Chapter - 4: Implementation of the ESIS

One of the objectives of performance audit was to examine whether the ESIC extended adequate medical, sickness, maternity, disablement, dependents and other cash benefits to the insured persons/ beneficiaries and whether quality of services delivered by various hospitals/ dispensaries was satisfactory. Audit also sought answers to the issue whether procurement of medicines and equipment was economic and effective. For this Audit examined the process of timely settlement of cash benefit claims, bed occupancy, services provided in various hospitals, system of procurement of medicines and equipment, availability of adequate human resource, etc. Significant issues emerging from audit examination are as follows :

4.1 Cash/Medical Benefits

4.1.1 Delays in settlement of claims of cash benefits

As per Citizen's Charter of ESIC, maximum time limit for payment of cash benefits after submission of claim under various categories is seven days for sickness benefit, 14 days for maternity benefit, one month for disablement benefit, three months for dependant benefit, one month for unemployment allowance and same day for funeral expenses.

Test check of related records for settlement of claims revealed instances of delays with respect to those declared in the citizen's charter. These delays were as given below:-

Table 4.1: Delays in settlement of claims

Sl. No.	State	Type of claim	No. of cases	Delays
1.	Andhra Pradesh	RGSKY	6	Up to 3 months
2.	Assam	Maternity benefit	17	3 to 108 days
	Assam	Sickness benefit	172	1 to 220 days
	Assam	Temporary disablement cases	11	2 to 374 days
3.	Chattisgarh	Sickness benefit	96	12 to 268 days

4.	Delhi	Disablement benefit	48	1 to 36 months
	Delhi	Funeral expenses	61	1 to 199 days
5.	Jharkhand	Dependant benefit	4	5 to 15 months
6.	Karnataka	Dependant benefit	120	1 to 10 months
	Karnataka	Permanent disablement benefit	190	5 days to 7 months
7.	West Bengal	Sickness benefit	35971	Up to 556 days
	West Bengal	Maternity benefit	61	Up to 249 days
	West Bengal	Temporary disablement benefit	4029	Up to 363 days
		Total	**40786**	

ESIC replied (May 2014) that in some cases, the claims were settled late due to incomplete documents submitted with the claims. It further stated that respective Regional Directors had since been advised to ensure timely payment to the IPs.

4.1.2 Excess payment in cash benefit claims

Various Cash benefits like sickness benefit, extended sickness benefit, maternity benefit, disablement benefit etc. are given to IPs. Instances of cash benefits more than permissible amounts were found in Andhra Pradesh (excess payment of ₹ 1.89 lakh in 1791 cases) and in Odisha (excess payment of ₹ 5.93 lakh in 791 cases, out of which ₹ 3.67 lakh was recovered subsequently).

ESIC stated (May 2014) that excess payment of benefit occurred due to wrong calculation of days or rate. It further stated that it was making efforts to recover excess payment from IPs.

4.2 Hospital Management

4.2.1 Bed occupancy

ESIC provides medical care to its IPs through a network of ESI hospitals, ESI dispensaries and diagnostic centers. The summarized position of bed occupancy[15] for 140 hospitals[16] during 2012-13 (**Annex-V)** is given in **Table 4.2**:-

[15] Averaged for a year during 2012-13
[16] Bed occupancy of 11 hospitals was not available

Table 4.2: Bed occupancy in ESI hospitals during 2012-13

Hospitals with number of beds commissioned	Number of hospitals under different levels of bed occupancy					
	<20 *per cent*	20 *per cent* to 40 *per cent*	40 *per cent* to 60 *per cent*	60 *per cent to 80 per cent*	Above 80 *per cent*	Total number of hospitals
Less Than 100	12	15	16	10	7	60
100 to 250	6	13	14	15	10	58
250 to 500	1	3	2	5	8	19
more than 500			2		1	3
Total	**19**	**31**	**34**	**30**	**26**	**140**

Audit observed that two out of three hospitals with more than 500 beds were having bed-occupancy less than 60 *per cent.* Similarly, 6 out of 19 hospitals with 250-500 beds, 33 out of 58 hospitals with 100-250 beds and 43 out of 60 hospitals with less than 100 beds were under-utilised i.e. operated with less than 60 *per cent* bed occupancy. About 35 *per cent* of the hospitals were having bed occupancy levels of less than 40 *per cent* and were thus underutilized.

