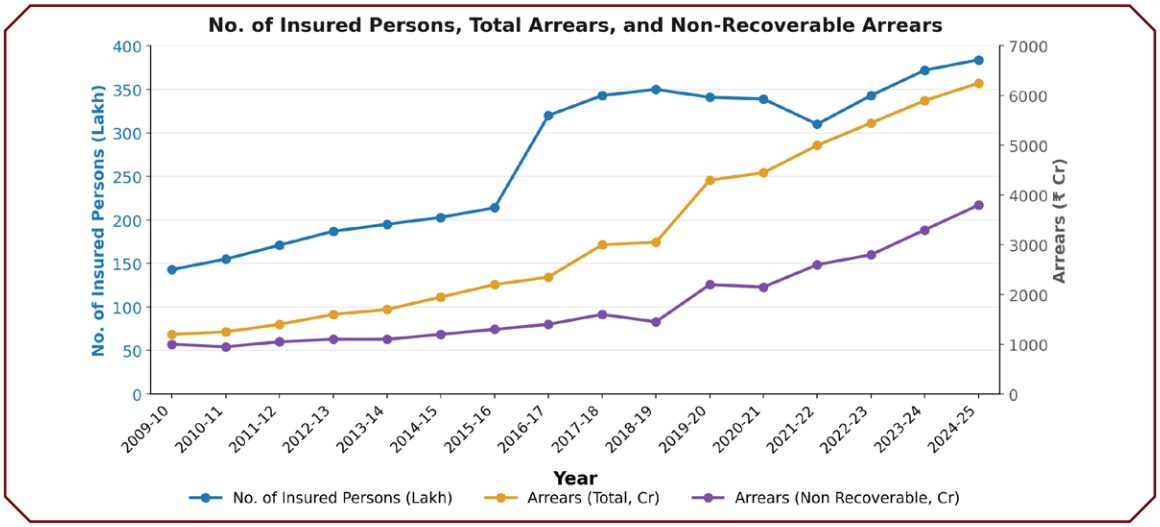
ESIC's Standard Note says that its "contribution income also includes the contribution income recovered from the defaulting employers by the Recovery Officers." In the same section, it separately shows outstanding arrears of contribution as dues against defaulting employers. That means arrears count as revenue when recovered/collected, not merely because they are outstanding on paper. The unrecoverable arrears are therefore loss in revenue to ESIC.

The rise in arrears has broadly tracked the increase in the number of insured persons over time.

[3] Organisation for Economic Co-operation and Development. (2025). OECD health statistics 2025

[4] Rees, S., Morjaria, A., Quilter-Pinner, H., & Norris, E. (2026). Bismarck versus Beveridge revisited: Does the model shape the outcome? Institute for Public Policy Research

Figure 15.8: ESIC Arrears (₹ Crore) and No. of IPs (Lakhs), 2009-10 to 2024-25



There are extensive recovery mechanisms under Sections 45C to 45I of the ESI Act, now Section 129 of the Social Security Code (Certificate Proceedings, Recovery Officers, attachment of property, arrest of employer), but these appear to be underused.

15.4 ESIC Reserves Have Risen Sharply; Large Surpluses Persist Beyond Actuarial Requirements; Potential to Invest into Benefits and Healthcare Access to IPs

The CAG (2014) had highlighted the build-up of surpluses and reserves within ESIC. Subsequently, in December 2022, *the Government permitted ESIC to invest up to 15% of surplus funds in equity ETFs*[5] (from publicly available documents, we are not able to establish if this investment has been made), noting a surplus of about ₹65,000 crore and annual accretions of ₹8,000-9,000 crore, further evidence of sustained accumulation of reserves.

2024–25 snapshot:

Total reserves & investments: ₹1,60,573 crore

Earmarked Reserve Funds: ₹50,690 crore (actuarial/specific purpose: PDB, DB, pensioners' medical, gratuity, depreciation/R&M, etc.)

Non-earmarked reserves (total): ₹1,09,882 crore

of which General Reserve Fund: ₹1,05,735 crore

Classification & implications:

ESIC clearly distinguishes between Earmarked (actuarial or specific liabilities) and non-earmarked funds. Interest on earmarked investments is credited back to those funds; interest on non-earmarked balances flows to the Income & Expenditure account, indicating that non-earmarked balances function as free surplus.

Even after covering actuarial/specific needs (~₹51,000 crore), ESIC holds >₹1 lakh crore in non-earmarked surplus, about 2× the earmarked corpus.

[5] Business Standard, "ESIC approves proposal to invest surplus funds in stock market through ETFs" (4 December 2022)

Figure 15.9: ESIC Reserve Funds Classification as on 31st March 2025

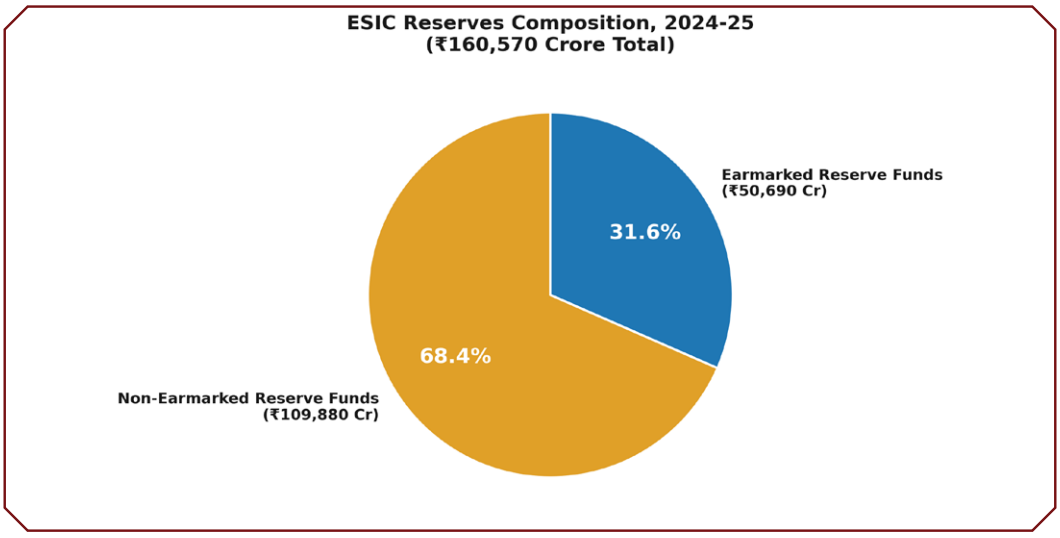
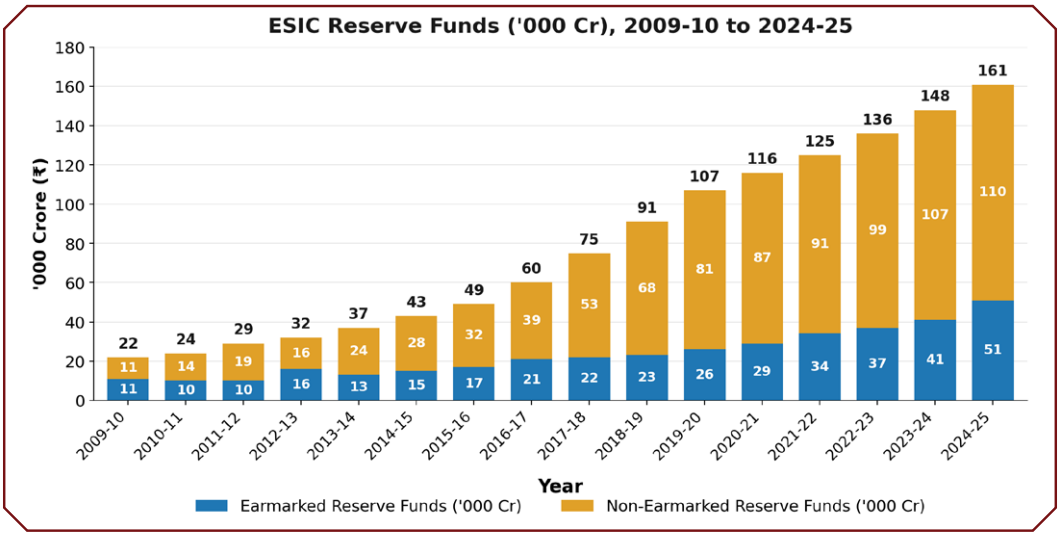


Figure 15.10: ESIC Reserve Funds (₹ '000 Crore), 2009-10 to 2024-25



Over the last 15 years, total reserves have roughly octupled, with non-earmarked balances consistently forming the bulk of the corpus.

Table 15.1: ESIC Reserve Funds Nature of Investment as on 31-03 2025

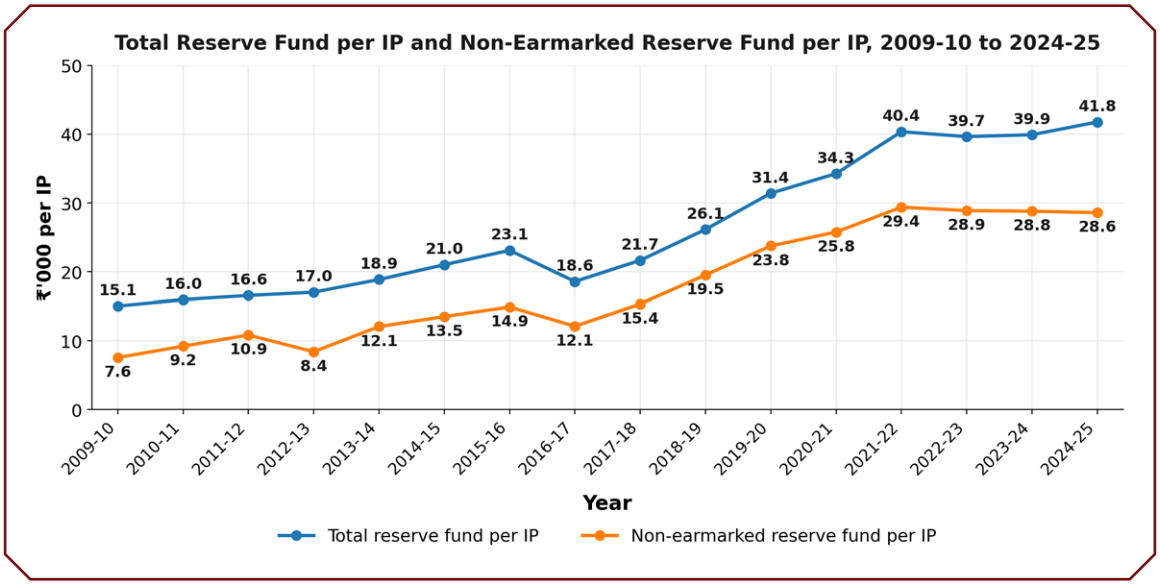
Sl. No.	Name of the Fund	Amount as on 31.03.2025 (Rs. in Crore)	Percentage
1	Fixed Deposits with Scheduled Commercial Banks (As per court orders)	46	0
2	Investment through Portfolio Managers	1,36,604	85%
3	Special deposit with Central Government	23,922	15%
	Total	1,60,573	

Of the "Investment through Portfolio Managers", the instrument-wise breakdown of the portfolio-manager corpus, i.e., how much in Government Securities, SDLs, PSU bonds, & short-term debt is not publicly available.

The 2023 Standing Committee report as of Feb 2023 had c.74% in government securities (Government securities, state development loans, government-guaranteed and government-serviced bonds), c. 21% in AAA-rated PSU bonds, and around c.5% in short-term debt instruments. Nothing more recent is available publicly.

It is unclear if the government permitted 15% investment in equity ETFs has ever been made.

Figure 15.11: ESIC Reserve Funds (₹ per IP), 2009-10 to 2024-25



While the investment framework for reserves is well-defined, the primary focus should shift toward utilising the surplus for insured persons, to expand and improve access to medical care and cash benefits, instead of again reducing premiums, ensuring that accumulated funds translate into tangible service gains. At c.₹28,000 per IP, ESIC's non-earmarked reserve funds could be a potential game changer if used to strengthen benefits and services for IPs.

15.5 Recommendations

15.5.1 Review ESIC financial viability with an independent actuarial review; assess whether the current contribution structure is sustainable under realistic growth and expenditure scenarios, and whether the answer is to increase premiums

15.5.2 Utilise ESIC's large, accumulated reserves toward IP benefits/access rather than further premium cuts

15.5.3 Enforce recovery mechanisms to recover employer arrears

Activate the underused mechanisms under Section 45 of the ESI Act/Section 129 of the Social Security Code to recover employer arrears.

15.5.4 Improve financial reporting

ESIC's current financial disclosures leave key aspects of its operations opaque. Examples include:

- The classification boundary between administrative and medical-benefit expenditure is not clearly drawn, particularly at the state level, making meaningful benchmarking difficult.
- State ESI schemes' fund utilisation is not consistently disaggregated in ESIC's public disclosures.

ESIC should adopt a standardised, publicly disclosed financial reporting framework that resolves these gaps, applied consistently across ESIC and ESIS operations and reconciled with reserves and payout figures reported elsewhere in the Annual Accounts.

Low Awareness and Low Perceived Quality Lead Women Garment Workers in Bengaluru to Increasingly Depend on Private Healthcare (Cividep India Case Study)

This qualitative study, conducted by Cividep India in the **Bangalore Urban district**, explores women garment workers' health challenges, healthcare access, and the role of ESI.

Data were collected from March to July 2023 through in-depth, semi-structured interviews with **25 purposively selected women garment workers hospitalised for at least one day between 2020 and 2023**. Participants were identified via trade unions and grassroots organisations and interviewed by trained researchers. Participants were mostly **migrants from rural Karnataka, aged between 27 and 53**, with nearly half having completed secondary education. Seventeen had 7-16 years of experience in the garment industry, working in roles like tailors, checkers, helpers, and ironers across 12 factories. Monthly wages ranged from ₹9,000 to ₹10,500. Work involved intense 9 AM-5 PM shifts with high production targets, limited breaks, dust exposure, and stress from supervisors, leading to exhaustion and health neglect.

Health histories revealed poor overall status, with latent health issues escalating post-employment. Hospitalisations stemmed from gynaecological/genitourinary conditions, infections, anaemia, kidney stones, and work-related injuries like burns or fractures. Co-morbidities included irregular periods, constipation, piles, thyroid issues, migraines, and mental stress from targets, attributed to prolonged sitting/standing, poor sanitation, restricted water intake, and dust. Workers attributed their health problems to harsh workplace conditions, often pushing through pain and exhaustion to meet production targets. *Awareness of ESI benefits among workers was low: a majority held ESI cards, but many misunderstood reimbursements and sickness benefits. Due to insufficient awareness of benefits, a few women wanted to opt out of ESI to get higher take-home pay.*

Workers' health-seeking pathways revealed a preference for private clinics for outpatient care owing to ESI's long waits, unavailability of doctors, rude staff, and superficial examinations without physical touch by doctors or sufficient information sharing. Factory nurses/doctors provided nothing beyond basic checks. *For inpatient care, 14 used ESI, 10 used private healthcare despite having ESI cards, and 1 opted for a public facility. The worker valued ESI's cost coverage but criticised delays and poor quality of service. Private facilities were chosen for emergencies and were perceived to have a better quality of care despite high costs.* Healthcare expenditures, in addition to indirect costs like transport, far exceeded incomes. Coping mechanisms involved PF withdrawals, the sale of jewellery, loans, quitting a job, or debt. These patterns highlight that while ESI plays an important role and continues to be used by many workers, it remains inadequate in addressing the full range of health needs and crises they face. Strengthening ESI's accessibility, responsiveness, and quality of care is essential for it to function as a more reliable safety net for women garment workers.

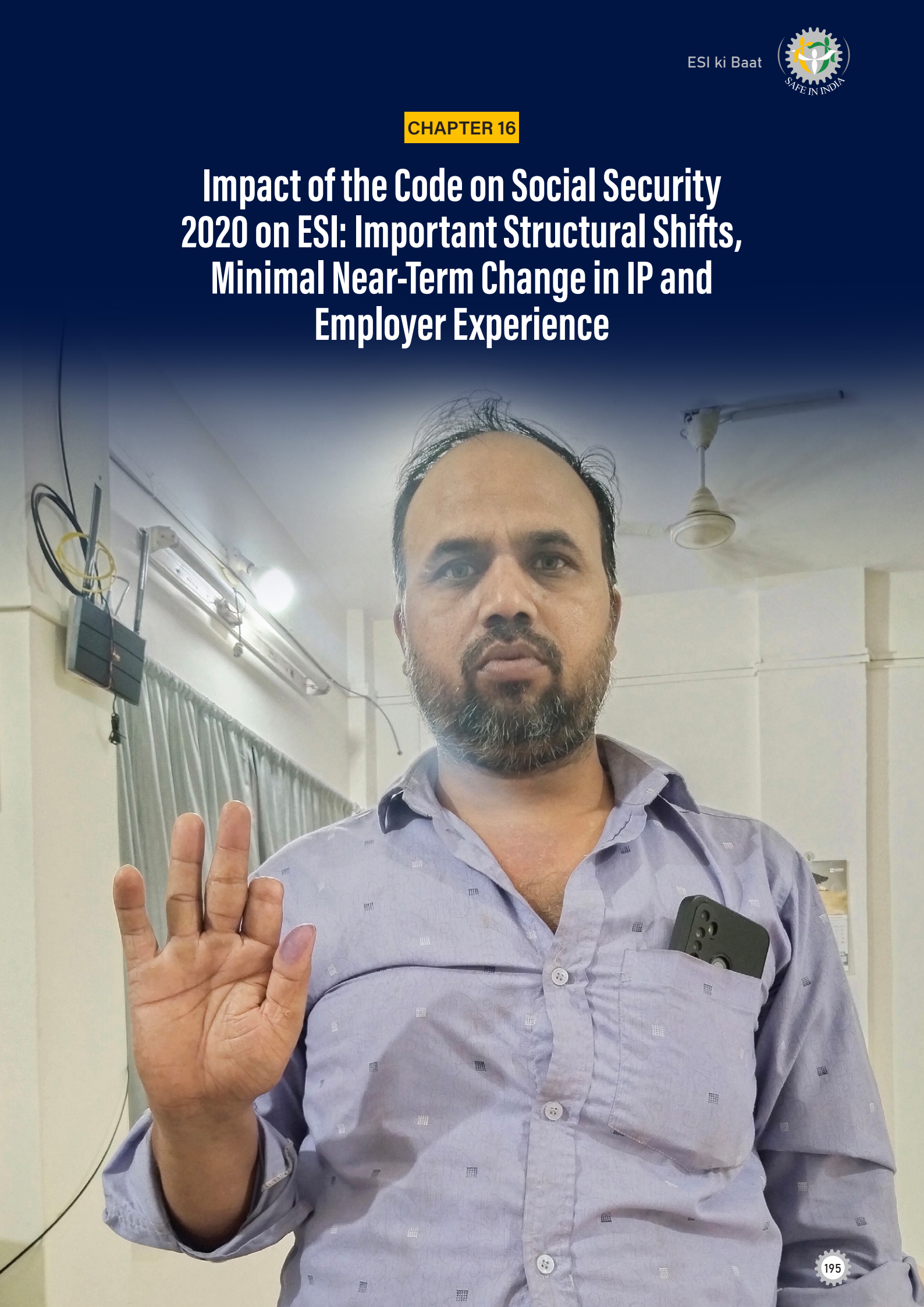
IPs spend on average Rs 2,500 per month on healthcare for themselves and their families, which is about 20–30% of their monthly wage.

The findings also highlight gendered occupational health gaps, calling for responsive ESI reforms, improved factory conditions, and gender-sensitive policies within both health systems and global garment supply chains.


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CHAPTER 16

Impact of the Code on Social Security 2020 on ESI: Important Structural Shifts, Minimal Near-Term Change in IP and Employer Experience



With the commencement of the Code on Social Security, 2020, the Employees' State Insurance Act, 1948, has been repealed for the provisions that have come into force, and the legal base for ESIC/ESIS now sits under Chapter IV of the Code. ESIC continues as the "Corporation" administering the ESI scheme. Most operative provisions relevant to ESIC, including the ESI chapter, were brought into force with effect through S.O. 5319(E).

In practice, the Code is mostly a consolidation and enabling framework, not an immediate redesign of day-to-day services for already-covered IPs. One key reason is the transition arrangement: rules, regulations and schemes under the earlier ESI Act continue for one year from commencement, unless they are replaced earlier or conflict with the Code. This means there is likely to be limited near-term change to existing processes and service delivery. At the same time, this transitional window is finite, and where new rules/regulations under the Code have not been notified in time, operational uncertainty could affect workers.

That said, ESIC has directed field offices to implement the Code's revised definitions while extending benefits, noting that the Code modifies definitions such as "dependant" and "family" (e.g., additional eligible relations) compared to the ESI Act, 1948, and these revised definitions should be applied for determining eligibility (File No. N-11011/2/2025-BFT-II, dated 21 November 2025).

ESIC has since published the Draft Employees' State Insurance (General) Regulations, 2026.

The top 5 changes for ESIC under the codes according to SII are:

1. Shift from "notified/implemented areas" to default pan-India ESI applicability
2. Improved governance via stronger Regional Boards, Local Committees and Committees to assist the Corporation
3. ESIC as a delivery platform for gig/platform/unorganised workers with a Social Security Fund
4. Wage definition change: overtime excluded from the ESI wage base
5. Power to pay the full admissible benefit and recover the capitalised value from defaulting employers

16.1 ESI Coverage Under the Social Security Code: A Shift Toward Universal Applicability

16.1.1 From "notified/implemented areas" to default pan-India ESI applicability; Potentially Positive for Workers

Code on Social Security, 2020: Applies to the whole of India and frames Chapter IV (ESI) applicability through the First Schedule as coverage for "every establishment" meeting the threshold, with roll-out linked to when benefits are provided (as notified). (Section 1 + First Schedule (Chapter IV); commencement via S.O. 5319(E), 21 Nov 2025.). The Draft Employees' State Insurance (General) Regulations, 2026 clearly states that they extend to the whole of India.

ESI Act: Under the ESI Act, 1948, ESI was implemented through area/date notifications (creating "ESI implemented/notified areas" in practice).

Positive Impact on Workers/IPs: ESI shifts from "implemented areas" to default pan-India applicability, meaning districts currently outside coverage (e.g., c.91 uncovered districts) are meant to come under ESI as services are rolled out. Roll-out still depends on actual capacity building, benefit/service availability and notification.

Challenge: It is unclear how ESIC services will be provided in areas without existing ESI facilities.

16.1.2 New coverage entry routes: hazardous/life-threatening work and voluntary opt-in for small units; Potentially Positive for Workers

Code on Social Security, 2020: Removes the "10 workers" minimum for hazardous/life-threatening occupations; ESI can apply even with one employee (once such occupations are notified). Separately, the Code allows Chapter IV to be applied to an establishment by notification where *the employer and majority of employees agree* (a statutory "voluntary opt-in" route). (Section 1(7) (agreement-based application by notification) and First Schedule (Chapter IV proviso on hazardous/life-threatening occupations).)

There is no standalone definition of hazardous/life-threatening occupations in the Social Security Code. The OSHWC Code, 2020, defines "hazardous" to mean "involving danger or potential danger." The OSHWC Code, 2020's First Schedule, has a list of industries involving hazardous processes lists 29 industries

ESI Act: Did not contain an explicit "hazardous even with 1 worker" trigger or an agreement-based opt-in route like the Code.

Positive Impact on Workers/IPs: Workers in high-risk micro units and small establishments (below the usual threshold) have clearer legal pathways to come under ESI over time.

16.1.3 Enabling ESIC as a delivery platform for schemes covering unorganised, gig and platform workers (with ring-fenced funding); Ring-fencing has to be watertight to be fair to existing IPs

Code on Social Security, 2020: Enables the Central Government to notify schemes for unorganised, gig and platform workers (and their families) to receive Chapter IV (ESI-type) benefits through ESIC. (Section 45, Section 114 and Section 141)

CoSS Section 114(4) prescribes a corridor: 1 to 2% of aggregator turnover, capped at 5% of amounts payable to workers. The specific rate applicable to each aggregator category is still to be notified.

Code on Social Security (Central) Rules, 2026: Creates a Social Security Fund credited to separate account(s) to meet expenses for schemes for unorganised/gig/platform workers. (Rule 49);

Draft Employees' State Insurance (General) Regulations, 2026 (Reg 117): Allows ESIC to charge other beneficiaries (e.g. gig and platform workers under the Section 44 scheme) for treatment in under-utilised ESIC hospitals.

ESI Act: Did not have an equivalent consolidated "scheme + dedicated fund" architecture for these worker categories routed through the Code framework.

Impact on Workers/IPs: Rule 49 and Draft Employees' State Insurance (General) Regulations, 2026, provide for user charges for unorganised, gig and platform workers using ESIC facilities. But it does not explicitly require the payments to be equivalent to IPs' payment through premiums. There is a risk of implicit cross-subsidy from existing contributors.

In the classic aggregator-pays-worker model, Section 114's 1 to 2% turnover rate with a 5%-of-payout cap lands roughly at 4 to 5% of worker earnings, broadly in the ballpark of formal ESI's 4%, depending on payout ratios (c.20 to 25%).

The design fails under emerging models, e.g. subscription fee model, where payout shrinks or disappears (to zero). Section 114 was calibrated for a business model the sector is already moving past.

SII's 2022 Recommendation to DG ESIC:

Expand ESIC coverage to gig, platform, and informal workers, without compromising current beneficiaries.

Cover additional worker categories via government/employer contributions, ensuring current insured persons (IPs) do not experience service/funding dilution.

The premium should be the same for new groups accessing the same services.

16.1.4 Strengthening Governance through Regional Boards, Local Committees and Committees to assist the Corporation

Draft Employees' State Insurance (General) Regulations, 2026 (Reg 9-10): Allows ESIC to set up Regional Boards and Local Committees

Draft Employees' State Insurance (General) Regulations, 2026 (Reg 8): Allows ESIC to set up Committees to assist the Corporation

Impact on Workers/IPs: Both Regional Boards and Local Committees exist under the 1948 Act and the 1950 Regulations, and have been constituted in some states (Haryana, for example), but in practice are largely inactive. Needs to be activated.

Reg 8 provides an open-ended power for the Corporation to constitute committees. This can be used to constitute a quality-of-claims / payment-benefit committee.

ESIS (ESI Society), which is an existing provision, is only operational in 4 states.

16.2 Important definitional changes to "dependants" and "wages", with implications for IPs

16.2.1 Definition changes for "family" and "dependant" – more family members covered; Potentially Positive for IPs

Code on Social Security, 2020: "Dependant" list explicitly adds a widower (if wholly/partly dependent) and uses "grandparent" (not limited to paternal) where no parent of the deceased employee is alive.

"Family" specifically adds father-in-law and mother-in-law of a woman employee within "dependent parents" (subject to the prescribed income ceiling). (Section 2 definitions ("dependant", "family") read with Chapter IV.)

ESI Act: "Dependent" did not include widower, and it referred to paternal grandparent (not "grandparent" generally). "Family" did not include parents-in-law in the definition itself.

Positive Impact on Workers/IPs: More family members are eligible for benefits.

