20

MINISTRY OF DEFENCE
(DEPARTMENT OF EX-SERVICEMEN WELFARE)

EX-SERVICEMEN CONTRIBUTORY HEALTH SCHEME

COMMITTEE ON ESTIMATES
(2016-2017)

TWENTIETH REPORT

(SIXTEENTH LOK SABHA)

LOK SABHA SECRETARIAT
NEW DELHI

TWENTIETH REPORT

COMMITTEE ON ESTIMATES
(2016-2017)

(SIXTEENTH LOK SABHA)

MINISTRY OF DEFENCE
(DEPARTMENT OF EX-SERVICEMEN WELFARE)

EX-SERVICEMEN CONTRIBUTORY HEALTH SCHEME

Presented to Lok Sabha on 9 December, 2016

_____

LOK SABHA SECRETARIAT
NEW DELHI

December, 2016/ Agrahayana, 1938(S)

EC No. ____

Price ₹ ____

Published under Rule 382 of the Rules of Procedure and Conduct of Business in Lok Sabha (Eleventh Edition) and Printed by the Manager, Government of India Press, Minto Road, New Delhi.

CONTENTS

COMPOSITION OF THE SUB-COMMITTEE ON DEFENCE OF THE COMMITTEE ON ESTIMATES (2015-16)

COMPOSITION OF THE COMMITTEE ON ESTIMATES (2016-17)

INTRODUCTION

ACRONYMS

PART - I

CHAPTER I **Introductory**
Structure of ECHS
Organization Chart of Central Organization ECHS
Command and Control set up of ECHS
Organization Chart of Regional Centre ECHS
List of Regional ECHS Centres
Types of ECHS Polyclinics
Membership
Contribution
ECHS Coverage
Financial Outlay

CHAPTER II **Performance and Evaluation**
Geographical Extent of ECHS
Present Status of Empanelment
Withdrawal of hospitals from empanelment under ECHS
Provision of online Billing and Claim Settlement
Referral Procedure for going to empanelled hospitals
Lack of Infrastructure and Excess Dependency on Empanelled hospitals
Deficiencies in working of empanelled hospitals
Provision of Smart Cards for Beneficiaries
Unaccounted Smart Cards
Irregularities in renewal of the agreement for supply of smart cards
Procurement and Supply of Medicine and Medical equipment
Shortage of Medical Staff, Paramedical Staff and Non-Medical Staff in Posts filled on Contractual Basis
Shortage of Medical Staff, Paramedical Staff and Non-Medical Staff in Posts reserved for Ex-servicemen
Armed Forces Medical College
Grievance Redressal Mechanism
Nature of Complaints being received

CHAPTER III **Other Issues and Constraints**
Acquisition of Land for Polyclinics
Efficacy of Policy Framework Governing ECHS
Dissatisfaction amongst ESM over treatment meted out & services provided under ECHS
Preparedness in wake of high incremental increase in number of beneficiaries under ECHS
ECHS Medical Store Supply Chain Management
Proposed Measures for Improvement of Supply Chain

Quality Council of India (QCI)
Fixed Medical Allowance
Non-Development of Audit Module for Post Audit in ECHS

PART - II

Observations and Recommendations

APPENDICES

I	State-wise List of ECHS Polyclinics
II	Time-frame for Procurement (Under single and Two-bid system)
III	Procedure for Payment and reimbursement of Medical expenses under ECHS
IV	Procedure for procurement of land in non-military for ECHS
V	List of 191 ECHS Polyclinics centre land is get to acquire
VI	Unit-wise total allotment: ECHS fund
VII	Funds state of last three years

ANNEXURES

I	Minutes of the Sitting of the Sub-Committee on Defence of the Committee on Estimates (2015-16) held on 11.09.2015
II	Minutes of the Sitting of the Committee on Estimates (2016-17) held on 09.12.2016

COMPOSITON OF THE SUB-COMMITEE ON DEFENCE OF THE COMMITTEE ON ESTIMATES (2015-16)

1.	Shri Kalikesh Narayan Singh Deo	Convenor
2.	Dr. Sanjay Jaiswal	Co-Convenor
3.	Shri J.C. Divakar Reddy	
4.	Shri Ram Tahal Choudhary	
5.	Col. Sonaram Choudhary	
6.	Shri Sultan Ahmed	
7.	Shri Vinod Khanna	
8.	Shri Ashwini Kumar Choubey	
9.	Shri P. Kumar	
10.	Shri Anil Shirole	

COMPOSITION OF THE COMMITTEE ON ESTIMATES (2016-17)

Dr. Murli Manohar Joshi – Chairperson

Members

2. Shri Sultan Ahmed
3. Shri A. Arunmozhithevan
4. Shri George Baker
5. Shri Kalyan Banerjee
6. Shri Dushyant Chautala
7. Shri Ashok Shankarrao Chavan
8. Shri Ashwini Kumar Choubey
9. Shri Ram Tahal Choudhary
10. Col. Sonaram Choudhary
11. Shri Ramen Deka
12. Shri Sanjay Dhotre
13. Shri P.C. Gaddigoudar
14. Shri Sudheer Gupta
15. Smt. Kavitha Kalvakuntla
16. Shri P. Kumar
17. Smt. Poonam Mahajan
18. Shri K.H. Muniyappa
19. Shri Rajesh Pandey
20. Shri Ravindra Kumar Pandey
21. Shri Raosaheb Danve Patil
22 Shri Bhagirath Prasad*
23. Shri Konakalla Narayan Rao
24. Md. Salim
25. Shri Arvind Ganpat Sawant
26. Shri Jugal Kishore Sharma
27. Shri Gajendra Singh Shekhawat
28. Shri Anil Shirole
29. Shri Rajesh Verma
30. Shri Jai Prakash Narayan Yadav

---

*Elected *vide* Lok Sabha Bulletin Part-II No. 3908 dated 28.07.2016 vice Shri Arjun Ram Meghwal appointed as Minister.

SECRETARIAT

1.	Shri Devender Singh	-	Additional Secretary
2.	Shri Vipin Kumar	-	Director
3.	Shri Srinivasulu Gunda	-	Additional Director
4.	Smt. Savdha Kalia	-	Committee Officer
5.	Shri L. Shantikumar Singh	-	Committee Assistant

INTRODUCTION

I, the Chairperson of the Committee on Estimates (2016-17) having been authorized by the Committee to present the Report on their behalf, do present this Twentieth Report on 'Ex-Servicemen Contributory Health Scheme' pertaining to the Ministry of Defence (Department of Ex-Servicemen Welfare).

2. The Committee on Estimates (2015-16) selected the subject 'Ex-Servicemen Contributory Health Scheme', a flagship scheme of the Ministry of Defence (Department of Ex-Servicemen Welfare) for detailed examination. The scheme aims at providing quality medicare to ex-servicemen pensioners and their dependents through a network of ECHS polyclinics, Armed Forces medical facilities and Private empanelled/Government hospitals spread across the country. The Sub-Committee on Defence of the Committee on Estimates (2015-16) took oral evidence of the representatives of the Ministry of Defence (Department of Ex-Servicemen Welfare) on 11 September, 2015.

3. The Report on the subject was considered and adopted by the Committee at their sitting held on 07 December, 2016.

4. The Committee wish to express their thanks to the representatives of the Ministry of Defence (Department of Ex-Servicemen Welfare), who appeared before them and placed their considered views on the subject. The Committee also wish to thank them for furnishing the information required in connection with the examination of the subject.

NEW DELHI;
07 December, 2016
Agrahayana 16, 1938 (Saka)

Dr. MURLI MANOHAR JOSHI,
CHAIRPERSON,
COMMITTEE ON ESTIMATES.

ACRONYMS

AFMSD	Armed Forces Medical Services Stores Depot
ALC	Authorized Local Chemist
DGAFMS	Director General of Armed Forces Medical Services
MMF	Monthly Maintenance Figure
ECHS	Ex-servicemen Contributory Health Scheme
ESM	Ex-servicemen
SEMO	Senior Executive Medical Officer
DESW	Department of Ex-servicemen Welfare
PCDA	Principal Controller of Defence Account
CDA	Controller of Defence Account
JCDA	Joint Controller of Defence Account
QCA	Quality Council of India
NABH	National Accreditation Board of Hospitals and Healthcare Providers
MoA	Memorandum of Agreement
MoD	Ministry of Defence
CFA	Competent Financial Authority
UTI-ITSL	UTI Infrastructure Technology and Services Limited
GoI	Government of India
EIR	Emergency Information Report
CAG	Comptroller and Auditor General of India
BPA	Bill Payment Agency
AG	Adjutant General
DPM	Defence Procurement Manual
EDL	Essential Drug List
CDL	Common Drug List
DDO	Direct Demanding Officers
DFPDS	Delegation of Financial Powers to Defence Service
IDS	Integrated Defence Staff
SOC	Statement of Case
NIV	National Institute of Virology
LP	Local Purchase
OPD	Out Patient Department
CPAP	Continuous Positive Airway Pressure
BiPaP	Bilevel Positive Airway Pressure
AFVs	Armed Forces Veterans
GOC	General Officer Commanding
SSC	Short Service Commission
TDLR	Training, Deputation and Leave Report Reserve
ENT	Ear, Nose and Throat
DNB	Diploma of National Board
MBBS	Bachelor of Medicine and Bachelor of Surgery
CPGRAMS	Centralized Public Grievance Redressal and Monitoring System
PCDA	Principal Controller of Defence Accounts
CGDA	Controller General of Defence Accounts
DEO	Defence Estate Officer
KSB	Kendriya Sainik Board
ICU	Intensive Care Unit
SFF	Special Frontier Force
NDG	Nepal Domiciled Gorkhas
DGFP	Directorate General of Family Planning
FMA	Fixed Medical Allowance
JCO	Junior Commissioned Officer
MoH&FW	Ministry of Health and Family Welfare

PART I

INTRODUCTORY

The Ex-servicemen Contributory Health Scheme (ECHS) which is a flagship scheme of the Department of Ex-servicemen Welfare, Ministry of Defence was launched on 1st April 2003. The Scheme aims at providing quality medicare to Ex-servicemen pensioners and their dependents through a network of ECHS Polyclinics, Armed Forces medical facilities and private empanelled/ government hospitals spread across the Country. It has been structured on the lines of the Central Government Health Scheme (CGHS) and endeavours to provide cashless treatment to its beneficiaries. At present, only allopathic treatment is provided under ECHS. The Scheme is financed by the Government through the budget under Defence Estimates.

1.2 Policy framework for the Scheme is laid down by the Government and executive control is exercised by the Secretary, Department of Ex-servicemen Welfare (DESW), Ministry of Defence. The Scheme is managed through the existing infrastructure of the Armed Forces to minimize administrative expenditure. This includes Static Headquarters of the three Services, spare capacity of the Armed Forces medical facilities, central procurement agencies of the Services, Defence land and buildings etc. Station Commanders assisted by the affiliated Senior Executive Medical Officer (SEMO) exercise functional control over the ECHS Polyclinics.

Structure of ECHS

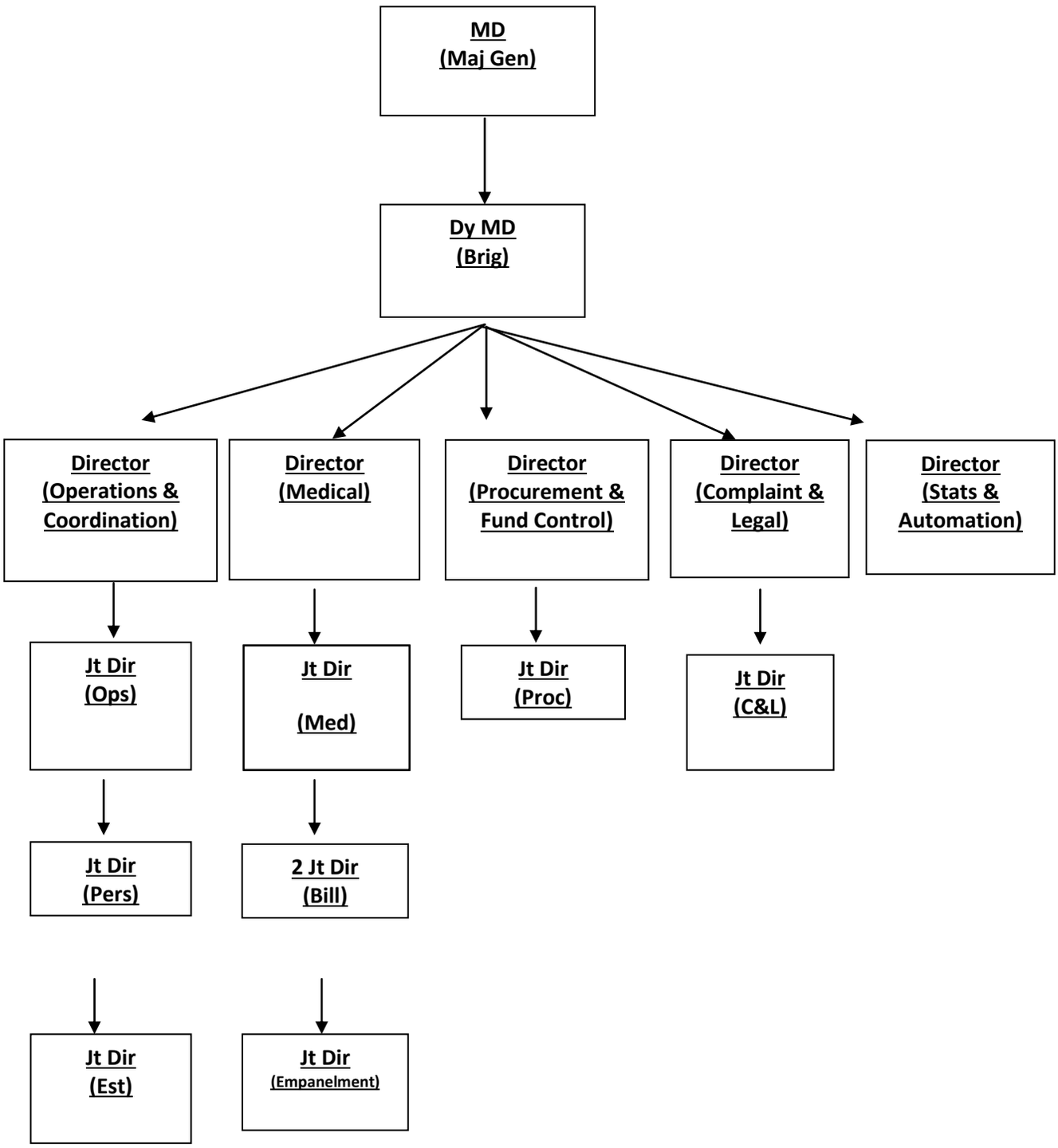
1.3 ECHS has a three-tier structure. A central body (Central Organisation) at the apex, regional bodies (Regional Centres) at the middle level and Polyclinics at the functional level. At present, Central Organisation, ECHS is headed by a serving Major General and Regional Centres by a Colonel. The Central Organisation ECHS is located at Delhi and functions under the Chiefs of Staff Committee through Adjutant General in the Integrated Headquarters of Ministry of Defence (Army).

1.4 At the regional level, there are 28 Regional Centres sanctioned across the Country. Each Regional Centre on an average has about 15 to 17 Polyclinics under it.