ESIC stated (May 2014) that reason for low occupancy was shortage of manpower and the quality of health care services being rendered. The matter was regularly taken up with the State Governments to improve the health care services.

4.2.2 Availability of beds

As per the norms prescribed for setting up of new hospitals by ESIC, the benchmark for opening a 100 bed new hospital is 25000 IPs i.e. 250 IPs per bed. The ESIC also projects requirement of beds based on ratio of one bed for 250 IPs in its Financial Estimates and Performance Budget every year. The data for number of IPs, number of beds required as per ESIC norms and actual availability and shortage of beds during 2008-09 to 2012-13 is given in **Table 4.3**:-

Table 4.3: Shortage of Beds

As on	31 March 2009	31 March 2010	31 March 2011	31 March 2012	31 March 2013
No. of IP Covered (in lakh)	129.38	143.00	155.30	171.01	185.82
No. of beds required as per norms (1 bed per 250 IPs)	51752	57200	62120	68404	74328
No. of beds available	23088	22030	22335	22823	22600
Shortage of beds	28664	35170	39785	45581	51728
***Per cent* shortage of beds**	55.39	61.49	64.05	66.63	69.59
No. of IP per Bed as per availability	560	649	695	749	822

From above, it may be seen that while the number of IPs increased by 56.44 lakh (44 *per cent*), the number of beds actually decreased by 488 (2.11 *per cent*) from 2008-09 to 2012-13. Further, although the capital expenditure on construction of hospitals, dispensaries, medical/ para-medical/nursing college, etc. had increased from ₹ 213.80 crore to ₹ 1671.44 crore (7.82 times*)* during 2008-09 to 2012-13, shortage of beds against the requirement increased from 55.39 *per cent* in 2008-09 to approximately 70 *per cent* in 2012-13.

ESIC stated (May 2014) that the above calculation was not based on factual norms. The demand for new hospitals was promptly considered and approved depending on the hospitals' qualifying the eligibility criteria for opening of new hospital and actual workload.Further, many new hospitals were approved and were at various stages of completion.

The reply of ESIC is not acceptable as the shortage had been calculated based on the figures of beds required and available as given in Financial Estimates and Performance Budget for respective years.

4.2.3 Multiple admissions per bed in ESI hospitals

4.2.3.1 Medical safety and care demands that not more than one patient is admitted against one bed. Scrutiny of occupancy register of various wards of ESI hospital at Noida, Uttar Pradesh for year 2012-13 revealed that as number of beds were not sufficient to cater to

the requirement of IPs, there were multiple admissions on one bed resulting in bed occupancy of more than 100 *per cent* during 2012-13.

Table 4.4: Bed occupancy in various wards (2012-13)

Name of ward	Number of beds	Bed occupancy (In *per cent*)
Gynecology Ward	42	155.11
Pediatrics and NIC	42	129.54
Male Medicine Ward	42	157.92
Female Medicine Ward	42	159.32

4.2.3.2 In ESI hospital Okhla also in-patient facilities in various wards were not of desirable standards as two or three patients were being admitted on single bed. During 2012-13, bed occupancy in various wards ranged between 61 to 205 *per cent*. In maternity ward, audit observed multiple cases of fresh delivery on a single bed posing health hazard to the infant and the mother.

Photo 4.1: Maternity ward of ESIC Hospital, Okhla

4.2.3.3 Similar situation was also noticed in ESI hospital Joka, West Bengal as shown in pictures.

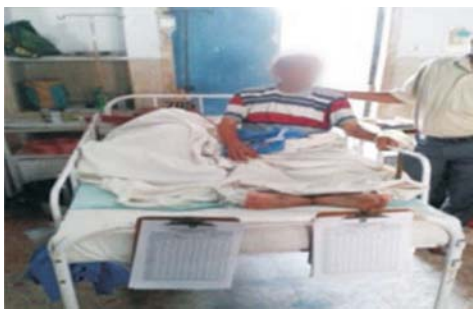


Photo 4.2 and 4.3: ESI Hospital, Joka, West Bengal

ESIC stated (May 2014) that as the growth of industrial development in Noida, Uttar Pradesh was very fast, number of beds fell short of requirement. The feasibility of enhancing the bed strength/setting up of new hospital was being examined.