16.2.2 Wage definition changes – more workers included under ESIC; workers' ESIC "wages" could be lower where overtime is significant, potentially reducing cash benefit rates

Code on Social Security, 2020: The Code's unified "wages" definition includes basic pay + dearness allowance + retaining allowance, and explicitly excludes components such as house rent allowance (HRA) and any overtime allowance (subject to the 50% add-back rule if excluded components exceed the threshold). (Section 2(88))

ESI Act: Under the ESI Act, "wages" was defined broadly as cash remuneration, with only a limited list of exclusions; so HRA was generally included (it is not excluded in Section 2(22)), and ESIC has explicitly clarified that overtime + normal remuneration together constitute a composite wage (i.e., overtime forms part of wages for contribution)

Positive Impact on IPs: Because HRA is now excluded from the wage base used for the ₹21,000 coverage threshold, more workers fall under that threshold and become eligible for ESI. The 50% add-back rule limits this effect for workers on allowance-heavy pay structures

Negative Impact on IPs: For workers whose monthly earnings depend heavily on overtime, excluding OT from "wages" can lower the wage base used to compute the standard benefit rate/average daily wages, which can pull down cash benefit amounts (SB/MB/TDB/PDB) unless the 50% add-back rule offsets it in allowance-heavy pay structures. Overtime is also not clearly mentioned on the salary slips (data from IPs supported by SII)

For an IP earning ₹16,000 a month, including ₹4,000 overtime, who loses 2 fingers (estimated loss of earning capacity: 20%), the illustrative monthly PDB would change as follows:

Old treatment:	**New treatment:**
Wage base ₹16,000	Wage base ₹12,000
90% of Income = ₹14,400	90% of income = ₹10,800
PDB at 20% = ₹2,880/month	PDB at 20% = ₹2,160

Difference: ₹720/month (decrease of 25%).

16.3 Stricter employer compliance and enforcement under the Code

16.3.1 Acknowledgement of claims included as part of the Regulations

Employees' State Insurance (General) Regulations, 2026: Includes a provision that the claim for any benefit shall be acknowledged electronically or otherwise.

Positive Impact on Workers/IPs: Improved visibility for payment benefit claims.

SII will report on the efficacy of implementation.

16.3.2 Day-0 Aadhaar-based ESIC registration (stricter onboarding rule)

Code on Social Security (Central) Rules, 2026: Requires the employer to register a new employee before/on the day of employment on the specified portal using Aadhaar; an insurance number is auto-allotted and valid for 30 days, becomes auto-invalid if the Declaration Form isn't updated within 30 days or Aadhaar is unauthenticated; employer is responsible for employee particulars, IP for family particulars. (Rule 18 (Insurance of employees))

ESI Act: Did not hard-code a day-0 Aadhaar/portal registration requirement or a 30-day auto-invalidation mechanism in the Act text.

Unclear Impact on Workers/IPs: Tighter compliance expectation (day-0 registration + data correctness), but also a new exclusion risk if the employer doesn't complete updates in time or Aadhaar authentication fails, since the insurance number can lapse automatically.

SII will report on the efficacy of implementation.

16.3.3 "Benefits first, recover later" strengthened (stronger protection against employer default); Potentially Positive for IPs

Code on Social Security, 2020: If an employer's failure to insure/register on time or pay contributions causes an employee to be disentitled (or to receive reduced benefit), the Corporation *may pay* the full admissible benefit to the employee first, and then recover the capitalised value of the benefit from the employer (Section 42)

ESI Act: Recovery from the principal employer is limited to the benefit difference/twice the unpaid contribution, as prescribed (Section 68 of ESI Act). The same was rarely implemented on the ground. Therefore, the potential impact of Section 42 of the Social Security Code is unclear.

Positive Impact on Workers/IPs: Increased deterrence against delayed registration/contribution.

Challenge: "*may pay*" indicates risk of IPs being denied full admissible benefit in employer default cases.

16.3.4 Web-based, randomised inspections (Inspector-cum-Facilitator model)

Code on Social Security, 2020: The Code enables Government to notify an "inspection scheme" that can include generation of web-based inspections, electronic calling of information, and randomised selection of establishments. (Section 122)

ESI Act: Did not hard-wire a scheme-based, web-generated/randomised inspection architecture in the Act text, but there was a role for physical inspectors

Unclear Impact on Workers/IPs: Potentially stronger compliance, but also could reduce physical inspections significantly.

Additionally, the dual role creates a structural tension: an Inspector-cum-Facilitator may be institutionally disincentivised to penalise the same employers they are meant to 'facilitate.'

SII has not yet been able to analyse the potential impact of this provision.

SII's submission on Draft Social Security (Central) Rules, 2025

Safe in India Foundation submitted detailed written suggestions to the Ministry of Labour & Employment on the Draft Social Security (Central) Rules, 2025, in February 2026, based on field experience supporting injured workers and analysing ESIC service-delivery gaps.

Main Recommendations:

i. Use ESIC Injury Data (Captured at ESIC Dispensaries/Hospitals) to Drive Preventive Healthcare and OSH Action
ii. Quality of ESIC Services Across Medical Care and Cash Benefit Payments
iii. Establish a Process Re-engineering Cell within ESIC
iv. Preventing Cross-Subsidisation If ESIC Facilities Are Shared with the Social Security Fund (Rule 65)
v. Timely Medical Board Assessments for Disability Benefit Payments
vi. Mandatory Disclosure of Rights at Employment
vii. Vocational Rehabilitation and High-Quality Prosthetics
viii. Preventing Exclusion Risk from Auto-Invalidation of ESIC Insurance Number (Rule 19)
ix. Supply Chain Accountability for Unorganised Workers



CHAPTER 17

The Structural Case for a Single, Universal Social Security System for Workers: Risk Pooling and the Limits of Choice



ESIC is the social security mechanism for a relatively high-risk segment of the workforce, and its design rests on a specific theoretical foundation, i.e., the pooling of risk across the entire formal workforce. Proposals to introduce competition or "choice" are often made without engaging this foundation. This chapter establishes the theoretical basis for ESIC for any reform.

17.1 Social security coverage for workers requires a single, compulsory, income-linked pool

The case for retaining a single pool is structural. It rests on three things that the market cannot supply for this workforce and must be set out before any reform is assessed: risk pooling at scale, cross-subsidy through income-linked contributions, and universal provision of a merit good.

17.1.1 The workforce is high-risk and low wage

The median worker supported by SII earns between ₹10,000 and ₹ 15,000 per month. The occupational risk for these workers is real and concentrated. Between 2016 and 2025, SII with its small outreach team located 11,352 injured workers from a footprint of just three districts (five Worker Assistance Centres) across two states (Haryana & Maharashtra); 2,514 in 2025 alone. *A population this exposed, at this wage, is exactly the profile a risk-rated market is built to exclude.*

17.1.2 Risk pooling works only at scale (Law of large numbers)

Pooling makes aggregate loss predictable: the larger and more heterogeneous the pool, the more stable the average and the lower the loading each member must bear (Barr, 2012)[1]. A single, workforce-wide pool is therefore the formal precondition for affordable cover. Fragmenting this pool raises the cost of cover for everyone left inside.

17.1.3 Income-linked contributions produce cross-subsidy and solidarity.

ESIC contributions are set as a percentage of wages, not as a function of risk: the employee pays 0.75% and the employer 3.25%, totalling 4% of wages (w.e.f. 1 July 2019). A lower-wage worker, therefore, pays less in absolute terms but receives the same benefit, so the structure transfers from high-wage to low-wage and from low-risk to high-risk workers, a cross-subsidy that is deliberate and constitutionally grounded, not an inefficiency (Barr, 2012). Private insurance cannot replicate this: competitive entry would peel away the lower-risk, higher-wage workers into cheaper products and collapse the contribution base.

17.1.4 Health is a merit good, provided universally rather than rationed by willingness-to-pay

Left to a private market, coverage for this population is (and will be) under-provided, because price excludes precisely those most exposed to risk (Arrow, 1963[2]; Musgrave, 1959[3]). Universal provision is a deliberate social choice against market rationing. And a voluntary market cannot hold even a well-designed pool together. The next section sets out why (see 17.2).

17.2 The argument that "competition will improve outcomes" is incorrect: the market structurally cannot serve this workforce

The market mechanisms that make private insurance work, i.e., risk pricing, risk classification, and voluntary participation, exclude low-wage, high-risk workers from affordable coverage. Three reinforcing failures, resolving into a single endpoint: adverse selection makes voluntary pooling unstable, cream-skimming strips out the cross-subsidy, and the two together drive a death spiral, leaving, for the most exposed workers, no market at all.

17.2.1 Adverse selection makes voluntary pooling unstable

In a voluntary market, insurers can always design a contract that pulls low-risk workers out of the common pool, leaving high-risk workers concentrated and premiums rising, and no stable pooling equilibrium can survive this.

[1] Barr, N. (2012). Economics of the welfare state (5th ed.). Oxford University Press

[2] Arrow, K. J. (1963). Uncertainty and the welfare economics of medical care. American Economic Review

[3] Musgrave, R. A. (1959). The theory of public finance. McGraw-Hill.

(Akerlof, 1970[4], Rothschild & Stiglitz, 1976[5]). Private disability insurance contracts induce disproportionate demand from high-risk occupations, earning negative profits at any premium feasible under compulsory social insurance (Chiu & Karni, 2014)[6]. The ESIC workforce (construction, manufacturing, chemicals) is exactly the population this describes.

17.2.2 Cream-skimming accelerates the breakdown, driven by actuarial pricing

As insurers refine risk classification, they identify overcharged low-risk policyholders and attract them away from competitors, concentrating risk among remaining insurers and triggering adverse selection spirals (Hoy, 1982[7]; Crocker & Snow, 1986[8]). Each round of refinement strips another layer of cross-subsidisation from the system.

The complementary mechanism operates on the benefit side: insurers also have an incentive to skim on the benefit side, designing packages that cap or exclude the high-volume, high-cost interventions ESIC's IPs disproportionately need, a service-level selection that deters high-risk lives without overt rejection (Frank, Glazer & McGuire, 2000)[9].

Please refer to 19.3.5, which covers how China's standard packages excluded the sickest and 19.6.2, which covers cases of empanelled hospitals refusing complex cases as part of AB-PMJAY.

17.2.3 These forces produce a death spiral.

Each round of refinement shifts more high-risk lives onto fewer insurers, raising their premiums and prompting further low-risk exit; the market unravels progressively over time (Hoy, 1982; Crocker & Snow, 1986). The harm is dynamic: this matters because a one-off comparison of premiums understates where the system ends up.

17.2.4 The endpoint is a missing market for the high-risk segment; and it is irreversible.

For the most exposed workers, the failure is not that cover is dear but that no premium the insurer would accept exists at all (Rothschild & Stiglitz, 1976; Chiu & Karni, 2014). Compulsory pooling is the only structure that sustains cross-subsidy against competitive entry (Barr, 2012). *And the damage is not reversible: once a single pool fragments, the low-risk, higher-wage lives that made it viable will not voluntarily return to rebuild it. Please refer to 19.2 for the global experience of attempting to reverse privatisations.*

Compulsory social insurance answers all three simultaneously: mandatory participation removes adverse selection, prohibition of risk classification removes cream-skimming, and workforce-wide pooling makes actuarial pricing irrelevant, which is why the single, income-linked pool set out in 17.1 is not one option among several but the only structure that holds.

17.3 "Worker choice" is, in practice, the employer's choice

In practice, choice becomes the employer's choice that will ultimately deny insurance altogether for this low-income category that is increasingly in non-permanent jobs.

17.3.1 Choice becomes the employer's (or contractor's) choice

The proposal to let workers divert ESIC contributions to licensed insurers ignores the ground reality: many low-wage contractual workers cannot get employers to issue even an e-Pehchaan card. Where employer obligations are optional or weakly enforced, employers do not act:

i. Even for mandatory registration, ESIC has needed special drives such as SPREE to bring in unregistered employers and employees

ii. SII's own experience bears this out; 16% of workers were registered only after an accident, and 64% received ESI cards only post-injury.

Compliance is already failing workers; weakening the mandatory structure worsens it.

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Worker Voice on "Choice"



"90% मालिक ऐसे हैं जो ये चॉयस बताएंगे भी नहीं...वो डायरेक्ट साइन ही करा के लेंगे।"

"इधर टिक मार्क करते हैं इधर मारो इधर मारो ऐसे करके साइन करा के ले लेते हैं जब क्लेम करने की बारी आती है अस समय वो बोलते हैं आप इसके अंदर बैठते ही नहीं।"

("90% of employers are the kind who won't even tell [workers] about this choice... they'll just get the worker to sign off on whatever they've picked"

"The workers aren't even allowed to read it. They [the contractor/employers] tick here, [say] 'sign here, sign here,' and get it signed that way. And when the time comes to make a claim, that's when they say, 'You don't even fall within this [policy].'")

Ram Singh, ESIC IP from Pune

17.3.2 A single pool protects workers from "product choices" they cannot assess

Even a willing worker cannot assess product quality, exclusions, or claim-rejection risk when enrolling. This is the Akerlof (1970) problem applied at the individual sign-up level rather than the pool level.

Worker Voice on "Choice"



"हर चीज कंपनियों के अंदर इंगलिश में कंपलसरी...इंगलिश में टर्म एंड कंडीशन पढ़ा दिए जाते हैं सारे के सारे, वो बेचारा क्या करेगा,उसको इतनी नॉलेज तो है नहीं, वो सर हिलाता है कि कोई नहीं, इसके भी आगे कर दो।"

("Everything inside the companies is compulsorily in English... all the terms and conditions are read out in English. What can the poor man do? He doesn't have that much knowledge; he just nods, Fine, do the next one too.")

Praveen Kumar, ESIC IP from Haryana

17.3.3 ESIC pays for delayed-onset disease that private insurers would deny, solving the attribution and latency problems with private insurance

Occupational diseases such as silicosis and asbestosis surface years after exposure and cannot be cleanly tied to a single employer or insurer at the point of claim, giving private insurers grounds to reject on a technical or documentary basis. A statutory system can be re-engineered to create fallback routes; a private insurer is structurally inclined to contest.

17.3.4 ESIC covers this worker profile by design; a private system screens it out

Based on SII data, most ESIC-eligible workers are young (almost half under 30), low-educated (>70% to Class 10), migrants, and on short-term contracts through contractors (>70%), without local family or social networks. If ESIC is replaced by private-insurance-style products, many will be rejected not because they are undeserving but because of their profile and insufficient employer support: incomplete documents, employer dependence. The statutory system can build fallback routes for exactly these cases; private insurers reject them on technical grounds.

The "choice" on offer is therefore illusory: it transfers decision-making to employers who have no incentive to act, against a workforce that cannot police product quality or assemble the documentation a private claim demands.

CHAPTER 18

ESIC and Private Insurance: A Comparative Assessment



The previous chapter made the structural case: a single risk pool is necessary for a low-wage industrial workforce, competition degrades it rather than improves it, and "choice" of insurer in practice becomes the employer's choice. This chapter asks, in concrete terms, how ESIC actually serves these workers compared with private insurance.

One difference shapes the comparison throughout: a private health insurer only finances care, while ESIC both finances and delivers it, and pays a basket of cash benefits that no insurance product offers. So the assessment runs across both functions, not only financing. The chapter assesses ESIC and private insurance on four dimensions: the cost of the cover and the value it returns (18.1), the benefit basket of cash and medical entitlements (18.2), the way care is actually delivered (18.3), and the institutional capability a national system carries that a private market cannot (18.4).

18.1 ESIC delivers more value for money than the market

ESIC's value proposition is better than the market, and its payout ratio is not worse, as some argue, but is comparable to and sometimes better for the customer than the private sector.

18.1.1 Private insurance is 2-4x ESIC and almost completely excludes Payment Benefits

Comparison with private insurers:

For the average worker, earning Rs. 15,000 per month (Rs. 1,80,000 per year)

- ESIC premium (annual) at 4% = Rs. 7,200
- (approx.) Medical Benefits share at 75% = Rs. 5,400
- (approx.) Payment Benefits share at 25% - Rs. 1,800
- (75%-25% approx. split based on the recent ratio of Medical and Payment benefits)

Medical Benefits:

At Rs. 5,400 per year, for a family of 4, only minimal micro-insurance is available in the private market, with a low sum insured of around Rs. 1 lakh total, restricted hospital networks, caps and sub-limits, waiting periods of up to three years, and significant exclusions. This is not comparable to ESIC's effectively unlimited health coverage across its own facilities.

Payment Benefits:

ESIC's basket of 9 cash benefits includes sickness, maternity, disability, dependents' benefit, and unemployment support through ABVKY. There are no private sector insurance products comparable to the ESIC Payment Benefits package.

Some private insurers have job-loss/loss-of-income riders or group products, but these are narrow, conditional, often rider/top-up or loan/EMI-linked products, not comparable to ESIC/ABVKY.

Against the total ESIC contribution (Rs 7,200/year), private health insurance at Rs 15,000- 30,000 is 2–4x more expensive for medical coverage alone, and still doesn't include any of the 9 cash benefits.

18.1.2 ESIC provides benefits = 93% of contribution; higher than private insurers

Two common efficiency criticisms of ESIC, that its payout ratio is low and that its administrative expenses are high, are misleading. The evidence below shows why.

Payout Ratio: After the contribution rate was reduced from 6.5% to 4%, ESIC benefit payments have been broadly at or above contribution income. The benefit-to-contribution ratio was approximately 103% in 2024–25 and averaged around 93% from 2020–21 to 2024–25 (ESIC Annual Reports,2020–21 to 2024–25)[1].

For comparison, in private health insurance, the 2024–25 incurred claims ratio for the most recent 5-year period was 88% for private-sector general insurers and 69% for standalone health insurers (IRDAI Annual Report, Table I.27) [2].

[1] ESIC Annual Reports,2020–21 to 2024–25

[2] IRDAI Annual Report 2024-25; Table I.27, Incurred Claims Ratio under Health Insurance Business of General and Health Insurers

Administrative Expenses: ESIC's administrative expense share declined over the last 15 years, dipped below 10% in 2021–23, but rose above 10% again in 2023–24 and 2024–25 (12%). It remains within the statutory limit of 15 per cent (Average 10% across 2020-21 to 2024-25).

For standalone health insurers in 2024–25, IRDAI shows operating expenses of about 16.2%, excluding commissions. But this still excludes the provider-side costs and margins embedded in claims (IRDAI Annual Report 2024-25, Table I.12 with Section I.2.2.19).

Please check Chapter 15 for detailed graphs on Payout Ratio and Administrative Expenses.

Dinesh Sharma, 32 years, Jharkhand



With SII's support, he secured a Permanent Disablement Benefit (PDB) pension of ₹23,000 per month from ESIC, along with ₹3.5 lakh in PDB arrears.

He used the arrears to buy a Tata Magic and contracted it with Haldirams, giving him a steady monthly income alongside his ESIC pension, which will help him support his family of 5 children.

Dinesh Sharma was injured on a power press in Pune.

18.2 The market cannot replicate ESIC's benefit basket at a comparable price

No private insurer in India offers or structurally can offer a package comparable to ESIC's to low-wage, high-risk workers at any comparable price. Section 32 of the Social Security Code makes these benefits statutory entitlements and cannot be renegotiated, repriced (i.e., contribution rates altered based on risk or claims experience), or withdrawn. Any alternative system would be required to provide all of this, making private substitution impractical.

18.2.1 Private Insurers are unlikely to be able to replicate ESIC's income-linked lifetime pension for injured workers – Permanent Disability Benefit

ESIC's permanent disability benefit is a lifetime, income-linked pension of a percentage of wages, determined based on disability %, paid monthly until death. No Indian private insurer offers anything comparable at ESIC's contribution levels, and this isn't a gap that competitive entry will close.

The product embeds three risks that private insurers may not be able to profitably absorb for this workforce.

i. Longevity risk: a worker disabled at 28 may draw benefits for 40+ years.

ii. Assessment risk: partial disability requires ongoing earning-capacity determination, creating moral hazard and administrative costs that scale poorly across a dispersed low-wage population.

iii. Affordability: the premium required to cover these risks actuarially would exceed what ESIC-wage workers can pay; ESIC manages it only because compulsory pooling forces cross-subsidisation from healthy, low-risk contributors.

Private insurers do sell lump-sum accident-disability products, but these are categorically different; they cap insurer exposure precisely where worker need is greatest. The lifetime income-replacement product ESIC provides is structurally incompatible with actuarial pricing in voluntary markets for high-risk, low-wage workers.

"Saral Suraksha Bima", mandated by IRDAI[3] to all general and standalone health insurers, is the regulator's best attempt at universal personal accident coverage. For permanent total disablement, it provides a full payout, a lump sum in the event of permanent partial disability, permanent total disability, or death due to an accident. *It does not have a lifetime pension or income-linking. One payment, and the insurer's liability ends.*

[3] IRDAI

Worker Voice on Benefits



"मुझे तो सहायता ही मिल रही इसी के साथ मेरा काम चल रहा है मेरा दूसरा कोई संभालने वाला भी नहीं है... (हसबैंड) पैरालाइज हुए... उसी से मेरा घर चल रहा है।"

("This support is all I'm getting, and my life runs on it; I have no one else to look after me... my husband was paralysed... my household runs on that alone.")

Kavita, Wife of a paralysed ESIC IP from Haryana

18.2.2 ESIC's Maternity Benefit: full wages, short waiting period; not available in private insurance

Private maternity insurance in India typically imposes waiting periods of 9 months to 4 years before maternity claims are admissible. Near-zero waiting period products exist but are rare, expensive, and come with restricted coverage; none are accessible to a low-wage factory worker paying ESIC-level contributions.

ESIC's maternity benefit, by contrast, requires only 70 days of contributions across the preceding two contribution periods and pays full wages for 26 weeks. A young migrant woman who joins a factory has no private insurance recourse that matches this combination of low eligibility threshold, full wage replacement, and zero additional premium.

18.2.3 ESIC's unlimited outpatient care, which private insurance does not cover

ESI currently provides unlimited outpatient care, something that private health insurance in India does not cover

18.2.4 Occupational Diseases: ESIC structurally doesn't have the private sector's attribution/denial and latency problems

Attribution/denial problem: When a worker develops silicosis, byssinosis, or noise-induced hearing loss, a private insurer's financial interest lies in disputing occupational origin, attributing the condition to lifestyle factors, smoking, or pre-existing conditions. A 2004 research paper estimated that US workers' compensation missed 46,000–93,000 occupational disease deaths and $8-23 billion in medical costs in a single year, with costs shifting to workers, families, and public programmes. We don't have a similar data point for India, but anecdotal examples highlight the same problem (Please check out 19.6.6 for details of observations from the CAG report on AB-PMJAY that highlights a similar issue). For ESIC, the medical complexity of determining occupational origin remains, but the institutional incentive to deny claims does not.

Latency: Many occupational diseases manifest only after prolonged exposure periods: chronic silicosis typically develops over 10–30 years; asbestosis has a mean latency of 20–45 years. Private insurance is annual or short-term. It will not be in force when the disease manifests, or will exclude it as pre-existing. Only a statutory system that tracks employment and exposure history across employers and decades can absorb this liability.

Workers suffer from such diseases disproportionately. E.g., workers from the ceramics sector suffering from silicosis.

18.3 Why ESIC must remain both financier and primary provider (for delivering care)

ESIC is both insurer and provider: the same institution that collects contributions also runs the hospitals and dispensaries that deliver most of the care, empanelling private hospitals only where its own network cannot reach or facilities are insufficient. A private model separates the two: a financier pays for treatment, and a distinct, profit-seeking entity provides it. That separation opens two gaps that an integrated system closes. The first is a cost gap: once payer and provider are different parties, each has reason to shift expense and responsibility onto the other, and ultimately onto the worker. *The second is an access gap: a financier empanels where the returns are, while a provider with a statutory mandate builds where the workers are.*

18.3.1 Integration removes the incentive to deny and shift costs

When one institution is both the insurer and delivers healthcare, there is no boundary between "what the policy covers" and "what the patient needs" for costs to leak through; payer and provider sit on the same balance sheet, so there is no second party to push expense onto. Separate the two, and that boundary becomes a live seam: the financier's interest is to define the covered package narrowly, the providers' to bill against it, and the worker funds whatever falls in the gap.

Data from an ILO research report and SII's experience with IP reimbursements highlight what could go wrong for workers.

Where a worker is referred to an empanelled private hospital instead of an ESIC facility, out-of-pocket costs could run roughly five to six times ESIC's own level for inpatient care and up to fourteen times at the non-empanelled private hospitals.4

Among workers supported by SII, who needed reimbursements, IPs wait a median of 175 days to be repaid, often only in part. Please refer to Chapter 5 for details.

The failures at ESIC's own outsourced edge are operational, not architectural.

Privatisation would generalise this problem: the seam that currently runs only along ESIC's outsourced edges would become the architecture of the whole system, and this would become the default for every insured worker.

The same split invites the opposite distortion: billing for procedures that are not needed, while "low-margin" services will go undelivered, exposing the worker at both ends.

Worker Voice on Private Health Care Delivery Experience



"वहां 62,000 बलि भर के उस आदमी का ट्रीटमेंट करवाया और उसको मिला सिर्फ ₹30,000...32,000 का नुकसान उस वर्कर का हो गया।"

("The worker was treated there [private hospital] by paying a bill of Rs. 62,000, and he received only Rs. 30,000... the worker suffered a loss of Rs. 32,000.")

Ram Singh, ESIC IP from Pune

The wider record of what private and PPP delivery has actually produced under India's publicly funded schemes is set out in Chapter 19 (19.6.3 and 19.6.5).

Internationally, strong public purchasers can manage private delivery; India's record shows purchasing governance is not yet at that standard, which is why retaining ESIC's own delivery core is the safer architecture here.

18.3.2 ESIC's medical network is built around worker locations; private insurance is not

Private insurance networks are concentrated in cities; densest in tier-1 cities and commercial areas. ESIC dispensaries and hospitals are specifically located near industrial estates, factory clusters, and lower-income worker geographies and industrial corridors. Dependence on private insurance companies will lead to inefficient delivery and low coverage in exactly the locations where ESIC workers are concentrated.

The pattern is familiar from retail banking, where private banks concentrate branches in profitable urban markets and thin out, or never enter, less attractive areas, while a national mandate is what holds a wider footprint in place.

18.4 ESIC's institutional capability, the market cannot replace

Some claims understate ESIC's importance by arguing that it is too small or that health is not its responsibility. These arguments are misleading for the reasons below.

[4] International Labour Organization. (2022). Accessing medical benefits under ESI Scheme: A demand-side perspective

18.4.1 ESIC already covers a quarter of formal wage workers

ESIC is not designed to cover every self-employed person, tiny shop, informal unit, government worker or high-wage employee. ESIC is designed to cover low-wage/salaried workers in the formal sector, and among this universe, ESIC's coverage is significant.

ESIC covers 3.84 crore insured persons and an estimated 14.91 crore beneficiaries5, which is not small at all, and coverage of eligible workers is significant, 10% of India.

PLFS 2025[6] estimates regular wage/salaried workers at 23.6% of all workers. Against even this broader relevant denominator, ESIC insured persons are around 26% of regular wage/salaried workers. Once higher-wage workers, workers in establishments below the ESIC employee-count threshold, excluded geographies and other excluded groups are removed, the real share would be higher.

This is also likely to rise because of reforms, broader coverage and universalisation under the new Social Security Code. SII[7] and other organisations[8] have reported on gaps in implemented areas; an implementation issue and not a design issue; increased coverage will also help increase the number of IPs covered.

18.4.2 ESIC is a social security institution, not just a hospital chain

ESIC is not merely a healthcare operator. It is a social security institution, with medical benefits, plus cash benefits and employment injury protections.

ESIC's specialised capabilities that are not easily replaced by government hospitals and the private sector, e.g.,

i. Network of Occupational Disease Centres; a specialised institutional footprint
ii. Employment-injury benefit architecture - TDB, PDB and Dependants' Benefit built into ESIC
iii. Facilities in locations where quality private provision may not be commercially viable, including industrial clusters, smaller towns and lower-income worker geographies. (This is similar to banking, where private banks may reduce or avoid branches in less commercially attractive locations, while public-sector institutions maintain a wider service footprint.)

But convergence at the state and district levels with the public health sector will help ESIC IPs, especially with the current scale of ESIC expansion, as long as the quality of the public health system's hospitals and dispensaries are on par with ESIC's.