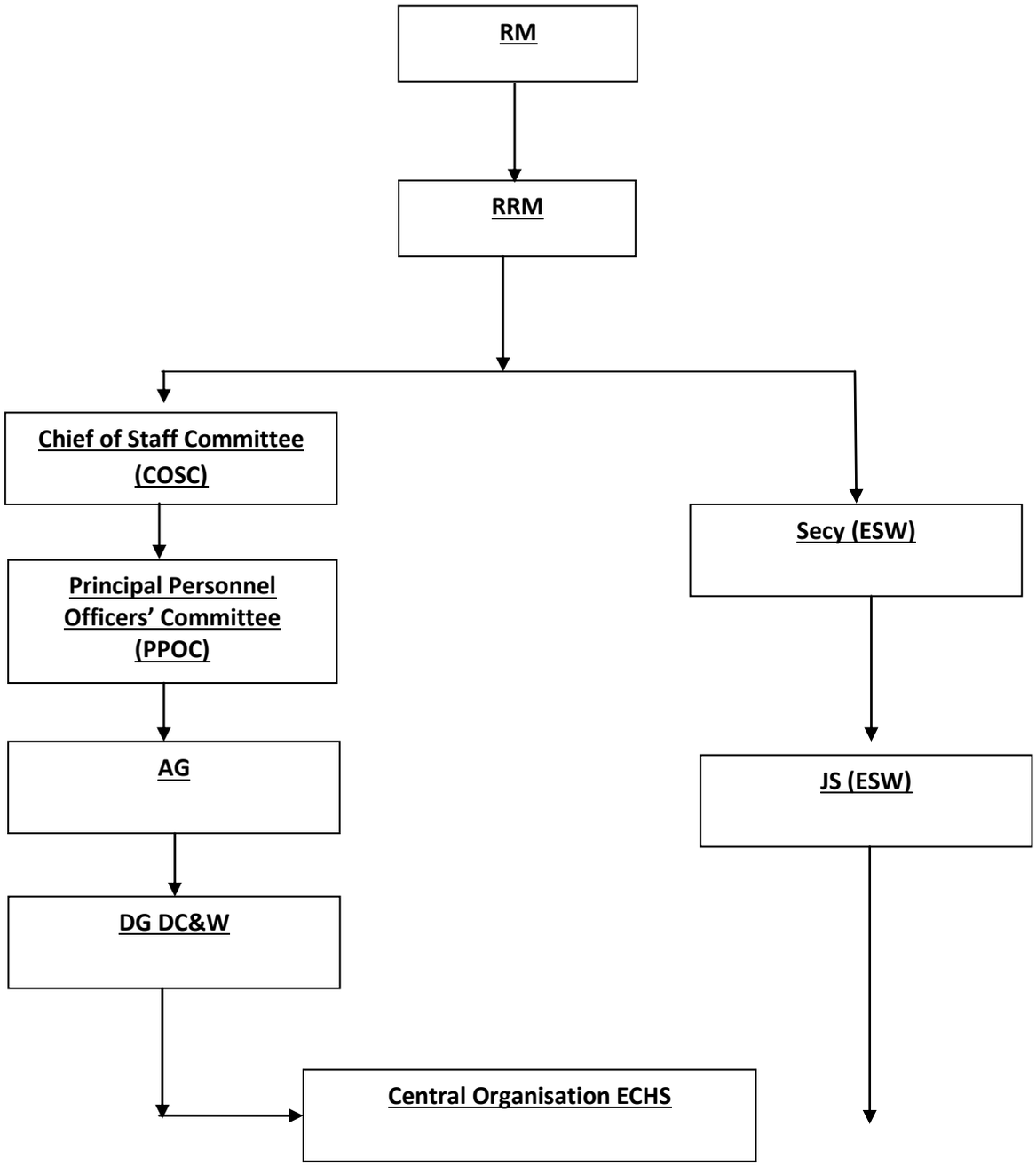
Regional Centres are responsible for overseeing the functioning of ECHS Polyclinics under their respective areas of jurisdiction.

1.5 ECHS Polyclinic is the nerve centre of the ECHS. It is structured to provide 'Out Patient Care' to include consultation with Doctors, essential investigations (Pathology, X-Ray, ECG etc), dental treatment and dispense medicines. The entire staff at ECHS Polyclinic is employed on contractual basis. Upto 60 percent posts of Doctors and 70 percent posts of Para-Medical/ Non-Medical staff are reserved for Ex-servicemen. The detailed Organisational structure of the Central Organisation, Regional Centres and ECHS Polyclinics is attached as follows:-

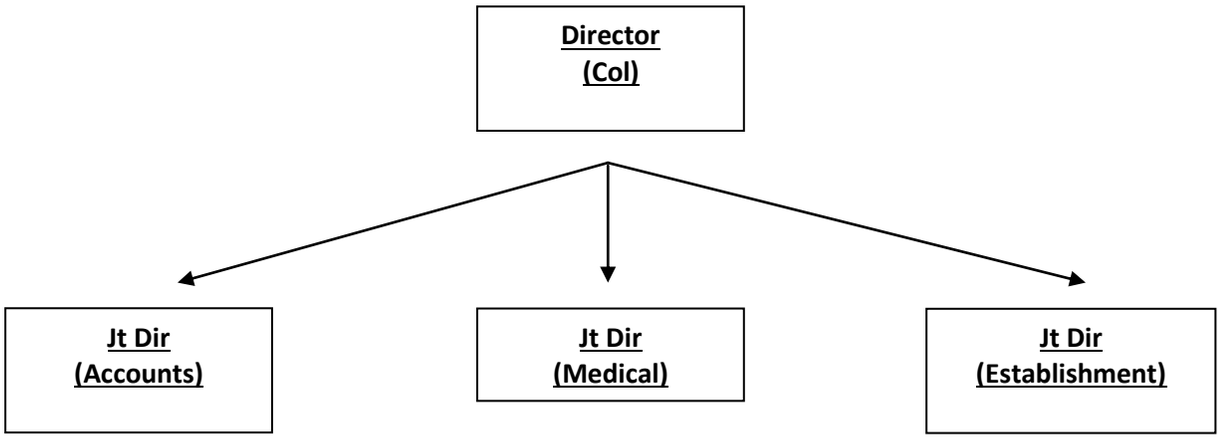
(a) **Organisation Chart of Central Organisation ECHS**



(b) Command and Control set up of ECHS



(c) Organisation Chart of Regional Centre ECHS



1.6 There are 28 Regional Centres in the country (as of September, 2015)

List of Regional ECHS Centres

Ser No	Regional Centre	Ser No	Regional Centre	Ser No	Regional Centre
1.	Delhi	11.	Patna	21.	Ahmedabad
2.	Chandimandir	12.	Guwahati	22.	Bagalore
3.	Pune	13.	Jammu	23.	Nagpur
4.	Chennai	14.	Jaipur	24.	Coimbatore
5.	Lucknow	15.	Hyderabad	25.	Ambala
6.	Kolkata	16.	Kochi	26.	Allahabad
7.	Jabalpur	17.	Trivandrum	27.	Jalandhar
8.	Ranchi	18.	Hisar	28.	Bareilly
9.	Dehradun	19.	Mumbai		
10.	Delhi (II)	20.	Vizag		

1.7 The authorization of Manpower in Polyclinic is as under:

Sl. No	Contractual Posts	Type of Polyclinic					Total
		A	B	C	D	E	
1.	Medical Officer	6	3	2	2	1	953
2.	Medical Specialist	2	2	1	-	-	200
3.	Dental Officer	2	2	1	1	-	470
4.	Gynaecologist	1	1	-	-	-	61
5.	Radiologist	1	1	-	-	-	61
6.	Officer-in-Charge	1	1	1	1	-	409
7.	Radiographer	1	1	-	-	-	61
8.	Lab Technician	1	1	1	1	-	409

9.	Lab Assistant	1	1	1	1	-	409
10.	Physiotherapist	1	1	1	-	-	139
11.	Pharmacist	1	1	1	1	-	409
12.	Nursing Asst	3	3	2	1	1	626
13.	Dental Asst/ Tech/ Hygienist	2	2	1	1	-	470
14.	Driver	2	2	1	1	1	487
15.	Chowkidar	1	1	1	1	-	409
16.	Female Attendant	1	1	1	1	-	409
17.	Peon	1	1	1	1	-	409
18.	Safaiwala	1	1	1	1	-	409
	Total	**29**	**26**	**17**	**14**	**3**	**6800**

1.8 The State wise list of ECHS Polyclinics is given at **Appendix - I**.

Types of ECHS Polyclinics

1.9 Polyclinics are categorized as either Military or Non-Military, depending on whether a Military hospital is co-located or not and are further categorized into five types, i.e. Type A to E, based on the number of Ex-servicemen residing in that area. They are:-

S. No.	Types of polyclinic	Ex-servicemen
(i)	Type A	Above 20,000
(ii)	Type B	Above 10,000
(iii)	Type C	Above 5,000
(iv)	Type D	Above 2,500
(v)	Type E	Less than 2500

1.10 Specialized treatment for serious cases (beyond the facilities available at the Polyclinics) is provided at Military and empanelled private hospitals (presently 1268 numbers). Rates for treatment at private hospitals are as per CGHS rates. In case of emergency, members are permitted to avail medical treatment at non-empanelled hospital on payment. Their medical treatment bills are reimbursed at approved (CGHS) rates.

Membership

1.11 All Ex-servicemen pensioners, including those in receipt of Disability / Family Pension and their dependents (as applicable under CGHS) are eligible for membership of ECHS. ECHS membership has also been extended to the following:-

(a) Territorial Army (TA) pensioners.
(b) Defence Security Corps (DSC) pensioners.
(c) Indian Cost Guard (ICG) pensioners.
(d) Military Nursing Service (MNS) pensioners.
(e) Special Frontier Force (SFF) pensioners.
(f) Nepal Domiciled Gorkha (NDG) pensioners.
(g) Whole time NCC officers.

1.12 Membership of ECHS has been made compulsory for all pensioners with effect from 1st April 2003 and is optional for earlier retirees.

1.13 The beneficiary base of ECHS has grown over the years. Year- wise increase in its membership is as under:-

As on	Members	Beneficiaries	Increase / Decrease
31 Mar 2005	78,999	3,63,261	-
31 Mar 2006	2,60,876	9,82,654	(+) 6,19,393
31 Mar 2007	4,24,823	15,07,412	(+) 5,24,758
31 Mar 2008	6,33,596	21,02,891	(+) 5,95,479
31 Mar 2009	9,51,763	30,21,920	(+) 9,19,029
31 Mar 2010	10,64,225	33,67,410	(+) 3,45,490
31 Mar 2011	11,58,559	36,59,263	(+) 2,91,853
31 Mar 2012	12,41,700	39,73,432	(+) 3,14,169
31 Mar 2013	13,33,984	43,03,846	(+) 3,30,414
31 Mar 2014	14,22,669	46,12,543	(+) 3,08,697
31 Mar 2015	15,08,370	46,86,036	(+) 73,493
30 Apr 2015	15,21,563	47,24,173	(+) 38,137

1.14 The status of ECHS is as under:-

Membership

(i) Ex-servicemen - 15,21,563
(ii) Dependants - 32,02,610
(iii) Total Beneficiaries - 47,24,173 (As on 30.04.2015)

1.15 As per the reply submitted by the Ministry in June, 2015, an exercise was carried out to identify the ineligible dependents. This has led to a reduction of 1,59,491 due to dependants who have become ineligible and beneficiaries who have passed away being removed from the list of beneficiaries. As on 1 January, 2015, a total of 15,21,563 Ex-servicemen are enlisted with the Scheme along with 32,02,610 dependents. The total beneficiaries of the Scheme is 47,24,173.

1.16 However, the average increase in the number of beneficiaries of ECHS at 8,09,634 during 2005-06 to 2008-09 has come down to 3,13,229 during the next four years i.e. 2009-10 to 2012-13. The average has come down further during 2013-14 and 2014-15. The Committee asked the Ministry to furnish the reasons for steep decline in the average increase in the number of beneficiaries during this period. The Ministry of Defence (DESW) in their written replies stated:

> "The reasons for increase in the number of Primary members in 2009 can be attributed to following:-
>
> (i) A closer analysis of the One Lakh additional primary members joining the scheme reveals that, in the year 2009 approx 16,000 Low Medical Category personnel were compulsorily retired, in addition Coast Guard was extended the membership of the scheme thus approx 20,000 additional primary members from Coast Guard were added. The balance 64,000 additional members joining the scheme can be attributed to the backlog of pre-retirees becoming a member, which has contributed to the variations (increase/ decrease).
>
> (ii) The fluctuation in the number of members joining the ECHS scheme is also in line with the recruitment and eventual retirement pattern of the Armed Forces, which is not uniform. There are possibilities of variation in number of persons retiring in a particular year in accordance with the pattern of recruitment"

Contribution

1.17 The amount of contribution paid for becoming ECHS member is same as that of CGHS. Presently, it varies from ₹ 15,000/- for Sepoys to ₹ 60,000/- for Officers. The Ex-servicemen who have retired prior to 1st January 1996, war widows and war disabled (including those disabled in internal security duties) are exempted from payment of ECHS contribution. Rates of contribution presently are as follows:-

Serial	Ranks	Contribution (in ₹)

(a)	Recruit to Havildar	15,000/-
(b)	Naib Subedar	27,000/-
(c)	Subedar to Major	39,000/-
(d)	Lieutenant Colonel and above	60,000/-

ECHS Coverage

1.18 At the time of inception of the Scheme, the Government had sanctioned creation of the Central Organisation, ECHS, 13 Regional Centres and 227 Polyclinics. In October 2010, expansion of ECHS network was approved by authorizing 15 more Regional Centres and 182 additional Polyclinics and 17 mobile clinics, making a total of 426 ECHS Polyclinics. Distribution of the same is as under:-

		Initial	**Additional**	**Total**
(a)	Military	106	06	112
(b)	Non-Military	121	176	297
(c)	Mobile Clinics	-	17	17
	Total	**227**	**199**	**426+6***

* in Nepal

1.19 Type-wise breakup of clinics is as under:-

	Type	**Military**	**Non-Military**	**Total**	**Percentage**
(a)	A	10	09	19	4.5%
(b)	B	17	24	41	9.6%
(c)	C	28	50	78	18.4%
(d)	D	57	214	271	63.6%
(e)	E	17	-	17	3.9%
	Total	**129 (30%)**	**297 (70%)**	**426***	

* Nepal not included

1.20 While furnishing the details of non-operational polyclinics, the category-wise location of these polyclinics is as under:

Location of Polyclinics	**Category of Polyclinics**
Khonsa (Tezu), Arunachal Pradesh	E
Along, Arunachal Pradesh	E
Lunglei, Mizoram	D
East Delhi	B
Nuh, Haryana	D
Shimla, Himachal Pradesh	E

1.21 The position of various types of centres/clinics is as under:

(a) Functional Regional Centres - 28

(b) Functional Polyclinics - 420 (426 sanctioned)+3(Nepal)

(c) Private Empanelled Hospitals - 1268

(d) Land acquired/available for construction of Polyclinic Buildings - 218 locations

(e) Polyclinics Buildings constructed - 140 locations

Further, the Government has sanctioned establishment of ECHS facilities in Nepal in February 2012. Three Polyclinics, along with a mobile clinic each have been sanctioned at Kathmandu, Pokhara and Dharan respectively. These measures will benefit about three lakh Nepal Domiciled Gorkha Ex-servicemen pensioners and their dependents. All the three static ECHS Polyclinics have been operationalised and functional w.e.f. Apr. 2014.

1.22 The year on year progress made in operationalisation of Polyclinics (A to E) is given below:

Type of Polyclinic	**Year wise operational status**							**Status as on date**
	2010	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	
A	18	0	01	0	0	0	0	19
B	38	0	02	0	0	01	0	41
C	70	02	05	0	01	0	0	78
D	101	30	56	42	31	07	01	268
E	0	05	06	03	0	0	0	14
Total	227	37	70	45	32	08	01	420

1.23 Present coverage of the scheme is as follows:-

Districts Covered: A total of 339 districts out of 659 districts in the Country have been covered, i.e. the geographical coverage is presently limited to 51 percent.