4.2.4 Deficiencies in functioning of dispensaries

ESIC provides medical care to its IPs through a network of ESI hospitals, ESI dispensaries, panel clinics and diagnostic centres. Medical care is largely administered through the respective state governments except in Delhi and Noida and model hospitals in states which are run directly by the ESIC.

Audit observed various deficiencies in infrastructural facilities in dispensaries as given in **Table 4.5**:-

Table 4.5: Deficiencies in dispensaries

Name of the State/ UT	Name of Dispensary	Area of concern
Chandigarh	Sector 23	Inadequate space
Chandigarh	Sector 29	Non-availability of x-ray facility for dental patients.
Rajasthan	Udaipur	The dispensary building was in poor condition with defective electric wires.
Rajasthan	Banswara	The dispensary building was in poor condition with broken boundary wall, doors and windows.
Rajasthan	Bhilwara	The dispensary building was in poor condition with problems in electrical wiring. As a result computers were not operational.
Rajasthan	Madri	The dispensary building was in poor condition with electrical problems, etc.

ESIC stated (May 2014) that the respective state governments were being constantly pursued to improve primary medical care in their states.

4.2.5 Deficiencies in the functioning of ESIC Hospital, Noida

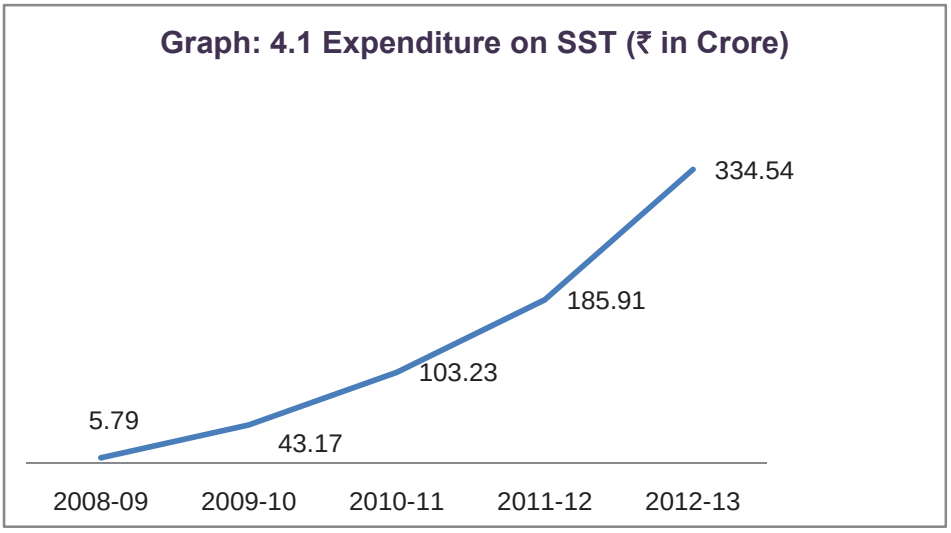
Although the 300 bed hospital at NOIDA was working since May 2011, two Incentive Care Units (ICUs) and one Critical Care Unit (CCU) were not operational in the hospital as of March 2013. As a result 216 equipment such as ICU ventilators, Patient Controlled Analgesia (PCA) pumps, etc. worth ₹ 8.16 crore purchased for ICUs/CCU between April and September 2011 were not utilized. Out of 216 equipment, 120 equipment were transferred to other ESIC hospitals[17]. The hospital authorities stated (October 2013) that ICUs/CCU could not be made operational due to shortage of staff in the hospital and the CCU was now being used for casualty services temporarily.

ESIC stated (May 2014) that the hospital authorities were in the process of establishing ICU.

4.2.6 Increase in expenditure on referral cases for non-availability of super speciality treatment (SST)

ESIC issued guidelines (July 2008) for referring its IPs for getting super speciality treatment by tying up with reputed government/semi government/private hospitals/institutions which provide cashless and hassle free treatment to IPs and their dependents. The services to be covered under SST were cardiology and cardiothoracic vascular surgery, neurology and neurology surgery, pediatric surgery, oncology and oncology surgery, urology and urology surgery, gastroenterology, endocrinology, burns and plastic surgery, reconstruction surgery and any treatment rendered to the patients by a super specialist. Audit observed that the expenditure on the super speciality treatment from empanelled hospitals had been consistently increasing over the years. The position of expenditure on SST in nine states test checked (details in **Annex-VI)** is given in **Graph 4.1**:-

[17] ESIC Hospital, Basaidarapur, ESIC Hospital, Rohini, New Delhi and ESIC Hospital, Ludhiana, Punjab



As would be seen, the expenditure on referral cases on SST had increased from ₹ 5.79 crore in 2008-09 to ₹ 334.54 crore in 2012-13 (about 57 times).