18.4.3 One national system migrant workers carry across states

India has 450 million internal migrants. Migrant workers lose access to social protection benefits upon moving to a different location. Portable social security systems are essential to ensure that migrants can access benefits across states[9]. Migrant workers risk losing access to social protection benefits upon moving to a different location in a private-sector-run system. ESIC, as a single statutory national system, prevents this.

What took 75 years to build cannot be bought back when alternate models underdeliver. ESIC's footprint and capabilities, if dismantled, cannot be rebuilt to order. Please refer to 19.2 for the global experience of attempting to reverse privatisations.

[5] ESIC Annual Report 2024-2025

[6] Periodic Labour Force Survey (PLFS) 2025

[7] CRUSHED 2025

[8] PTRC's studies in Thangadh and Morbi

[9] Srivastava, R. (2020). Vulnerable internal migrants in India and portability of social security and entitlements. Institute for Human Development

CHAPTER 19

Social Security: Evidence from International and Indian Experience



Chapters 17 and 18 set out the structural argument and a comparative assessment of ESIC and private insurance. This chapter turns to the evidence: what the international and Indian record shows about social insurance, health financing, and care delivery under public, private, and mixed arrangements. It covers international experience (19.1 to 19.4) and the Indian experience (19.5 & 19.6), distinguishing throughout between the financing and insurance function and the delivery function, where the evidence differs.

A final section (19.7) examines the relationship between worker protection and economic productivity.

19.1 Global bodies and international evidence point to a public core as essential to social security

This section sets out the evidence on the financing and insurance function where it applies across social security, i.e., both payment and medical benefits. It draws on the stated positions of the global standard-setting bodies, the architecture of the systems that perform best, and the specific case of occupational-injury protection, where ESIC's design has clear international parallels.

19.1.1 The ILO and WHO treat compulsory, publicly organised pooling as the foundation of universal coverage

The two standard-setting bodies for social security and health financing converge on the same structural point: coverage for a whole population rests on compulsory, pooled, publicly organised financing, with voluntary and private arrangements unable to carry that role alone.

The ILO's flagship World Social Protection Report 2024–26[1] frames universal, statutory social protection as the direction of travel.

The WHO reaches the parallel conclusion on financing. It treats pooling, i.e., the accumulation of prepaid funds on behalf of some or all of the population as a core function of any move toward universal health coverage[2], and its assessment of whether private cover can substitute is direct: *no country has reached universal population coverage by relying mainly on voluntary contributions to insurance schemes, and compulsion, with subsidy for the poor, is a necessary condition for universality*[3]. The adverse-selection mechanism behind this is set out in Chapter 17.

19.1.2 The World Bank reversed its own position on privatisation

The World Bank was, for years, a central promoter of multi-pillar pension privatisation. Subsequent reform reversals and the financial crisis triggered a documented process of policy learning inside the Bank, moving it from a standard privatisation-led model toward a more cautious, context-specific framework that combines a strong public core with supplementary private roles, with greater emphasis on basic protection, coverage, risk pooling, fiscal sustainability and implementation capacity.[4] The institution most associated with promoting privatisation no longer treats it as the default.

19.1.3 The best-performing Social Security systems keep a mandatory public core, with private provision only at the margins

Across high-income systems, the common feature is a mandatory public or quasi-public core, with private provision confined to the service-delivery margins. Germany's statutory sickness funds (Krankenkassen)[5], France's Sécurité Sociale[6], and Japan's statutory employees' and national health insurance[7] remain public or quasi-public in their core architecture.

[1] International Labour Organisation, World Social Protection Report 2024–26: Universal social protection for climate action and a just transition (2024)

[2] World Health Organisation, Health financing (https://www.who.int/health-topics/health-financing)

[3] Anything goes on the path to universal health coverage? No. Bulletin of the World Health Organisation

[4] Heneghan, M. (2022). Social policy learning inside the World Bank: The case of multi-pillar pension reform. Social Policy & Administration

[5] German Federal Ministry of Health / BMG; GKV-Spitzenverband

[6] CLEISS – The French Social Security System; INRS – Social insurance for occupational risks in France

[7] Japan Health Policy NOW; JETRO – Japan's social security system; Japanese Law Translation / Industrial Accident Compensation Insurance Act

These are not lightly regulated private markets: in Germany, both health and accident cover are administered by statutory, non-profit, self-governing public-law bodies rather than by shareholder insurers. The detailed cost-and-outcome comparison with the more privatised US model is set out in 19.3.

19.1.4 Occupational injury insurance done right: Germany's integrated statutory accident insurance

Germany's statutory accident insurance (Berufsgenossenschaften/DGUV) is the closest international analogue to ESIC's employment-injury function and is especially instructive because it is not private compensation insurance.[8] It is a statutory system that integrates prevention, rehabilitation and compensation in a single institution, the same combination ESIC is structurally capable of.

The case for prevention-led integration is not only social but also economic: the ISSA's international "Return on Prevention" study, conducted with the DGUV, found a return-on-prevention ratio of about 2.2, meaning every unit invested in workplace prevention returned roughly 2.2 in economic benefits to companies[9]. (This is developed further in the productivity material in 19.7.)

19.1.5 Occupational injury insurance (not) delivered through fragmentation and private carriers: the US workers' compensation record; costs shifted to tax payers

In the United States, employment-injury cover is delivered largely through profit-driven private insurers. Where employers and insurers set the terms, coverage narrows: under the "opt-out" arrangements in Oklahoma (and the long-standing non-subscriber option in Texas), employers could provide their own plans with narrower coverage, excluding conditions and capping treatment, until the Oklahoma Supreme Court struck the arrangement down.[10] Under-coverage then exports cost to the public: one study found workers' compensation covered less than a third of injured workers' medical costs and lost earnings, leaving government programmes such as Social Security, Medicare and Medicaid to fill roughly $30 billion of the gap.[11]

The instructive exception sits inside the same country. Four states, North Dakota, Ohio, Washington and Wyoming, place employment-injury cover in a single, exclusive, non-profit public fund rather than competing private carriers.[12] These funds carry no shareholder interest, so there is no profit incentive to deny or narrow claims, and being the sole carrier, they need neither marketing nor risk-selection.

19.2 On cash benefits, pension privatisation has been widely reversed

The clearest cash benefit evidence comes from the international experience with pension privatisation and its subsequent unwinding.

19.2.1 Most countries that privatised their pensions later reversed course

ILO's 2018 report, *Reversing Pension Privatizations. Rebuilding public pension systems in Eastern Europe and Latin America*[13] records that between 1981 and 2014, 30 countries privatised their mandatory public pensions in whole or part; by 2018, 18 of them had reversed the privatisation, among them Argentina, Hungary, Poland, Bolivia and several Baltic states, and the ILO characterised the campaign as a failure. The recurring failure modes were consistent: coverage stagnated or fell, benefit adequacy deteriorated, financial-market and demographic risk shifted from institutions onto individuals, gender and income inequality worsened, and social dialogue eroded.

19.2.2 Chile, the pioneer of pension privatisation, has turned back toward public insurance

Chile pioneered the mandatory private individual-account model (AFPs) in 1981. Starting October 18, 2019, Chile experienced the largest mass protests in its history, primarily demanding pension reform [14]. 85.7% of Chileans

[8] DGUV – German Social Accident Insurance

[9] International Social Security Association (with DGUV / BG ETEM), The return on prevention: costs and benefits of investments in occupational safety and health (2013).

[10] Michael Grabell and Howard Berkes, "Inside Corporate America's Plan to Ditch Workers' Comp," ProPublica / NPR, 14 October 2015

[11] ProPublica/NPR, The Demolition of Workers' Comp (Grabell & Berkes, 2015)

[12] U.S. Congressional Research Service, Workers' Compensation: Overview and Issues, Report R44580, 2016.

[13] International Labour Organization, Reversing Pension Privatizations: Rebuilding public pension systems in Eastern Europe and Latin America (2018).

[14] Sasse, L. (2021). The reasons for the mass protests in Chile 2019/2020. Institute for International Political Economy Berlin, Working Paper No. 166.

perceived that the demonstrations were mainly triggered by discontent with the pension system[15]. *The privatised AFP system, sold to workers on the promise they would retire on 70% of their salary, was instead paying a mere 20–30% of wages*[16]. Meanwhile, the AFP fund managers themselves had accrued 25% annual returns on investment from 2006 to 2015. Those few businesses did well. The workers faced poverty in old age, resulting in unrest.

The reversal highlighted in 19.2.1 has since reached the pioneer itself. Law No. 21,735 (2025) replaces the pure individual-account model with a mixed system, retaining the AFPs but adding a feature the original lacked: a mandatory employer contribution phasing in to 8.5%, that funds a new public, pooled and partially redistributive layer (the Autonomous Pension Protection Fund) alongside a strengthened Universal Guaranteed Pension[17]. A hybridisation rather than abolition, but the pioneer of full privatisation has put compulsory, employer-funded, pooled public insurance back at the centre.

19.3 On medical financing, private insurers tend to raise costs and segmentation; publicly run single pools have achieved universal coverage

This section covers the financing and insurance function for medical benefits: what the record shows when private insurers run health financing, and what single public pools achieve.

19.3.1 Chile: private health insurers deepened segmentation and increased cost

Chile, which reversed its pension privatisation (19.2), opened health insurance to private insurers (ISAPREs) for higher-income groups (1981) while the public FONASA scheme remained the backbone of coverage (started in 1979). The outcome, studied extensively in medical literature, is instructive: the literature suggests that Chile's public FONASA system remained the backbone of coverage and equity, while the ISAPRE-based private component increased segmentation, inequity and administrative cost. [18] [19] [20]

19.3.2 Colombia: private-insurer-led health financing in prolonged crisis; leading to partial nationalisation

In Colombia, private insurers (EPS) act as intermediaries between the state and providers, receiving a per-capita public payment to manage care, a model of regulated competition with private participation. It is now in sustained crisis: the state has taken control of the two largest insurers, Nueva EPS, with over ten million users, and Sanitas, with almost six million, after they failed financial reserve requirements. Another major insurer exited the system in 2024, citing unsustainable losses, and patients have reported denied medicines and services[21]. The government has sought to remove the EPS intermediaries and route funds through a single public fund, but the reform was shelved[22].

Insurers blame structural underfunding and delayed government transfers; the government blames mismanagement and fund diversion[23].

19.3.3 Developed-country comparison: Publicly run Germany spends less for better outcomes than the mostly privately run United States

Given India's ambition to become a developed country by 2047, it is instructive to compare how developed countries organise social security and health insurance for workers.

Germany: Mandatory, *employer-employee co-funded*, non-profit sickness funds. Universal coverage. Workers

[15] Rozas-Bugueño, J. (2024). Challenging the policy space: The legitimation of alternatives in Chilean pension policy. Latin American Policy

[16] Kenyon, T. (2020). Solving Chile's crisis starts with fixing its pension system. Americas Quarterly.

[17] Ley N° 21.735 (2025), Biblioteca del Congreso Nacional de Chile

[18] Unger, J.-P., De Paepe, P., Cantuarias, G. S., & Herrera, O. A. (2008). Chile's neoliberal health reform: An assessment and a critique. PLOS Medicine

[19] Roman-Urrestarazu, A., Yang, J. C., Ettelt, S., Thalmann, I., Seguel Ravest, V., & Brayne, C. (2018). Private health insurance in Germany and Chile: Two stories of co-existence, segmentation and conflict. International Journal for Equity in Health

[20] Crispi, F., Cherla, A., Vivaldi, E. A., & Mossialos, E. (2020). Rebuilding the broken health contract in Chile. The Lancet

[21] Colombia Insurers Fear Petro's Takeover, Insurance Journal (2024)

[22] Colombia's Council of State Blocks Petro's Healthcare Reform Decree, ColombiaOne (2025)

[23] Colombia's Healthcare System in Crisis, ColombiaOne (2025)

choose between c.100 funds (non-profit sickness funds - self-governing public-law bodies)[24], but all funds have i*dentical benefits, cannot deny coverage, cannot price by individual risk*, and *cannot operate as shareholder-profit insurers*. Competition is on service quality only. Administrative costs: 3.86% of spending (Germany's National Association of Statutory Health Insurance Funds)[25].

United States: Employment-based private, for-profit insurance. Fragmented, no universal coverage (Centers for Medicare & Medicaid Services)[26]. Insurers compete in part through plan and network design that favours lower-risk enrolees, and through claim denial.[27]. *Among ACA marketplace insurers, in-network denial rates ranged from 3% to 36%.* 17% of respondents said an insurer denied care recommended by a doctor (Commonwealth Fund Survey, 2024)[28]. Administrative costs: ~8% of spending[29]

The outcome: *Germany spends less per capita yet achieves a life expectancy 2+ years higher than the US. KFF estimates that in 2024, 80.1% of uninsured people in the US were in low-income families.*

Among high-income countries, the US is the outlier. Australia, Canada, France, Germany, Japan, the Netherlands, New Zealand, Norway, South Korea, Sweden, Switzerland and the United Kingdom all keep universal public/ statutory protection at the core[30] **(**participation is mandatory and universal)**.** *Switzerland and the Netherlands use private insurers more centrally, but even they do so under mandatory universal coverage, standard benefits, open enrolment, community rating and strict public regulation*[31].

19.3.4 Thailand, Costa Rica, Taiwan and South Korea: single public pools reached universal coverage for lower costs; no competing private insurers.

The following positive cases span very different income levels, and all share one feature: a single public pool rather than competing insurers.

- **Thailand** has three publicly managed schemes (UCS, SSS, CSMBS), each covering a distinct population segment by occupation, with one public insurer per segment and no private insurers competing on risk**.** Thailand reached universal coverage in 2002[32] and reduced average household out-of-pocket medical spending by about one-third, reduced catastrophic health spending, and expanded use of services, especially among those previously uninsured [33]

- **Costa Rica** has universal health coverage provided through *a single public national social health insurance programm*e, the Caja Costarricense de Seguro Social.[34] The World Bank and OECD describe this as a success story with near-universal access, effective protection from catastrophic health expenditure, and strong value for money. [35]

Among higher-income countries,

- **Taiwan** achieved universal coverage almost overnight in 1995 by merging three public schemes into a single national insurer, now covering 100% of the population and running on notably low administrative costs[36] [37]

- **South Korea** merged its many separate insurance societies into a single national pool in 2000, expressly to pool risk efficiently and reduce administrative costs.[38]

The recurring lesson is that consolidating into one public pool, not fragmenting into competing insurers, is what delivers universal coverage efficiently

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[24] Germany's Federal Health Ministry Definition

[25] Germany's National Association of Statutory Health Insurance Funds

[26] Centers for Medicare & Medicaid Services; www.cms.gov

[27] KFF, Claims Denials and Appeals in ACA Marketplace Plans in 2024 (March 2026).

[28] Commonwealth Fund Survey (2024)

[29] OECD (2022), Understanding differences in health expenditure between the United States and OECD countries, OECD Publishing

[30] Commonwealth Fund, U.S. Health Care from a Global Perspective (2023)

[31] KFF, International Comparison of Health Systems (2025).

[32] Thailand's Universal Coverage Scheme: Achievements and challenges. World Bank. 2012

[33] Wagstaff, A. (2014). We just learned a whole lot more about achieving universal health coverage. World Bank Blogs.

[34] Primary health care that works: The Costa Rica case study. World Bank. 2017.

[35] OECD. (2017). OECD Reviews of Health Systems: Costa Rica 2017. OECD Publishing.

[36] Commonwealth Fund, International Health Care System Profiles: Taiwan (2026)

[37] Lu & Hsiao, on Taiwan's single-payer NHI, Social Science & Medicine (2017)

[38] Thirty years of national health insurance in South Korea, Health Policy and Planning (2009)

19.3.5 China: package-based insurance created coverage gaps

Private insurers and hospitals manage financial risk through standardised benefit packages, i.e., defined procedures at fixed rates, but packages are themselves a source of coverage gaps. Despite covering over 95% of its population, China's reliance on differing packages (publicly pooled but differing packages) across schemes produced significant gaps, with lower-tier beneficiaries receiving less comprehensive cover and lower reimbursement. [39] [40]

Package-based arrangements would produce two predictable consequences:

- **Standard packages exclude the sickest patients:** Complex cases exceeding package cost are refused, prematurely discharged, or unbundled into multiple admissions - the most serious conditions face the worst access.
- **Provider cream-skimming**: Private hospitals will rationally prefer patients profitable under the package rate and avoid those whose care costs exceed it. High-cost workers are concentrated back into residual public capacity, now under-resourced because capacity was ceded.

Please check out 17.2.2, which discusses package-design skimming as theory .

19.4 On delivery, the evidence is mixed, though outsourcing care to private providers has been associated with worse outcomes.

The delivery of care is the one aspect where the international evidence does not point in a single direction. On financing and insurance, the record is consistent; on delivery, it depends on how the delivery is structured and what the private-sector involvement is supposed to do.

19.4.1 Private clinical delivery has been associated with a decline in care quality

A meta-analysis pooling studies across more than 26,000 hospitals found that private for-profit ownership, compared with not-for-profit, was associated with higher death rates and roughly 19% higher costs.[41] An umbrella review of systematic reviews reached the same conclusion for high-income countries: both mortality and payments were higher in for-profit facilities than in not-for-profit ones, a tendency confirmed in studies that controlled adequately for confounding.[42]

An observational study of NHS outsourcing in England between 2013 and 2020 found that handing services to the private sector corresponded with significantly increased treatable mortality, attributed to a decline in care quality. *Two mechanisms are identified: private providers cutting costs at the expense of quality, and cream-skimming, which concentrates the most complex cases in public providers that lack the extra staff or funding to absorb them.*[43]

A systematic review across eight high-income countries reached consistent conclusions: outsourcing care is associated with more avoidable admissions, higher treatable mortality, and staffing reductions.[44]

The pattern also holds in lower-income settings: public provision has been associated with higher treatment success for tuberculosis, HIV and vaccination, and rapid, extensive privatisation with worse health-system performance.[45]

The evidence is not unanimous. Some studies find that patients in private facilities are no more, or even less, likely to die. The discrepancy may be largely explained by patient selection and the same cream-skimming dynamic identified in Chapter 17.

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[39] Gruber, J., Lin, M., Yang, H., & Yi, J. (2025). China's social health insurance in the era of rapid population ageing. JAMA Health Forum

[40] International Labour Organization. (2025). China's experience in pursuing universal health coverage. ILO

[41] Devereaux et al., A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals, CMAJ (2002)

[42] Does Ownership Matter? An Overview of Systematic Reviews of the Performance of Private For-Profit, Private Not-For-Profit and Public Healthcare Providers, PLOS One (2014)

[43] Goodair, B., & Reeves, A. (2022). Outsourcing health-care services to the private sector and treatable mortality rates in England, 2013–20: an observational study of NHS privatisation. The Lancet Public Health

[44] Goodair, B., & Reeves, A. (2024). Systematic review: effects of outsourcing healthcare services

[45] Basu et al., Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review, PLOS Medicine (2012)

19.4.2 Private financing for building public hospitals results in increased costs

Where public hospitals have been built with private capital, the long-run cost has run well above public borrowing.

In the UK's Private Finance Initiative, the National Audit Office concluded that overall cash spending on PFI and PF2 projects is higher than publicly financed alternatives, with the cost of capital for a typical PFI project at 6-7% against government borrowing of 1.5-2.5%, making the revised PF2 model two to three times more expensive than public finance.[46] New PFI projects were halted in 2018 after the NAO judged the model poor value for money, yet NHS trusts still face more than £21 billion in future payments, and the 2018 collapse of Carillion, a major PFI contractor, left hospital projects stranded and forced the state to step back in.[47]

19.4.3 Management of public facilities by private players: Split record

Contracting a private operator to manage a publicly owned facility has exhibited mixed results.

In Brazil, outsourcing hospital management to private operators increased output and productivity, but private hospital care proved inflationary.

In England, Circle became the first private company to run an NHS hospital in 2012, then withdrew just three years into a ten-year franchise; the Public Accounts Committee called it an innovative but ultimately unsuccessful experiment built on unachievable savings projections, with no one held to account, and the regulator rated the trust "inadequate" and placed it in special measures.[48] [49]

Lesotho's public-private referral hospital improved clinical performance, but the scheme has been widely criticised for consuming a large share of the national health budget and diverting resources from primary care.[50] [51]

What appears to work: management contracts over facilities that remain publicly owned, and not transferring public hospitals, patients and financing to a profit-driven owner.

19.5 India's insurer-led financing for the poor moved toward public pooling

India's insurance schemes (RSBY earlier; AB-PMJAY now) function as an inpatient top-up for people who had little or no cover; *for ESIC members, who already have integrated comprehensive cover, a similar model would be a contraction, not an expansion.*

19.5.1 RSBY to AB-PMJAY: When India rebuilt medical insurance for the poor, it consolidated the pool and disintermediated

The Rashtriya Swasthya Bima Yojana (RSBY, launched in 2008), carried risk through commercial insurers selected by competitive bidding, and the pool was fragmented at the district level. Premiums were bid district by district (variable, ranging from ₹331 to ₹825 per household in 2011) and re-tendered annually, districts entered in a staggered fashion, and renewal was uncertain from year to year.[52]

PMJAY (2018), which subsumed RSBY, consolidated this. States run the scheme in trust, insurance or hybrid mode. By 2024, 23 of 33 states/UTs ran trust mode (the State Health Agency holds the risk and pays providers directly)[53]. In insurance mode, e.g., in Gujarat, the State Health Agency contracts a single insurer for the whole state rather than district by district as per the National Health Authority[54].

On financing medical insurance, India re-pooled at the state scale and disintermediated (most states shifted towards a Trust mode without a private insurer sitting in between the state and hospitals).

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[46] National Audit Office, PFI and PF2 (HC 718, 2018

[47] House of Commons Library, PFI: costs and benefits (SN06007)

[48] UK Parliament, Public Accounts Committee, Circle's withdrawal from Hinchingbrooke Hospital (2015)

[49] The Health Foundation, Withdrawal of independent provider from Hinchingbrooke (2015)

[50] Basilico, M. et al (2022). Observational study of the clinical performance of a public-private partnership national referral hospital network in Lesotho: Do improvements last over time? PLOS ONE

[51] Oxfam, A Dangerous Diversion. Will the IFC's flagship health PPP bankrupt Lesotho's Ministry of Health? (2014)

[52] Dror, D. M., & Vellakkal, S. (2012). Is RSBY India's platform to implementing universal hospital insurance? Indian Journal of Medical Research

[53] Vahab, Anfaz & Dreze, Jean. India Forum. (2025, February 27). How healthy is health insurance?

[54] National Health Authority. (n.d.). About PM-JAY: Implementation models (trust, insurance, hybrid). Government of India.

The redesign's logic points towards the same direction that this report argues for ESIC. Assessments (including one with a co-author affiliated to the National Health Authority) note that when an insurer's margin is tied to claim pay-outs, the incentive is to reject claims or empanel few or weak hospitals, a misalignment with the access and financial-protection objectives of a public scheme and treats trust mode as removing that intermediary so the state retains funds and stewards purchasing directly. [55] [56]

On delivery, PMJAY relies heavily on private providers, which is discussed in 19.6.

19.5.2 On financial protection, the record is poor for RSBY and mixed for PMJAY

On financial protection, RSBY's record is poor. A difference-in-differences study on NSSO data (N = 346,615) found no statistically significant reduction in inpatient, catastrophic or outpatient out-of-pocket (OOP) spending; the likelihood of a household incurring any OOP rose by about 30% and non-medical spending by about 5%.[57] A Maharashtra evaluation found no effect on catastrophic expenditure[58], and a later assessment found no material gain in financial security for enrolled households.

PMJAY's record is mixed. Economic Survey 2024–25[59] and the National Health Accounts[60] attribute the decade-long fall in the OOP share of health spending, from 62.6% to 39.4% from FY15to FY22, partly to insurance expansion, and value the OOP avoided on covered hospital episodes at over ₹1 lakh crore

Facility-level studies report zero OOP for the specific covered procedure[61].

On the other side, independent household studies that measure *net* total household OOP find little change: a study of PMJAY in Chhattisgarh found no reduction in OOP or catastrophic expenditure on enrolment, with OOP higher for private-sector treatment.[62]

The two are reconcilable: the favourable figures measure the saving on the covered episode, the null findings the household's total spending.

The persistent gap has a structural cause: the schemes cover hospitalisation only. Outpatient consultations, medicines and diagnostics, which make up the bulk of household health spending and are a principal driver of health-related impoverishment, fall outside the package.[63] A scheme that does not cover them cannot remove the OOP they generate; however, it is financed. OOP, therefore, remains a live problem under PMJAY; its *delivery-side* drivers, e.g., extra billing and cost-shifting at empanelled hospitals, are examined in 19.6.

For previously uncovered households, RSBY and PMJAY added inpatient cover onto a weak baseline, a marginal improvement, even without a measured OOP reduction. ESIC members are differently placed: they already hold an integrated entitlement spanning outpatient and inpatient care, medicines, diagnostics and cash benefits within a single system.

An insurance-purchasing model of the RSBY/PMJAY type, which covers hospitalisation but not outpatient care, medicines or cash benefits; substituting it for ESIC's entitlement would narrow the scope of cover, not widen it. An addition for those who had little, a subtraction for those who already hold comprehensive cover.

On the comparative efficiency of private insurers and ESIC: claim settlement and administrative cost, please see 18.1.2."

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55 Angell, B. J., Prinja, S., Gupt, A., Jha, V., & Jan, S. (2019). The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana and the path to universal health coverage in India: Overcoming the challenges of stewardship and governance. PLoS Medicine,

56 Furtado, K. M., Raza, A., Mathur, D., Vaz, N., Agrawal, R., & Shroff, Z. C. (2022). The trust and insurance models of healthcare purchasing in the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana in India: Early findings from Chhattisgarh state. BMC Health Services Research

57 Karan, A., Yip, W., & Mahal, A. (2017). Extending health insurance to the poor in India: An impact evaluation of Rashtriya Swasthya Bima Yojana on out-of-pocket spending for healthcare. Social Science & Medicine

58 Ghosh, S. (2014). [Maharashtra RSBY and catastrophic health expenditure

59 Economic Survey 2024–25. (2025). Government of India, Ministry of Finance (p.330).

60 Ministry of Health and Family Welfare, National Health Accounts Technical Secretariat. (2026). National health accounts estimates for India 2022–23 (10th NHA estimates)

61 Kamath, S., et al. (2024). Out-of-pocket expenditure for selected surgeries under AB-PMJAY, private health insurance and uninsured patients in a tertiary care teaching hospital in Karnataka. Cureus.

62 Garg, S., Bebarta, K. K., & Tripathi, N. (2020). Performance of India's national publicly funded health insurance scheme (PMJAY) in improving access and financial protection for hospital care: Findings from household surveys in Chhattisgarh state. BMC Public Health

63 Sinha, R. K. (2018). Impact of a publicly financed health insurance scheme (Rashtriya Swasthya Bima Yojana) from equity and efficiency perspectives. Vikalpa

19.6 Delivery of publicly funded healthcare through private providers in India has expanded reach significantly but has also produced documented structural problems that ESIC's integrated model avoids; reform should address these potential problems.

India's publicly funded schemes, RSBY earlier, PMJAY currently, deliver care through a combination of government hospitals and private providers.

19.6.1 PMJAY extended healthcare access by empanelling private hospitals at scale; ESIC must continue doing the same on its path to universalisation

PMJAY has extended a formal hospitalisation-cover framework to India's population at a very large scale, empanelling a large national network of hospitals since 2018 including c.16,000 private hospitals[64]. c.1,250 of the empanelled private hospitals are in aspirational districts.

There has been measurable improvement in healthcare access through PMJAY and RSBY, e.g., a 2025 study on time-to-treatment-initiation for cancer found that patients diagnosed after 2018 had 36% higher odds of starting treatment within 30 days, and when stratified by PMJAY enrolment, the improvement was 90% among enrolled patients versus 33% among the non-enrolled[65].