Financial Outlay

1.24 Budget is allotted to ECHS through the Army budget. Over the years, since its inception the allotment is as under:-

	Financial Year	**Revenue Allotment (in Crores)**	**Capital Allotment (in Crores)**
(a)	2003-04	13.53	0.00

(b)	2004-05	93.42	17.98
(c)	2005-06	188.12	21.35
(d)	2006-07	324.14	23.20
(e)	2007-08	489.91	8.10
(f)	2008-09	640.14	9.50
(g)	2009-10	889.92	6.40
(h)	2010-11	1061.04	3.60
(i)	2011-12	1225.95	3.00
(j)	2012-13	1450.98	5.43
(k)	2013-14	1789.46	12.45
(l)	2014-15	2260.58	5.11
(m)	2015-16	2639.00	30.00

1.25 Expenditure of ECHS for the last five years is as follows (₹ In crores):-

Expenditure Heads	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**
Capital						
(a) Purchase of land	0.59	0.24	0.85	0.30	0.35	0.0292
(b) Construction of building	4.13	2.20	1.79	1.92	3.87	5.0643* (5.0100)
(c) Purchase of Medical Equipment	1.19	0.37	0.31	0.45	6.48	1.5199* (1.4674)
Total	**5.91**	**2.81**	**2.96**	**2.67**	**10.70**	**6.6139**
Revenue						
(a) Salary	41.49	45.95	49.42	58.85	110.80	135.99
(b) Medicine	307.79	345.16	366.26	385.68	399.67	471.96
(c) Medical Treatment	569.69	657.34	796.83	966.93	1250.77	1604.68
(d) Others	6.49	6.86	11.58	19.32	22.17	23.54
Total	**925.46**	**1055.31**	**1224.09**	**1430.78**	**1783.41**	**2236.17**

* The matter of over booking by PCDA/CDA/JCDA was taken up with CGDA. ₹ 146.74 lakh under code head 907.40 and ₹ 5.43 lakh under code head 907.39.

1.26 Administrative expenditure in ECHS is very low as the Scheme utilizes existing infrastructure of the Services and the medicare delivered at Polyclinic is through 100 percent contractual employees. Expenditure pattern of revenue budget for the last financial year 2014-15 was as follows:-

Expenditure Heads		Sanctioned (in Cr)	Expenditure (in Cr)	Percentage
(a)	Salaries	142.00	135.99	95.76%
(b)	Medicines	487.77	471.96	96.75%
(c)	Medical Treatment	1605.74	1604.68	99.93%
(d)	Miscellaneous	25.07	23.54	93.89%
Total		**2260.58**	**2236.17**	**98.92%**

2. PERFORMANCE AND EVALUATION

Geographical Extent of ECHS

2.1 The Ministry of Defence (Department of Ex-Servicemen Welfare) while elaborating on the geographical coverage of ECHS stated that the Government initially sanctioned 227 Polyclinics in Dec 2002 and thereafter the Scheme was expanded in 2010, wherein 199 additional Polyclinics were sanctioned. This makes a total of 426 ECHS Polyclinics across the Country. Presently out of 659 districts of the Country, 339 districts are covered by ECHS Polyclinics. Out of 426 ECHS Polyclinics 418 are operational and remaining eight Polyclinics will be made functional shortly. It was directed that further expansion of the Scheme will be taken up once the presently sanctioned Polyclinics are operationalized. The opening of new ECHS Polyclinics will be considered based on the population of ESM, availability of Medical, Para Medical Staff and other norms. There may be no increase in the number of Polyclinic in the current year.

2.2 In respect of the 17 mobile clinics approved under ECHS having become operational and the Government's plan to add more mobile clinics, the Committee were informed that at present there is no plan for opening of new mobile polyclinics. The Ministry in its written reply stated:

> "During the expansion of the Scheme in Oct 2010, 17 Type E Mobile clinics were added into the Scheme. Presently out of 17 Type E mobile clinics 14 mobile clinics are functional. Reasons for non-functional status of balance three are due to change of locations of two mobile clinics and procedural delay in employment of staff at remaining one mobile clinic."

2.3 Further, in context of increasing the geographical coverage of the ECHS from its current coverage of 51 percent, the Ministry submitted as under:

> "The permission to enhance and go for expansion after 426 will be given. I have 67 stations readily available with me and I have got the statement ready. When this 67 stations come up, I will reach a figure of 59 per cent instead of 51. To give a little indication, we should see the ethos on which it was built and it was felt that as a planning parameter, we must need to have one polyclinic per district. It may so happen that in a district there will be more than one. For example, in Delhi and NCR, I have a total of 14 polyclinics existing. There could be a place or district where Ex-Servicemen

number is so low that I do not have a polyclinic. But the parameters are available."

2.4 On being asked further about the roadmap for increasing the geographical extent of the ECHS polyclinics, the MoD (DESW) elaborated that the ECHS Polyclinics are set up based on the number of Ex-Servicemen residing in the area. Setting up of new ECHS Polyclinics will be considered on the basis of the number of ESM in the district in the next phase of expansion plan.

2.5 Queried about the insufficiency of the polyclinics in some States and their non-judicious distribution in respect of the geographical coverage, the Ministry testified:

> "It gets decided by the population centres and the demographic requirements of the beneficiaries who are there. I will just give a little brief as to how it is done. The Commands are the ones which decide based on the requirements of the population of ex-servicemen there. What happens is that the clamour is for every location to have a polyclinic. .....Everybody feels; naturally I will also feel the same. But the Command headquarters being the nodal agencies decides – they are actually plotted on the map – to see where it is required. He cannot possibly provide it to all the places. So he looks at a place which is centrally located. For example, as you have rightly said, UP has got the maximum number of polyclinics which is 49 today followed by the other States which you made a mention about Haryana and Rajasthan.....Regarding Kerala also there is a little dichotomy. The size of the State is small in terms of the sq. metres but the density of population is high.....The size of Rajasthan is much bigger and of Haryana is much bigger but the clientele gets distributed that much."

Empanelment of Hospitals with Polyclinics

(a) Present Status of Empanelment

2.6 Empanelment of hospitals for cashless medical treatment is crucial for ECHS as 92 percent of the members are jawans who do not have the financial capacity to pay up-front and seek reimbursement. Presently, out of 418 functional Polyclinics, some of the Polyclinics (71) do not have empanelled hospitals at their location. This is due to civil medical facilities not willing to get empanelled because of low CGHS rates at which their bills are being reimbursed. The total number of Private Empanelled Hospitals under ECHS is 1268.

2.7 While elaborating on the process of empanelment also leading to delay in empanelment in some cases, the Committee were informed that Empanelment of Hospitals is a Continuous Process. It is a purely voluntary application system. Though advertisement and meeting with hospitals are regularly carried out, empanelment cannot take place till the hospitals apply for the same. The stage of empanelment are as follows:-

(i) Submission of application to Regional Centres.

(ii) Applications scrutinized for completeness by Regional Centres.

(iii) Application forwarded to Central Org ECHS.

(iv) Scrutiny for legal requirements at CO ECHS.

(v) Application complete in all respects is forwarded to QCI (Quality Council of India)/NABH (National Accreditation Board for Hospitals and Healthcare Providers) for inspection.

(vi) Inspection by QCI/NABH and submission of report to Central Org ECHS.

(vii) Tabling in Screening Committee of QCI recommended applications and application of 'NABH accredited and CGHS empanelled hospitals'.

(viii) Minutes of Screening Committee meeting forwarded to DESW for issue of Govt letter.

(ix) Forwarding of Govt letter to Regional Centres for signing of MoA.

(x) MoA signed between Regional Centres and hospital and BPA issues login Id for online billing and referral.

2.8 When asked to elaborate whether all established polyclinics are empanelled with the empanelled hospitals, the MoD (DESW) in their reply stated:

> "Presently there are 71 Polyclinics which do not have any empanelled hospitals in their location. Technically no beneficiary is denied treatment as he is permitted to avail medical facility from neighboring district/ nearest hospital empanelled. Empanelment of hospitals for cashless medical treatment is crucial for ECHS as 90 percent of the members are jawans who do not have the financial capacity to pay up front and seek reimbursement. Reasons for non-availability of empanelled facilities are due to non-availability of hospitals who meet the laid down standards for empanelment. Special efforts would be made to cover the uncovered areas while empanelling hospitals with the ECHS Polyclinics."

2.9 In respect to the arrangement made at these 71 polyclinics in cases where patients need to be referred to hospital both in general and emergency cases, the MoD (DESW) submitted:

> "Though these 71 Polyclinics do not have an empanelled hospital in their districts/town/village, all the empanelled hospitals of the Regional Centre are empanelled with these Polyclinics. The following arrangements are made for the polyclinics not having an empanelled hospital/diagnostic centre in the district. All Govt hospitals are deemed empanelled & ECHS members can take treatment in such hospitals. TA/DA is also granted for referral to empanelled hospitals which are outstation. In case treatment is taken in a local non-empanelled hospital in emergency, reimbursement is permitted. Sanction of MD ECHS is accorded if required when planned treatment is proposed to be carried out in a local non-empanelled hospital."

2.10 The Committee further asked the Ministry regarding steps being initiated to increase the reach of ECHS. The MoD (DESW) in the post briefing replies informed:

> "All Govt hospitals are deemed empanelled with ECHS and some of the hospitals have signed MoA with ECHS to provide cashless treatment. The MoA is required only for cashless treatment. Provision exists for 80 percent advance for treatment in Govt hospitals which are not providing cashless facility. Empanelment of hospitals is a purely voluntary application from hospitals side. Frequent meetings at Regional Centre level and Station Headquarters level is held with hospitals explaining the benefits of the Scheme. Wide publicity is being given by publishing advertisements in leading newspapers regarding empanelment of hospitals with ECHS."

(b) Withdrawal of hospitals from empanelment under ECHS

2.11 The Committee were provided details of empanelled facilities which have not renewed the MoA/ rejoined with ECHS are as follows:

(i) Empanelled facilities which have not Renewed MoA till date - 407.
(ii) Empanelled facility which have rejoined after establishment of on - line billing - 46.

2.12 The MoD (DESW) in the post briefing replies elaborated on the reasons as well as corrective steps initiated to address the problem of withdrawal of hospitals from empanelment under ECHS and stated as under:

"Processing and payment of all the empanelled hospital bills was done manually through the Station Commanders and Senior Executive Medical Officer (SEMOs) of Military Hospitals prior to 01 Apr 2012. Since no additional staff was authorized for the above task, processing of empanelled hospital bills were very slow and it resulted in corresponding delay in their payment. In order to overcome the same, 'on-line' billing was introduced in ECHS w.e.f 01 Apr 2012. Initially five Regional Centres out of the 28 Regional Centres were brought 'on-line'. This was extended to five more Regional Centres with effect from 01 Apr 2013. With introduction of 'on-line' billing, the speed with which the bills are processed has increased considerably and it has also ushered in a lot of transparency. Presently all 28 Regional Centres are on-line. The powers of various Competent Financial Authorities (CFA) have been enhanced for clearing the hospital bills expeditiously."

2.13 When the Committee pointed out the dissatisfaction amongst ECHS beneficiaries regarding the treatment meted out at empanelled hospitals, the representative of MoD (DESW) admitted during the oral evidence:

"..... there are other shortcomings in terms of treatment meted out to my patients when they go to an empanelled hospital. A large number of times, we come to know. Then we intervene and get it sorted out. Then the hospital says that they do not have an ECHS bed. There is nothing called a classical ECHS bed. He has done an MoA with me; he has to honour every patient who goes there. So, these are some of the impediments, which I have to encounter on day-to-day basis, to resort to getting it done."

(c) Provision of online Billing and Claim Settlement

2.14 When asked whether the online billing mode under ECHS has been initiated at all the 28 Regional Centres, the Committee were informed that on-line billing has been extended to all the 28 Regional Centres w.e.f. 01 April, 2015. Further, regarding the plan to outsource administrative services to third party administrators for faster and smoother claim settlements, the Ministry stated that the claim settlement function migrated from manual to online bill processing with a pilot project at five Regional Centres in 2012. Also UTI-ITSL was the agency which undertook the project. The function has now been extended to all the 28 Regional Centres w.e.f. 01 April, 2015. The Committee were further informed that UTI-ITSL under control of Ministry of Finance was nominated to undertake the on-line bill processing as they were undertaking the same function for CGHS and which is a semi-Government enterprise.

2.15 Asked about any proposal of the Government to enhance financial powers of ECHS polyclinics and regional centres for speedy disposal of bills/claims, the Ministry denied the same by submitting that:

> "The existing CFA powers for approval of hospital bills are
> Director Regional Centre - upto ₹ 3 lakh.
> Dy MD ECHS - between ₹ 3 lakh to 5 lakh.
> MD ECHS - between ₹ 5 lakh to ₹ 10 lakh.
> Dept of DESW. - above ₹ 10 lakh.
>
> The existing CFA powers are adequate and no proposal is under consideration for revision."

(d) Referral Procedure for going to empanelled hospitals

2.16 The Committee were provided details by the Ministry of the referral procedure for an ECHS beneficiary to go to an empanelled hospital as under:

(i) In respect of Military Polyclinics, the patient is to be referred to service hospitals for available facilities. The service hospitals will treat the patient if the specialty exists or has spare capacity to treat a patient. In case facilities/ beds are not available at service hospital, the patient is directly referred to empanelled hospital.

(ii) In case patient reports to service hospital and is advised treatment at empanelled hospital then the patient has to obtain a referral to empanelled hospital from the Polyclinic.

(iii) In respect of Non-Military Polyclinics, the veterans are directly referred to empanelled hospitals without need of going to service hospital.

(iv) In an emergent situation ECHS patients can directly get admitted to empanelled hospitals where no ECHS polyclinic exists.

(e) Lack of Infrastructure and Excess Dependency on Empanelled Hospitals

2.17 The Committee noted that expenditure to the tune of 68 – 72 percent is towards payment to empanelled facilities under Revenue heads of ECHS from 2012-13 to 2014-15, therefore establishing that the scheme is mainly dependent on outsourcing. The MoD (DESW) in their written replies submitted that as per GoI, MoD letter dated 30

December, 2002 medical treatment to a beneficiary will only be provided through ECHS Polyclinic, Service hospital and civil empanelled facilities and employment of manpower in Polyclinics would be purely on contractual in nature. The revenue expenditure is minimized by treating patients in military hospitals wherever spare capacity is available.

2.18 The Ministry further provided the details of expenditure incurred towards payments made to the empanelled facilities as under:

Financial Year	Allotment (Rs in Cr)			Expenditure incurred towards Empanelled Medical Facilities only (₹ in Crores/%age)
	Capital	Revenue	Total	
2003-04	0	13.53	13.53	Not Allotted/ Expended
2004-05	17.98	93.42	111.40	1.36 /(1.22%)
2005-06	21.35	188.18	209.53	113.53 /(54.18%)
2006-07	23.20	324.14	347.34	187.19 /(53.89%)
2007-08	8.10	489.91	498.01	253.49 /(50.90%)
2008-09	9.50	640.14	649.64	368.40 /(56.70%)
2009-10	6.40	889.92	896.32	539.60 /(60.20%)
2010-11	3.60	1061	1064.60	657.37 /(61.74%)
2011-12	3.00	1226	1229.00	796.83 /(64.83%)
2012-13	5.43	1451	1456.40	966.93 /(66.39%)
2013-14	12.45	1789.5	1801.90	1248.24 /(69.27%)
2014-15	5.91	2260.6	2266.50	1604.68 /(70.79%)
2015-16	30.00	2609.00	2639.00	1731.90 /(65.62%)

(f) Deficiencies in working of empanelled hospitals

2.19 In the light of various deficiencies noted by the Committee in the working of empanelled hospitals under ECHS effecting the efficacy of ECHS as well as causing unaccounted expenditure, the Committee asked the Ministry to elaborate on the reasons for delay in raising of Emergency Information Report (EIR) as well as issue of overlapping claims, raising of inflated bills, non-provisioning of cashless service and charging of additional payments over ECHS rates being reported by beneficiaries in the empanelled hospitals with regard to the same, the Ministry informed as follows:

> "It is stated that the short comings pointed out by CAG are regularly attended with by CO, ECHS through system of internal auditing. Details are as follows;
> **Delay in Raising EIR:** The EIRs have been issued only after the genuineness of medical emergency has been established. In all the cases the patient has been admitted and treated in the said hospitals but their

emergency admission has not been accepted or accepted after a delay by ECHS authorities. The fact that ECHS beneficiary has been treated cannot be denied even though not physically verified by OIC Polyclinic.