Such substantial increase in referral expenditure could be because of non-availability of SST services with ESIC hospitals or lack of confidence in medical services being provided by ESIC. For example, as against sanctioned strength of 21 cardiologists and 17 neurologists, the ESIC had only two cardiologists and one neurologist across the country.

ESIC replied (May 2014) that steps were being initiated to make SST more effective and efficient. Possibility to provide SST through in house facility or PPP model would also be examined.

4.2.7 References of IPs in spite of existence of Dental College

Although ESIC Dental College, Rohini was established in March 2010, it was observed that three ESIC hospitals at Okhla, Noida and Jhilmil were referring their patients for dental treatments like removal of denture, capping of teeth, bridge work, etc., to empanelled private dental clinics. The details of IPs referred and expenditure incurred on these referral cases during 2010-11 to 2012-13 are given in **Table 4.6**:-

Table 4.6: Dental Cases referred and expenditure incurred by three hospitals

(₹ in lakh)

Name of Hospital	2010-11		2011-12		2012-13	
	No. of cases	Expenditure	No. of cases	Expenditure	No. of cases	Expenditure
ESI Hospital, Okhla	689	8.01	949	10.34	663	7.71
ESI Hospital, Noida	292	4.50	353	7.26	318	9.03
ESI Hospital, Jhilmil	179	9.39	540	13.07	707	17.42
Total	**1160**	**21.90**	**1842**	**30.67**	**1688**	**34.16**

The practice of referring its IPs to empanelled private dental clinics was imprudent given the fact that ESIC's Rohini Dental Hospital had such facilities.

ESIC stated (May 2014), that instructions had been issued to all the hospitals in Delhi that they should refer all the dental patients to Dental College, Rohini as far as possible.

4.2.8 Referral cases because of non-availability of CT Scan and MRI facility in three ESI Hospitals (Delhi/Noida)

'Norms and standards of Staff and Equipment for ESI Hospital and Dispensaries', provides for CT Scan and MRI facility in a 250 or 500 bed hospital. Audit observed that the ESI hospital, Jhilmil (300 beds) and ESI hospital, Noida, (300 beds) did not have these facilities and patients were being referred to ESIC approved empanelled diagnostic centers for these services. Details of patients referred for CT scan and MRI during 2011-12 and 2012-13 are detailed in **Table 4.7**:-

Table 4.7: Details of referral cases

(₹ in lakh)

Name of Hospital	Year	CT Scan		MRI	
		Number of IPs referred	Expenditure	Number of IPs referred	Expenditure
ESI Hospital, Jhilmil	2011-12	2053	46.63	1778	43.84
	2012-13	2802	66.71	4542	61.17
ESI Hospital, Noida	2011-12	1257	33.47	1706	47.75
	2012-13	4005	100.93	1166	31.05
Total		**10117**	**247.74**	**9192**	**183.81**

Hence as these hospitals did not have these facilities which were required as per norms, a significant number of cases were being referred with attendant expenditure. This expenditure of ₹ 4.32 crore could have been avoided if these hospitals had got these facilities installed.

ESIC stated (May 2014) that specific cases of disproportionate increase of referral were being looked into.

4.2.9 Equipment lying idle

Medical Superintendent of the hospital is responsible for making purchases and timely installation of procured equipment. Audit observed that 142 medical equipment worth ₹ 9.43 crore (cost of nine equipment was not available) were lying idle in various hospitals/dispensaries as on March 2013 (details in **Annex-VII)**. As a result, the medical benefit/ care from these equipment could not be derived by IPs and significant expenditure incurred on these equipment was rendered unfruitful.

It was also observed that 156 equipment in ESI hospital Joka, West Bengal (**Annex-VIII**) were installed after delays ranging from 92 to 876 days.

ESIC replied (May 2014) that audit observation has been noted for expeditious follow up.