The evidence in the rest of this section is not a case against private participation in publicly funded care. It concerns what happens when private delivery becomes the primary channel for publicly funded care rather than a bounded supplement to an integrated public provider. ESIC already empanels private hospitals for tie-up care where its own network cannot reach, and this bounded arrangement is appropriate even with the operational issues. The failures at ESIC's own outsourced edge are operational, not architectural.

Most of the findings below come either directly or indirectly from the government; e.g., the CAG's audit and AB-PMJAY's anti-fraud detection.

The recommendation this evidence supports is therefore architectural: an integrated public core, with private tie-ups scoped to genuine facility and geographic gaps.

19.6.2 Private providers generated supplier-induced demand, leading to unnecessary procedures on patients

Supplier-induced demand is when a healthcare provider recommends more treatment or more expensive treatment than the patient actually needs, to increase the provider's own revenue.

Where a private provider's (hospitals') revenue depends on the volume of insured procedures, there is an incentive to operate unnecessarily.

Unnecessary hysterectomies under RSBY: In response to a public interest litigation at the Supreme Court in 2013, highlighting the fact that in the States of Bihar, Chhattisgarh and Rajasthan, in particular, "unnecessary hysterectomies" were carried out under the RSBY as well as other government schemes, the Chief Justice recorded that "from the counter affidavits filed by the States of Rajasthan, Bihar and Chhattisgarh, it emerges that there is a considerable degree of substance in the facts which have been highlighted in the petition." [66]

The same pattern appeared under a different scheme: in Andhra Pradesh, private hospitals were reported to have performed mass unnecessary hysterectomies on poor women under the **Aarogyasri insurance scheme** around 2010.[67]

Supplier-induced demand is a general risk of fee-for-service reimbursement and is documented in ESIC tie-up settings too.

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[64] Reply of MoS Health, Shri Prataprao Jadhav, Rajya Sabha, 31 December 2025). Reported by DD News.

[65] Halder et al. Access to timely cancer treatment initiation in India: extent, determinants and trends. Lancet Reg Health Southeast Asia. Feb 2025

[66] Dr. Narendra Gupta v. Union of India (Writ Petition (Civil) No. 131 of 2013).

[67] Roli Srivastava. Pushed into hysterectomies. The Hindu. 10 June 2016.

Worker Voice on Supplier Induced Demand



"केस ऐसा भी था, पराइवेट में उसको हाथ काटने को बोल दिया; ESI में गया तो हाथ नहीं कटा, बच गया।"

("There was even a case where the private hospital said the arm would have to be amputated; he went to ESI and the arm was saved.")

Bhupendra Singh ESIC IP from Haryana

19.6.3 Empanelled private hospitals cherry-picked profitable cases, turning away complex patients

Empanelled private hospitals have been reported selecting profitable cases and refusing complex patients under Ayushman Bharat, a predictable response where reimbursement is fixed per package, but the cost per patient is not[68]. This is similar to the Chinese example discussed in 19.3.5.

19.6.4 Out-of-pocket expenditure persists under cashless-promise schemes; patients at private facilities paid c.₹54,000 per hospitalisation (NITI Aayog study)

There are hospital-level studies showing PMJAY works well at point of service in specific settings: a Karnataka tertiary-hospital study of 1,021 cardiac surgery patients found AB-PMJAY patients incurred zero OOPE across all surgeries, versus median OOPE of ₹1.15 to 1.72 lakh for the uninsured, and a parallel OBG study found the same zero-OOPE result[69].

But patients accessing private facilities under PMJAY incurred, on average, ₹53,965 in out-of-pocket expenditure per hospitalisation on medicines, transport and diagnostics, according to an evaluation study commissioned by NITI Aayog[70].

Mixed financing structures systematically push costs onto patients because the boundary between what is covered and what is not becomes a site of cost-shifting (Please refer to 18.3.1). ESIC's integrated model, where the insurer is also the provider, closes the gap between what a package covers and what the patient actually needs.

The CAG's first performance audit of the Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (Report No. 11 of 2023), covering September 2018 to March 2021, recorded the same leakage from the other direction: beneficiaries meeting diagnostic costs themselves and travelling long distances for absent specialities.[71]

19.6.5 Fragmented accountability due to weak governance; patients had to pay to receive treatment they were promised free

Poor quality of hospital services is a leading beneficiary grievance related to PMJAY, and three in four grievances arose from demands for payment to receive treatment. The study identified weak governance of private hospitals and low scheme awareness as drivers. [72]

[68] Krishan Murari. Haryana to Manipur - private hospitals struggle with Ayushman Bharat. The Print.

[69] Kamath S, Singhal N, Jeffin J, Brand H, Kamath R. Out-of-Pocket Expenditure for Selected Surgeries in the Cardiology Department for Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), Private Health Insurance, and Uninsured Patients in a Tertiary Care Teaching Hospital in Karnataka, India." Cureus 16(6). 15 June 2024.

[70] Indian Express. (2026, March 8). Rs 54k out-of-pocket expenditure per hospitalisation in private facilities under PMJAY: Study commissioned by NITI Aayog.

[71] Comptroller and Auditor General of India. (2023). Performance audit of Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (Report No. 11 of 2023).

[72] Malhotra, Shefali and Kumar, Vignesh and Zadey, Siddhesh and Divan, Vivek and Dubey, Sweta, Patient Struggles: Grievances in Ayushman Bharat (January 13, 2025).

19.6.6 Providers exit when reimbursement terms change, denying patients care at empanelled hospitals

Reimbursement delays have triggered provider withdrawals. When dues went unpaid, providers expectedly withdrew.

Haryana: About 600 private hospitals suspended Ayushman Bharat services from 7 August 2025 over roughly ₹490–500 crore in unpaid dues.[73]

Chhattisgarh: Hospitals halted treatment over unpaid bills in the same period. [74]

Nationally: ₹12,161 crore in PMJAY dues was outstanding as of February 2025, about 8.7% of the ₹1.4 lakh crore in admissions authorised since inception (IndiaSpend, citing RTI data).

Hospitals also reported claims pre-approved at admission being rejected at settlement, shifting the loss back to the provider and, where providers de-empanel or turn patients away, back to the patient.

This has been reported for ESIC empanelled hospitals too.

19.6.7 The CAG's 2023 audit documented fraud, cost leakage, and quality gaps in AB-PMJAY, including 3.42 lakh detected cases of unnecessary surgeries

The CAG's first performance audit of the Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (Report No. 11 of 2023), covering September 2018 to March 2021, recorded the following from the scheme's own transaction data:

Fraudulent claims for the dead. 88,760 patients were recorded as having died during treatment, yet 2,14,923 claims were shown as paid for fresh treatment of these same patients (3,903 claims /₹6.97 Cr actually paid)

Impossible beneficiary records. Multiple beneficiaries were linked to single mobile numbers; 43,197 households recorded "family sizes" of 11 to 201 members.

Same patient, multiple hospitals. Patients were shown to be admitted to more than one hospital for the same period, with no system control to prevent it.

Public-only procedures billed by private hospitals. Private hospitals were paid for procedures reserved under scheme rules for government facilities (e.g., Andhra Pradesh, Punjab).

Excess payments and quality failures. ₹57.53 crore in excess payments to hospitals across four states; empanelled hospitals that did not meet minimum infrastructure or quality standards.

The scheme's own anti-fraud machinery points the same way: roughly 3.42 lakh fraud cases, including unnecessary surgeries, have been detected under AB-PMJAY.[75]

The CAG audit and the administrator's own detection are independent confirmations of the same vulnerability.

Worker Voice on Excessive Billing by Private Hospitals



"इलाज होता है 1 लाख का, लेकिन बजट दिखाया जाता है 3 लाख का, तो वो गवर्नमेंट पे उल्टा ही असर पड़ेगा।"

("The treatment costs ₹1 lakh, but the bill shown is ₹3 lakh, so it is a loss for the government.")

Ravinder Sharma, ESIC IP from Faridabad

[73] IndiaSpend. (2025, August). How patients — and private hospitals — are struggling with Ayushman Bharat.

[74] NewsBytes. (2025, September 5). Chhattisgarh hospitals halt Ayushman Bharat scheme treatment over unpaid bills.

[75] The Print. Nearly 3.42 lakh fraud cases, including unnecessary surgeries, detected under AB-PMJAY. 2025 March 4.

19.6.8 Private hospital handovers under PPP and BOOT failed and were terminated or reversed across states; poor patients they were meant to serve bore the cost

Health PPPs in India have a mixed record: some arrangements, largely bounded functions, have extended access durably; others, mostly whole facility transfers, have been terminated within years.

The 108-emergency ambulance service is India's flagship health PPP success. The 108 call-centre-based ambulance system is free of cost and one of the largest PPP initiatives in India, functioning across 20 states and two UTs, and EMRI now operates around 9,600 ambulances across 17 states with coverage extending into rural, hilly and tribal areas.[76]

But there have been numerous reversals, spanning every level of care.

Primary care (PHC outsourcing). In Rajasthan (2015), 30 PHCs and 99 sub-centres were outsourced; an assessment recorded no gains in quality, efficiency or innovation, and the planned expansion to 300 PHCs was abandoned. In Bihar, at least two rounds of PHC outsourcing over the last decade collapsed within two years and were abandoned.[77]

In contrast, a durable PHC-PPP example is Karuna Trust which manages PHCs in partnership with state governments across Karnataka (26), Arunachal Pradesh (11), Meghalaya (11), Manipur (4), Odisha (8) and Tamil Nadu (1), largely in remote and underserved areas.[78] Karuna Trust notably is a non-profit operator.

Secondary care (CHC outsourcing). In Uttarakhand (2013), 12 community health centres were outsourced with Asian Development Bank / Department of Economic Affairs technical support and sophisticated contracting. Within 30 months the contracts were terminated: providers inflated output figures, failed to deploy specialists, and drew poor-service complaints; the dispute ended in Supreme Court litigation.

In contrast, Chiranjeevi Yojana (Gujarat, 2005), where the state contracted private post-graduate obstetricians with in-patient facilities (secondary-level obstetric care) to provide delivery care including caesareans to poor women; at its peak it partnered with one-third of the state's private obstetricians, covered 40% of the state's population, and lasted more than a decade. It won a Wall Street Journal Asian Innovation Award and was recommended for national scale-up but impact evaluations remain contested[79].

Tertiary care (super-speciality handover). The **Rajiv Gandhi Super-Speciality Hospital (RGSSH / "OPEC Hospital"), Raichur, Karnataka**, built with OPEC assistance and handed to Apollo (AHEL) in 2002, was terminated after eleven years. A Government of Karnataka evaluation found only 154 of 350 beds operational; only about 40 beds serving BPL patients against a contractual 140; BPL utilisation of 25% of inpatients and 15% of outpatients in a region that was roughly two-thirds BPL; contracted specialities (nephrology, gastroenterology) absent; BPL patients paying *more* on average than above-poverty-line patients; and no third-party evaluation in a decade (Government of Karnataka, 2011; Karpagam, Vasan & Setalvad, 2013). [80] [81] The hospital was re-nationalised and reopened under full public management in 2015.

In contrast, the Pradhan Mantri National Dialysis Programme runs largely in PPP mode inside district hospitals across states, has scaled substantially[82].

Build-operate-transfer (BOOT). In Chhattisgarh (2017), a tender to run six 100-bed hospitals on a BOOT model failed because no private hospital was willing to bid; the market declined the arrangement on offer.

The pattern recurs beyond these: the **Udupi** district and maternal-and-child hospital, handed to a private operator (BRS Ventures), was abandoned mid-project amid fraud allegations and returned to government control; **Seven Hills Hospital, Mumbai,** failed to honour the reserved-bed obligations attached to the public land it was built on; and Karnataka's **Arogya Bandhu** scheme, which placed 52 PHCs with private operators, was withdrawn in 2016 for non-compliance and poor outcomes.

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[76] EMRI Green Health Services (formerly GVK EMRI), operator page - https://www.emri.in/108-emergency/

[77] Sundararaman, T., & Garg, S. (n.d.). Twenty years of public private partnerships: Time for a re-think

[78] Karuna Trust. https://www.karunatrust.org/primary-health-care/

[79] Iyer et al. Characteristics of private partners in Chiranjeevi Yojana, a public-private-partnership to promote institutional births in Gujarat, India - Lessons for universal health coverage. PLoS One. 2017.

[80] Government of Karnataka, Department of Health and Family Welfare. (2011). Review of the PPP project: Rajiv Gandhi Super-Speciality Hospital, Raichur.

[81] Karpagam, S., Vasan, A., & Setalvad, A. (2013). Evidence-based planning—A myth or reality: Use of evidence by the Planning Commission on public–private partnership (PPP). Social Change

[82] PMNDP website at pmndp.mohfw.gov.in

The structural implication of this section is not for exclusion of private providers from publicly funded care, but for an integrated public core, with private tie-ups scoped to genuine facility and geographic gaps. This is the recommendation this chapter supports.

19.7 Worker protection is a productive investment, not only a welfare cost

The added cost of privatisation is borne ultimately not only by workers but also by most businesses. Sections 19.1-19.6 show that privatised, insurer-led and PPP arrangements tend to narrow coverage, raise administrative and capital costs, and shift expenditure back onto patients, providers and the public purse. The corollary is that a well-functioning public system is not a dead-weight charge on employers but a productive investment: where coverage is real and accessible, the spending returns to firms through a healthier, more present and more secure workforce.

The Economic Survey 2024–25 recommended that improving working conditions is good for business[83], a position Safe in India had recommended and welcomes. A body of academic research, including ILO-linked evidence, supports the stronger claim that social insurance is a productive investment rather than only a welfare cost.

The ILO estimates that occupational accidents and work-related diseases cost roughly 4% of global GDP each year, about US$2.8-3 trillion, in lost working time, compensation, interrupted production and medical expenses.[84] Country-level studies put the range at 1.8-6% of GDP. This is the burden that prevention, rehabilitation and reliable cash-and-medical cover are designed to reduce; where the system works, that cost is averted rather than absorbed by employers, workers and the exchequer.

19.7.1 Across countries, social insurance and health cover are associated with higher productivity and revenue per worker, without lower profits

Five strands of evidence, spanning low-, middle- and high-income economies, point the same way.

1. **ILO study of SMEs in Indonesia (2019)[85]:** A 10% increase in social security spending was associated with 0.4% to 1.8% higher revenue per worker, and profits did not decline. So, higher social security spending was not inimical to profit. Indonesia's social security here spans both social insurance and health insurance (though not direct healthcare delivery), across two systems, and the study considers both.

2. **Vietnam, two SME studies (2017[86], and 2021[87]), of small- and medium-sized enterprises):** social insurance contributions can raise firm performance on three measures: return on equity, labour productivity and total factor productivity. The 2017 study found a 10% increase in social security coverage associated with a 1.4–2.0% gain in revenue per worker and a profit gain of up to 1.8%. As in Indonesia, Vietnam's social security spans social insurance and health insurance (not direct delivery), here through a single integrated administrator; both studies consider both.

3. **United States MEPS data (2016)[88]:** health insurance can operate as a productive factor; insured workers miss substantially fewer workdays than uninsured workers, equivalent to about 5.5 additional workdays per year.

4. **International Trade Union Confederation (2021)[89]:** For India, 1% of GDP invested in social protection (healthcare, cash transfers, pensions and unemployment protection) is estimated to carry a GDP multiplier of 1.25–1.32%.

5. **Meta-analysis: health insurance and economic performance (2024)[90]:** Pooling 479 effect values from 34 independent samples, it found a strongly positive correlation between health insurance and economic performance.

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83 Economic Survey 2024–25; Chapter on Employment and Skill Development: Existential Priorities (pp. 387–389)

84 ILO, Global Estimates of Occupational Accidents and Work-related Illnesses (2017); ILO, "Work hazards kill millions, cost billions.

85 ILO; To what extent is social protection associated with better firm level performance?: a case study of SMEs in Indonesia; 2019

86 Lee et al. (2017), "Social security and firm performance: The case of Vietnamese SMEs," International Labour Review (Wiley/ILO)

87 Huynh, T. N. (2023). Impacts of social insurance on firm performance: evidence from Vietnamese small- and medium-sized enterprises. International Journal of Emerging Markets,

88 Dizioli, A., & Pinheiro, R. (2016). Health insurance as a productive factor. Labour Economics

89 International Trade Union Confederation. (2021). Investments in social protection and their impacts on economic growth. ITUC. Study conducted by Development Pathways

90 Fan, C., Li, C., & Song, X. (2024). The relationship between health insurance and economic performance: an empirical study based on meta-analysis. Frontiers in Public Health

This is consistent with the occupational-injury evidence in 19.1.4, where the ISSA/DGUV "Return on Prevention" study put the return to companies at roughly 2.2 for every unit invested in prevention. *The mechanism is the same throughout: protection that workers can actually use returns to the firm as attendance, productivity and avoided disruption.*

19.7.2 The available counter evidence identifies the conditions for productivity, not a case against social insurance

The evidence is not uniformly positive. Several studies find that contributions set too high, or enforced too unevenly, can reduce firm productivity, including studies of Chinese private enterprises[91] [92] and the broader Latin American payroll-tax literature.[93] [94]

The most developed version of this critique is Levy's analysis of Mexico, where social security financed by payroll taxes on formal employment, running alongside parallel benefits extended free to informal workers, is shown to subsidise informality, misallocate labour and lower aggregate productivity.[95] *Levy's response is not to retreat from social protection but to move toward universal entitlements that do not penalise formality. The lesson is again one of design: how the function is financed and to whom it is extended, not a case against the public provision of it.*

These findings do not overturn the positive evidence above; they specify the conditions under which social insurance is productive: contributions pitched at the right level, benefits workers can actually access, and enforcement consistent enough that compliant firms are not undercut by evaders. Those are conditions of design and delivery; they bear on how a public scheme such as ESIC is run.

[91] Zhang, M., Shi, H., & Shi, V. (2021). Social insurance contributions ratio and productivity of private enterprises in the heavy pollution industry: Evidence from China. Journal of Cleaner Production

[92] Li, J., Zhao, Z., Cong, L. M., & Xu, Y. (2024). Impact of social insurance law on total factor productivity: Evidence from Chinese micro and small businesses. Applied Economics

[93] Kugler, A., & Kugler, M. (2009). Labor market effects of payroll taxes in developing countries: Evidence from Colombia. Economic Development and Cultural Change

[94] Heckman, J., & Pagés, C. (2004). Law and Employment: Lessons from Latin America and the Caribbean. NBER/University of Chicago Press

[95] Levy, S. (2008). Good Intentions, Bad Outcomes: Social Policy, Informality, and Economic Growth in Mexico. Brookings Institution Press.

CHAPTER 20

Recommendations: Top 15 Strategic & Policy Recommendations and 100+ Tactical Recommendations



Since 2017, SII has been making recommendations for implementation by all key stakeholders to improve worker safety and social security in India. The top 15 strategic and policy recommendations for ESIC are given below in 20.1. The top recommendations for other government ministries and departments can be accessed in SII's CRUSHED 2026 report (page 91).

RAG Explanation: Green = Fully Implemented, Amber = Partially Implemented, Red = Not Implemented

20.1 Top 5 Strategic & Policy Recommendations to Ministry of Labour & Employment on ESIC

Sl. No.	Top 15 strategic and policy recommendations to ESIC	Status
1	Improve the Social Security Code & Rules to include 'quality' in it. (The idea that ESIC is to provide certain social insurance services is now 70+ years old, and ESIC should add focus on 'quality of services') (2017)	ESIC 2.0 focuses on quality of services, but quality hasn't been included in the Code and Rules.
2	Cover Gig/Platform workers and informal workers; but not at the cost of services to currently covered IPs, and at the same premium levels, funded by state/employers, as the current formal sector IPs.	New Social Security Code Rules enable ring-fenced Social Security Fund for schemes (Rule 64), but ESI-equivalent financing safeguards (4% contribution) are not explicit. *
3	Ensure the financing function for workers' social insurance is retained with a single, non-private entity with mandatory contribution, risk pooling, i.e., ESIC. For delivery, the core should stay with ESIC and be expanded/ improved, with private providers insourced where necessary	Increased privatisation is being discussed but no actions taken.
4	Restructure the Corporation (effectively the board) towards balanced representation: 25% each of government, employers, workers (including contract workers), and truly independent experts, with equal power. Amend the Regional Board and Local Committee composition to include representatives of contract and non-permanent workers, who can be IPs themselves and representatives of NGOs/Civil Society.	
5	Constitute ESI Societies in all states Ring-fenced Society accounts will remove the state treasury as a gating step for in-kind delivery (drugs, diagnostics, staffing) and IP reimbursements	Only 4 states have ESI Societies.

*See Chapter on the Social Security Code and draft rules for details.

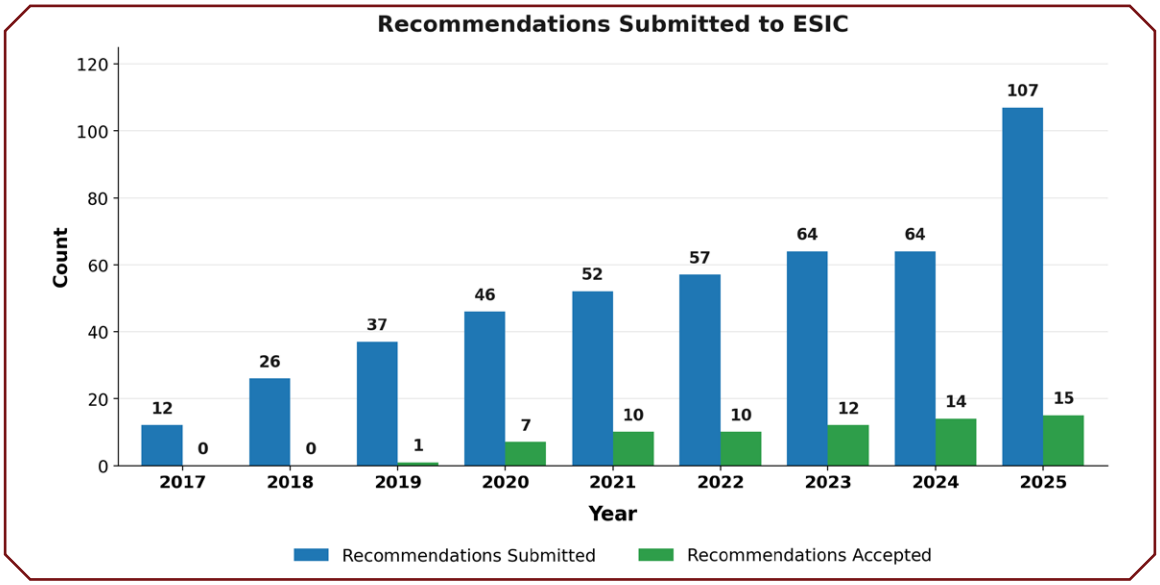


20.2 Top 10 Strategic & Policy Recommendations to ESIC

Sl. No.	Top 15 strategic and policy recommendations to ESIC	Status
1	Establish a 'process re-engineering cell,' given the nature of business, to make the process worker centric. (All large service organisations need constant customer feedback-driven incremental and non-incremental process improvements. The absence of this unit within ESIC is a missed opportunity) (2017)	ESIC has a P&D (Planning & Development) department at HO and is currently working on a ~2-year timeline for reengineering processes.
2	Improve proactive healthcare by leveraging technology and using ESIC's structured and unstructured national data on sickness, injuries and death of workers to identify hot spots of these incidences and focus on ESIC's limited resources (2022)	
3	Create a system to effectively monitor and enforce the Citizens' Charter turnaround times Develop customer experience metrics (e.g. claims completed/ received, accident reports received/total injuries). Publish a public dashboard of user-facing indicators and branch-level + regional level performance	Under discussion as per the Citizens' Charter
4	Cover Gig/Platform workers and informal workers; but not at the cost of services to currently covered IPs, and at the same premium levels, funded by state/employers, as the current formal sector IPs.	New Social Security Code Rules enable ring-fenced Social Security Fund for schemes (Rule 64), but ESI-equivalent financing safeguards (4% contribution) are not explicit. *
5	Set up a Quality of Claims Management Governing Council or Payment Benefit Committee to review and improve claims processes. Amend the Regional Board and Local Committee composition to include representatives of contract and non-permanent workers, who can be IPs themselves and representatives of NGOs/Civil Society.	
6	Review ESIC financial viability with an independent actuarial review; assess whether the current contribution structure is sustainable under realistic growth and expenditure scenarios, and whether the solution is to increase premiums	Revenue Reforms Cell for augmentation of ESIC resources and implementation of progressive revenue reforms constituted
7	Utilise ESIC's large, accumulated reserves only toward IP currently mandated benefits/access	
8	Institute regular, independent performance and social audits, in addition to financial audits Institute regular, structured feedback through surveys, ESIC's apps, and in-person channels at dispensaries and branch offices.	Feedback for medical benefits launched - July 1st 2026
9	Improve compliance among employers and shift power directly to workers on registration, benefit access (e-Pehchaan), family inclusion, and accident reporting, so coverage does not remain hostage to employer action.	
10	Create an ESIC facilitator model, similar to the ASHA or PMJAY's Arogya Mitra.	

20.3 SII has made 100+ tactical recommendations to ESIC since 2017 of which 15 have been accepted fully and 13 others partially

Figure 20.1. Status of Recommendations made to ESIC

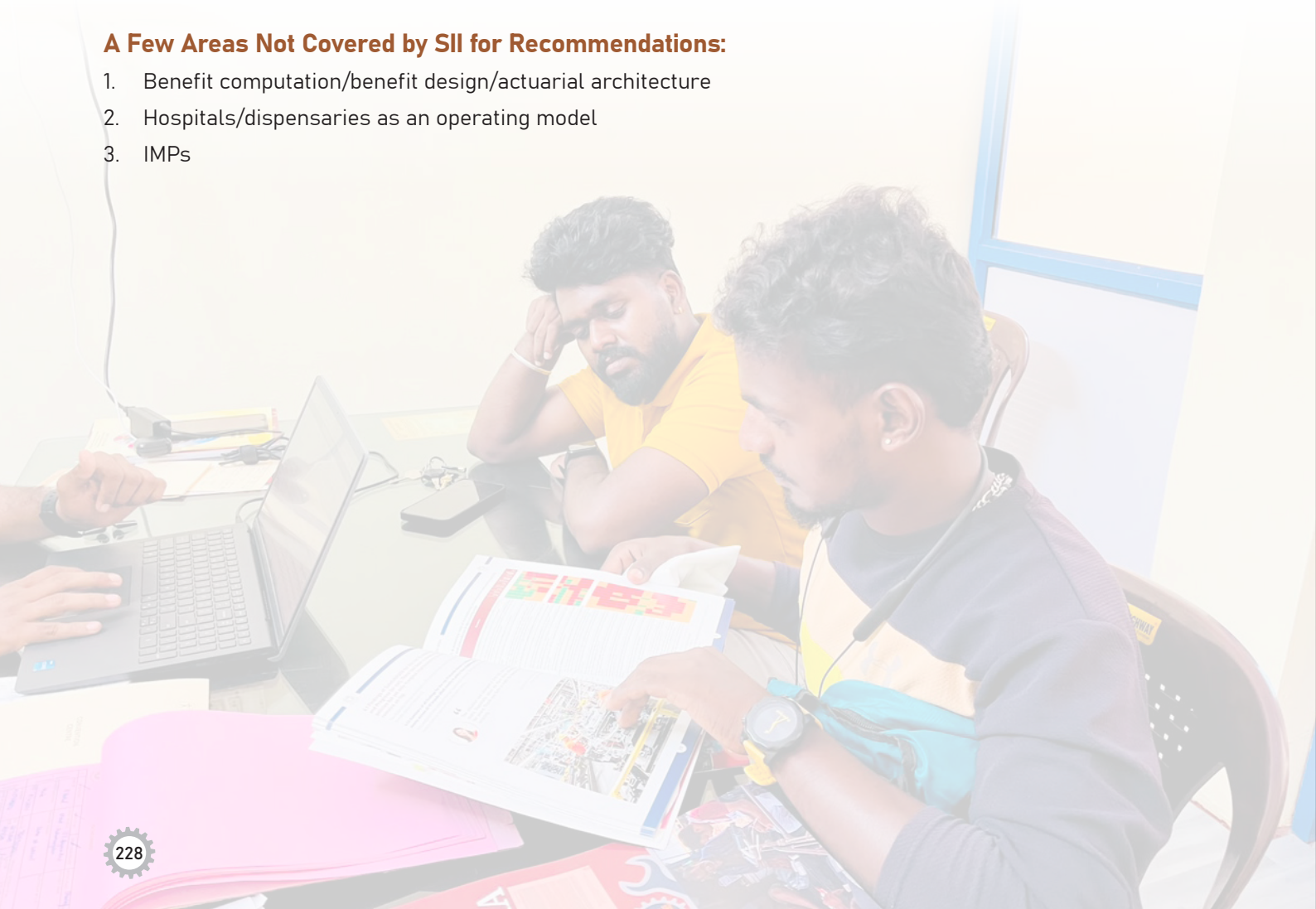


SII has submitted 107 recommendations to ESIC. Of these, 15 have been accepted and fully implemented, and 13 have been partially implemented. We continue to engage with ESIC to drive action on the remaining recommendations and hope to see further progress informed by the evidence presented in this report.