Overlapping Claim: During online claim processing the admission history of the patient is also visible and all claims have been processed by deducting the overlapping periods. Only two (02) claims, have been found to be paid extra and recoveries in these two cases from concerned hospitals have been deposited in treasury"

2.20 With regard to the mechanism in place to check such irregularities, the Committee were informed in response to a specific query:

"(a) As per the information received from CO, ECHS, online billing system has made the process of providing treatment by empanelled hospital quite transparent. The whole audit trail with the history of all admissions is available online, while a claim is processed. Checks at Bill Processing Agency (BPA) level by medical processors and medical approvers at Regional Centres and Central Org ECHS are in place to detect and correct such occurrences.

(b) All the hospitals have been advised to get a signed undertaking from the patient who chooses an implant at a higher cost than ceiling rates.

(c) Helpline numbers are available for veterans to report any billing/payment problems. All such cases are being dealt with on a daily basis by the Regional Centres"

2.21 Further, while elaborating on the roadmap crafted to check the anomalies in the working of empanelled hospitals, MoD (DESW) submitted:

"Except for a few cities the number of empanelled hospitals is very less which gives them kind of monopoly over the patient. There is a need to empanel more and more hospitals so as to provide competition and prevent hospitals from dictating terms. 95 more private hospitals/ nursing homes and diagnostic laboratories have been empanelled with ECHS vide MoD Office Memorandum dated 28th April, 2016, thereby the total number of medical facilities empanelled with ECHS is 2029. A proposal for the treatment of ECHS members from all Government (Central/State/Local self Government) Hospitals, Regional Cancer Centers and Institutes of National importance at their rates (not at CGHS rates) is under consideration.

Respective Stn HQs are in the process of recovering excess payment made to hospitals and reconciliation.

(a) The suggestion by CAG for negotiating with hospital for discount on medicine bills does not appear to be practicable as hospitals are private parties and all negotiations have to be carried out as per DPM 2009. Every hospital having a different discount on different medicine will make bill processing almost impracticable.

(b) The internal checks proposed to be incorporated are as below:-

(i) **Rate Integration Module**: System change in BPA portal to prevent hospitals from entering more than authorized rates.

(ii) Strengthening of med approver system by increase in manpower to have a robust internal audit system.

(iii) **Post Audit Module**: Online post auditing of bills will greatly reduce the processing of bills."

Provision of Smart Cards for Beneficiaries

2.22 With regard to the provision of smart cards for all ECHS beneficiaries, the Committee were informed in response to a specific query as follows:

> "The process of provisioning of smart cards to ECHS beneficiaries commenced in the year 2003 and the first tenure of the contract with the SITL firm was till 2009 and in this process 16 KB cards were issued to the beneficiaries. In the yr 2009 the contract was renewed and 32 KB cards were introduced. As on date both variety of cards are operational and beneficiaries are being extended benefits without any compulsion for up gradation. Govt funds are not involved in card making as the expenditure on this account is borne by the ESM."

2.23 The provisioning of the smart cards commenced in 2003-04, the Committee further queried regarding customization of smart cards to save complete details of the health disorders of the beneficiaries. In response to the same, the MoD (DESW) in the post briefing replies stated that the cards have a 16/32 Kb chip embedded. These chips besides having the basic details of the beneficiaries also have health status related details. However, in respect of measures undertaken to study the complete health data, it was further informed that the morbidity data available from respective polyclinics is analysed and based on the inferences drawn the resources are positioned at respective Polyclinics. The percentage of various diseases and the corresponding expenditure is analyzed.

2.24 While replying to specific query regarding reasons for charging the beneficiaries for making of smart cards and procuring of necessary approval for doing the same, the Committee were informed that as per the information given by CO, ECHS, the Smart Card is meant for facilitating the beneficiaries and usage of IT application to extend better facilities to the ESMs. Accordingly, the ESMs were individually charged for the Smart Card. Approval of AG was taken before processing of the case for Smart Card and contract was concluded and renewed after due approval of Competent Financial Authority (CFA) i.e Adjutant General (AG). It was also submitted that charging the beneficiaries for the card has not resulted in any loss to the exchequer. Moreover, on the contrary the ECHS has benefited in terms of automation as the cost of card included the IT backbone to be provided by the vendor. As per the information given by CO, ECHS, since 2004 until the expiry of the contract on 31st May, 2015, the firm has collected Rs 49,13,03,685/- for card making.

Unaccounted Smart Cards

2.25 Regarding the Internal Control System established to weed out the unaccounted cards and hence prevent any extra payment to M/s SITL, it was stated:

> "As per information submitted by CO, ECHS presently there is no mechanism available with ECHS to check multiple enrolments of beneficiaries.
> Till 31 May 2015 the mechanism to prevent multiple enrollment of ECHS beneficiaries under the scheme was in place as the contract with the firm making the smart card i.e. M/s SITL was operational. The same firm had provided MIS at the polyclinics and the software was linked to the beneficiary database maintained by the firm accordingly it was possible to detect any duplicate enrolment. After a valid manufactured card is received by the beneficiary it is activated on his first visit to the parent polyclinics by recording the biometric details of the beneficiary. Therefore adequate checks and balances were put in place to prevent multiple enrolments in the scheme.
> Instructions have been issued to CO, ECHS to provide polyclinic wise list of ECHS members/dependents. CO, ECHS have also been directed to insure that ineligible person are not made the member of ECHS and if ineligible persons are the member of ECHS, their name should not only be deleted and Smart Card issued to them are deactivated immediately but appropriate action should be taken against them for fraudulent membership."

2.26 The Ministry, however, assured that:

> "A new RFP for contracting an agency for supply of cards is under consideration. Adequate checks and balances have been incorporated based on observations of the CAG performance audit report in the proposal to prevent any defaults of such nature in future."

Irregularities in renewal of the agreement for supply of smart cards

2.27 The CAG in the performance audit has found irregularities in renewal of the agreement for supply of smart cards with same firm namely M/s Score Information Technologies Limited (SITL) with increased cost without sanction of CFA. Responding to the reasons for such irregularities and also the existence or otherwise of the well established procedure for awards as well as renewals, DESW stated that –

> "The extension was given by the then Competent Financial Authority (CFA), the Adjutant General. The ECHS was placed as an attached office of DESW only in Oct 2009 for only executive role (policy formulation). The AG's Branch is still responsible for administrative and technical control. Prior to that AG's Branch was authorised by the Ministry to enter into any agreement/ renew or termination in respect to the Scheme. The same is evident from the fact that the initial agreement and its subsequent extension was done by Adjutant General's Branch. "
>
> DPM 2009 is the established procedure to be followed for award and renewal of contract".

2.28 With regard to the procedure undertaken for renewal of the agreement of SITL pertaining to issuing of smart cards the DoESM submitted that Renewal was carried out after due deliberations and approval of Competent Financial authority i.e. Adjutant General.

2.29 The DoESM informed that a total amount of ₹ 49,13,03,685 was collected from the beneficiaries since 2004 until the expiry of the contract.

2.30 In written reply to a query as to whether the ECHS has taken cognizance of the bribery allegation against an employee of M/s. SITL for the issuance of certificates for provision of satisfactory services and if so the details therfreor, DESW submitted that :

"(a) As per the information given by CO, ECHS, a complaint was received in September 2011 from the then Director (Operations and Coordination) of Central Organisation ECHS that some officials of SITL, the Company that manufactures Smart Cards for ECHS and develops and deploys ECHS Management Information System (MIS) at its Polyclinics, had made an attempt to bribe him for obtaining a favourable feedback on the performance of the Company with ECHS. A Show Cause Notice was issued to the Company based on the same by the then Managing Director in October 2011. SITL replied to the Show Cause Notice, denied all the allegations made regarding their officials having attempted to bribe the Officer in ECHS and therefore, requested that the Show Cause Notice issued to the firm be withdrawn. The Company was however, informed by ECHS management that the tone and tenor used by SITL in their reply to the Show Cause Notice was not acceptable and that the same should be withdrawn and an unconditional apology tendered by the firm. SITL, accordingly issued an unconditional apology. The issue was brought to the notice of the AG and VCOAS by the then Managing Director. Based on directions of the VCOAS, the Managing Director, once again issued another 'Show Cause Notice' to SITL and sought reasons as to why its contract with ECHS should not be terminated and the firm blacklisted with ECHS. SITL replied to the Show Cause Notice and submitted the following for consideration by ECHS:-

(i) SITL denied all the allegations and refuted that any of its officials had attempted to bribe Officers in Central Organisation in ECHS.

(ii) The firm submitted that all the officials who were alleged to have been associated with the issue were immediately moved out of the ECHS vertical by the Company.

(iii) The firm reiterated that it had already tendered an unconditional apology.

(iv) It reassured ECHS that it would abide by the terms and conditions laid down in the Agreement between ECHS and SITL.

(v) The Company also reiterated that it would extend its fullest cooperation in successful execution of the ECHS project and fulfill all its obligations as laid down in the Agreement.

(b) The main deterrent in bringing the entire operations of SITL to stand still was the fact that each of the 47 lakh beneficiaries of ECHS were

in possession of a Smart Card issued by the firm. The Smart Card is a pre-requisite for registration and identification of the patient when he/ she reports to the Polyclinic/ hospital for treatment, generating a referral which forms the basis for billing and issue of medicines. SITL is also responsible for the MIS in each of the Polyclinic and the servers on which the same are executed and managed by the firm since Central Organisation is neither structured nor equipped to take on the same. Given the enormity of the beneficiary base and financial expenditures likely to be incurred if a change was to brought about, the same needs to be done on termination of the present contract. Any decision to terminate services of SITL also has to be done after ensuring that a viable alternative is in place as it could otherwise jeopardise the functioning of the entire Scheme. These concerns were also brought to the notice of the AG and VCOAS.

(c) Contract of SITL was terminated on 31 May 2015."

Procurement and Supply of Medicine and Medical equipment

2.31 One of the major difficulties being faced by ECHS beneficiaries is non-availability of all the medicines at ECHS Polyclinics. The estimated satisfaction level is about 60-65 percent. This aspect is important as 90 percent of ECHS beneficiaries are treated at Polyclinic level, with about 10 percent being referred for further specialized treatment to Military/empanelled hospitals. Non-availability of prescribed medicines therefore, affects majority of the clients.

2.32 The procurement and supply of medicines to ECHS beneficiaries is the mandate of O/o DGAFMS. The medicines are supplied to Polyclinics through central procurement process and three AFMSDs located at Delhi, Mumbai and Lucknow are the nodal points for supplying to all the 426 Polyclinics. For the purpose of undertaking this procurement, funds are placed at the disposal of O/o DGAFMS by Central Organisation ECHS. In addition SEMO in station are empowered to procure medicines through local purchase to make up shortfall. At present 60 percent satisfaction level has been achieved pan India. Numbers of initiatives are under consideration for improving the satisfaction level. Outsourcing of Pharmacy as a pilot project at two Regional Centre is under consideration, so that the long procurement and supply chain can be shortened making the supply chain more dynamic and responsive. In addition introduction of Authorized Local Chemist (ALC) as functional under CGHS is being considered by the Study Group constituted to give recommendation on ‘Long Term Perspective of the Scheme’.

2.33 Further, while elaborating on the procurement of medicines, the MoD (DESW) in their written replies stated that the medical stores are procured in ECHS under two categories:

Towards emergent issue of medicine by Polyclinic ECHS

(aa) Type A & B Non-Military Polyclinics ECHS are authorised to procure upto ₹ 50,000/-pm through the controlling Stn HQ (ECHS Cell).

(ab) Type C & D Non-Military Polyclinics ECHS are authorised to procure upto ₹ 30,000/-pm through the Controlling Stn HQs (ECHS Cell).

Other than above, all medical store procurement for ECHS are carried out by O/o DGAFMS.

2.34 The details of ECHS budget allocation for central procurement of medical stores and expenditure thereof during the last three financial years is tabulated below:

Financial year	Allocation (₹ in crores)	Expenditure (₹ in crores)
2012-13	385.00	385.68
2013-14	393.6377	398.7211
2014-15	480.0985	471.9613

The allocation of funds for procurement of medicines locally on ad-hoc and urgent basis by the ECHS polyclinics is not done by the DGAFMS.

2.35 Asked about the low level of availability of medicines at Polyclinics, the MoD (DESW) submitted that:

"(a) The existing system of budgeting , procurement, stocking , distribution and disposal of medicines for the Armed Forces is based on planning, analysis and checking of the requirement at various levels. This requirement is based on Monthly Maintenance Figure (MMF), generated by ECHS Polyclinics and vetted by SEMOs, which is calculated on actual necessity at user end. Adequate stocking of medicines is considered essential for ensuring optimal clientele satisfaction. The timelines for procurement as laid down in DPM -2009 and its supplement 2010 is placed at **Appendix - II**.

(b) The procurement action is carried out in three tier, at the Armed Forces Medical Stores Depots (AFMSDs) and Service Hospitals (SEMOs), in addition to central procurement through Rate Contract based on the requirement. All the

stakeholders are allotted delegated financial powers under ECHS to ensure financial propriety and judicious utilisation of ECHS funds in accordance with provisions of Defence Procurement Manual (DPM) -2009, including policies and Standard Operating Procedures which are scrutinized by audit authorities and various administrative echelons.

(c) Synergy in central and peripheral procurement is challenging for widespread medical echelons, especially when there are inherent difficulties in logistic and supply chain management.

(d) In actual practice the indents from the polyclinics are sent once every quarter to the depots/ DDOs through their SEMOs. The procurement action having already been done by the depots/ Dos based upon the projected MMF, the medicines are issued to the polyclinics through their SEMOs. Ideally the demands are required to be placed by the polyclinics three months in advance so that by the time these are due, medicines are already segregated and kept ready for despatch.

(e) However, in practice, delays take place due to non-availability of stores for transport to the particular place. The process of procurement itself takes anywhere from 2-4 months in the depot/ DDOs.

2.36 In respect of alternate proposals for procurement, the Committee were informed that Outsourcing of Pharmacy services at few stations was under consideration.

2.37 The Managing Director of ECHS during oral evidence elaborated on the issue of challenges being faced for providing medicines to the beneficiaries by submitting:

> "One of my biggest challenges is medicines. The medicine procurement is being done. But for example, a person is prescribed 10 medicines. At times, of 10, may be two or three are not there. So, he feels that he has not got his medicines. My biggest complaint register is filled with medicine requirement."