4.3 Procurement of medicines and surgical items

Procurement of medicines and surgical items are normally done through rate contracts, while medicines/surgical items which are not covered under rate contract or are covered under rate contract but are not available, can be purchased locally from the empanelled chemists. Rate contracts for medicines are concluded by ESIC for all States centrally, and for surgical items these are done by Directorate (Medical) Delhi i.e. DMD (for Delhi and NCR) and by Senior State Medical Commissioners (SSMC) in respective states. DMD also empanels local chemists for purchase of medicines in Delhi/NCR, while for states, SSMC are responsible for the empanelment of local chemists. Normally rates of medicines and surgical items are higher when procured under local purchase as compared to those under rate contract.

4.3.1 Local purchase of medicines

Data of 19 hospitals and four dispensaries test checked indicated that the expenditure on local purchase in these cases increased from ₹ 6.15 crore (during 2008-09) to ₹ 16.61 crore (during 2012-13) i.e. by 169.89 *per cent.* Unit wise details of local purchases are given in **Annex-IX.** Large increase in quantum of medicines purchased locally bypassing the rate contract procedure was financially imprudent, besides indicating weaknesses in its contracting process. These are discussed as under:

4.3.2 Excess payment on procurement of Drugs and Dressing

ESIC entered into rate contracts for the supply of three items viz. bandage cloth, gauze than and cotton roll throughout India, with nine firms from 17 December 2009 to 16 December 2011 (extended to April 2012) and subsequent rate contracts were valid from 11 April 2012 to 30 April 2014.

Audit observed that ESIC hospitals at Rohini, Jhilmil and Noida had purchased only 24.16 *per cent* (bandage cloth), 28.16 *per cent* (gauze than) and 13.47 *per cent* (cotton roll) of the total purchase made for 2011-12 and 2012-13 under rate contract and procured remaining

stocks of these items from empanelled local chemists. The rates of local purchases were higher by 108.28 to 443.65 *per cent* for these three items as compared to the rates of rate contract. Procurement at higher rates resulted in avoidable payment of ₹ 44.77 lakh on these dressing items.

Similarly, ESIC hospitals incurred extra expenditure of ₹ 1.80 crore on purchase of medicines from local chemists despite existence of rate contract as below:-

Table: 4.8: Details of extra expenditure on medicines

Sl. No.	Name of Hospital	Amount of extra expenditure (₹ in lakh)	Period of purchase
1.	ESIC Hospital Noida	104.99	2011-12 and 2012-13
2.	ESIC Hospital Jhilmil, Delhi	26.77	2011-12 and 2012-13
3.	ESIC Hospital Joka, West Bengal	10.59	2008-09 to 2012-13
4.	ESIC Hospital Naccha Ram, Hyderabad	18.06	2008-09 to 2012-13
5.	ESIC Hospital Beltole, Assam	15.24	2011-12 and 2012-13
6.	ESIC Hospital Ezhukone, Kerala	4.19	2010-11 to 2012-13
	Total	**179.84**	

Thus, the hospitals incurred extra expenditure of ₹ 2.25 crore on purchase of medicines and dressing material which could have been procured through rate contracts.

ESIC replied (May 2014) that the prices increased significantly in a short span of time due to which suppliers failed to supply the medicines on the existing rates. In such cases, the local purchases were made from approved local chemist.

The reply is not acceptable as the suppliers were bound to supply the medicines in accordance with the terms of rate contract till their validity. In case of non-supply, the extra expenditure involved in procuring supplies from elsewhere was liable to be recovered from the supplier. However, no such recovery of extra expenditure was found on records, which indicates that the provisions of the rate contract were not being enforced.

Recommendation: ESIC may procure its medicines through rate contracts to effect economy and minimize procurement through local purchase.

ESIC stated (May 2014) that constant efforts were being made to maintain the local purchase to minimum and orders had been issued in this regard.