Please see the Annexure for the full list of recommendations and their RAG status.

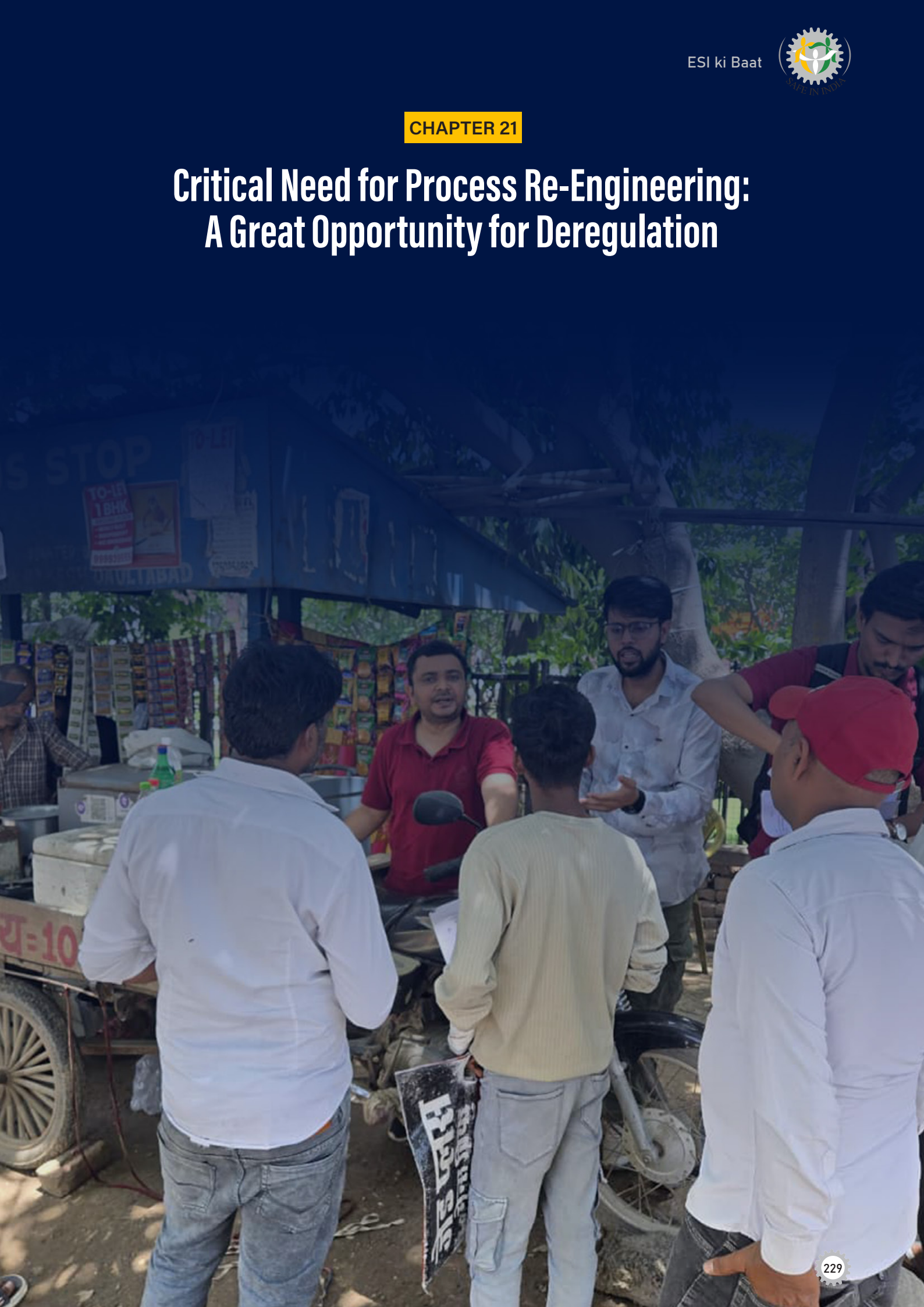
A Few Areas Not Covered by SII for Recommendations:

1. Benefit computation/benefit design/actuarial architecture
2. Hospitals/dispensaries as an operating model
3. IMPs



CHAPTER 21

Critical Need for Process Re-Engineering: A Great Opportunity for Deregulation



Main recommendation: ESIC should establish a 'process re-engineering cell,' like all good process organisations, given the nature of business, to make the process worker-centric, while also improving the employer experience.

The idea is a system-wide, feedback-driven re-engineering approach that continually redesigns end-to-end worker and employer journeys, combining incremental and breakthrough changes under clear metrics and accountability.

Process re-engineering is deregulation for IPs and employers. Every checklist that is not standardised, every duplicated form, every visit that adds nothing to determine benefit entitlement is a regulatory cost borne by workers and employers. Deregulation through reengineering will lead to the removal of procedural friction and non-statutory documentary demands, not any dilution of statutory entitlement. Re-engineering the ESIC interface is deregulation that reaches the shop floor.

All large service organisations need constant customer feedback-driven incremental and non-incremental process improvements. The absence of this unit within ESIC is a missed opportunity.

ESIC currently has a P&D (Planning & Development) department at ESIC HO and a Citizens' Charter of Services (CoS) to drive transparency, accountability, and timely service for premium-paying customers. However, the CoS isn't sufficient. It outlines services, responsible authorities, and documents required. But it does not define stepwise turnaround times, stage-level ownership, performance reporting or accessibility standards. Escalation paths for Charter breaches are not specified in the Charter text. Hence, while strengthening the Charter is necessary, process re-engineering is required to deliver predictable, well-managed, worker-centric outcomes.

This chapter presents the re-engineering priorities from the worker's perspective. The detailed redesign of processes will require ESIC-led workshops, as proposed by SII, with workers, employers, ESI staff and independent process/reengineering experts.

21.1 ESIC's Current Processes Are High-Friction for IPs - The Case for Process Re-Engineering; Chapters 2 to 10 have shown evidence of the following issues:

From the insured person's (IP) perspective, many current processes create high friction: too many steps and handoffs, persistent queues, heavy documentation/data ping-pong, access and awareness gaps, and low observability, making redesign essential.

21.1.1 Too many steps & handoffs: Shuttling between counters; duplicate loops multiply IPs' effort.

IPs navigate long, multi-touchpoint trails (BO, dispensary, SRO/RO), often re-submitting the same information. Each handoff adds travel, time, and error risk.

Example: For PDB, two near-identical form loops (RM-3 and BI-1A) require about six in-person trips before a Medical Board date, duplicating data already captured in TDB.

21.1.2 Chronic bottlenecks & queues; IPs wait significantly longer than Citizen Charter norms for medical care and cash benefits.

Capacity caps and uneven scheduling create predictable backlogs that block payments and stretch timelines.

Example: Medical reimbursements routinely breach the 30-day turnaround target set in the Citizen's Charter; workers assisted by SII waited 6 to 24 times the target

21.1.3 Documentation burden & data ping-pong: Duplicate asks and non-standard lists; IPs chase paperwork and face errors.

Non-standard checklists and duplicate asks force IPs to hunt for papers that aren't required by rules or already exist in ESIC records.

Example: A marriage certificate was demanded for Maternity Benefit in Faridabad (later withdrawn after SII recommendation and HO review), despite no such legal requirement.

21.1.4 Access, inclusion & awareness gaps: Digital exclusion, language barriers and low awareness; IPs miss entitlements.

Low awareness and digital prerequisites (smartphone, email, portal know-how) exclude many; assisted options are inconsistent.

Example: Surveys show 87% unaware of the ESIC helpline, 58% didn't know how to file a grievance by any means, and 72% lacked a usable email, blocking online access.

21.1.5 Low observability: Minimal tracking and notifications; IPs make repeat visits with no status clarity.

Minimal tracking and notifications force IPs into repeat visits to learn what's pending and where.

Example: After files are sent for Medical Board approval, there's no visibility or defined TAT; IPs get no automatic confirmation about completeness, leading to repeated follow-ups.

Small fixes won't move the needle. Addressing these frictions requires system-wide process re-engineering, so ESIC runs simpler, faster, and more transparently, while IPs get timely, predictable benefits.

This is core to ESIC's purpose: make the insured person the VIP, and design every process around that promise.

21.1.6 Digitisation without removing offline requirements: online steps are added, but offline work often continues.

In several ESIC processes, digitisation has not replaced the physical process; it has simply been added on top of it. IPs therefore end up doing both online and offline work for the same claim, increasing effort, travel and delay instead of reducing them.

Workers who prefer digital routes find that the digital channel is incomplete; offline steps are still required. Workers with limited digital literacy find that the offline channel is incomplete; some steps are available only online. Neither channel works end-to-end for the worker who wants to use it.

Example: In Sickness Benefit, IPs may receive printed certificates but still need to take them physically to the BO for upload, without which the claim is effectively not created.

21.1.7 Non-standard regional processes: the same ESIC benefit can work differently across locations, creating unequal burdens for IPs.

Despite a common ESIC framework, actual processes often vary across regions, and sometimes even within the same state.

Example: BOs in Pune provided a printed checklist for payment-benefit documents, while BOs in Haryana did not.

Ranjay Kumar, 29 years old, from Motihari, Bihar

Ranjay Kumar lost three fingers of his left hand while working on a power press machine at an auto company in Pune in 2017.

His fitness was certified in December 2017, entitling him to a Permanent Disablement Benefit (PDB) pension from ESIC from then. But for years, whenever he approached the ESIC branch office, staff told him his file was lost, could not be traced, or that the case was too old, and asked him to come back later. Frustrated, he stopped going.

He met an SII field executive in 2024. SII took up the matter with the ESIC branch office, and his application for the Medical Board was finally submitted on in June 2025, nearly eight years after the injury.

21.2 Principles for Worker (IP)-Centric Process Re-Engineering

These principles are grounded in established frameworks: **ISO 9001:2015** (process approach and risk-based thinking), **Business Process Reengineering**, **Lean/Lean Six Sigma**, and the **European Commission's Once-Only Principle** and SII's experience supporting IPs.

1. **IP centricity:** design every journey to reduce worker effort, visits, confusion, and waiting time; faster, clearer service is the main test of reform. Design processes around the claim flow, not the departments.
2. **Give more (managed) control to IPs; lower employer dependence, not zero employer role, :** employer inputs remain relevant, but the system should give the IP fallback routes whenever employer action is delayed, missing, or manipulated.
3. **Ask once, use multiple times:** once ESIC has verified identity, contribution, wage, medical, or family data, it should be reused across stages and benefits.
4. **Separate digital and offline channels cleanly:** online filing should not still require the IP to physically carry the same papers; offline should remain a genuine alternate route, not an incomplete, shadow process.
5. **Standardisation first, localisation only where essential:** checklists, forms, reason codes, letters, and timelines should be national; localisation should mainly be language, contact points, and minor operational adaptation.
6. **Measurement and observability for all stakeholders:** IPs, employers, branches, regions, and HO should each be able to see status, delay point, owner, and next step.
7. **Data as an operating asset:** ESIC data should be used not only to pay claims, but also to detect bottlenecks, improve compliance, target resources, and identify health/service gaps.
8. **Non-Compliance deters service delivery:** registration, contribution payment, Accident Reports, wage particulars, and contractor accountability directly determine whether benefits reach the worker.
9. **Continuous improvement, not one-time cleanup:** ESIC needs a standing capability to test, learn, fix, and scale changes in cycles.
10. **Technology follows process redesign:** simplify the journey first; then automate. Do not digitise confusion. Default to straight-through processing – internally, automate routine, rules-based cases; send only exceptions to humans
11. **Equivalent access for digital and non-digital users**: the system should work for tech-literate and non-tech-literate IPs alike, with assisted-digital and in-person support.
12. **Clear accountability by journey and stage:** each major service journey should have named owners, stage owners, and escalation paths.
13. **Reasoned administration:** any rejection, deficiency, denial, or refusal should state the reason, evidence used, next remedy, and appeal route.
14. **Do not punish the IP for system and employer failure:** employer default, internal transfer delays, scheduling failures, or missing ESIC follow-up should not shift the burden onto the worker.
15. **Awareness and utilisation are the real tests**: a service that exists but is unknown, unusable, or too hard to access is not a functioning service.
16. **Technology and AI should be operational, beyond optics:** use it for bottleneck detection, guided support, stock-out prediction, and service-gap alerts.
17. **Break bottlenecks and add buffer capacity and resilience:** identify recurring choke-points such as Medical Boards, medicine availability, and build enough buffer capacity, fallback arrangements, and escalation mechanisms so that one delayed step does not stall the whole journey.
18. **Deregulate (Keep only what is necessary):** every document, approval, visit, data field, and process step should have to justify its existence; if it is not essential for entitlement, verification, safety, or audit, it should be removed.

21.3 Two Simple Examples of Process Re-Engineering

21.3.1 Re-Engineering Example – Redesigning the path for Medical Board application (process, technology, & communications)

Problem summary:

i. Process complexity: The "simple" ask to appear before a Medical Board actually spans *nine steps* and typically *six in-person trips* (≈4 to BO, 2 to Dispensary), driven by two near-identical form loops and a repeat fitness check (RM-3 loop, BI-1A loop, and a second "fit for Board" confirmation).

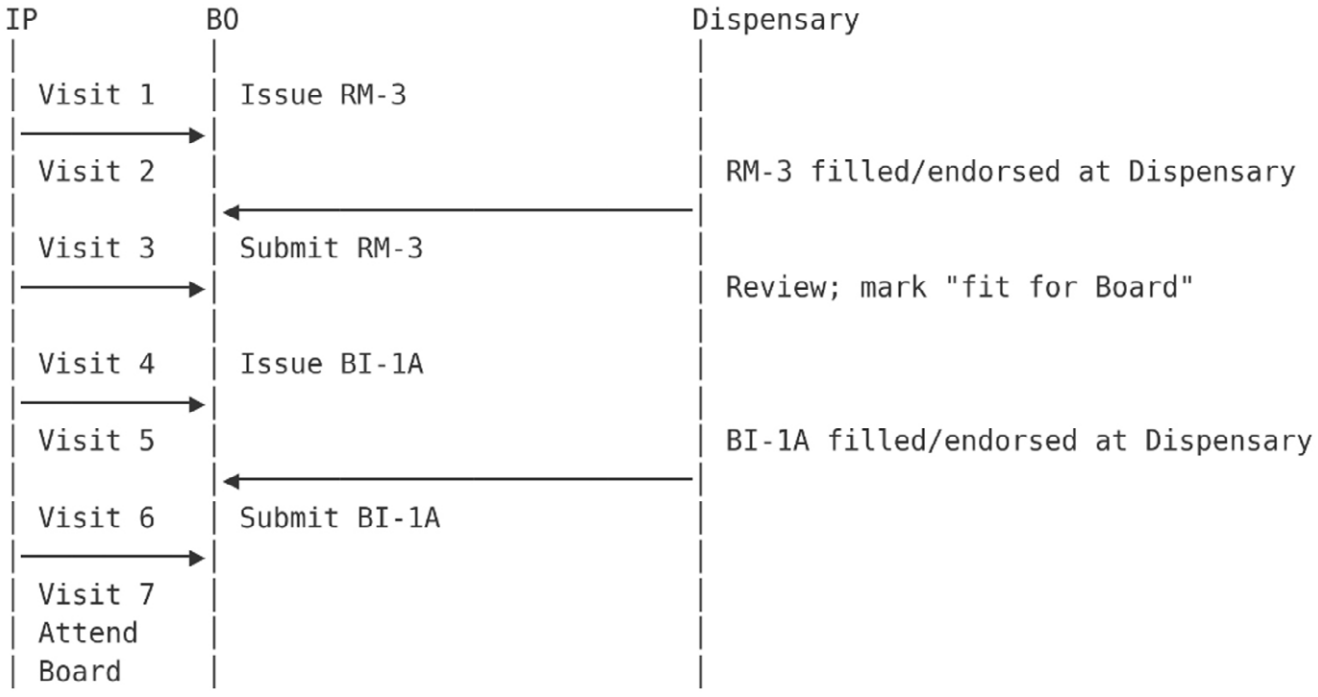
ii. Low/no technology: RM-3 and BI-1A are physically shuttled; referrals progress only when the IP hand-carries papers, causing delays, missing documents, and rework.

iii. No proactive communication: IPs receive no status updates, prompting extra visits just to learn what is pending.

Impact of re-engineering for this process:

	From	To
No. of steps (for worker)	9	2
No. of worker visits	6	2

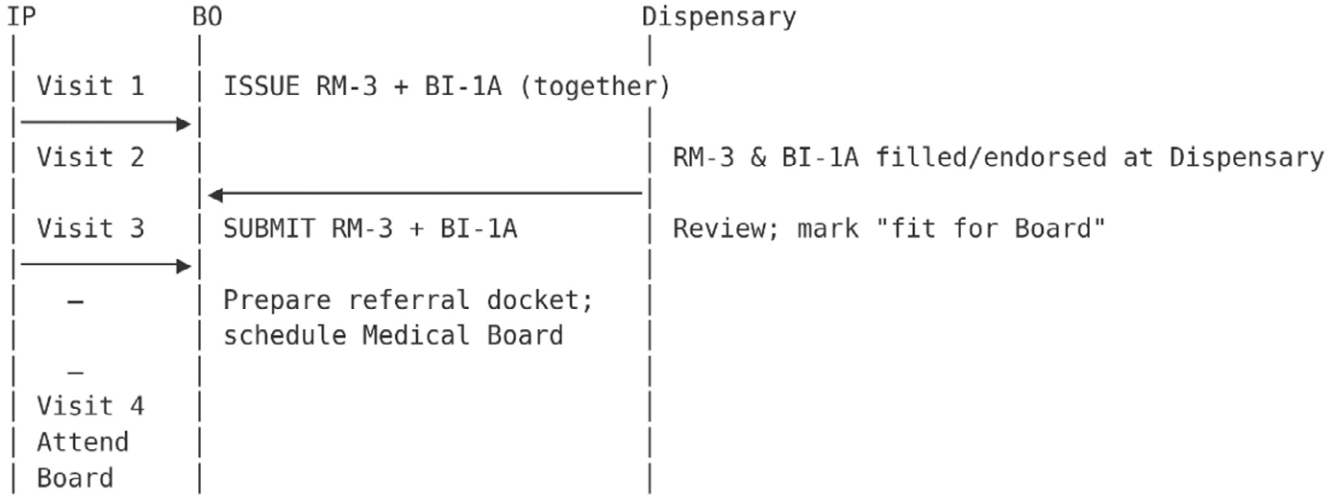
Figure 21.1. As-is PDB referral from TDB to Medical Board: duplicate RM-3 and BI-1A loops, repeat fitness check, and about six IP visits.



Process simplification (at source):

- One-time bundle: Issue BI-1A and RM-3 together, pre-filled from ESIC records where possible. This removes the second, separate RM-3/BI-1A trips.
- Eliminate duplicate fitness check: Treat the TDB final/fitness certificate as sufficient for "fit for Board," unless an exception is flagged.
- Complete the bundle along with the TDB process, i.e. when the IP visits BO with a fitness certificate, whenever a potential PDB is indicated, so the referral moves without additional counter visits.

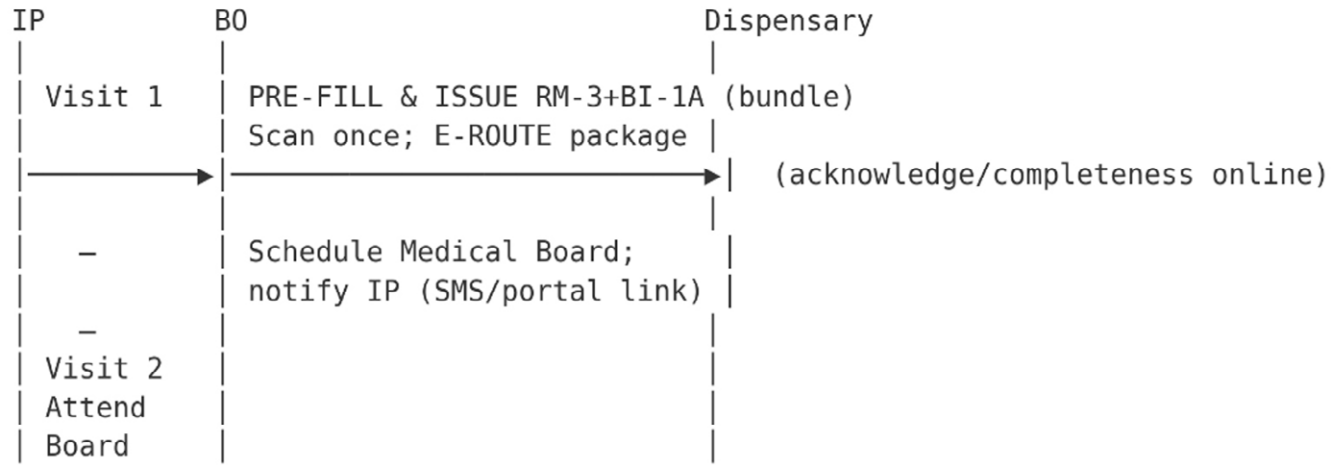
Figure 21.2. Process-only redesign: RM-3 and BI-1A bundled; paper movement retained; IP visits reduced.



Digital movement (no hand-carry): Scan/capture once at BO; e-route RM-3 and BI-1A to the Dispensary; track acknowledgements and completeness online.

Proactive status & notifications: Automatic updates (SMS/WhatsApp/portal) at each milestone, with a tracker link showing current step, owner, due date, and next action.

Figure 21.3. Full redesign (process + tech + comms): bundled forms, digital referral, and live status updates; IP visits down to two (TDB closure and Board).



21.3.2 Re-Engineering Example – Redoing the Maternity Benefit (MB) checklist on first principles, with fallback paths (document alternatives)

What we see today (illustrative): Non-standard checklists across BOs (e.g., an 18-item list that included a marriage certificate, though the rules don't require marriage). HO review removed it in Faridabad, but Pune still asks for it. Employer affidavits (e.g., "child confirmation" or "rejoining" letters) are demanded locally despite no legal basis; they stall claims when employers are uncooperative. Payslips/attendance slips are requested for in some BOs, even though proof of employment/wages can come from ESIC records and other evidence (if details of pay heads available)

Idea: Keep a document only if it proves: (i) coverage & wage basis (eligibility/employment/contributions), (ii) maternity status & timing (pregnancy/EDD; delivery/miscarriage), or (iii) identity & payability (KYC/bank). Remove everything else.

Proposed standard checklist with backup options:

Sl. No.	Item	Purpose	Primary	Alternatives
1	**Identity & bank**	Identify & pay	Aadhaar + NPCI-enabled bank	Govt photo ID + passbook/ cheque/statement
2	**Coverage & wage**	Confirm ESIC coverage & wage basis	Form 10 Or ESIC portal: IP status, contributions, wage data	Employer filing with ESIC; appointment/contract letter; bank statement (wage credits); muster/attendance record
3	**Pregnancy / EDD (pre-delivery)**	Confirm pregnancy & timing	EDD certificate from ESIC/ empanelled provider	Treating doctor's certificate (prescribed format)
4	**Event (delivery/ miscarriage)**	Confirm event & period	Birth certificate (or hospital discharge summary)	Discharge card + later birth certificate; doctor's certificate (miscarriage)
5	**Contact for updates**	Notify milestones	Mobile (SMS/WhatsApp) ± email	Alternate family number; postal address

Documents to eliminate (not required by rule or duplicate of data on record):

- Marriage certificate.
- Routine payslips/attendance slips (where employer filings contain details of pay heads).

Implementation notes:

- One national checklist (no local add-ons without formal approval/citation).
- Prefill from records (identity, coverage, wage) and ask for only the delta.
- "Ask once": store verified evidence in an evidence locker for reuse on related claims.
- Status clarity: deficiency reasons mapped to each line item; SMS/WhatsApp + portal show what's missing and acceptable substitutes.

Outcome to target: fewer visits and resubmissions; faster pre-delivery and post-delivery payments; reduced drop-offs due to uncooperative employers or hard-to-obtain documents.

21.4 Common Business Process Re-Engineering Ideas

21.4.1 Payment Benefits

(Please refer to Chapters 2 to 5; Chapters 7 to 8)

1. **Removal of unnecessary steps:** identify and remove process steps that do not add real value, especially repeated applications, duplicate approvals, and internal loops that make the IP do the same work twice. The TDB–PDB / Medical Board journey is the clearest example.
2. **Separate digital and offline channels**: once something is submitted online, the same material should not have to be physically carried or resubmitted offline. Offline should remain available, but as a complete alternative route, not as a compulsory second track.
3. **Use/reuse ESIC's own record data:** data already collected by ESIC in one stage should be reused in later stages and across benefits. For example, information collected during TDB should help make PDB faster, and ESIC's own treatment records should reduce repeat verification.
4. **Uniform checklist + acknowledgements:** each benefit should have one standard national checklist limited to what is essential, with approved substitute documents where needed. Every submission should generate an acknowledgement showing what has been received, what is pending, and what happens next.
5. **Increased visibility:** the IP should be able to see where the case is through SMS, letters, centralised trackers, portal/app, and branch-office view. This should cover both the acknowledgement of receipt and the later stage-wise progress.

6. **MI for performance management:** ESIC should create office-wise and regional MI that tracks time taken, pendency, overdue cases, rework, first-time-right rates, and user satisfaction. In grievance redressal, this should include satisfactory resolution, not only disposal.

   i. Core metrics should include: application-to-decision time, decision-to-credit time, pendency, overdue cases, rework, first-time-right rate, branch-wise delay points, and satisfaction.

   ii. Grievance systems should publish both disposed and satisfactorily resolved rates.

7. **Stage-wise service standards and timed processes:** ESIC should define and track time standards for every major stage of every benefit journey, not only a few end points. For example, the Medical Board within a month from submission of all forms, the Decision Letter within a month after the Board, and the first payment within a month after the DL. Delays caused by ESIC or the employer should not prejudice the IP's entitlement, place in the process, or time to benefit.
8. **Accident Report alternatives:** the IP should not suffer because the employer failed to file, delayed, or manipulated the Accident Report. ESIC should create alternate routes such as direct-to-ESIC reporting, reliance on clinical records/IP statement, and independent assessment where employer versions conflict.
9. **Reasoned rejections and refusals**: any rejection should come with a reason. This should apply not only to compensation and reimbursement, but also to hospital-side decisions such as not referring to a specialist or refusing reimbursement-related documents. Tech and standardisation should help record and communicate these reasons clearly.