2.38 While elaborating further on the issue of non-prescription of generic medicines by the doctors and Central procurement and supply chain management, the MD, ECHS stated:

> "While on the issue of medicines, we appreciate that there is a concern. We appreciate that there is room for improvement. But I would request the

hon. Convenor and the respected Members to understand that branded medicines prescribed by a civil empanelled hospital and their instant availability in a service hospital, there will always be desire versus requirement mismatch. Availability mismatch is bound to happen, particularly, if a person is prescribed a certain drug by a brand name of, let us say, a multinational company; and we give him a generic medicine. You would appreciate, Sir, as a medical professional. He will not be satisfied with that..... it is a common perception. It is a perception bias. You would appreciate, pharmacologically and active ingredient-wise, there is no difference, but this is where the significant issue comes. Again statistically, no dispensary, howsoever utopian situation we may encounter, can take care of a 100 per cent instant availability of medicines prescribed by heterogeneous civil empanelled hospitals with their super specialists and their own commercial considerations notwithstanding. However we have taken measures, which is to equip the SEMOs with a budget to take care of provision of medicines, to take care of the last mile. Where our central procurement and central supply chain management cannot deliver, they are given a budget for local purchase. The local purchase is constrained by one element. If one follows the procedures, which are laid down in our procurement manuals, the lead time is six to eight weeks. Now, this is difficult, in terms form a client perspective. He is bound to be dissatisfied if we are taking that long. However, Sir, there are emergency powers of ₹ one lakh, which are available, per RFT, which means that emergency drugs for ₹ one lakh can be purchased on a short-term emergent basis. Now, this only takes care of a certain level of dissatisfaction"

2.39 In respect of non-prescription of generic medicines by doctors at empanelled hospitals, it was further submitted:

"We have issued instruction through our medical channels. Unfortunately, they are not following it. They are not governed by our laws or our dictates or our policies. So, they are pretty much at a freedom to do whatever they want to do.....We give generic medicines. We do not give branded medicines because we are mandated by the Government to give generic ones. We procure only generic medicines and we prescribe generic medicines however with quality safeguards in place. I must add that while we are in the generic segment, the qualitative safeguards are in place..... When the empanelment takes place, the instructions are given that they would only prescribe generic medicines. But most of the doctors claim that they are so busy that they do not have time to do all this. They prescribe branded medicines."

2.40 On being asked about measures being taken to increase the satisfaction level pertaining to availability of medicines for beneficiaries, the Committee were apprised that the following measures have been adopted and are being refined to improve availability of medicines at all echelons, with a view to improve functional efficiency and enhance clientele satisfaction:

(a) Instructions and advisories to be issued to ECHS empanelled civil hospitals to issue prescriptions of drugs in **Generic Nomenclature** and **Not 'Brand Names'** in line with Supreme Court judgment.

(b) Boost in the supply of Essential Drug List (EDL) for ECHS and Common Drug List (CDL) medicines by the Depots.

(c) Enhanced coverage of Central Rate Contracts and Price Agreements of medicines at SEMO/ Fmn/ Stn level.

(d) Increase in number of Direct Demanding Officers (DDOs) is expected to improve coverage of Central Rate Contracts.

(e) Significant increase of delegated financial powers of all CFAs as per DFPDS-2015, will allow all SEMOs/ Comdts/ COs to procure more medicines as per demand/ requirement.

(f) A board of officers has been constituted by O/o DGAFMS to assess the clientele satisfaction of ECHS beneficiaries and propose remedial measures.

2.41 The MoD (DESW) also elaborated on the following proposals to improve availability of medicines:

(a) Inherent financial powers under which CFAs of each hospital can procure medical stores in such emergent situations.

(b) Allocation of Transportation budget for distribution and issue of medicines to ECHS Polyclinics.

(c) Formation/ Station HQs should be made responsible for transportation of medicines for ECHS clientele from Depots/ DDOs/ SEMOs to the ECHS Polyclinics.

(d) Correct projection and analysis of MMF by ECHS Polyclinics which is essential for proper planning of procurement and supply chain management of medicines.

(e) Automation linkages, compatible with 'i-aushadhi' software developed by HQ IDS (Med), will ensure real time data and inventory management of medicines.

(f) Proactive measures and progressive strategies have been instituted to improve the functional efficiency of the healthcare management of ECHS beneficiaries, with inter organization synergy amongst all stakeholders with clear delineation of duties and responsibilities at each echelon Augmentation of the humans, financial, infrastructural and logistic resources in the high ECHS workload AFMS healthcare institutions is critical to improve clientele satisfaction of the ECHS beneficiaries.

2.42 The MoD (DESW) during the oral evidence also informed the Committee of other measures being worked out for improving the availability of medicines. It was stated:

> "In so far as the availability of medicines is concerned, there is a Committee headed by the Adjutant General of the rank of a Lieutenant General and with representatives of the central organisation, which is seized of the matter. We are deliberating on what could be the best model, which can be achieved to improve satisfaction levels insofar as the medicine availabilities are concerned. I will briefly sum up by saying that there are three models. One is to augment the existing system. Second is, whatever is not available with the Armed Forces hospital be made available by the authorised local chemists. Thereby the dissatisfaction level gets reduced. Third is total outsourcing. The pros and cons of all these three models have been worked out. In the foreseeable future we expect to come out with solutions that will be forward looking and progressive and minimise dissatisfaction."

2.43 While elaborating on the procedure for providing medical equipment to patients for Domiciliary Use, the Committee were informed that:

(a) The procurement procedure for medical equipment for domiciliary use is as per para 9 (g) of MoD letter dated 19 December, 2003 **(Appendix - III)**. The procedure for issue of such domiciliary use medical equipment is under the aegis of Central Org ECHS.

(b) Medical store items which are not scaled are procured through Statement of Case (SOC), raised by individual units as per their requirement. Moreover, sufficient financial powers have been delegated to various DDOs/ CFAs/ SEMOs for procurement of NIV stores through Local Purchase (LP) within their delegated financial powers in consultation with IFAs which normally takes 1-2 months. In addition, emergency powers for procurement of medical stores up to Rs 01 Lakh have been delegated to CFAs of various medical units/ establishments for procurement of medical stores. All medicines prescribed by doctors are to be procured and supplied. However for certain conditions, reimbursement of one

month medicines is permitted post hospital discharge. Medicines prescribed in OPD are not reimbursable. As of now there is no provision for reimbursement of medicines purchased by veterans. This can be overcome by outsourcing and by empanelment of Authorized Local Chemists as is the case in CGHS. Presently there is no system of reimbursement of medicines purchased by an individual.

2.44 About dissatisfaction over availability of medical equipment, the Committee enquired about the major hurdles being faced by the Ministry in the ready availability of medical equipment. In reply to the same, it was informed that Government has not got any reports on dissatisfaction over the availability of medical equipment. However, details of the arrangements made for optimal availability of medical equipment were given as below:

(a) Medical equipment is optimally available in service hospitals for OPD and inpatient treatment, diagnostics and therapeutic intervention for the serving as well as the veteran clientele.

(b) The constraints to ensure optimal availability of medical equipment and stores to ECHS beneficiaries at the ECHs Polyclinic level are:

(aa) Manpower constraints for major additional workload for procurement, distribution, stocking and issue of medical equipment and stores for ECHS polyclinics.

(ab) Financial constraints at SEMO level, without inherent powers.

(ac) No authorised transportation budget for despatch of medial stores from AFMSDs to Polyclinics.

(ad) No effective automation for ECHS inventory and supply chain management.

(c) Equipment are authorized for Domiciliary use of individual veteran. These include Hearing Aids, Oxygen Concentrators, CPAP, BiPap and Nebuliser. These are procured by local Station Headquarters and issued to veterans based on specialist recommendation. Ceiling rates are fixed by CGHS for these equipments.

2.45 The Committee were also informed that the Ministry proposes to consider reimbursement in line with CGHS Policy and authorization of equipment like wheel chairs, walkers, mattresses, etc. under Orthotic Aids. It was further informed that the most frequently needed medical equipment are the 'Hearing Aids'. The domiciliary medical equipment authorised are Hearing Aids, Oxygen Concentrators, CPAP, BiPap and Nebulisers. All have been given a life of five years after which they can be reissued. However, replacement/ repair of faulty equipment is covered under manufacturer warranty only.

2.46 In respect of the dichotomy prevalent in the system for providing of medical equipment, the representative of MoD (DESW) deposed:

> "That is the little dichotomy in the system where we have a specified list. We get governed by the DGAFMS and the CGHS. They are in consonance. I will give you an example. I have an individual whose hearing aid has gone bad at four years. I can only replace the hearing aid after five years. So, maybe I will try and give it; I do not have the authority to give him a hearing aid before five years. But, the specialist has said that it has gone bad; I mean the old man cannot hear. So, I am going to give it. I am trying to cover up myself by saying that, maybe you pay 20 per cent, that is one-fifth of the cost. I think, there must be a lien available which we are working out. An equipment which is required by the individual which has been certified by the doctor that he requires it. Like, somebody is looking for a portable oxygen concentrator from me now and I am not able to give it because it is not authorised. I do not have the lien to sanction it.....I would make a point here. The distinction needs to be made between medical equipment in hospital settings and medical equipment for domiciliary use which means that patients who are discharged from hospitals may require an oxygen concentrator, may require a BiPAP or a CPAP machine to assist their breathing, may require a hearing aid, may require other such devices and nebulizers. This is where the procedural impediments need to be improved upon. We are seized of the matter. But, between the ECHS and us, we are trying to figure out modalities by which we can make it user friendly for the veteran clientele. While I continue with this, the critical care life saving equipment available in service hospitals is adequate, functional, serviceable and there is no issue there."

Shortage of Authorized Medical Officers, Specialists, Paramedics and Non-medical Staff

(a) Shortage of Medical Staff, Paramedical Staff and Non-Medical Staff in posts filled on Contractual Basis

2.47 In respect of availability of Medical Officers and Specialists in ECHS Polyclinics, the Committee were informed that there is a deficiency of Medical Officers and Specialist in ECHS Polyclinics. The deficiency is mainly due to their non-availability and low remuneration. The deficiency of Medical Officer is mostly at remote areas due to their non-availability. The authorized and present state of Medical Officer and Specialist in ECHS Polyclinics are as follows:

Category	Auth	Held
Medical Officer	953	760
Medical Specialist	322	168

2.48 The Committee observed that against 953 authorized Medical Officers, 760 are in-service and against 322 authorized Medical Superintendents only 168 are in service despite all being on contract basis. In reply to a specific query regarding the same, the MoD (DESW) in a post evidence reply stated the reason for shortage of Medical Officers and Specialists (Medical Specialists, Gynaecologist and Radiologist) in ECHS Policlinic as follows:-

(a) Non-operationalisation of all Polyclinics. Presently, 418 out of 426 Polyclinics have been operationalized. As a result the sanctioned posts in the polyclinics are not filled up.
(b) Medical Officers/Specialists (Medical Specialists, Gynaecologist & Radiologist) not willing to join ECHS due to lower remuneration.
(c) Non-availability of Doctors.
(d) Resignations due to various reasons.

2.49 While elaborating on the reasons for shortage of medical specialist, it was submitted during the oral evidence;

> "In the case of medical specialists they are far and few. MD doctors coming for ₹ 55,000 will be difficult for us to get. So, we have allowed to work for only five hours as a part time and thereafter, he can do his work on his own."

2.50 Further, in reply to a query regarding the reasons for shortage of medical officers and specialists in ECHS polyclinics, MoD (DESW) submitted:

(i) Non-operationalisation of 06 Polyclinics.

(ii) Medical Officers/Specialists (Medical Specialist, Gynaecologist & Radiologist) not applying to join due to low remuneration.
(iii) Non-availability of Doctors in certain places.
(iv) Recruitment being a continuous process.
(v) Resignations due to various reasons.
(vi) Contract period is only for one year at a time

2.51 However, it was stated that various measures are being taken to increase recruitment/check attrition rates. For instance:

(i) Wide Publicity is being done to fill up the vacancies vide Army Placement Agency, Kendriya Sainik Board/ Rajya Sainik Board/ Zila Sainik Board, Director General Resettlement, Advertisement in National/Regional Newspapers, ECHS Website, Word of Mouth advertisement, Information to various Records of the existing vacancy.

(ii) MoD vide letter date 27 Nov 2015 has increased the remuneration of Officer- in-charge, Medical Officer and Dental Officer to ₹ 60,000/- per month and remuneration of Specialists (Medical Specialists, Gynaecologist, Radiologist) has been enhanced to ₹ 70,000/- for first year and ₹ 80,000/- for second year of contract. It will not only help to attract better talent but also help in retaining them.

2.52 The MoD (DESW) in reply to an observation regarding diversion of manpower at bigger polyclinics at the cost of efficacy of the lending polyclinics stated:

"(a) There were Polyclinics where the patient load is more than the category of the Polyclinic that it was designed for. At the same time there were Polyclinics where the Daily Average Sick Report is very less. To ameliorate the situation Deptt of ESW vide letter date 27 Jun 2007 allowed MD ECHS to transfer vacancy from low pressure Polyclinics to high pressure Polyclinics. The transfer is valid for one year. After one year the vacancy gets reverted to the parent Polyclinic. The transfer of vacancy cases are considered and speaking order is given by the MD ECHS for transfer of vacancy based on the merit of the case only. CO, ECHS is mandated to ensure that the transfer of vacancy is not at the cost of efficient/ effective working of lending Polyclinics.

(b) The CAG itself has commented on shortage of manpower. The ECHS does not exceed the total sanctioned strength at any given time."

2.53 The MoD (DESW) also informed the Committee that it had sanctioned 1709 interim vacancies in the year 2013 bringing the total strength of contractual staff to 6800.

2.54 In reply to a specific query regarding shortage of nurses and paramedical staff across various hospitals, the Committee were informed in the written replies regarding the shortage as follows:

Nurses:

There is 11.37 percent shortage of nursing staff as on 31st Aug 2015, in Armed Forces Hospitals.

Phase III of manpower augmentation is likely to come through with the authorization of additional 683 Nursing Officers.

Paramedical Staff:

There is deficiency of 2642 paramedical personnel. However, the required personnel have already been recruited and are presently undergoing training. After they complete their training, the deficiency will be made up.

2.55 The Committee were further informed that 100 percent staff in ECHS Polyclinics are engaged on contractual basis. Normal turnover of contractual staff leaving midway in the contract period for better opportunities does take place. Upward revision of remuneration has taken place thrice, last one being in 2014 as per details given below:-

Category	**Remuneration**	
	Previous	**Revised**
Officer	25,000/-	46,000/-
Para Medical Staff	10,500/-	15,000/-
Non-Medical Staff	6,500/-	8,970/-

2.56 The Committee were also informed of the revision in the salaries of medical officers under ECHS. The MoD (DESW) elaborated that ECHS staff remuneration are based on CGHS approved scales and follow their guidelines. In the recent time salary of Medical Officer in CGHS has been revised accordingly. Steps to increase remuneration of Medical officers, Dental Officers and Specialist on the lines of CGHS is under consideration as mentioned below:-

	Category	**Remuneration**	
		Existing	**Proposed**
(i)	Medical Officer	₹ 46,000/-	₹ 60,000/-
(ii)	Dental Officer	₹ 46,000/-	₹ 60,000/-
(iii)	Specialist	₹ 55,000/-	₹ 72,000/-

(b) Shortage of Medical Staff, Paramedical Staff and Non-Medical Staff in posts reserved for Ex-servicemen

2.57 All the posts of Doctors, Para Medical, Non-Medical Staff reserved for ESM are not filled. The main cause of non-filling of reserved posts is the non-availability of suitable ESM as per qualification requirements for the said posts. Details of authorized and present state of reserved posts of ESM are as follows :

S.No	Category	Auth	Reserved	Held
(i)	Medical Staff	1745	1047	223
(ii)	Para Medical Staff	2523	1766	481
(iii)	Non-Medical Staff	2123	1486	441

2.58 In regard to posts of Doctors, Para medical and non-medical staff reserved for Ex-servicemen, the deficiency is as high as 78 per cent for medical staff, 72 per cent for paramedical staff and 70 per cent for non-medical staff. In the Post Briefing replies, the MoD (DESW) submitted:

> "The reasons for shortage of Ex-Servicemen in ECHS Polyclinics are as follows :-
>
> (a) **Non-operationalisation of Polyclinics**: Presently 418 out of 426 Polyclinic have been operationalised.
>
> (b) **Non-availability or less availability of Medical and Paramedical Staff:** This is mainly due to the fact the bulk of the Armed Forces Veterans (AFVs) can be employed as Non-Medical Staff only. Veterans meeting the QR of Medical & Para Medical Staff are limited in number and hence lesser is their availability.
>
> (c) Non-hiring of staff due to deficiency of ambulance and medical equipment to avoid financial loss to the exchequer as per policy.
>
> (d) Personnel other than Ex-Servicemen are employed in lieu to fill up the vacancies"

2.59 Asked whether the Government was considering recruiting people from outside of ECHS to allow for proper service, it was informed:

> "There is a provision to select suitable civilian candidates in case no ESM is available for the post against reserved vacancies. Such selection is

carried out only after endorsement of Non-availability of ESM candidate by General Officer Commanding (GOC) Area/Sub Area. The alternate arrangements being made for continued service in face of such shortage are as follows:

(a) In case no Ex-Servicemen is available, suitable candidate are selected after taking a certificate from GOC Area.