4.3.3 Purchase of same surgical item at different rates by ESI hospitals

Test check of stock register of surgical items at ESIC hospital, Jhilmil for the period 2012-13 revealed that during the same period ESIC Jhilmil had purchased the following items either by conducting limited tender enquiry or through direct purchase from local chemist. The rates were much lower than the rates at which purchases were being made by the ESIC hospital, Noida. The comparative rates of Jhilmil and Noida hospitals for various items are as below:-

Table 4.9: Difference in rates in two hospitals

Sl. No.	Name of surgical item	Rate of items purchased from Local chemist by ESIC, Noida (₹ per item)	Rate of items purchased from local market by the ESIC Jhilmil (₹ per item)
1.	Oxygen Face Mask (Paed.)	47.50 and 52.50	36.75
2.	I V Canula 20 nos.	35.70	5.53
3.	I V Canula 24 nos.	52.50	15.23
4.	Dynaplast/plastic adhesive bandage	440	429
5.	Ryle's tube 14,16,18	Between 27.20 and 31.20	10.50
6.	I V Canula 22 nos.	35.70	7.49
7.	E.T. tube cuffed 8.5 no.	144.30	73.50

Similarly ESIC hospital, Noida locally purchased the surgical gloves at rates between ₹ 18.62 and ₹ 20.58 plus five *per cent* VAT during the year 2012-13 while the same were purchased at ESIC Jhilmil hospital at a rate of ₹ 10.83 per pair plus five *per cent* VAT.

Coordinated action during procurement process even for local purchase could have resulted in better economy.

ESIC stated (May 2014) that the audit observation had been viewed seriously and necessary action would be taken.

4.3.4 Under-assessment of reorder level

DMD places supply orders for drugs/medicines when the stock reaches below the Re-order Level[18] (ROL). The ROL as per the DMD norms works out as three months stock or 1/4th of the annual recommended quantity. However, the ROL maintained in ESIC was 1/8th of annual quantity i.e. 1.5 months stock during 2012-13. Examination of the Re-Order Level report generated on 25 March 2013 revealed that the lower ROL resulted in medicines being out of stock as under:

1. In case of SET A medicines (Tablets), out of 239 drugs below ROL, 83 were not available in stock with DMD.
2. In case of SET B medicines (Injections), out of 152 drugs below ROL, 75 were not available in stock with DMD.
3. In case of SET C medicines (Syrups), out of 68 drugs below the ROL, 14 were not available in stock with DMD.
4. In the cases of 39 drugs, orders placed on three or more than three occasions were pending with pendency ranging from two to 36 months.

DMD while admitting the fact that the ROL was maintained at a lower level due to the space constraint, increased the ROL to the level of 1/6th i.e. two months with effect from April 2013.

[18] Re-order level = Daily average usage x Lead time in days + Safety stock, Daily average usage = Total annual quantity recommended /365 days, Lead time = six weeks or 42 days (As per terms and conditions of DG, ESIC rate contract) and Safety stock = five weeks extension time + one week processing time = six weeks (if the item is under extension /stock out position.

ESIC stated (May 2014) that attempts were being made to maintain the ROL to 1/4th of the total annual requirement by pooling space in DMD and other hospitals in NCR.

4.3.5 Non-compliance of Policy for shelf life

As per the instructions on quality control of drugs issued (August 1999) by Directorate Medical Delhi (DMD), drugs which had passed their one sixth of shelf life should not be accepted. Audit observed that medicines worth ₹ 2.34 crore were purchased in four locations i.e. Directorate (Medical) Delhi, ESIC model hospital, Rourkela, Odisha, ESIC hospital, Nacharam, Andhra Pradesh and ESIC hospital, Joka, West Bengal, and in all these cases the required shelf life had lapsed leading to non compliance of policy regarding shelf life of medicines.

ESIC stated (May 2014) that instructions for shelf life were being followed at DMD. The reply was not tenable as the DMD itself purchased medicines of ₹ 2.14 crore during 2009-10 to 2012-13 wherein one sixth shelf life was over before delivery.

4.3.6 Inefficient Medicine Testing Procedure

As per instruction (no. 4) contained in the rate contract for procurement of drugs and dressings, sample testing of drugs supplied would be conducted through government/government approved labs and no medicine would be distributed before receipt of test report. Audit observed that in 76 cases in four states[19], medicines were distributed by the hospitals/dispensaries before receipt of test report. The test reports received from labs after a delay of 40 days to 296 days, confirmed that the medicines were of sub-standard quality. Further, in ESIC hospital, Chennai, samples of injections, ointments, syrups were not sent for testing during 2008-09 to 2012-13.

The failure of hospitals in securing compliance with the required provisions led to supply of sub standard drugs to IPs posing serious health hazard.