21.4.2 Medical Benefits

(Please refer to Chapter 6)

10. **Hospitals – medicine availability through tech / AI:** ESIC should use technology and AI to improve medicine availability, predict stock-outs, identify repeated shortages, and flag abnormal patterns in prescribing or referrals.
11. **Hospitals – equipment campaign:** ESIC should run a hospital-equipment readiness campaign with uptime tracking, downtime logging, repair timelines, and visibility on non-functioning critical machines.

21.4.3 Registration and Technology

(**Please refer to** Chapters 10 & 12)

12. **e-Pehchaan / day-1 access alternatives:** workers should be able to access benefits from day 1, even where the physical card has not been given. Aadhaar-linked verification, temporary identity, printable access, and worker download options should reduce card dependence.
13. **Exception tracking**: ESIC should separately track recurring failures such as PAR, wrong dispensary, missing family details, delayed DL, delayed first payment, and missing card delivery, so they become visible operational issues rather than hidden worker problems.
14. **Worker-controlled corrections:** mobile number, bank account, family details, and dispensary selection should be easier for the worker to initiate or correct, instead of remaining too dependent on employer action.
15. **Contractor / principal employer visibility:** where contractors are involved, principal employers should be able to see contractor-side ESIC compliance more clearly, especially on registration, contributions, and reporting.
16. **AI-assisted information:** ESIC should provide multilingual AI-assisted support for eligibility, required documents, next steps, status checks, and routing, but it should connect to real workflows and escalation channels rather than remain a standalone chatbot.

21.5 Building the Business Process Re-Engineering Cell: Mandate, Stakeholders, and Operating Model

21.5.1 There is a need to establish a dedicated Re-Engineering Cell (beyond incremental ad-hoc fixes)

Since the pain points span policy, SOPs, data, and operations, ad-hoc fixes by individual units cannot deliver coherent, end-to-end improvements. A dedicated Re-Engineering Cell provides the cross-functional mandate, methods, and accountability to run a sustained programme.

Mandate: Lead redesign of the full claim pathway (apply, verify, decide, pay) across policy, SOPs, forms, data and systems, supported by external consultants.

Composition: A small, cross-functional team (service design, policy, operations, data/analytics, IT, change).

Operating model: The Cell owns methods, standards, coaching and quality gates; delivery remains with line teams, with clear stage owners.

21.5.2 Engage external expertise where appropriate

Purpose: Speed up delivery, add specialist capability, and provide assurance through independent review, while building ESIC's own capacity.

Partner types (four groups):

Delivery specialists: service-design/turnaround firms; process-mining and analytics providers; payments and process-operations experts.

Voice & inclusion partners: worker-facing NGOs/labour organisations; accessibility and plain-language/content design experts.

Knowledge & peer practitioners: universities/policy schools for methods and evaluation

Government: peer government teams that have executed comparable reforms.

Approach: Use time-bound statements of work with clear objectives; pair external experts with the Cell for explicit skill transfer.

21.5.3 Embed worker and employer voice by design (to ensure IP-centric outcomes)

Include insured persons, employers, and front-line staff before and after each change and make their input visible in decisions.

Pre-redesign discovery & quick usability test of current forms/steps.

Pilot feedback from IPs and front-line staff during live trials.

Post-go-live review to confirm outcomes and spot regressions.

21.5.4 Technology as an enabler of the Re-Engineered process

Start with the target outcomes (STP up, "ask once," visible status), then select the minimum tech to achieve them.

- Remove legacy manual steps that add no rule or risk value.
- Automate routine validations and straight-through cases.
- Test redesigned steps via quick usability tests and limited pilots.
- Build only features that demonstrate clear value in pilots.
- Instrument the flow with trackers and alerts for real-time transparency.

21.5.5 Make re-engineering a continuous programme, not a one-time exercise

Run re-engineering in short, repeatable cycles with baselines set up front and clear pilot-to-scale gates. After each cycle, publish what changed and why, and revisit flows as volumes, regulations, or risks evolve.

Continuous re-engineering, rather than periodic clean-ups, becomes the operating norm.

Pilot Test Cases for ReEngineering

1. ESIC's Call Centres – outsourced since 2018; has been found to be ineffective in resolving IP issues
2. ESIC Mitra chatbot, introduced in 2023 to assist with ESIC-related queries; currently not functioning.

21.6 Business Process Re-engineering will make benefits easier for IPs and employers to access and will make ESIC more efficient, reducing the workload on ESIC staff, and making their life better

21.6.1 For insured persons (IPs): access will be easier, faster, and clearer

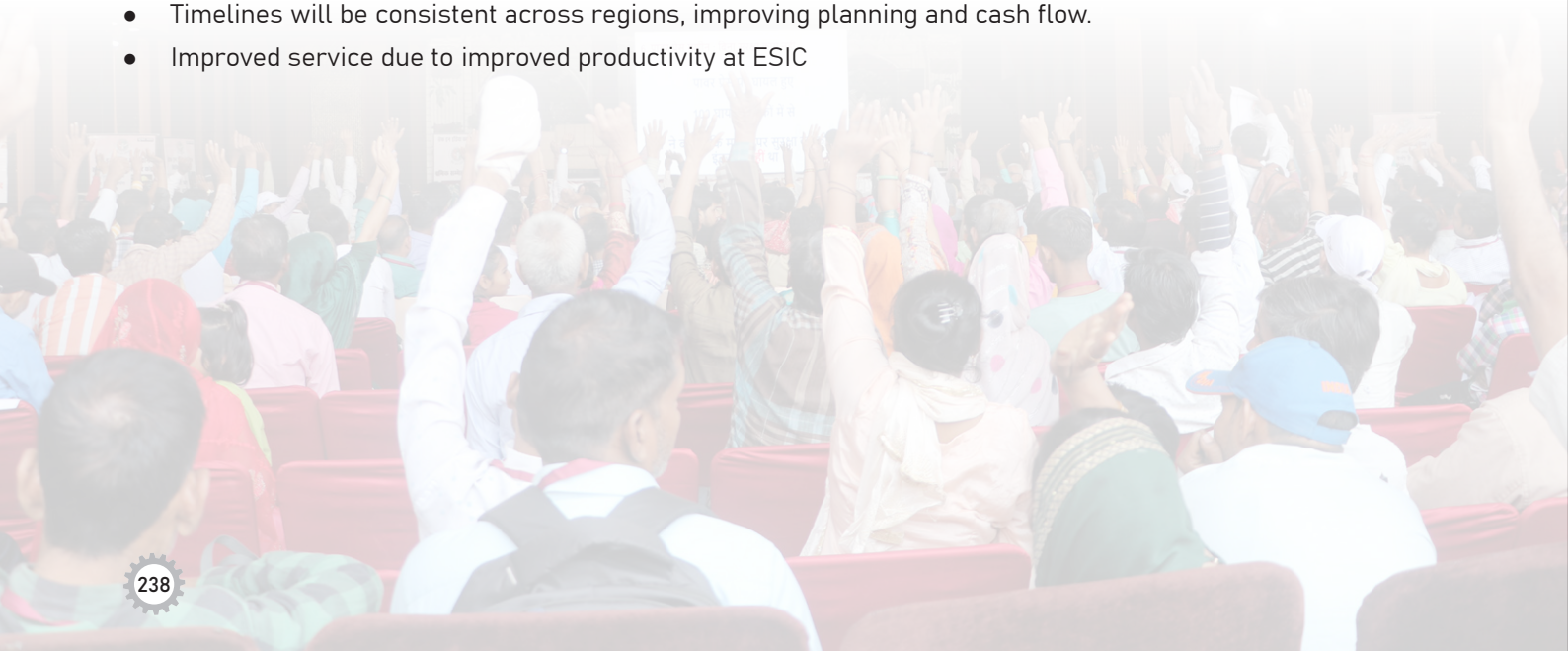
- Outcomes will be quicker and more predictable as steps are reduced and straight-through processing increases.
- Effort will fall as "ask once" replaces repeat document uploads and visits.
- Transparency will improve through live status, named owners, timelines, and reason codes.
- Access will be inclusive with equivalent service online and at counters, across languages and abilities.

21.6.2 For ESIC: operations will be simpler, leaner, and more controllable

- Throughput will rise and cost-to-serve will drop as routine cases are automated and handoffs reduced.
- Quality and compliance will strengthen via rule/risk tags, standard reason codes, and auditable trails.
- Management control will improve with stepwise TATs in SOPs and branch dashboards aligned to the Service Charter.

21.6.3 Deregulation for employers/MSMEs and their HR, admin: compliance will be lighter, clearer, and more predictable; will be more productive

- Duplication will be reduced for data and documents across interactions.
- Disputes will decrease as status becomes visible and decisions are reasoned.
- Timelines will be consistent across regions, improving planning and cash flow.
- Improved service due to improved productivity at ESIC



CHAPTER 22

Leveraging ESIC Data for Improving ESIC Services, Reducing ESIC Costs, and Improving Working Conditions – A Latent Opportunity for India



Main recommendation: Use ESIC's OSH-relevant data to drive proactive, preventive and curative healthcare and a data-informed national OSH strategy, improving working conditions and boosting Indian labour productivity and MSME professionalism, as highlighted in the Economic Survey 2024–25.

In practice, this means leveraging ESIC's rich structured (e.g. claims, establishments, timestamps, Post Accident Registrations) and unstructured (clinical notes, narratives, Accident Forms) data to identify hot spots, e.g., prevalence of specific injuries, diseases (e.g. Silicosis), factories, inform OSH policy and workplace productivity strategies (especially for MSMEs), and enable targeted interventions, e.g. risk-based business audits based on accident and illness trends.

Fewer blanket inspections and risk-targeted enforcement through better data will help achieve deregulation in the manufacturing sector.

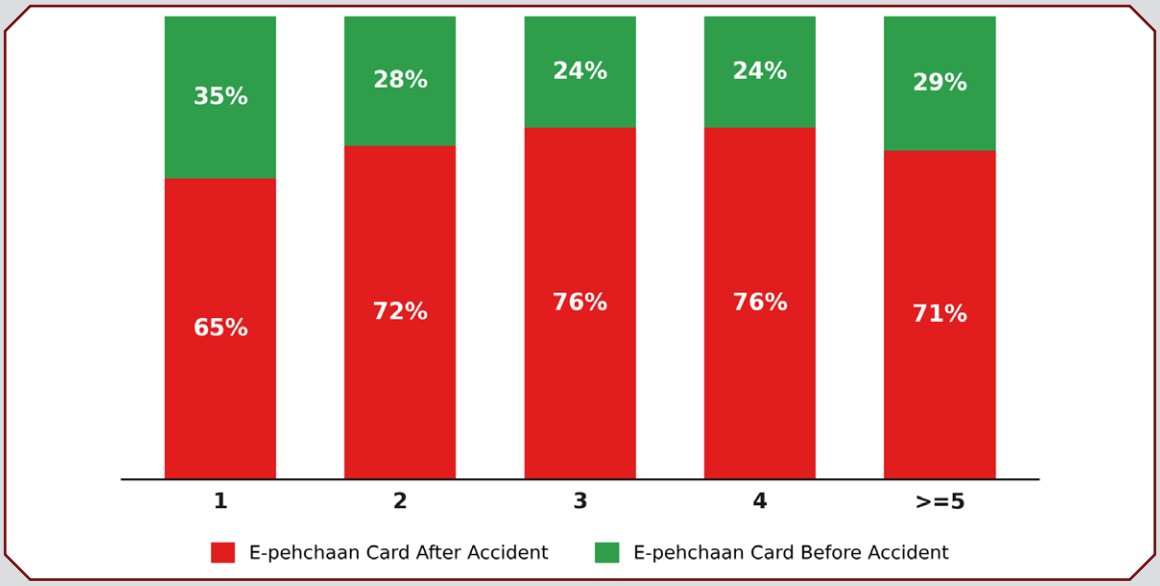
Expected Positive Impact on IPs and Employers:

- Safer, more professional factories: earlier intervention in high-risk establishments and hazards, reducing serious injuries, sicknesses and deaths.
- Lower inspection requirement in low risk factories
- Better care & faster benefits: improved treatment pathways (triage, referrals, rehab) and quicker claim processing through proactive, data-led follow-up, e.g. TB health camps.
- Higher productivity & MSME professionalism: fewer disruptions, better compliance, and stronger operational discipline.

Factories with poorer ESIC compliance also appear to have worse working conditions: SII data

Injured workers who received their ESIC e-Pehchaan card after the accident also had a higher severity of loss of fingers. This could indicate that the employers who withhold the e-Pehchaan cards from the workers until after the injury also foster a poorer and less safe work environment. This proportion appears to increase in cases of injuries where 2 or more fingers are lost.

Injury Severity (Fingers Lost) vs E-Pehchaan Card Status (before vs after accident)



22.1 ESIC's national coverage and worker and employer-focused data collection make its OSH/working conditions data exhaustive and highly valuable

22.1.1 ESIC's time-stamped, establishment- and location-mapped OSH-relevant data: the only such source at the national scale

ESIC organically collects extensive OSH-relevant data, spanning establishment & location details, insured person (IP) and employee identifiers, injury/sickness/death events, healthcare pathways, claims/benefits, and payments.

Below is a non-exhaustive, indicative list of ESIC's OSH-relevant data, both structured and unstructured data.

Structured data (fields in tables with consistent codes) – examples

- **Establishment / Location**
  - ESIC establishment code; name; NIC industry code; ownership type
  - Address; district, state; geo tags (where captured); inspector/RO codes
- **Person (Insured Person / IP)**
  - IP number; name; age/sex; wage band; contribution/coverage status; employment dates
- **Event: Injury / Sickness / Death (OSH)**
  - Event type (injury, sickness, death); mechanism (where coded); date/time; place of occurrence
  - Link to establishment + shift/contractor (if captured); MLC/FIR flags
- **Claims / Benefits**
  - Claim ID; benefit type (DB/PDB/TDB/SB); filing date; decision date; approval/rejection code; % disability
  - Medical Board/Appeal flags and dates
- **Healthcare Pathway**
  - Hospital/dispensary ID; visit/admission dates; referral out/in; procedure/test codes (where available)

Unstructured data (free text/files) – examples

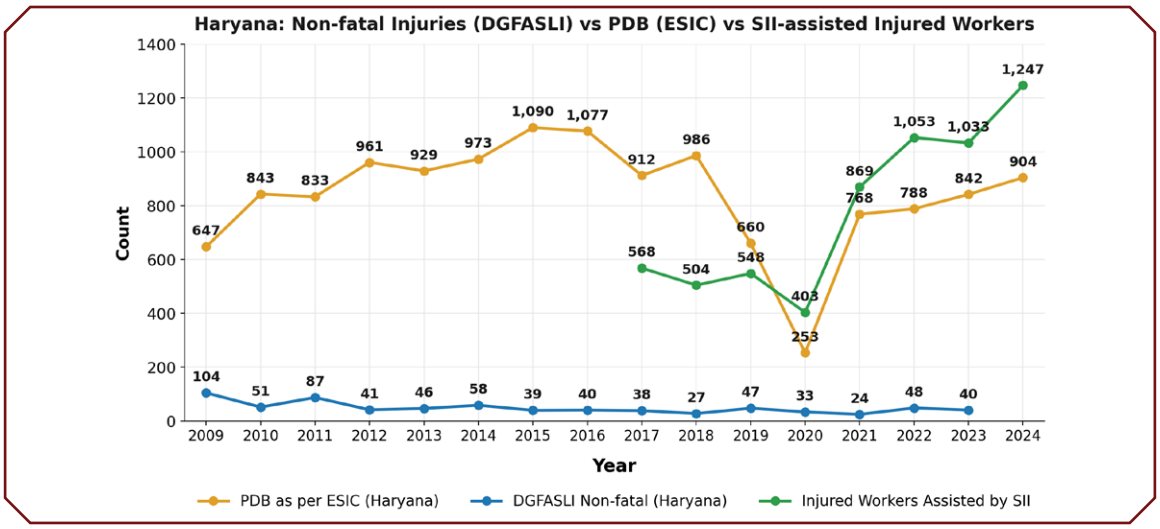
- **Accident Forms & other documents from employers**
  - Accident Forms (Form 12), Accident Book, FIR, Other related documents
- **Clinical notes & narratives**
  - Doctor/hospital notes describing injury mechanism, body part, severity, recovery/rehab advice
- **Free text on forms**
  - "Cause/circumstances of accident," employer remarks, claimant statements
- **Scans & uploads**
  - FIR/MLC, discharge summaries, Board certificates, employer letters, referral slips, images/photos
- **Correspondence**
  - Emails/letters/attachments tied to claim progression or compliance

22.1.2 ESIC Data Covers up to 40 times of other Government sources: Evidence from a DGFASLI Comparison

Because ESIC data originate in workers seeking treatment and benefits, they are closer to ground reality than administrative accident returns, though still not perfect. SII's work with insured persons (IPs) shows that complex, time-consuming processes still deter reporting.

For Haryana, a simple check using PDB (serious, disabling injuries only) makes this clear. Figure 22.1 compares 15 years of ESIC PDB counts with DGFASLI's factory accident data and SII-assisted injured workers, revealing large gaps. (DGFASLI compiles its figures via correspondence with State/UT Chief Inspectors of Factories.)

Figure 22.1: DGFASLI's reported factory injuries are only about 5% of ESIC's PDB cases (Haryana – ESIC PDB (serious disabling injuries) vs DGFASLI factory injuries vs SII assisted injured workers, 2009–2024)



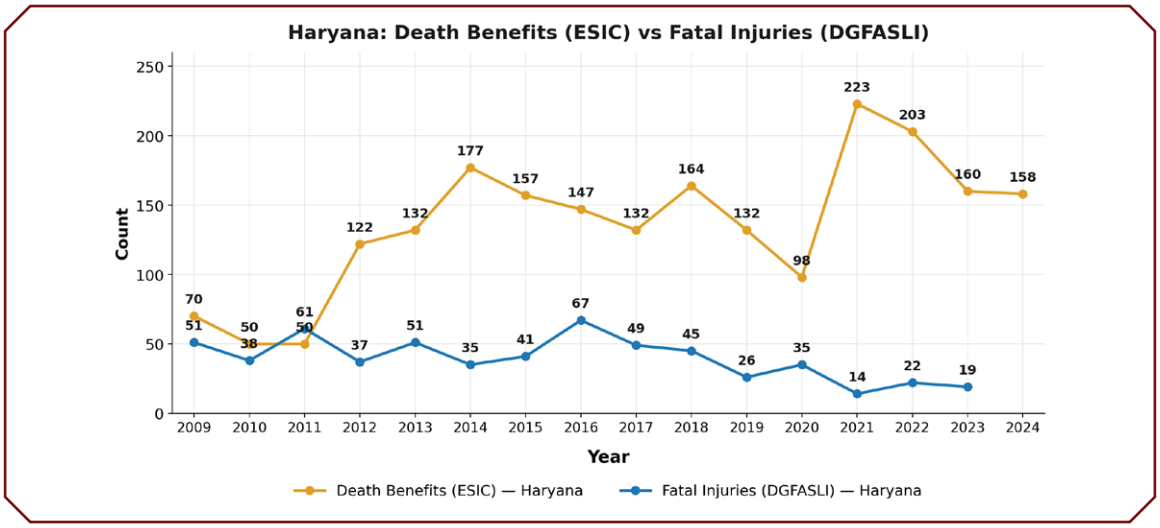
Over 2009–2023, DGFASLI's reported factory injuries are only about 5% of ESIC's PDB cases for Haryana, indicating severe underreporting in the factory-returns dataset.

Even after adjusting ESIC data for its non-factory share (nationally, factories account for approximately 54% of ESIC coverage (proxy from ASI 2022–23 factory employment ÷ ESIC insured persons as on 31-03-2023), the under-reporting in DGFASLI remains substantial. Given Haryana's industrial profile, its factory share of ESIC is likely above 54%, which would only widen the observed under-reporting gap.

At the all-India level, the divergence is smaller than in Haryana, but it persists. And since PDB captures only a subset of all injuries (the serious, permanent-disability cases), the true injury incidence is higher still, which is another reason why systematically using ESIC data will reveal more of the national OSH burden than factory-only returns.

Similarly for the fatality cases, Figure 22.2 compares ESIC DB with DGFASLI fatal injuries for Haryana.

Figure 22.2: Haryana – ESIC DB (Death Benefits) vs DGFASLI factory injuries, 2009–2024



Over 2009–2023, DGFASLI-reported fatal injuries are only ~29% of ESIC Death Benefit (DB) cases in Haryana. The gap widens notably after 2012, again suggesting substantial underreporting in the DGFASLI series.

A possible explanation for part of the gap is that ESIC and DGFASLI do not cover an identical set of cases. ESIC may treat some injuries as employment injuries that would not normally appear in DGFASLI factory accident returns, including certain commuting accidents and other cases arising around work. ESIC data may also include some doubtful non-fatal commuting accident claims that are treated as employment injuries in practice, while employers have little disincentive to support such claims because they do not directly bear the compensation cost and may not report them to the factory inspectorate. In addition, eligibility rules differ: under the Workmen's Compensation framework, compensation can be denied in some circumstances such as intoxication or wilful disregard of safety instructions, whereas such factors do not generally affect benefit eligibility under the ESI scheme in the same way. These differences may explain some part of the gap, but they cannot plausibly explain gaps of the order of 40 times.

22.2 Potential Uses of ESIC Data for national improvements in Data/Reporting, Hotspot Identification, ESIC Services and Labour/MSME Productivity Improvement

This section outlines how ESIC data can (1) strengthen OSH reporting, (2) identify high-risk OSH hotspots and establishments with follow-ups, and (3) improve ESIC services through faster benefits and better care pathways. And indirectly labour/MSME productivity.

22.2.1 Using ESIC Data to Build a Reliable OSH Reporting System and Culture in India

Using, even anonymised, ESIC data to publish annual national, state, district, and industry level counts and rates of accidents among insured persons (minor injuries, disabilities, and deaths) and embedding these into existing outputs/reports, such as MoLE's DGFASLI (Annual Statistics of Industrial Injuries), the Labour Bureau (QES tables/ briefs), MoSPI (ASI and related abstracts), and NITI Aayog/DMEO dashboards, as well as indices where SDG 8.8 is currently missing (e.g., NITI SDG India Index, State SDG dashboards, sectoral performance scorecards).

This approach can be applied to Occupational Health, too. For example, identifying silicosis in a cluster of stone-crushing units or noise-induced hearing loss in metal fabrication.

22.2.2 Using ESIC Data to Identify High-Risk OSH Hotspots and Establishments and Drive Corrective, even Business-Friendly, Action

Finding hotspots using ESIC data:

Using ESIC benefits and medical data to spot where OSH risk is highest - by state, district, industrial cluster, and down to the factory level. E.g. Locations with high DB/PDB/TDB cases per 1,000 insured persons, repeat incidents at the same unit, sudden spikes over past levels, and common patterns (e.g., power-press crush injuries) are to be flagged, creating a clear, ranked list of hotspots and factories needing attention.

AI can be used to achieve this at scale by:

- Analysing the accident reports and other data, and picking out the common injury patterns hidden in them, e.g., power-press crush cases clustering at particular units.
- Tracking the numbers continuously and flag a factory or cluster the moment injuries rise above its own normal level.

Acting on the hotspots - examples:

State Labour / Factories Inspectorates (Feed into inspection data) for Risk-Based Sampling: prioritising inspections from the list, risk-based sampling, checking basic hazard controls (guarding, LOTO, training), issuing improvement notices with fix-by dates, and recording closure status (fixed/not fixed), with re-inspecting repeat cases.

ISH / DISH (State Industrial Safety & Health Directorates): providing on-site technical guidance, running toolbox trainings for high-risk machines, validating machine-guarding and LOTO implementation, and maintaining a simple registry of fixes completed in each hotspot.

DGFASLI: conducting targeted technical checks in flagged clusters, issuing hazard-specific advisories (e.g., safe press operation), supporting focused safety drives with state inspectorates, and sharing short "how-to-fix" notes for common hazards.

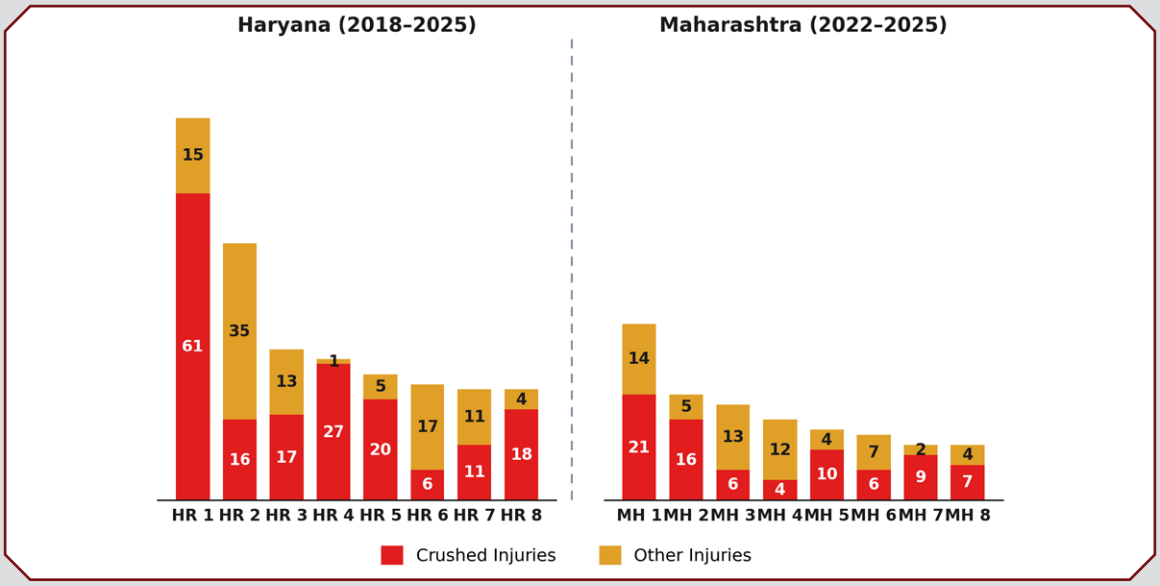
MoMSME & DPIIT (Department for Promotion of Industry and Internal Trade): linking cluster support and scheme benefits (e.g., ZED, tool-rooms, common facility upgrades) to basic safety compliance in flagged areas and publishing simple checklists MSMEs are using to close gaps.

MHI & BIS: Identifying injury-prone machinery (e.g., power presses, cutting tools, or lifting equipment) and developing or enforcing standards.

Buyer/OEM ecosystems (and equivalents in other sectors): requesting basic safety evidence from vendors in flagged clusters (guarding/LOTO/training logs), setting time-bound corrective actions, and including OSH items in supplier audits and retention criteria.

Identification of High-Frequency Injury Sites within the Automotive Supply Chains by SII using data collected from Workers

SII has analysed the frequency with which specific factories reappear in SII's records and identified the pattern of "High-Frequency Factories", those linked to 20+ assisted injuries in Haryana (2018-2025) and 10+ assisted injuries in Maharashtra (2022-2025).



22.2.3 Data-Led ESIC Service Improvement: Faster Benefits and Better Care Pathways

Using accident and injury data for better hospital, dispensary and IMP capacity planning:

By analysing injury volumes, types, and severity by district/industrial cluster, ESIC can predict where trauma, ortho, physio and diagnostics demand will be highest. This helps target staffing, emergency hours, equipment/consumables, and IMP empanelment and training to real hotspots, reducing overload, improving referral quality, and ensuring faster, more continuous care.

Improving treatment pathways through location-linked data:

When ESIC hospital and clinic data are connected to accident and injury records, patterns of referrals, admissions, and follow-up care can be tracked by location. This makes it possible to see, for example, which districts have frequent delays in moving workers from first treatment to specialist care. Such insights help identify where hospitals or clinics need strengthening, so injured workers receive better and quicker treatment. Specialist preventive medical camps can be conducted at hotspots.