(b) Station Commander have been empowered to hire suitable candidate temporarily for three months to cater for contingency arising in case any candidate resigns from the post."

(c) Armed Forces Medical College

2.60 The Committee were given details of status of AFMS MOs and Dental Officers in the post briefing replies as under:-

Services	**Auth**	**Held**	**Defi**	**%**
AFMS	6099	5878	221	3.62
Dental Offr	658	642	16	2.43

However, it was further informed that in so far as Armed Forces Medical Services (AFMS) is concerned, there is some deficiency of Medical Officers (MOs) due to Premature Retirement (PMR), Superannuation, Release/Resignation after Short Service Commission (SSC) and no provision of Training, Deputation and Leave Reserve (TDLR).

2.61 The Ministry of Defence (DESW) informed the Committee regarding the categorization of Medical Specialists as sanctioned in service as under:

S.No	**Specialty**	**Total in Pool**
(a)	Anaesthesiology	259
(b)	Anatomy	11
(c)	Aviation Medicine	116
(d)	Biochemistry	14
(e)	Dermatology & Ven	56
(f)	ENT	101
(g)	Forensic Medicine	7
(h)	Gen Medicine	358
(i)	Gen Surgery	379
(j)	Marine Medicine	20
(k)	Microbiology	40

(l)	Nuc Medicine	10
(m)	Obst & Gynaecology	153
(n)	Ophthalmology	108
(o)	Orthopaedic Surgery	59
(p)	Paediatrics	112
(q)	Pathology	157
(r)	Pharmacology	18
(s)	Physiology	25
(t)	PSM	164
(u)	Psychiatry	63
(v)	Radio Therapy	13
(w)	Radio Diagnosis	122
(x)	Resp Medicine	20
(y)	Transfusion	1
	TOTAL	**2386**

The Committee were also informed that there is no deficiency of Specialist officers in AFMS.

2.62 Major General R.S. Grewal explained the two modes of entry into the Armed Forces Medical Service as under:

> "We have two modes of entry into the Armed Forces Medical Service. The first is through the Armed Forces Medical College, which is taken in an annual intake of approximately 125 people per year. This figure, however, can be increased. But again there is a Government sanction for taking these many people only. We also have a direct entry modality of entry which is from the Medical Colleges across the country which is undertaken through a Written Examination followed by an Interview.
>
> So, these are the two modes of entry into the Armed Forces Medical Service. In this, there is a further sub division into the Short Service Commission Category and the Permanent Commission Category. We have approximately a 60:40 ratio of Short Service Commission versus the Permanent Commission which is the present situation as it stands today"

2.63 It was further submitted:

> "Our annual average intake approximately is 60 to 70 per cent from the AFMC and the remaining is made up from the Pan Indian colleges..... But it depends on the year-wise attrition, as per the number of people who retire..... A significant number want to stay back. In fact, we extend the Short Service Commission by five plus five years and often it goes up to the third term also. So, they are utilised till such time as we can extend their services as per the Government rulings. So we have no issues in so far as retention is concerned.

The AFMS is constrained to take only that many permanent cadre officers and therefore that is the only limiting factor. That also allows us the cadre growth in subsequent echelons of hierarchy."

2.64 The Committee asked whether the Armed Forces Medical College, Pune fully meets the need of doctors to serve the Armed Forces. It was informed that sanctioned in July, 1962 with an annual intake of 120 students, it was further revised in May, 1999 to 130 Indian + 05 foreign students. However, no proposal is there to increase the intake since requirement of AFMS is being met through AFMC (50 percent) and remaining from civil Medical Colleges in order to provide representation on Pan India basis.

2.65 About the steps taken to increase recruitment from Civil Medical Colleges, the Ministry submitted as under:-

(a) Incentives of antedate seniority is given for Post Graduation, Post Graduate Diploma and house job done prior to joining service.

(b) The facility of doing in-house courses for Diploma of National Board (DNB) and Post Graduation is given to Short Service Commissioned officers based on merit of All India Post Graduate Entrance Exam.

(c) Opportunity is given to become Permanent Commissioned officers after 2 years of service.

(d) Lifelong disability pension is granted to Short Service Commissioned officers who suffer disability during service.

The Government further also approved augmentation of manpower of 10,590 by accretion of posts. The accretion was to be done in three phases. 3530 posts each have already been created in Phase-I and Phase-II (total 7060). Accretion of 3530 posts in Phase-III is under consideration of the Government.

2.66 While elaborating on the compulsory period of service for successful students after passing out and regarding details of those who opted to stay back after serving for this compulsory period, the Ministry furnished the following data:

S No	Year of commission (SSC	Total No of intake	Total No of officers	Remained in service	Year of Release

	Officers)		Released		
1	2004	46	22	24	2011
2	2005	52	20	32	2012
3	2006	59	20	39	2013
4	2007	61	18	43	2014
5	2008	51	27	24	2015
6	2009	44	6	38	2016
7	2010	33	0	33	Offrs resigned from service
8	2011	38	2	36	
9	2012	43	3	40	
10	2013	61	0	61	
11	2014	56	2	54	
12	2015	53	0	53	
		597	**120**	**477**	

2.67 The bond money for medical cadets joining Armed Forces Medical College, Pune for MBBS course has already been increased from the session 2014. The bond money for AFMC cadets was enhanced to ₹ 25 lacs from the session 2014, which is to increase every year by ₹ 1 lac to maximum of ₹30 lacs.

2.68 While elaborating on the number of MBBS doctors passed out from AFMC and who have opted to pay bond money as against joining services in the last ten years, the details were provided as under:

S.No	Years	Regular Batch		Irregular Batch	
		No. Passed	Opted Paid Out of Service Liability	No. Passed	Opted Paid Out of Service Liability
(a)	2006	132	08	-	-
(b)	2007	132	04	-	-
(c)	2008	138	21	04	04
(d)	2009	132	18	-	-
(e)	2010	122	28	12	05
(f)	2011	122	26	13	-
(g)	2012	124	16	09	03
(h)	2013	113	15	20	04
(i)	2014	121	21	15	03
(j)	2015	125	23	08	01

Grievance Redressal Mechanism

2.69 The Ministry of Defence (DESW) while elaborating on the existing mechanism in place to get feedback from the beneficiaries stated that During discharge from

empanelled hospital, the veteran's feedback form is attached to bills of the hospital. Regular e-mail, telephonic complaints are attended to. Moreover, Centralized Public Grievance Redressal and Monitoring System (CPGRAMS) and other grievance redressal mechanisms are also in place. Interactions with ESM and ESM associations are also regularly held at various levels. Recently a meeting was held with recognized ESM Service Association. Based on the feedback received in this meeting and Performance Audit Report, corrective measures are being taken.

2.70 Asked about the number of complaints received from beneficiaries under the ECHS in the last three years and the number of complaints appropriately discharged, the Ministry replied as under:

(i) **CPGRAM (01 Sep 12 to 01 Sep 15)**

Grievances Received	**Cases Disposed Of**	**Pending**
401	**361**	**40**

(ii) **Gen Complaints**

Grievances Received	**Cases Disposed Of**	**Pending**
2424	**1803**	**621**

2.71 Asked to furnish the details of the year-wise data for last ten years on the number of complaints, the Ministry furnished the following data, stating that the complaints prior to 2009 do not exist.

Grievance Source	**Receipt**	**Remarks**
Complaints		
Gen Complaints (2009)	366	
Gen Complaints (2010)	377	
Gen Complaints (2011)	414	
Gen Complaints (2012)	428	
Gen Complaints (2013)	747	

Gen Complaints (2014)	968	
Gen Complaints (20015	929*	*Complaint received upto 01 Oct '15.
Total	**4229**	
CPGRAMS (01 Sep 2012 to 01 Oct 2015)		
DARPG	13	
Local/Internet	307	
Pension	20	
PMO	40	
President Sectt	21	
Total	401	
Grand Total	**4630**	

The Nature of complaints related to the following areas:

Nature of complaints being received are given in succeeding paras.

Against the Functionaries:

(i) OIC ECHS Polyclinics to MD ECHS.
(ii) OIC ECHS Cell, Station Headquarters.
(iii) Staff of ECHS Polyclinics.
(iv) Doctors at ECHS Polyclinics.
(v) Referral Procedures.
(vi) Denial of Treatment.
(vii) III treatment by Polyclinics staff.

Eligibility and ECHS Card:

(i) Eligibility for ECHS Membership in respect of Non-Defence personnel.
(ii) Eligibility of Ex-Recruits for ECHS.
(iii) Eligibility of World War II veterans/SSCOs/ECOs for ECHs members.
(iv) Upgradation/Renewal/Change of Cards.
(v) Status for application of ECHS membership cards.

Medicine/Claims:

(i) Non-availability of Medicine at ECHS Polyclinics.
(ii) Non-issue of medicines for longer durations.
(iii) Shortage of life saving medicines.
(iv) Reimbursement of Med claims.
(v) Emergency treatment in Empanelled/Non-Empanelled/ Govt Hospitals.

Against Empanelled Hospitals:

(i) Negligence by Hospitals.

(ii) Denial of Treatment by Empanelled Hospitals.

General Complaints:

(i) Refund of Contributions.
(ii) Shortage of doctors.
(iii) Opening of additional ECHS Polyclinics.
(iv) Improvement in ECHS Polyclinics.
(v) Extension of Contractual employment.
(vi) Referral procedures.
(vii) Treatment abroad

2.72 In respect of a system of vigilance to address the issue of corruption on receiving of some complaints, the Ministry during the oral evidence on 11.09.2015 submitted:

> "We have a system in place. It is not classically in the central organisation because of the authorisation. But we make use of all formations. For example, if a complaint comes, through my Station Headquarters, Regional Centre and the Formation Headquarters, it is investigated. We have started a new system. In the empanelled hospitals, we make a team of one doctor and one officer, who physically goes to that hospital after having taken the lists from the polyclinic as to who all are admitted in that hospital. At times, we have found that the patient was not there or may be he was discharged three days back, but his name was still continuing."

2.73 In written reply to a query regarding major shortcoming in the complaint redressal mechanism of ECHS leading to pendency in disposal of complaints, MoD, DESW submitted as under:

> "Major shortcomings in the complaint redressal mechanism of ECHS are as under:
>
> (a) **Provisioning of Medicines**: Provisioning and procurement of medicines is at present time consuming and less responsive.
>
> (b) **Accountability of BPA**: Time delay at the level of Bill Processing Agency (BPA) is a major shortcoming needs to be curbed. Process is on to ensure fast processing of bills so that best facilities opt for empanelment under the scheme.
>
> (c) **Commercialisation**: Empanelled hospitals are in the habit of inflating bills through commercial/unethical medical practices.
>
> (d) **Fast Expanding Membership Base:** It is a challenge to handle the fast expanding ECHS membership base and managing the scheme.

(e) **Non-Review of CGHS Rates at regular intervals."**

2.74 In respect of the reforms being worked upon to allow for early redressal in a time bound manner, the following reforms as elaborated upon by the MoD, DESW in its written replies are as under:

"(a) **Provisioning of Medicines:** At present, Procurement and provisioning of medicines for ECHS are carried out by the office of DGAFMS. Process of provision of medicines by DGAFMS will be streamlined to ensure the availability as per members requirement. Alternatives are being explored in the form of Outsourcing of Pharmacy or Authorised Local Chemists to ensure availability of durgs/medicines.

(b) **Timely Payment of Bills:** To ensure timely payment, BPA has been asked to step up its performance by deploying additional required personnel. Process is on to ensure fast processing of bills so the best facilities opt for empanelment under the scheme.

(c) **Accountability of Empanelled Facilities:** Process is on to make empanelled hospitals more accountable for their service. Control measures are being imposed to ensure that they maintain correct, ethical and healthy medical practices as per the MoA and action will be taken as per MoA in case of default and deficiency in service.

(d) **Responsiveness:** Process is on, to increase the responsiveness of Polyclinics, Empanelled hospitals and Service hospital on the complaints made by members.

(e) **Increase Awareness Levels Amongst Members:** Awareness of policies & procedures among ECHS beneficiary is low. Process is on to increase awareness through websites, pictorial charts and notices at CSD Canteens and Polyclinics. Helplines have been created at Regional Centres and Central Org ECHS besides hosting a website."

3. Other Issues and Constraints

Acquisition of Land for Polyclinics

3.1 The procedure for acquisition of land for construction of buildings for ECHS Polyclinics is laid down vide MoD letter No 24(14)/03/US(WE)/D(Res) dated 31 January, 2005 (copy enclosed at **Appendix - IV**). Towards acquisition of land for ECHS Polyclinics, Defence Minister and Secretary, ESW have written to all the Chief Ministers and Chief Secretaries of the State Government respectively with a request to allot a piece of land for construction of building for ECHS Polyclinics as a welfare measure for Ex-Servicemen residing in the State.

3.2 Of 191 ECHS Polyclinics, there are three Military and 188 Non-Military Polyclinics. Major difficulties are faced to locate a suitable piece of land which is to be purchased from State Governments/Individuals. Despite concerted efforts by various Formation Headquarters, the process of acquiring land has not gained momentum, primarily because of the procedural delays involved. Moreover, even at locations where land has been provided by the State Governments, the Defence Estate Offices (DEOs) take a considerable amount of time in taking over the land and completing various formalities.

3.3 Efforts are being made to acquire land for construction of Polyclinic buildings at all the location where defence land is not available. DO letter has been written by the Defence Minister to all the Chief Ministers on 21 Aug 2007 and from Secretary (ESW) to all the Chief Secretaries of the States concerned on 22 Jan 2010 and 28 Feb 2012 to facilitate the acquisition of land. Regular liaison is carried out by formation HQs with civilian authorities for the said land. The KSB has also been requested to assist in identifying the land for ECHS Polyclinics. The provisions of new Land Act will make the process more tedious. The status of acquisition of land is as under:

(i) Total ECHS Polyclinics	- 426
(ii) Land acquired	- 221 location
(iii) Land yet to be acquired	- 188 location
(iv) Land not required	- 17 (mobile clinic)

The list of polyclinics where land is yet to be acquired is attached as **Appendix - V**.