[19] Gujarat, Karnataka, Kerala, West Bengal

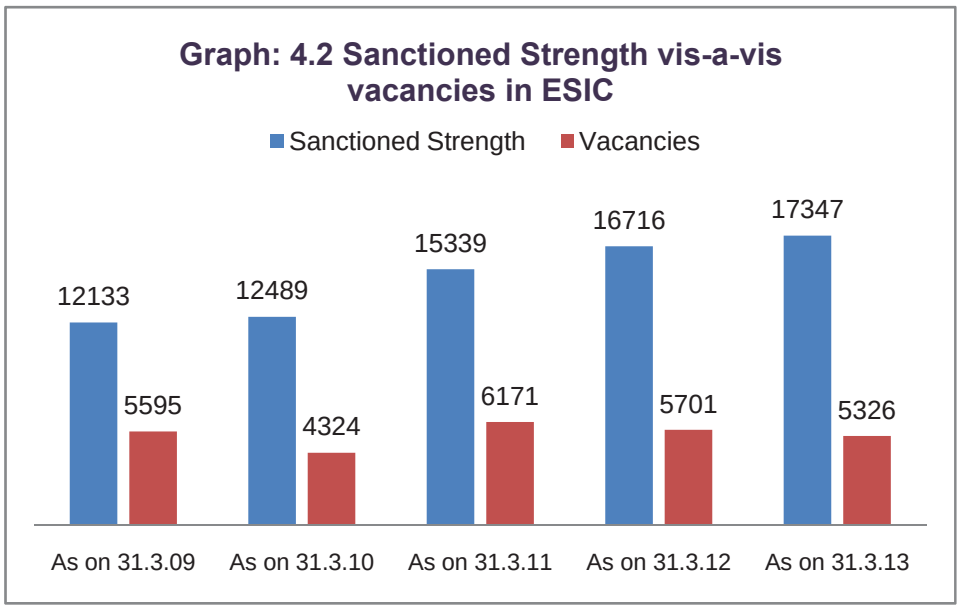
ESIC stated (May 2014) that the Chennai Industrial Laboratory refused to carry out the testing of injections and syrups. It also stated that matter had been taken up with the Director of Drug Controller, Tamil Nadu.

4.4 Human Resource Management

As ESIC provides service to IPs, sufficiency and quality of human resources is important for its service delivery. In this regard, audit observations are as under:

4.4.1 Shortage of staff

Analysis of the data relating to the availability of staff revealed that the services of ESIC were adversely affected with large number of vacancies (Ministerial staff, Medical staff) in all cadres throughout audit period i.e. from 2008-09 to 2012-13. Overall position of the vacancies across the ESIC vis-à-vis sanctioned strength is given in **Graph 4.2**:



The vacancy status of medical personnel, as of 31st March 2013 is detailed in Table 4.10:-

Table 4.10: Sanctioned post and men-in-position for medical posts

Post	Sanctioned	Men-in-position	Vacant (*per cent* of the sanctioned)
Specialists	824	489	335 (41)
GDMO[20]	1859	1445	414 (22)
Medical Officers (Ayurveda, Dental, Homeopathy)	101	82	19 (19)

Source: Reply to parliamentary question 463 dated 5/08/2013

Thus, the ESIC run hospitals were facing significant shortage of doctors. The shortage of 41 *per cent* of the specialists had an adverse impact on the specialists' services of the ESIC hospitals, leading to an increase in the quantum of referral cases.

ESIC stated (May 2014) that Recruitment Regulations were under revision in consultation with the Ministry and the recruitment would be undertaken thereafter.

4.4.2 Non retention of trained PG students

ESIC decided (2009-10) to establish a Post Graduate Institute of Medical Science and Research (PGIMSR) at Rajajinagar, Bangalore in the same premises where the 500 bed model hospital was already operational.

As per conditions stipulated in bond filled by the students before admission, students after completing PG courses should serve in the ESI hospitals for a period of five years and execute a bond for ₹ 7.5 lakh with interest @15 *per cent* per annum in case of violation of the above terms. Audit found that only two out of ten students who became Post Graduates during 2012-13 were serving in the ESI hospitals. Thus, ESIC could not utilize the services of its PG students despite taking service bond of five years.

ESIC replied (May 2014) that issues related to bond and its enforcement were being reviewed.

[20] General Duty Medical Officer