Additionally, if ESIC contribution rates were linked to an employer's safety rating, with employers receiving poorer OSH ratings paying higher contribution rates than those with better ratings based on OSH inspections, it could create a stronger incentive to prevent workplace accidents and occupational diseases.

Using enrolment and medical-usage data to strengthen compliance and coverage:

Patterns in new registrations, post-accident enrolments, and family medical-service usage can help ESIC detect possible employer non-compliance, such as withholding of e-Pehchaan cards, under-reporting of workers, and non-payment of dues. Analysing these anomalies enables targeted audits, quicker corrective action, and improved recovery of outstanding contributions. This data-led approach can also strengthen factory-level risk detection.

At present, neither the contribution rate nor inspection priority is linked to a factory's OSH record or to the rate of injuries and sickness reported from that factory. Even under the Shram Suvidha Portal's risk-based sampling approach, injury rates are not factored into inspection selection. ESIC data could help fill this gap by identifying units with unusually high injury incidence, repeated post-accident enrolments, or other warning signals for closer scrutiny. This would strengthen ESIC's coverage integrity, reduce manual effort, and help ensure that eligible workers receive timely protection and benefits.

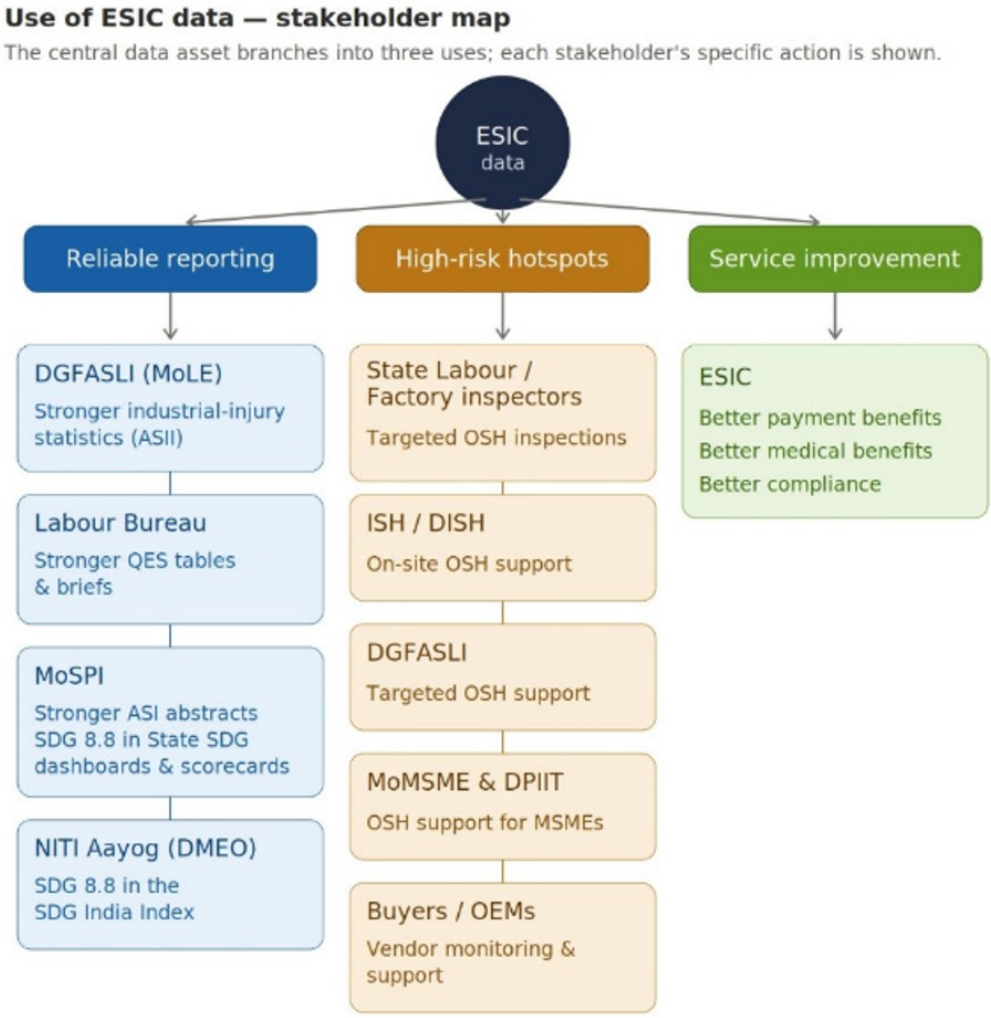
Pilot Data Ideas

1. Identify the top 1000 least safe factories in India and facilitate improvements in them.
2. Identify the top 10 least safe industrial clusters in India and facilitate improvements in them.
3. Identify non-compliant factories; e.g., salary slip denial, offer letters denial.
4. Integrate app-based worker reporting of grievances/accidents with the database

22.2.4 Stakeholder Map: Uses of ESIC Data and Stakeholders

Below is a compact stakeholder map linking each use of ESIC data to stakeholders.

Use of ESIC Data	Stakeholder	Specific Use/Action
Building a Reliable OSH Reporting System	DGFASLI (MoLE)	Strengthened Annual Statistics of Industrial Injuries
	Labour Bureau	Strengthened QES tables/briefs
	MoSPI	Strengthened ASI and related abstracts
		Inclusion of SDG 8.8 with ESIC data in State SDG dashboards, sectoral performance scorecards, etc.
	NITI Aayog (DMEO)	Inclusion of SDG 8.8 with ESIC data in the SDG India Index
Identifying High-Risk OSH Hotspots	State Labour / Factories Inspectorates	Targeted OSH inspections
	ISH / DISH (State Industrial Safety & Health Directorates)	Targeted on-site OSH technical support
	DGFASLI	Targeted OSH support
	MoMSME & DPIIT	Targeted OSH support for MSMEs
	Buyers/OEMs	Targeted vendor monitoring and support
ESIC Service Improvement	ESIC	Improved ESIC payment benefits
		Improved ESIC medical benefits
		Better compliance



Other stakeholders:

Researchers/NGOs: Potential for independent evaluation using anonymised extracts.

22.3 Data, Not Documentation, Caught the 2019 Maternity Benefit Fraud

The standard defence of excessive documentation (forms, documents) is fraud prevention. The largest fake-claim fraud uncovered in ESIC's recent history suggests the reverse.

In 2019, ESIC's own Vigilance Department uncovered a large-scale Maternity Benefit fraud at the Faridabad Regional Office. Once the probe scope widened to six years, over 1,600 fraudulent claims and more than ₹8 crore in fraudulent disbursement were traced at the interim stage.

The modus operandi: female employees of private companies, in collusion with contractors and ESIC officials, submitted forged medical reports and claimed Maternity Benefit multiple times per year; in several cases, four deliveries in a single year.[1]

Rather than excessive documentation, what revealed the issue was data, i.e., claim-frequency analysis detectable only by looking across claims, not within any single claim's paperwork.

This was a crude fraud. Four deliveries a year can be flagged on a spreadsheet. The next attempt may not be this greedy; it may be spread thin across many beneficiaries, use plausible frequencies, and exploit gaps between ESIC and other systems (EPFO, GSTN, Ayushman Bharat). Detecting it will need anomaly detection across claim histories, cross-system verification, provider-level pattern analysis, and AI-assisted red-flagging.

To prevent fraud, ESIC needs a more data-backed approach rather than documentation burden on IPs.

[1] IANS, "ESIC maternity leave scam: Number of cases shoot up to 1,600," Business Standard, 1 June 2019.

CHAPTER 23

About Safe In India Foundation



23.1 About Safe in India Foundation (SII)

Safe in India Foundation (SII) addresses two under-reported and under-addressed issues and opportunities for India.

Opportunity 1: Improving working conditions in Indian manufacturing (especially OSH) to improve Indian Labour Productivity (currently 130th) and MSME professionalism (half of global emerging market average), which is needed for faster, better, more equitable growth:

Focusing on Occupational Safety and Health (OSH) reflects modern, progressive management. The misconception that OSH is merely a cost must shift. It is a proven investment. Research shows a strong link between better work environments and higher productivity. Indian MSMEs, already lagging large firms and even MSMEs in other emerging economies, must improve.

Frequent injuries, like widespread finger amputations in automotive supply chains, not only cause human suffering but also reduce quality, scalability, and competitiveness. Poor OSH contributes to India's low labour productivity (130th) and MSME efficiency, harming inclusive economic growth.

Opportunity 2: Helping & empowering workers towards Social Security by improving ESIC (Healthcare and insurance) access for workers and their families and the quality of services for c.10% (14.5 crore) of India:

Nearly 3.5 crore workers in India, those earning below ₹21,000/month in establishments with over 10 employees, are registered for the Employees' State Insurance Scheme (ESIC), a globally significant but underutilised social security program offering healthcare, maternity, disability, and insurance benefits. Yet, service delivery gaps result in poor experiences for both workers and employers.

23.2 SII's 4 complementary pillars of activities

Safe in India is a registered Section 8 Company, supported by the batch of IIMA91, IIT88, Azim Premji Foundation, Vikram Lal Family Foundation, IndusInd Bank, Macmillan Education, Forbes Marshall, Tata Chemicals and many others. *SII has not applied for FCRA and accepts only domestic funding.*

Pillar 1: Assisting injured/disabled workers to access ESIC healthcare and compensation benefits.

SII has now supported c.16,000+ workers, mostly injured, in ESIC's disability, unemployment, and pension benefits, since 2016, and helped them obtain Rs. 160+Cr from ESIC through five Workers Assistance Centres in two states, Haryana and Maharashtra. SII's sixth centre in Tamil Nadu was opened in 2026.

Figure 23.1: Injured Workers assisted by SII for their ESIC healthcare and compensation continue to increase significantly every year

Injured Workers Assisted (Cumulative)

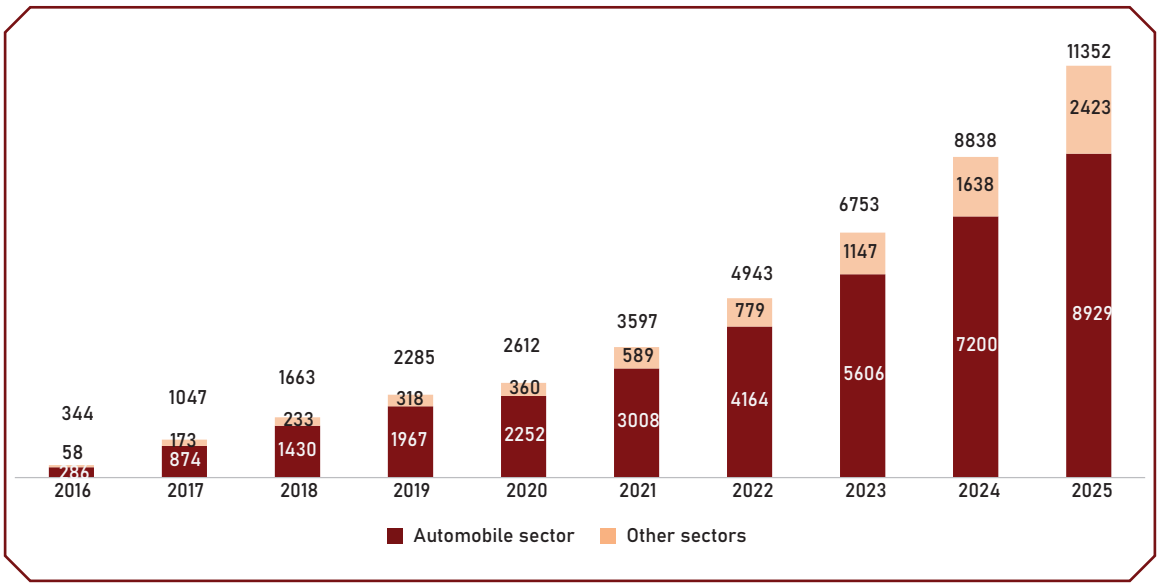
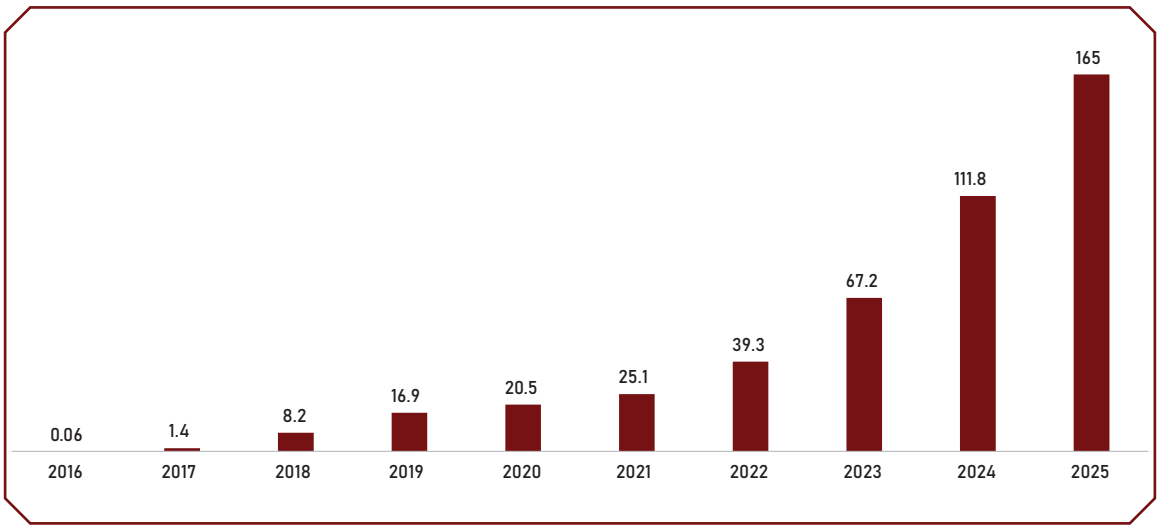


Figure 23.2: Total ESIC compensation value obtained by injured workers assisted by SII has crossed Rs 160cr+

Compensation Value (in Cr.) (Cumulative)

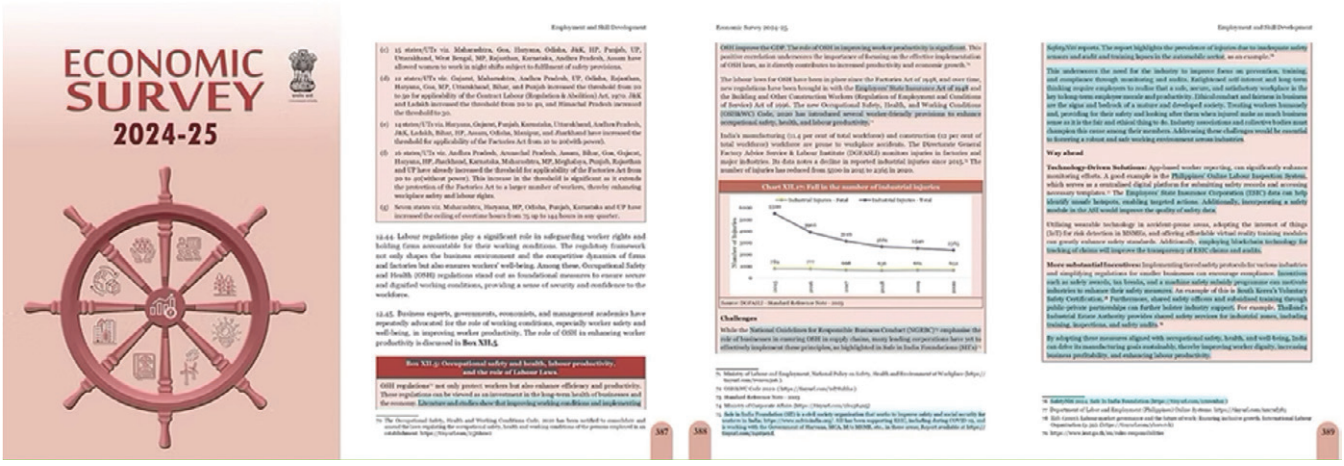


In 2025:

- *4,836 workers received direct assistance - the highest ever.*
- *₹53.36 crore in ESIC healthcare and compensation was secured - the highest ever*

Pillar 2: Nudging to improve Workplace Safety in Manufacturing, especially the Automotive Sector's deeper supply chain, nationally.

Safe in India's Pillar 2 focuses on driving systemic improvements in workplace safety across the Indian manufacturing sector, with a particular emphasis on the deeper supply chains of the automotive industry. This is achieved through sustained engagement with key stakeholders, including the top 10 automobile brands, apex bodies like SIAM and ACMA, investors, non-financial auditors, and central and state governments. SII's annual report series, CRUSHED (since 2019) and SafetyNiti (since 2021), have become reference points for actionable insights and widely accepted recommendations. In March 2026, SII came out with Shramik Suraksha 2026, with 10 simple, actionable points for workers to empower them on issues related to ESIC, and Safety and Professionalism in their factories.



Encouragingly, SII's submission on Occupational Safety and Health (OSH) has been recognised in India's Economic Survey 2024-25, under the pivotal chapter on "Employment and Skill Development: Existential Priorities" (pp. 387–389). SII continues to emphasise that automobile brands possess the technical, managerial, commercial, and ethical capacity to lead this transformation, ensuring safer workplaces while strengthening their supply chain resilience and national productivity.

SII, in partnership with the Indian Institute of Corporate Affairs (IICA), conducted a research study on BRSR practices of 80 listed auto companies, analysing the BRSR disclosures of these companies. The findings were presented to key sectoral stakeholders. This work is contributing to the new National Guidelines for Responsible Business Conduct (NGRBC) for the automobile sector.

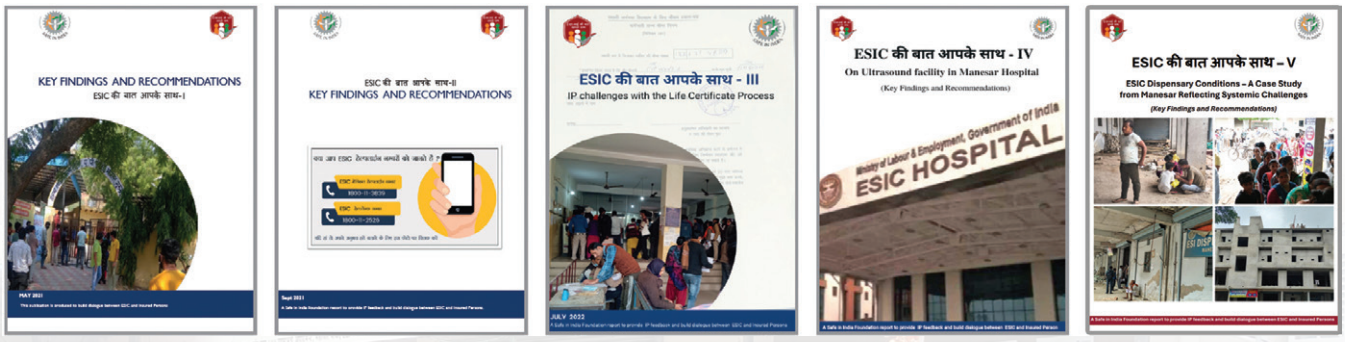
Our recommendation on power-press safety standards, which was approved by the Bureau of Indian Standards, awaits enforcement.



Pillar 3: Improving ESIC's Healthcare & Compensation Services Nationally.

SII engages with ESIC regionally and nationally to help improve the 'quality' of their services. ESIC has already accepted 15 of SII's c.100 recommendations (13 others partially), potentially impacting lakhs of workers throughout India. SII won National Award from the Hon'ble Labour Minister for this work.

In the efforts to ensure that workers' voices reach the ESIC's top executives/board, SII continues to use real data-based evidence of workers' experiences with healthcare and compensation services through its recommendations to ESIC for national/state-level policy/process improvements. For this, SII has been publishing worker-voice through 'ESIC Ki Baat Aapke Saath' reports to make tactical and strategic recommendations since 2017. SII continues to acknowledge the improvements in the ESIC ecosystem, though highlighting the need to still walk miles.





Labour Minister's National Award for Assistance to ESIC

Safe in India received ESIC's national recognition, conferred by the Union Labour Minister in 2021, as one of the top 5 organisations (NGO/corporate) that assisted ESIC during COVID-19.



Pillar 4: Increasing Awareness on Safety & ESIC Services among workers.

SII continues to acknowledge the necessity of imparting the workers with knowledge and awareness in addition to assisting them with processes. SII has been doing this through the use of offline and online platforms of communication, varying from in-person training sessions, Group Discussions, IEC material to social media.

With a focus on educating and empowering workers with the knowledge of ESIC & workplace safety and influencing key stakeholders towards improving workplace safety & social security, SII has been amplifying the workers' voice through SII's YouTube Channels and Facebook pages. SII's Hindi and English Facebook pages for workers now have 1,51,500 and 11,000 followers respectively, generating over 65,000 interactions annually and more than 12.6 million views. Additionally, SII is enhancing awareness among approximately 15,000 workers through direct outreach using the WhatsApp Business API

In 2025, our digital ESIC and safety content was viewed by over one million workers nationwide - a record for us.

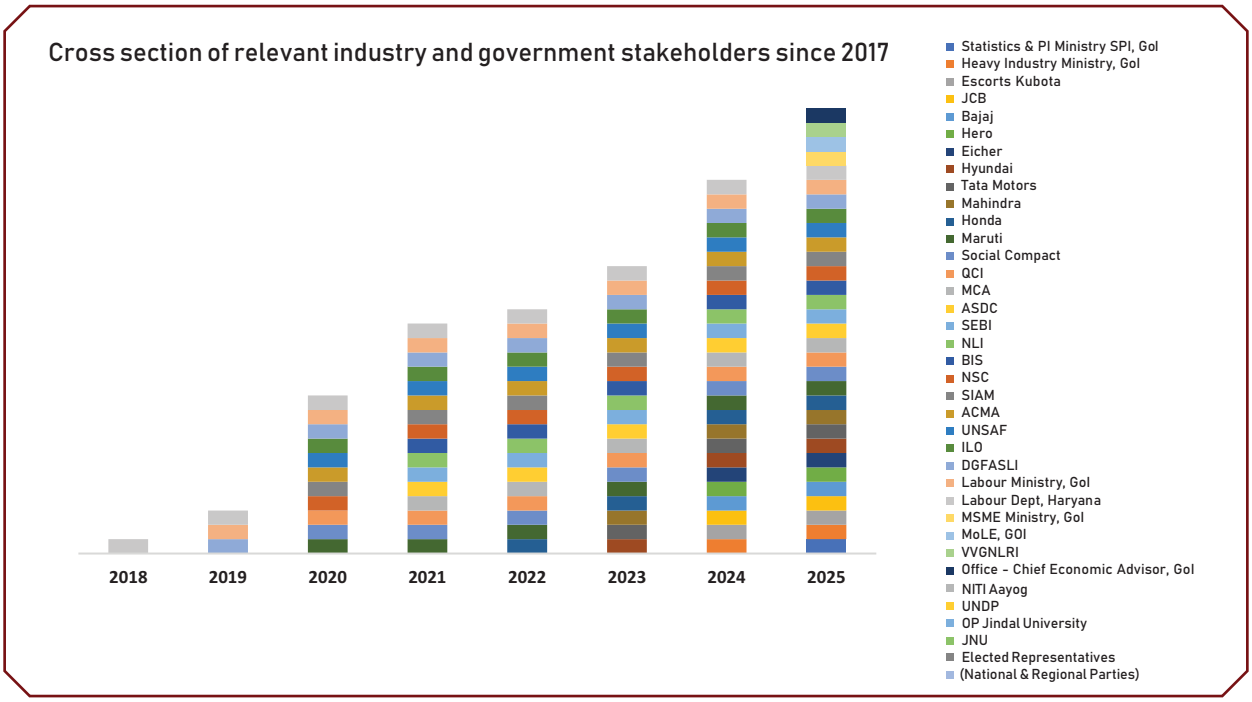
In 2025, 48 worker training sessions were conducted in Pune factories and Gurgaon communities. Additionally, 4,800+ workers were trained on ESIC, health rights and documentation.

23.3 SII's engagement with a cross-section of stakeholders continues to grow

SII engages with the automotive sector industry, the government, and other relevant organizations to advocate improvements in OSH in the automotive sector supply chain includes:

1. Top 10 automobile brands in India (by net sales)
2. SIAM and ACMA (automotive industry associations)
3. Government of India - Ministries of MSME, Labour & Employment, Heavy Industries, CEA, MoSPI, DG FASLI, and BIS
4. Haryana State Labour Department & Industrial Safety and Health (ISH) (Gurugram & Faridabad) and Maharashtra ISH
5. Indian Institute of Corporate Affairs (IICA) under the Ministry of Corporate Affairs,
6. Other institutions, e.g. Niti Aayog, SEBI, NSDC, etc.

Figure 23.3: Cross-section of relevant industry stakeholders engaged with since 2017



In addition, SII has been engaging with an increasing number of partner Civil Society Organisations (e.g., Social Compact, Aajeevika Bureau, Praxis, & WFF) and academic institutions to champion and amplify the cause of OSH across industries and in India.

SII Enabled a ₹1 Crore Diagnostic Equipment Donation for ESIC Faridabad Hospital

To improve access to quality diagnostics for insured workers, SII facilitated the donation of advanced medical equipment (worth ₹1 crore) to ESIC Faridabad in 2022, particularly important in the post-COVID-19 context, with support from HDFC Bank. These machines could not be purchased under existing ESIC purchase policies.



SII Enabled Donation of 5 Multi-Parameter Patient Monitors for ESI Manesar Hospital and Mohan Nagar Hospital, Pune (July 2026)

Through Safe in India Foundation, 5 Multi-Parameter Patient Monitors have been successfully provided to ESI Hospital, Sector 3, Manesar and Mohan Nagar Hospital, Pune.



ESIC Training for Forbes Marshall supply chain in Pune

Forbes Marshall (a Pune-based company) has partnered with Safe in India Foundation under Social Compact, a platform that brings companies and civil society together to improve worker well-being outcomes, to train suppliers (employers/supervisors) and workers on practical ESIC compliance and access (eligibility, registration, cards/dependents, documentation, and benefit pathways).

Programme reach in Pune so far: 60+ ESIC sessions, 1,500+ workers reached, 1,000+ workers received ESIC cards, 800+ dependents added, 30+ workers/families supported to access ESIC healthcare/benefits, and one previously unregistered factory now registered under ESIC.



SII does not provide commercial consulting and has been providing all advice pro-bono and will continue to do so.

Major References

These references were used throughout the report:

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Safe In India Foundation. (2021–2025). Beneficiary support records and internal case data [Unpublished internal data].

Safe In India Foundation. (2022-2026). Focus group discussions and interviews with insured persons and employers [Unpublished field research].

Additionally, references used locally in all chapters are mentioned in the footnotes.