3.4 The year-wise data regarding the land acquired is as follows:

Sl. No	Year	Number of Stations where land acquired
(i)	Up to 2007	136
(ii)	2008	17
(iii)	2009	10
(iv)	2010	08
(v)	2011	03
(vi)	2012	21
(vii)	2013	04
(viii)	2014	11
(ix)	2015	11

3.5 Further, the Committee sought the response as received from concerned States regarding facilitating of acquisition of land in the concerned States. However, the information sought was yet to be furnished to the Committee.

Efficacy of Policy Framework Governing ECHS

3.6 Ex-Servicemen Contributory Health Scheme (ECHS) was setup on the basis of recommendations of a Group of Ministers which was duly approved by Cabinet in its meeting held on 16th October 2002. In the meeting of Cabinet held on 22.01.2002, Group of Ministers was constituted for ECHS to work out the modalities and bring up their recommendations on ECHS. CCS in its meeting held on 16.10.2002 approved the implementations of ECHS as approved by Group of Ministers.

3.7 Asked about the efficacy of the policy framework governing ECHS, the Ministry submitted:

> "The Scheme has been able to provide/ deliver the medical care facilities to Ex-servicemen (ESM) and their dependents since inception. The policy framework has been found to be effective with well-defined Administrative and Technical control being exercised by Adjutant General through the Formations and Department of Ex-Servicemen Welfare for policy formulation. C&AG of India has carried out Performance Audit report on Implementation of Ex Servicemen Contributory Health Scheme (ECHS) and its draft report is given to the Government. Remedial action will be

taken to address the shortcomings pointed in the report in consultation with all stakeholders."

3.8 Further, on being asked about the need for customization to further suit the need of servicemen and Ex-servicemen, the Committee were informed:

"It is designed as per ESM requirements as recommended by the Service Headquarters. Performance Audit on ECHS was carried out by Comptroller & Auditor General of India (C&AG) and the draft report has been received. Corrective measures will be taken on the short comings in consultation with all stakeholders to ensure delivery of quality services. As per the available records, scheme has been designed as per the needs and requirement of ESM. However it is clarified that no such study on merit and demerits of CGHS has been conducted."

3.9 The Committee while taking note of the existing cap of ₹ 3500 per month on the income to extend the benefit of ECHS to the dependents on the lines of CGHS, asked the Ministry whether there was any plan to review the existing cap for ECHS beneficiaries. The Ministry replied in the negative.

Dissatisfaction amongst ESM over treatment meted out and services provided under ECHS.

3.10 The Committee while taking note of the dissatisfaction being reported due to inadequate service and differential treatment being meted out to in-service and Ex-servicemen beneficiaries, asked the Ministry to comment on the same. The reply was:

"No such report is available in Ministry. However as per information's provided by DGAFMS, Armed Forces Medical Services (AFMS) has always endeavoured and consistently provided comprehensive, healthcare services to all its clientele, including the Veterans fraternity through its various medical units/ establishments, and service hospitals. AFMS has always ensured that there is no discrimination amongst its clientele, and the services provided are purely guided by the clinical considerations of the patients, rather than any other extraneous factors.

Traditionally, since inception the AFMS has been providing quality healthcare to the veterans with empathy and compassion. This has continued even after the commencement of ECHS, as a scheme. Once a patient comes under the care of AFMS, they are provided with the healthcare services by the highly proficient Specialists, Senior Advisers, Consultants and Medical & paramedical staff. The same medical equipment available for such care is utilised without any discrimination. The facilities of diagnostics, therapeutics and convalescence are equitably provided for all and the administrative support like dietary services,

housekeeping, laundry and janitorial services are extended to all patients equitably, irrespective of their being serving personnel or veterans."

3.11 However, the Ministry admitted that non-availability of medicines, especially 'Branded Medicines', prescribed by the ECHS empanelled civil hospitals, is considered the major cause of dissatisfaction amongst the ECHS clientele. The representative testified:

"There are other shortcomings in terms of treatment meted out to my patients when they go to an empanelled hospital. A large number of times, we come to know. Then we intervene and get it sorted out. Then the hospital says that they do not have an ECHS bed. There is nothing called a classical ECHS bed. He has done an MoA with me; he has to honour every patient who goes there."

3.12 On the question of parity in treatment of the ex-servicemen vis-a-vis serving officers, Major General R.S. Grewal deposed:

"To address your question about life saving and critical care, the life saving and critical care which is provided in the Armed Forces Medical Service Hospital does not allow for any distinction between a serving person and a veteran. A serving soldier or his or her dependent are given treatment at par with other defence personnel. So there is no question of not allowing them. The instance you referred to, perhaps, pertains to a patient who is prescribed a ventilator which is assisted ventilation for the lungs which is governed by the ECHS and which the ECHS procedures take as much time for him to get reimbursement of the money.

In so far as when we are concerned, in-patient treatment for life saving and critical care is provided in the ICU setting with excellent outcomes without being immodest.

In so far as the treatment coverage is concerned, in the AFMS Hospitals we go by the availability of in-service capacity which means that if in a service hospital, already the bed occupancy and other parameters are optimally utilised it is then that we refer our patients to Empanelled Hospitals.

By and large, as I earlier pointed out, 25 per cent Ex-servicemen, at any point of time, are treated in service hospitals at no cost with good satisfaction."

3.13 While elaborating on the special treatment given to senior veterans, the Ministry, during oral evidence on 11.09.2015 submitted:

"Well, we have a system in the polyclinic also where the senior veterans above 70 are given special treatment. We call it a white card. So, they do not have to stand in the lines. They may straightaway go to the Medical Officer."

3.14 The Committee were further informed that priority is given for consultation and collection of medicine at all ECHS Polyclinics for Senior Citizens, Male 75 years and Female 70 years. The ECHS beneficiaries who are senior citizens/or are disabled are provided special care and compassion when they visit any service medical facility. The following 'Old age, user-friendly measures have been instituted at all service hospitals/med units:

(i) All senior citizen beneficiaries of ECHS have been issued with a special card (White Card), which ensures the following facilities for them:

(ii) Registration on priority for OPD and diagnostic facilities

(iii) Consultation by Medical Officer / Specialist on priority

(iv) Separate window for issue of medicines at Dispensary

(v) Early appointments for diagnostic and therapeutic procedures

(vi) In all service hospitals, helpdesks have been provided in OPD areas where volunteers / designated personnel provide all the requisite support to patients, especially to the senior citizens.

3.15 Further, during discharge from empanelled hospital, the veteran's feedback form is attached to bills of the hospital. Regular e-mail, telephonic complaints are attended to. Moreover, CPGRAMS and other grievance redressal mechanisms are also in place. Interactions with ESM and ESM associations are also regularly held at various levels. Based on the feedback received in this meeting and Performance Audit Report, corrective measures are being taken.

Preparedness in wake of high incremental increase in number of beneficiaries under ECHS.

3.16 Polyclinics categorized as type A to E have a certain designed capacity and the provision of manpower and equipment in the polyclinics are also based on their

categorization. However, the actual dependency of ESM was manifold as against their designed capacity. While elaborating on the reasons it was stated:

> "ECHS Polyclinics were established based on assessed strength of ESM in various districts of the country. Over the years in most cases the ESM population has either increased or witnessed changes. The medical staff authorized to the polyclinic was based on assessment that it will be sufficient to handle the patient load. In some cases the medical staff is less and not able to handle the patient load. In addition, the following has also resulted in the requirement to upgradation of polyclinics:-
>
> (i) ECHS is a compulsory Scheme for post 01st April 2003 Armed Forces personnel retirees and there is no provision to surrender the membership. Hence, it added on to the dependency base of a Polyclinic.
>
> (ii) ECHS membership has been extended to other categories and services, such as Coast Guard, Special Frontier Force (SFF) pensioners and Nepal Domiciled Gorkhas (NDG) Ex-Servicemen, etc.
>
> (iii) General awareness about the scheme amongst the veterans has increased who had earlier not taken ECHS membership."

3.17 While accepting the need to upgrade certain polyclinics, the Committee were further informed about the arrangements put in place to overcome the additional load on polyclinics:

> "Proposal is already under consideration for upgradation of Polyclinics, which are over loaded. CO,ECHS has been directed to delete the names of bogus person who are not eligible to be a member of ECHS Also provision of additional manpower for the overloaded Polyclinic has been arranged by the following methods:-
>
> (i) Transfer of vacancies through CO, ECHS order.
>
> (ii) Utilizing welfare funds at the disposal of Army HQ/ Army Formations and other Services.
>
> (iii) Deptt of ESW has allowed an increase of 1709 posts (bringing the total to 6800 posts) and simultaneously ordered for an independent Board of Officers (BOO) to work out the requirement of contractual manpower at ECHS polyclinics. The report of BOO for requirement of manpower has been received and is under examination.
>
> A case for upgrading Polyclinics (by revision of land and built up area) which are working at capacities more than their designed capacity is under consideration."

3.18 In the wake of high incremental increase in the number of beneficiaries of ECHS every year, the Committee were informed during the oral evidence on 11.09.2015:

> "Our growth is immense. In 2005, the total number of beneficiaries were 3,63, 061 which has now crossed 47 lakh beneficiaries. In 2003-04 the expenditure was 13.5 crore and in the current year the Budget allocation is ₹ 2659 crore."

3.19 The Committee were further given details of the steps put in place to deal with the increased number of beneficiaries every year:

> "(i) The DESW had sanctioned interim 1709 vacancies in the year 2013 bringing the total strength of contractual staff to 6800. An independent Board of officers to work out the requirement of contractual manpower at ECHS Polyclinics was ordered. The Board of officers for manpower review has recommended for increase of persons of various categories of contractual staff.
>
> (ii) DGAFMS is mandated with the responsibility of planning, budgeting, procurement, stocking, distribution issue and supply chain management and maintenance of medical stores, including drugs and non-expendable / expendable medical equipment / items, for the ECHS. The main objective of DGAFMS is to provide required quantity of medical stores of established quality with adequate longevity & their timely delivery at the place of need complying with financial propriety & probity. With the added request / demand of 'branded' medicines with the increased number of beneficiaries every year, following measures have been instituted.
>
> **ECHS Medical Store Supply Chain Management**
>
> (a) **Medical Stores : Drugs and Medical Consumables**: The procurement of drugs and medical consumables for ECHS beneficiaries is being undertaken by O/o DGAFMS, AFMSDs and SEMOs (Commandants/ COs of hospitals/ medical/ dental units) as per procedure approved by the Govt.
>
> (b) **Forecast Planning of Medical store inventory management:** O/o DGAFMS undertakes the procurement and provisioning of medical stores based on a sound, time-tested forecast planning through Monthly Maintenance Figures (MMF). This exercise of arriving at realistic MMF of any user establishment is based on their annual consumption pattern from the previous year. The major stakeholders, i.e. Central Org ECHS through its Regional Centres, and Polyclinics, in consultation with the (SEMOs), are required to collate, analyse and consolidate the annual demands and MMF for drugs and other medical stores in respect of all ECHS Polyclinics and forward the same to O/o DGAFMS by the 30th Nov of each year. These cogent demands form the basis for forecast planning for the ensuing year.

(c) **Budget: ECHS**: The O/o DGAFMS on obtaining their annual consumption patterns, forwards budget estimates for drugs and consumables for the forthcoming financial year to Central Org ECHS by 30 Dec each year, for intimation to DGFP for allocation of budget. The accurate budget projections for the forthcoming year largely depends on realistic MMF received from the environment.

(d) The detailed ECHS Budget allotment of last 3 years to SEMOs, to cater to the requirements of dependent ECHS Polyclinics, is placed at **Appendix - VI**.

(e) **Essential Drugs List (EDL) for ECHS:-** Considering the geriatrics related morbidity profile of the healthcare dependent majority of veterans, adequate steps have been taken to formulate a new EDL for ECHS, wherein medicines to cover Oncology, Cardiology, Respiratory, Nephrology, Rheumatology and Metabolic Diseases have been included.

(f) **Central Rate Contracts (RCs)** have been concluded for 301 medicines and consumables. 50 percent of the medicines on the EDL for ECHS have been placed on Central Rate Contracts (RCs).

(g) **Proposed Measures for Improvement of Supply Chain:**

(i) Conclusion of RCs of the remaining EDL for ECHS is being given due priority.

(ii) Depots have been directed to ensure maximum compliance of EDL for ECHS and Common Drugs List (CDL) for service clientele.

(iii) 168 of the CDL medicines are under Central Rate Contract. Concerted efforts are being undertaken to increase RC coverage of the remaining CDL and EDL.

(iv) SEMOs can operate RCs of drugs as per DFPDS- 2015.

(v) RC firms/ OEMs have been asked to fulfil the LP demands placed by SEMOs for ECHS medicines.

(vi) Increase in the delegated financial powers (DFPDS-2015) should also address the non-availability of medicines significantly.

(vii) Inputs are being collated from Line Depts and Depots to increase the number of Direct Demanding Officers (DDOs) to improve the coverage of Central RCs and better supply chain management of medicines.

(viii) Introduction of i-Aushadi software to bring in the desired level of automation and to further streamline the supply chain management.

(ix) e-Procurement is being implemented for AFMS procurements in line with the existing Government guidelines to bring in the transparency and hasten up the procurement process."

3.20 In respect of budget shortfalls being expected in light of increased annual beneficiaries, it was stated that adequate budget is provided by the Govt. to ECHS and same has been confirmed by MD,ECHS. The detailed ECHS funds state for the period for 2012-13 to 2015-16 is placed at **Appendix - VII.**

3.21 The Ministry also further elaborated that a number of shortcomings have been noticed during provisioning of better medicare services to ECHS beneficiaries, which are primarily linked with non-availability of medicines, fixed medical allowance to beneficiaries who are residing in area not covered by ECHS, full reimbursement of expenditure incurred during medical treatment in an emergency, authorization of medical equipment to physical challenged ECHS beneficiaries and so on. To overcome the above shortcomings following cases are under consideration:

(i) Outsourcing of Pharmacy operation in two Regional Centres as a pilot project.

(ii) Full reimbursement of emergency medical treatment.

(iii) Restoration of Fixed Medical Allowance (FMA) to persons residing in districts not covered by ECHS.

(iv) Change in authorization of ward category for JCOs in empanelled medical facilities

(v) Speedier empanelment of hospitals.

Miscellaneous

(i) **Quality Council of India (QCI)**

3.22 Quality Council of India (QCI) is part of National Accreditation Board for Hospitals and Healthcare Providers (NABH) which have their own guidelines/ standards. QCI inspects the hospitals based on the same criteria as were used by Station Board of Officers during the period 2003-2011. The criteria for inspection are briefly part of the application form which specifies minimum criteria in each department. However, on being asked as to how often are the empanelled hospitals reviewed by Quality Council

of India to continue, revise or discontinue services of empanelled hospitals, the Ministry submitted in reply to a written query that QCI does the initial inspection only. The review inspections of empanelled hospitals are done locally based on complaints or feedback from patients.

(ii) **Fixed Medical Allowance**

3.23 ECHS is based on the same lines as that of CGHS and following the guidelines of MoH&FW meant for CGHS. The Committee while noting that the allowance receivable per month by beneficiaries in districts not covered by the CGHS/ECHS is not adequate, asked the Ministry to comment on the norm being followed under ECHS and also on any plans to revise the same. However, the Ministry submitted in the post briefing replies that presently ECHS beneficiaries are not eligible for Fixed Medical Allowance (FMA) @ ₹ 500/- pm. Hence for entitling FMA to ECHS members residing at districts not covered by ECHS Polyclinics or Armed forces Clinics or Armed Forces Hospitals and not availing of OPD facilities is under consideration.