Annexure

Strategic and Tactical Recommendations; Since 2017

Status: Green (accepted/implemented), Red (not accepted), Amber (partially accepted/declined and therefore still potential improvements possible)

Strategic, Policy and Governance Recommendations

Sl. No.	Category	Benefit	Recommendation	Explanation	Status
1	Policy		Improve the Social Security Code & Rules to include 'quality' in it. (The idea that ESIC is to provide certain social insurance services is now 70+ years old, and ESIC should add focus on 'quality of services') (2017)	ESIC 2.0 focuses on quality of services, but quality hasn't been included in the Code and Rules.	Amber
2	Policy		Establish a 'process re-engineering cell,' given the nature of business, to make the process worker centric. (All large service organisations need constant customer feedback-driven incremental and non-incremental process improvements. The absence of this unit within ESIC is a missed opportunity) (2017)	ESIC has a P&D (Planning & Development) department at HO and is currently working on a ~2-year timeline for reengineering processes.	Amber
3	Policy		Improve proactive healthcare by leveraging technology and using ESIC's structured and unstructured national data on sickness, injuries and death of workers to identify hot spots of these incidences and focus on ESIC's limited resources (2022)		Red
4	Policy		Cover Gig/Platform workers and informal workers; but not at the cost of services to currently covered IPs, and at the same premium levels, funded by state/ employers, as the current formal sector IPs.	New Social Security Code Rules enable ring-fenced Social Security Fund for schemes (Rule 65), but ESI-equivalent financing safeguards (4% contribution) are not explicit. *	Amber
5	Policy		Ensure the financing function for workers' social insurance is retained with a single, non-private entity with mandatory contribution, risk pooling, i.e., ESIC. For delivery, the core should stay with ESIC and be expanded/ improved, with private providers insourced where necessary	Increased privatisation is being discussed but no actions taken.	Amber

Sl. No.	Category	Benefit	Recommendation	Explanation	Status
6	Governance		Restructure the Corporation (effectively the board) towards balanced representation: 25% each of government, employers, workers (including contract workers), and truly independent experts, with equal power.		Red
7	Governance		Amend the Regional Board and Local Committee composition to include representatives of contract and non-permanent workers, who can be IPs themselves and representatives of NGOs/Civil Society.		Red
8	Governance		Constitute ESI Societies in all states Ring-fenced Society accounts will remove the state treasury as a gating step for in-kind delivery (drugs, diagnostics, staffing) and IP reimbursements		Red
9	Governance		Set up a Quality of Claims Management Governing Council or Payment Benefit Committee to review and improve claims processes		Red
10	Governance		Review ESIC financial viability with an independent actuarial review; assess whether the current contribution structure is sustainable under realistic growth and expenditure scenarios, and whether the solution is to increase premiums		Red
11	Policy		Utilise ESIC's large, accumulated reserves toward IP benefits/ access		Red
12	Governance		Institute regular, independent performance and social audits, in addition to financial oversight		Red
13	Governance		Institute regular, structured feedback through surveys, ESIC's apps, and in-person channels at dispensaries and branch offices.	Feedback for medical benefits launched - July 1st 2026	Amber
14	Policy		Create an ESIC facilitator model, similar to the ASHA or PMJAY's Arogya Mitra.		Red
15	Policy		Raise and index the wage ceiling to bring in workers who deserve coverage but have been excluded by inflation; Raise to at least ₹33,000		Red
16	Governance		Include representatives of small tier 2/3 MSME factories in ESIC governing bodies (National, Regional and Local)		Red

Sl. No.	Category	Benefit	Recommendation	Explanation	Status
17	Governance		Activate the Regional Boards and Local Committees with timely constitution/reconstitution and meetings		Red
18	Governance		Make ESIC management accountable for delivering quality of service		Red
19	Governance		Publish agendas and minutes of all ESIC governing body meetings on the ESIC website	The agendas and minutes are available in the public domain on ESIC website under "circulars".	Green
20	Governance		Improved regular, structured, public reporting through a Public Accountability Report on ESIC's performance and a Public Costs Report		Red
21	Governance		Institute an annual independent review specifically focused on ESIC's ongoing and increasing privatization/outsourcing efforts		Red

Re-engineering and MIS Recommendations

Sl. No.	Category	Benefit	Recommendation	Explanation	Status
22	MIS	All Benefits	Create a system to effectively monitor and enforce the Citizens' Charter turnaround times	Under discussion as per the Citizens' Charter	Amber
23	MIS	All Benefits	Develop customer experience metrics (e.g. claims completed/received, accident reports received/ total injuries)		Red
24	MIS	All Benefits	Publish a public dashboard of user-facing indicators and branch-level + regional level performance		Red
25	MIS	Occupational Diseases	Publish OD data by state and by disease and link it to the corresponding benefits		Red
26	MIS	Occupational Diseases	Publish an annual ODC/ IOHER performance report		Red
27	ReEngineering	All Benefits	National standardised document checklist for all benefits; made available at all BOs/dispensaries		Red
28	ReEngineering	All Benefits	Require acknowledgement of all claims received by ESIC BOs	Acknowledgement of claims received is part of Draft Regulations (Reg 29)	Amber
29	ReEngineering	All Benefits	Set a firm 15-day timeline for BO to send case files with complete documents to SRO		Red

Sl. No.	Category	Benefit	Recommendation	Explanation	Status
30	ReEngineering	All Benefits	Digitise the end-to-end claims pipeline. Replace paper-based submission and hand-carried files with a single digital workflow. Keep separate non-overlapping digital and offline processes.	Digitised claims processes have been launched for multiple benefits but not implemented as fully online processes.	Amber
31	ReEngineering	All Benefits	Send automated notifications and updates to beneficiaries and employers at defined checkpoints - claim progress and required documents		Red
32	ReEngineering	All Benefits	Continuous performance monitoring of the automated claims system, with IP and employer feedback loops and periodic review		Red
33	ReEngineering	All Benefits	Properly implement the Dhanvantri system, the Hospital Information System, in Gurgaon-Manesar and other neglected regions		Red
34	ReEngineering	All Benefits	Introduce system-led verification: auto-pull contribution/wage data from ESIC data; allow IP self-declaration (post-audit) if employer doesn't submit data/data is missing		Red
35	ReEngineering	TDB & PDB - Accident Report	Allow IPs or their representatives to submit accident notice letters online in a standard simple format		Red
36	ReEngineering	TDB & PDB - Accident Report	Include accident notification functionality in the AAA+/Umang app		Red
37	ReEngineering	TDB & PDB - Accident Report	Appoint Social Security Officers to full strength so they can chase accident reports from employers		Red
38	ReEngineering	TDB & PDB - Accident Report	Introduce significant monetary penalties for employers who delay accident report submission beyond 48 hours		Red

Sl. No.	Category	Benefit	Recommendation	Explanation	Status
39	ReEngineering	TDB & PDB - Accident Report	Conduct independent medical/technical assessment; where employer filings are late/inconsistent; give presumptive weight to clinical records/IP statements		Red
40	ReEngineering	TDB & Sickness	Re-engineer the Medical Leave Certificate process to reduce visits and delays as per SII's suggested model		Red
41	ReEngineering	TDB & Sickness	Automate submission of Medical Leave Certificates (MLC) from dispensary to Branch Office. Digital generation of MLC where possible	Process for submission of Medical Leave Certificate is automated but IPs are often still given printed copies and are then required to carry the physical document to the BO, where it is uploaded again.	Amber
42	ReEngineering	TDB & Sickness	Create effective help desks at hospitals so workers do not need to visit dispensaries solely for documentation (Medical Leave Certificate submission)	Help desk is available for IPs, but they are not effective for this purpose	Amber
43	ReEngineering	TDB & Sickness	Complete leave approval and certification at a single location (hospital or dispensary) for sick/injured workers		Red
44	ReEngineering	TDB & Sickness	Remove the MRE Process (an internal record-management document) from IP's workflow, i.e., the IP shouldn't be physically carrying it between BO, dispensary etc. - Make it internal	Medical Record Envelope now handled internally	Green
45	ReEngineering	TDB & Sickness	When rest slips (Medical Certificate) are submitted at the Branch Office, a ledger number (acknowledgment) should be compulsorily provided		Red
46	ReEngineering	TDB & Sickness	Provide rest slips (Medical Certificate) online to IPs, while allowing occasional offline issue where it reduces IP delay		Red

Sl. No.	Category	Benefit	Recommendation	Explanation	Status
47	ReEngineering	TDB & Sickness	Allow proxy submissions of ESIC foms and documents by family members of IPs without ID surrender		Red
48	ReEngineering	TDB	Auto-start TDB on first valid (eligible for TDB) medical certificate		Red
49	ReEngineering	PDB	Issue RM-3 and partially filled Bi1a together when worker submits Fitness Certificate to reduce visits and delays		Red
50	ReEngineering	PDB	Direct PDB application for obvious permanent disablement cases, i.e. no need to apply for PDB post TDB fitness:		Red
51	ReEngineering	PDB	Elimination of Medical Review step for PDB, where permanent disability is obvious during TDB Medical Review; "fitness for Board" check should rely on the Certificate already given at the TDB stage		Red
52	ReEngineering	PDB	Remove BO-visit requirement to release PDB		Red
53	ReEngineering	PDB	Enforce fixed monthly Medical Board calendars; twice where caseloads require	Medical Boards are monthly at most locations. Exceptions exist.	Amber
54	ReEngineering	PDB	Multi-channel Medical Board intimation - ESIC website, notice board outside Branch Offices, along with SMS and letter notifications		Red
55	ReEngineering	PDB	PDB Decision Letter should not be linked to arrears receipt		Red
56	ReEngineering	PDB	Publish clear turnaround times and service levels for issuing decision letters and monitor compliance		Red
57	ReEngineering	PDB	Centralise Decision Letters - to be issued centrally (all India) instead of RO/SRO level		Red
58	ReEngineering	PDB	Dispatch Decision Letters digitally + by post. Send decision letters to IPs via WhatsApp where possible		Red

Sl. No.	Category	Benefit	Recommendation	Explanation	Status
59	ReEngineering	PDB	Make Decision Letters available online through IP portal and Umang app		Red
60	ReEngineering	PDB	Enable online submission of Life Certificates with online acknowledgements	e-Jeevan Praman available online now.	Green
61	ReEngineering	PDB	Accept all Life Certificate formats with required fields		Red
62	ReEngineering	PDB	Provide an authoritative national list of Life Certificate attestors		Red
63	ReEngineering	PDB	Remove employer attestation requirement for Life Certificates (not required as per rules; implementation gap exists)		Amber
64	ReEngineering	PDB	Accept Life Certificates at any ESIC office/bank/e-LC		Red
65	ReEngineering	TDB & PDB	Stepwise SLAs in Citizens' Charter for TDB/PDB stages		Red
66	ReEngineering	Sickness	Simplify/remove two-day waiting period for genuine continuous illness		Red
67	ReEngineering	Maternity	Adopt one national standard document checklist for Maternity Benefits to be used across all BOs		Red
68	ReEngineering	Maternity	Remove the Marriage Certificate requirement from requirements	Removed from requirements. But not implemented, with BOs using their own lists.	Amber
69	ReEngineering	Maternity	Drop payslip/attendance-slip requirements and accept alternative proofs of employment/wages. e.g. ESIC contribution records		Red
70	ReEngineering	Maternity	Eliminate/combine forms to reduce the burden on IWs' application process. Eliminate Form 17. Combine Form 18 & 19. Eliminate Form 18 & 19 (2nd time) for ESI hospital deliveries		Red

Sl. No.	Category	Benefit	Recommendation	Explanation	Status
71	ReEngineering	Maternity	Pay confinement benefit before the expected date of childbirth when the claim was filed ≥14 days in advance, and within 14 days of document submission if the claim was filed post-childbirth		Red
72	ReEngineering	Maternity	Post child birth, issue Form 18 digitally by default and allow proxy pick-up (by relatives)		Red
73	ReEngineering	Maternity	For ESIC-hospital deliveries, auto-initiate and auto-process claims at admission/discharge, with zero in-person steps at BO/dispensary		Red
74	ReEngineering	Maternity	Allow remote/tele-verification for verification using videos post child birth and for sickness benefit in difficult pregnancies		Red
75	ReEngineering	Maternity	Automatic maternity benefit for miscarriage; sickness for extended recovery		Red
76	ReEngineering	ABVKY	Ensure clear definition of unemployment in ABVKY and pay all eligible IPs as per scheme conditions	A clear definition was provided in FAQs & Introduction to ABVKY available on the national website.	Green
77	ReEngineering	ABVKY	Remove or defer affidavit notarisation requirement so workers incur costs only after eligibility is confirmed	Condition for submitting the claim in Affidavit Form has been dispensed with. This was announced on 08.11.20 by MOLE.	Green
78	ReEngineering	ABVKY	Standardise ABVKY documentation requirements across all Branch Offices	BO at Gurugram, Manesar, Dharuhera and Bawal had standardised docs for ABVKY, i.e.Form AB1, AB2, bank details and Aadhar	Green
79	ReEngineering	ABVKY	Define a clear 15-day ABVKY payment cycle and monitor turnaround, making BO accountable for documentation completion		Amber
80	ReEngineering	ABVKY	Clarify that Aadhaar is encouraged but not mandatory and accept alternative government IDs		Amber

Sl. No.	Category	Benefit	Recommendation	Explanation	Status
81	ReEngineering	ABVKY	Set up ABVKY helpdesks at each BO with trained staff, pamphlets, posters and SMS campaigns plus MIS on applications	ABVKY Help Desk was set up at Manesar, Gurgaon, Dharuhera, and Bawal BO	Green
82	ReEngineering	ABVKY	Review ABVKY system configuration to prevent incorrect application of benefits and resolve IT issues		Red
83	ReEngineering	ABVKY	Allow single-form ABVKY applications covering multiple months		Red
84	ReEngineering	ABVKY	Use SII's granular data to analyse ABVKY implementation and improve processes nationally		Red
85	ReEngineering	ABVKY	Reduce worker dependence on employers and empower IPs to use their own ABVKY logins more transparently	As per the notification dated 16.09.20, under relaxed eligibility conditions, the ABVKY claim of the IP need not be forwarded by his employer. However, for verification of the claim and for filing AB2 form, the IP continues to be dependent on the employer	Green
86	ReEngineering	ABVKY	Ensure IPs can update their bank account details themselves for ABVKY payments	For ABVKY, the IP can update the bank details themselves	Green
87	ReEngineering	Reimbursements	Simplify first-time online registration - make the requirement of employer and bank verification for reimbursements as exception and not the rule		Red
88	ReEngineering	Reimbursements	All referrals and Not Available (N/A) OPD slips should be issued in both digital and hard copy formats (standardised) through the ESIC system, automatically stored in the IP's online account		Red

Sl. No.	Category	Benefit	Recommendation	Explanation	Status
89	ReEngineering	Reimbursements	Introduce a standardised 'Non-Availability Certificate' for cases where services such as medicines and diagnostic tests cannot be provided, which can then be attached to the external provider's bill and submit for reimbursement.		Red
90	ReEngineering	Reimbursements	Sever the reimbursement rate cap from the cases where ESIC was not able to deliver timely treatment; reimburse the actual billed amount		Red
91	ReEngineering	Grievance Redressal	CPGRAMS should report resolved cases, not just disposed cases, and publish satisfaction scores		Red
92	ReEngineering	Grievance Redressal	Issue an Action Sheet at each Suvidha Samagam and track every case to closure		Red
93	ReEngineering	Grievance Redressal	Maintain MIS of complaints from helpline and Suvidha Samagam and update IPs on status		Red
94	ReEngineering	Grievance Redressal	Redesign Suvidha Samagams as open Jan Sunwais rather than closed-door meetings		Red
95	ReEngineering	Grievance Redressal	Integrate CPGRAMS into the ESIC IP portal/app via single sign-on and one-click grievance filing		Red
96	ReEngineering	Job Loss	Create a mechanism to identify injured workers discontinued shortly after accidents using ESIC employer data		Red
97	ReEngineering	Occupational Diseases	Create a new/different form for OD to replace Accident Reports		Red
98	ReEngineering	Occupational Diseases	Create a non-Accident-Report route for ODs		Red
99	ReEngineering	Occupational Diseases	Protect ex-IP access in long-latency ODs through a clearer framework		Red

Sl. No.	Category	Benefit	Recommendation	Explanation	Status
100	ReEngineering	Medical Benefits	Replace ESIC's current periodic medicine-supply model with a technology-based inventory management system; with real-time stock visibility across dispensaries and hospitals, auto-triggered reorder against consumption data		Red
101	ReEngineering	Medical Benefits	Set clear adoption targets for the use of digital tools at hospitals, dispensaries and branch offices.		Red
102	ReEngineering	Medical Benefits	Explore new delivery mechanisms as alternatives for dispensaries, e.g., work-site-based sites and integration with functional AB-HWCs (Ayushman Bharat - Health and Wellness Centres).		Red
103	ReEngineering	Registration	Disallow PAR declines where evidence shows worker should have been covered under ESIC		Red
104	ReEngineering	Registration	Create MIS on the number of PARs, late registration, no-card, unpaid contribution, and contractor-linked or primary employer- linked non-compliance and reasons, and monitor them proactively		Red
105	ReEngineering	Registration	Where employers register workers late, require employers to pay IPs as per ESIC norms if ESIC declines the claim		Red
106	ReEngineering	Registration	Standardise PAR decline letters and clearly include reasons for decline and identifies principal employer/factory		Red
107	ReEngineering	Registration	Clearly indicate the appropriate Branch Office on TIC (Temporary Identification Certificate) and against each IP online	The appropriate branch office is mentioned in the TIC.	Green

Sl. No.	Category	Benefit	Recommendation	Explanation	Status
108	ReEngineering	Registration	Integrate ESIC onboarding with the day-1 appointment letter; Remove the 10-day worker registration rule and require ESIC coverage from day of joining		Red
109	ReEngineering	Registration	Replace separate IP numbers with Aadhaar numbers as permanent ESIC identifiers	Although IP no is not replaced with Aadhaar, it is mandatory for IPs to link their IP number with Aadhaar, this problem will be resolved.	Amber
110	ReEngineering	Registration	Share more power directly with workers, not only employers, in registration, e-Pehchaan access, family addition, and correction of basic data fields - Delete Form 2 and provide workers direct ability to update family details in ESIC systems.	IPs can update family details but requires employer approval	Amber
111	ReEngineering	Registration	Allow workers to update family details via the AAA+/Umang app without employer intermediation		Red
112	ReEngineering	Registration	Create a day-1 access model that does not depend only on the physical e-Pehchaan card		Red
113	ReEngineering	Registration	Create an escalation window at BO/Dispensary for workers who are injured or very sick, so that they can be registered or activated on the basis of evidence of employment in an ESIC-registered business		Red
114	ReEngineering	Registration	Create at least a periodic self-certification requirement for employers that they have given ESIC cards/access details to all eligible workers from day 1.		Red
115	ReEngineering	Registration	Improve principal-employer visibility over contractor compliance: responsibility should be clearer, and visibility stronger, where contractors are involved.		Red
116	ReEngineering	Registration	Automate dispensary and facility allocation based on verified geography		Red

Sl. No.	Category	Benefit	Recommendation	Explanation	Status
117	ReEngineering	Field Governance & Compliance	Replace the current random/rotational selection for both inspections and coverage surveys with a risk-based algorithm.		Red

Operational Recommendations

Sl. No.	Category	Benefit	Recommendation	Explanation	Status
118	Operational	All Benefits	Awareness campaigns across benefits		Red
119	Operational	TDB & Sickness	Improve quality and durability of medical leave certificates	The quality of the paper issue has been resolved. The paper is generated through print	Green
120	Operational	TDB & Sickness	Ensure on-time employer submission of Form 10, with accountability for delays		Red
121	Operational	TDB & PDB	Form 142 (for payment of travelling expenses) to be issued with Medical Board intimation		Red
122	Operational	Sickness	Awareness campaigns for sickness benefit eligibility		Red
123	Operational	Maternity	Commission surveys to understand why many women are not availing maternity benefits		Red
124	Operational	Reimbursements	Provide online assistance for digitally unsavvy IPs for account setup and form filling for Reimbursements		Red
125	Operational	Grievance Redressal	Print ESIC helpline numbers on e-Pehchan cards, OPD tickets and slips		Red
126	Operational	Grievance Redressal	Train helpline teams for better first-time resolution and track call quality and performance		Red
127	Operational	Grievance Redressal	Keep the helpline technically robust so IPs do not have to call multiple times to connect		Red
128	Operational	Grievance Redressal	Automate ministry selection in CPGRAM so complainants do not have to choose it manually		Red
129	Operational	Grievance Redressal	Make the CPGRAM website multilingual with regional language options	Done. Available in multiple languages	Green

Sl. No.	Category	Benefit	Recommendation	Explanation	Status
130	Operational	Grievance Redressal	Provide CPGRAM links on the UMANG app and IP portal to increase accessibility	Available on UMANG app & AAA+ app	Green
131	Operational	Grievance Redressal	Run a uniform post-closure satisfaction survey across CPGRAMS, helplines and Suvidha Samagam		Red
132	Operational	Grievance Redressal	Improve grievance response quality with clear, actionable replies and fewer re-openings		Red
133	Operational	Grievance Redressal	Hold Suvidha Samagam sessions as scheduled and enforce compliance in failing offices		Red
134	Operational	Grievance Redressal	Publicise Suvidha Samagam dates and venues in advance to IPs and employers via multiple channels		Red
135	Operational	Grievance Redressal	Boost awareness of grievance mechanisms with simple guides, assisted filing and multilingual materials		Red
136	Operational	Grievance Redressal	Ensure Branch Office managers are present for Suvidha Samagams		Red
137	Operational	Grievance Redressal	Inform employers about Suvidha Samagams through WhatsApp		Red
138	Operational	Grievance Redressal	Make the chatbot a real multilingual digital assistant		Red
139	Operational	Grievance Redressal	Build a more reliable employer grievance-and-update system and publicise them		Red
140	Operational	Job Loss	Enhance ESIC regulations to penalise employers who dismiss injured workers and channel penalties to the worker		Red
141	Operational	Rehabilitation	Design specific rehabilitation schemes for permanently disabled workers and communicate them widely		Red

Sl. No.	Category	Benefit	Recommendation	Explanation	Status
142	Operational	Rehabilitation	Allocate specific funds to rehabilitation schemes based on data on permanently disabled workers		Red
143	Operational	Rehabilitation	Outsource rehabilitation services where ESIC cannot effectively deliver them internally		Red
144	Operational	Medical Benefits	Increase ESIC hospital capacity in Gurgaon/ Manesar to meet ESIC norms	500-bedded ESIC super-speciality hospital - foundation stone laid in Manesar in 2022	Green
145	Operational	Medical Benefits	Review hospital capacity availability in all locations nationally to avoid similar gaps		Red
146	Operational	Medical Benefits	Specify actions required from governments when hospital capacity falls more than 20 percent below norms		Red
147	Operational	Medical Benefits	Scale up the 'beds at dispensaries' initiative from pilot sites to dispensaries across the country		Red
148	Operational	Medical Benefits	Operationalise in-house ultrasound facility at ESIC Manesar hospital	Available	Green
149	Operational	Medical Benefits	Review ultrasound service availability in ESIC hospitals nationally to avoid similar gaps		Red
150	Operational	Medical Benefits	Avoid referrals from Manesar to distant ESIC hospitals and instead implement/improve IMP private cashless referral schemes		Red
151	Operational	Medical Benefits	Expand dispensary access, ensure minimum 8-hour OPD and core diagnostics at every dispensary, and make OP care cashless		Red
152	Operational	Medical Benefits	Increase bed capacity, fill specialist posts, keep critical units functional, and reduce persistent hospital under-occupancy		Red

Sl. No.	Category	Benefit	Recommendation	Explanation	Status
153	Operational	Medical Benefits	Human resource overhaul: solve for the chronic shortage of doctors, specialists, and nurses; recruitment, retention, compensation, and career-path reform; use ESIC's own medical colleges as a direct recruitment pipeline		Red
154	Operational	Medical Benefits	Maintain medicine buffers, make medicines cashless, and ensure ultrasound/ diagnostic access through on-site or nearby cashless tie-ups		Red
155	Operational	Medical Benefits	Keep empanelled hospitals live, fast-track small medical claims, and track/publish inpatient out-of-pocket spending		Red
156	Operational	Medical Benefits	Integrate AAA+ and Umang for OPD booking, tele-consults, e-prescriptions and claim tracking; strengthen helpline and awareness on medical entitlements		Red
157	Operational	Medical Benefits	Do not require IPs to register at dispensary/ IMPs before referral to an ESIC hospital		Red
158	Operational	Medical Benefits	Introduce token systems to manage queues and waiting time at high-traffic locations		Red
159	Operational	Non Compliance	For employment-injury cases, ESIC should investigate data on cases where the first point of care wasn't a nearby ESIC hospital/dispensary or empanelled facility, where available.		Red
160	Operational	Non Compliance	Enforce SLAs and penalties for late or false Form-12, abstention and wage-particular filings; prosecute repeated wilful misstatements		Red

Sl. No.	Category	Benefit	Recommendation	Explanation	Status
161	Operational	Non Compliance	Activate the underused mechanisms under Section 45 of the ESI Act/ Section 129 of the Social Security Code to recover employer arrears.		Red
162	Operational	Non Compliance	Voluntary certification for ESIC consultants, with a basic knowledge test, a published code of conduct, and a delisting mechanism for verified complaints		Red
163	Operational	Employer Support	Conduct regular employer satisfaction surveys		Red
164	Operational	Employer Support	Increase employer awareness, especially on specifics, not just general ESIC familiarity, through targeted campaigns		Red
165	Operational	Field Governance & Compliance	Recruit Social Security Officers and Branch Managers up to sanctioned strength	A recruitment notice for SSO came out in March 2022, but positions continue to be vacant	Amber
166	Operational	Field Governance & Compliance	Use strengthened Social Security Officer cadre to improve governance of small factories and ESIC compliance		Red
167	Operational	Offices	Ensure reliable power backup for ESIC offices via professionally managed inverters		Red

I appreciate Safe In India Foundation's sustained engagement with ESIC and its efforts to bring workers' experience into the policy and administrative discourse. I hope this report will contribute constructively to the continuing evolution and strengthening of the ESI system.

Shri Ashok Kumar Singh, IAS
Director General, ESIC

ESI ki Baat 2026 is a truly monumental and comprehensive report on the ESIC. The report draws on case studies, many of which have been carried out by partners of SII, and secondary literature to present a 360-degree picture of the ESIC. This picture extends from the micro to the macro issues. Each benefit given by ESIC is examined at length, and process issues which can ramp up the efficiency of ESIC are elaborated. At the macro level, two issues are examined in depth. These include ESIC's compatibility and adjustment to the Code on Social Security, 2020, and a comparison of ESIC to private insurance and delivery. The final chapter sums up the strategic recommendations. All in all, this report is momentous and extremely comprehensive. Hope it gets the attention it deserves.

Dr Ravi S. Srivastava
Professor and Director, Centre for Employment Studies, Institute for Human Development, New Delhi;
Former Full-Time Member, National Commission for Enterprises in the Unorganised Sector (NCEUS), Government of India

This report makes the case for why and how ESI must be saved, revitalised and expanded, and why it must be recognised as an integral part of the struggle to achieve the right to health in India. Given the strong lobbies which push for privatisation in the name of reform, this report also highlights the urgent need to build a public understanding of ESIC and the need for public action to save this institution before it is too late.

Dr T. Sundararaman
Former Executive Director, National Health Systems Resource Centre (NHSRC), MoHFW
Former Dean, School of Health Systems Studies, TISS

ESI as a social insurance programme is excellent, but it has a major design defect: it restricts benefits to a working population below an earning threshold. The time has come to universalise access to ESI to all workers, organised and unorganised, with all existing benefits, rather than separate schemes for different classes of workers. ESI should become a means for uniting the entire workforce into a common and universal-access social insurance for their dignity and well-being.

Shri Ravi Duggal
Independent researcher on public health, health financing and social security; formerly Country Manager, International Budget Partnership.

"पूणे में पावर प्रेस मशीन पर मेरा हादसा हुआ। SII की मदद से मुझे ESIC की पेंशन ₹23,000 महीना, ₹1 लाख TDB और ₹3.5 का रूका हुआ पैसा मिला। उस रूके हुए पैसे से मैंने एक टाटा मैजिक ली और उसे हल्दीराम के साथ कॉन्ट्रैक्ट पर लगा दिया। आज उसी की कमाई और ESIC पेंशन से मैं अपनी पत्नी और पांच बच्चों की देखभाल कर पा रहा हूँ।"

("I was injured on a power press in Pune. With SII's help, ESIC's disability pension of ₹23,000 a month came through, along with ₹1 lakh in TDB and ₹3.5 lakh in arrears. I used the arrears to buy a Tata Magic and contracted it with Haldiram's. Today, that income along with my ESIC pension is what supports my wife and our five children.)"

Dinesh Sharma, 32, ESIC Insured Person, Jharkhand

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