(iii) **Non-Development of Audit Module for Post Audit in ECHS**

3.24 The non-development of audit module in ECHS leads to fake claims being raised in some cases. The Committee, in reply to a query regarding inadequate post audit to verify the authenticity of the bills raised thereby leading to anomalies, were informed in the written replies:

> "A pilot project to develop an online audit module is under progress under the aegis of Principal Controller of Defence Accounts (PCDA), Secunderabad and is being evaluated at Regional Centre Hyderabad. A number of iterations on the module with respect to workflow and IT application have taken place. The training of the CGDA staff is underway. The module once accepted by CGDA will be implemented pan India."

3.25 About the extant internal checks to verify the authenticity of the bills, the DESW submitted that instructions have been issued to CO ECHS to have adequate checks to verify the authenticity of the bills.

PART - II

OBSERVATIONS/RECOMMENDATIONS

1. Need for greater geographical coverage: The Committee note that at the time of inception of the Ex-Servicemen Contributory Health Scheme (ECHS), 227 polyclinics under 13 Regional Centres were sanctioned to provide 'out patient care' to the beneficiaries. However, in 2010, 182 additional polyclinics under 15 more regional centres along with 17 mobile clinics were sanctioned, making a total of 426 ECHS polyclinics. The Committee are concerned to note that the scheme has so far covered only a total of 339 districts out of 659 districts in the country restricting the geographical coverage to a mere 51 per cent. Further, the Committee also note that out of total 426 ECHS polyclinics, 418 are operational. Notably, any further expansion shall be undertaken only upon making the already sanctioned polyclinics operational, taking the coverage to 59 per cent instead of 51 per cent. The Committee are dismayed to note the non-judicious distribution of polyclinics in some States. Due to excess load on already existing polyclinics with respect to their designated capacity and inadequacy of resources, the Committee express their serious concern over the lack of efficient medicare being provided to ESM. The Committee therefore recommend that effective steps be taken to operationalize the 426 polyclinics already sanctioned and measures be taken expeditiously to further increase geographical coverage of the scheme by taking up the next phase of expansion to 67 stations. The Committee also recommend that the expenditure incurred on public transport by the remote area designated beneficiaries for visiting ECHS centres upto the rank of non-JCOs and below be reimbursed till such designated remote geographical coverage of ECHS centres is completed. The Committee further recommend that a precise plan be drawn up for subsequent expansion of the polyclinics network and thereby better

geographical coverage of ECHS considering the incremental increase in the number of beneficiaries and the mounting load on the existing polyclinics and the Committee be apprised of the same.

2. Acquisition of land for polyclinics: The Committee note that of the total 409 polyclinics sanctioned, land has been acquired for 221 locations and buildings have been constructed for 140 locations. Land is yet to be acquired for non-military clinics in case of 188 sites. The total non-military polyclinics stand at 297 of which only 109 are operating from permanent locations. The Committee are of the considered view that major difficulties are faced where land is to be acquired from State Governments or individuals. The Committee further note that even where land is acquired, a considerable amount of time is taken at the end of the Ministry of Defence (DESW) to complete formalities and construct a permanent building as 68 locations are such where land has been acquired but a permanent building is yet awaited. The Committee also note that despite some efforts being made to coordinate with the States to expedite acquisition, there is inordinate delay in acquisition and consequently in construction of clinics. They, therefore, recommend that concerted efforts be made to accelerate the process for acquisition of land and early construction of medical infrastructure for ESMs. The Committee would like to be apprised of the action taken in this regard.

3. Empanelment of Hospitals: The Committee note that a total of 1268 private hospitals have been empanelled under ECHS. The Committee further note that due to delayed clearance of bills, as many as 407 empanelled hospitals withdrew from the empanelment and despite the introduction of online billing only 46 hospitals have rejoined ECHS. The Committee are dismayed to note that 71

polyclinics out of a total of 418 functional polyclinics did not have any empanelled facility in its location. This reflects poorly on the reach of the scheme. The mere 51 per cent geographical coverage of the scheme in the country and further non-availability of empanelled facility in another 71 polyclinics indicates lack of services and the resultant hardships being faced by the beneficiaries. Taking a serious view of the hardships being faced by ex-servicemen, the Committee recommend that along with increasing the geographical coverage of the scheme, immediate steps be also taken to ensure that adequate hospitals are empanelled with every polyclinic. The concerns of private hospitals for not empanelling with ECHS be addressed at the earliest and station headquarters be directed to give wide publicity of the scheme to ensure that more hospitals volunteer to be empanelled with the ECHS. The Committee also recommend that the existing CFA financial powers be adequately enhanced from time to time to ensure speedy settlement of bills. Taking note of excessive load of ECHS beneficiaries on polyclinics and army hospitals and the avoidable shuttling of ECHS beneficiaries between polyclinics and hospitals especially at non-military stations, the Committee recommend that the referral procedure for going to an empanelled facility be simplified and made beneficiary friendly.

4. Treatment provided to beneficiaries at empanelled facilities: The Committee note that the treatment meted out to the ECHS beneficiaries at the empanelled hospitals is the main cause of dissatisfaction amongst the beneficiaries. The representative of Ministry of Defence conceded before the Committee that many private hospitals refuse to honour ECHS patients despite signing of MoA with the Ministry, thereby causing a lot of inconvenience to the beneficiaries. Further, the Committee also note that despite clear instructions at

the time of empanelment, many doctors at private facilities take to prescribing of 'branded medicines' in place of generic in the name of lack of time. Such a conduct on the part of private facilities and doctors causes further dissatisfaction amongst beneficiaries. The Committee, therefore, recommend that a written clause to the effect of prescribing generic medicines be incorporated in the agreement at the time of empanelment with a provision for debarring of such a hospital and also for legal action against such doctors and hospitals who refuse to treat ECHS patients or delay their treatment.

5. Shortage of Manpower: The Committee note that the present strength of 760 medical officers and 168 medical superintendents is against 953 and 322 authorized strength respectively. Further, the existing strength of 168 medical specialists for 418 operational polyclinics indicates the apparent hardships being faced by the beneficiaries in the polyclinics, especially those 71 polyclinics which do not even have the facility of an empanelled hospital. The Committee seek reasons as to why 1709 interim contractual vacancies have been sanctioned in 2013 despite the already existing 6800 contractual standing partially unfilled. The Committee, therefore, recommend that the proposed hike in remuneration be made applicable without any further delay. Further, the Committee also feel that the hike from ₹ 46,000 to ₹ 60,000 and from ₹ 60,000 to ₹ 72,000 for Medical Officers and Medical Specialists respectively may not be adequate enough an incentive to retain the doctors. Further incentivization in the form of special hardship allowance may also be considered for doctors and specialists posted in remote areas. Also on the lines of the provision for specialists, Medical Officers may also be allowed to continue with private practice for some hours after fulfilling of contractual commitments towards ECHS in far flung and remote districts.

6. Shortage of Manpower in posts reserved for ESM: The Committee note severe shortages of manpower to the tune of 78 per cent for medical staff, 72 per cent for paramedical staff and 70 per cent for non-medical staff in posts reserved for the ESM. The Committee believe that such a huge shortfall cannot be due to mere recent developments but due to prolonged neglect. In the first place, the posts reserved, if not filled, can be filled up by civilian candidates but only after an endorsement to such effect is issued by the General Officer Commanding (GOC) Area/Sub Area. The huge backlog reflects poorly on the performance and flawed policies of the Ministry. Further, as for doctors, the shortage also exists in unreserved posts, but the same is not true for paramedical and non-medical staff, which could have been filled well in time if opened for civilian candidates. The action plan of the Ministry merely talks of wide publicity and a proposal to increase the remuneration of medical staff. However, no proposal for revision of remuneration of paramedical and non-medical staff was brought to the notice of the Committee. Therefore, the Committee recommend that such posts be filled by available candidates at the earliest after receiving endorsement from the concerned GOC's and the proposal to revise remuneration of medical staff be considered and adopted without any delay. An action plan to fill up these posts from available candidates, civilian or ex-servicemen, should be drafted considering the need for introducing special incentives/allowances especially in remote areas. The Committee would like to be apprised of action taken in this regard.

7. Armed Forces Medical College: The Committee note that there is some shortage of medical officers and medical specialists in the Armed Forces Medical Services. The annual average intake is from the AFMC and rest from pan Indian Colleges. However, the Committee are surprised to note that the annual intake of

120 students sanctioned in 1962 was revised only in 1999 to 130 students. Considering the shortage of medical officers in the various polyclinics, also around 4 percent shortage in AFMS and the rising number of beneficiaries, the Committee recommend that the intake of AFMC be suitably enhanced. Further, the Committee urge the Government to look into the timely revision of manpower in the AFMS to overcome chronic shortages.

8. Retention of doctors passing out from AFMC: The Committee note that the 130 students admitted for the MBBS programme in AFMS are liable to serve in the medical services of the Armed Forces on successful completion of MBBS for at least seven years failing which the bond money amounting to ₹ 25 lakhs to ₹ 30 Lakhs is forfeited. However, despite such deterrent measures to retain the passing out students and a substantial increase in bond money from ₹ 15 lakhs to ₹ 25 lakhs in academic session 2014, the percentage of MBBS doctors passing out of AFMC and opting to pay bond money has substantially increased. For instance, from 2006 to 2015, the percentage of MBBS doctors opting to pay bond money increased from 6 percent to 18 percent respectively creating trouble for the scheme already struggling with deficiency of medical officers due to premature retirement and release/resignation after Short Service Commission. The Committee also note that though the bond amount has been revised as students found it relatively convenient to pay a lesser amount to move to lucrative medical practices, the high stress and hazardous working environment involving service by MO's in remote areas, bad terrains and war zones at a pay lower than that being offered in private corporate hospitals and no further avenues of upgrading of education after MBBS for 7 years of services in case of Short Service Commission and 4 years in case of permanent commissioned cannot be overlooked as major deterrents for MBBS students to serve in the

Armed Forces Medical Services. The Committee further observe that such a trend has the potential to affect the plans of AFMS to roll out trained candidates as doctors to serve in the Armed Forces Medical Services and hence needs to be contained at the earliest. The scheme, therefore, calls for a revisit and the Committee recommend that a revision of the compulsory period of service expected from an MBBS pass out as Medical Officer and introduction of better incentives and opportunities for further education be considered to contain the growing attrition rate. The Committee would like to be apprised of action taken in this regard.

9. Shortage of Medicines & Lack of Medical Equipment at ECHS Polyclinics and Army Hospitals: The Committee are dismayed to note that a major difficulty being faced by ECHS beneficiary is of non-availability of medicines at ECHS polyclinics leading to a dismal 60 percent level of satisfaction amongst the beneficiaries. Having regard to the fact that about 90 per cent beneficiaries are treated at polyclinic level, non-availability of medicines affects the clientele hugely. The Committee are further perturbed to note that the medicines prescribed in OPD are not reimbursable as is the case with CGHS, leading to considerable inconvenience to veterans in absence of both lack of empanelled authorized local chemists and no provision for reimbursement. The Committee view such a serious lacunae in service provision as major hurdle for ECHS and therefore recommend immediate provision for reimbursement of medicines on the lines of CGHS for prescribed but unavailable medicines. Further, the Committee recommend that the supply of essential drugs listed by ECHS and the common drug list be assured. Further, the number of Direct Demanding Officers be suitably increased to improve coverage along with a further increase in the financial powers of all Competent Financial Authorities (CFAs) for better

inventory management of medicines. Further, the concept of Authorized Local Chemists (ALCs) be introduced and made functional at the earliest in line with CGHS. The Committee desire that the existing system of budgeting, procurement, stocking, distribution and disposal of medicines be analyzed and simplified for being made less time consuming and veteran friendly. The Committee also note that the Ministry formed a Committee to minimise dissatisfaction over availability of medicines and to suggest suitable measures in this behalf. They would like to be apprised of the suggestions made by the Committee appointed by the Government and the action taken to implement them within the timeframe given.

10. Issue of domiciliary equipment. The Committee note that lack of timely availability of medical equipment for domiciliary use is another area of concern for the veteran clientele. The Committee are dismayed to note that a major dichotomy exists in providing of medical equipment to the beneficiaries as not only the procedural impediments lead to delay in providing of such equipment but also the prescribed minimum period of five years for use of such equipment. The Committee recommend that the clause of five years for use of medical equipment be done away with, on production of a certificate regarding faultiness of the equipment outside of warranty period and the need for issue of a new or better equipment. Further, the Committee also desire that procedural modalities be smoothened for early procurement and timely supply of medical equipment.

11. Provisioning of Smart Cards: The Committee note that Smart Cards were provisioned to ECHS beneficiaries from the year 2003 and the contract for the same was provided to a private firm. Up till 31 May, 2015, the contract was operational with the firm. However, the Committee are perturbed to note that on culmination of the contract, no internal control system to weed out unaccounted cards and to check multiple enrolments of cards and beneficiaries is in place

resulting in raising of fake bills in the name of ineligible persons with expired cards or with fraudulent membership. The Committee were further informed during evidence regarding instructions issued to Central Organization (CO), ECHS to check any misuse of smart cards that should have been ideally deactivated but in absence of any mechanism continue to avail the facility/service. The Committee are anguished to note the inability of the Ministry for not contracting a new agency for supply of smart cards despite the expiry of contract in May, 2015. Such delay on the part of the Ministry not only causes loss to the public exchequer due to raising of ineligible bills but also causes serious inconvenience to the beneficiaries. The Committee also take a strong view of the lack of adequate checks and balances to prevent multiple enrolments in the scheme and recommend immediate action to rectify the anomaly and ensure timely awarding of contracts for smooth functioning of the scheme.

12. Unauthorised extensions: The Committee observe that CAG in the performance audit has found irregularities in renewal of the agreement for supply of smart cards with the same firm with increased cost without sanction of CFA. When asked as to the reasons for the same, DESW instead of furnishing the rationale, merely stated that the extension was given by the then Competent Financial Authority (CFA), the Adjutant General and the ECHS was placed as an attached office of DESW only in October, 2009 for only executive role (policy formulation). Further, the Department stated that AG's Branch is still responsible for administrative and technical control. Prior to that, the Committee were informed that AG's Branch was authorised by the Ministry to enter into any agreement/renew or termination in respect to the Scheme. Taking serious note of the delay on the part of DESW to furnish specific reply, the Committee, therefore, recommend that they be furnished the basis of renewal of the contract

with the same firm with increased cost at the earliest but positively within three months of the presentation of this Report.

13. Overcharging for health smart card: The Committee note that approximately ₹ 50 crore was collected from the beneficiaries of ECHS since 2004 until the expiry of the contract. On the one hand, DESW states that charging the beneficiaries for the card has not resulted in any loss to the exchequer, on the other, it submits that ECHS has benefited in terms of automation as the cost of card included the IT backbone to be provided by the vendor. The Committee are of the considered view that since the cost of card is stated to have been included in the IT backbone itself, the firm might have included the cost of provision of smart card also in their price quoted for the contract. They, therefore, may be apprised of the rationale for charging the beneficiaries of ECHS separately since it is claimed that the cost of card is included in the IT backbone itself, which was paid for by ECHS.

14. Revamping of internal audit: The Committee are surprised to find that there is no post audit mechanism in ECHS despite having budgetary allocations of ₹ 2200 crore approximately. There does not appear to be concurrent audit also. The Committee, therefore, recommend that a robust audit module should be put in place at the earliest to detect malpractices concurrently such as unauthorized use of ECHS, double payment of the bills, etc and the Committee be apprised.

NEW DELHI;
07 December, 2016
Agrahayana 16, 1938 (Saka)

Dr. MURLI MANOHAR JOSHI,
CHAIRPERSON,
COMMITTEE ON ESTIMATES.

Appendix - I
Para 1.8

State-Wise List of ECHS Polyclinics

Ser No	Polyclinics	Ser No	Polyclinics
Andaman and Nicobar (01)		**Bihar (18)**	
1.	Port Blair	34.	Ara
Andhra Pradesh (18)		35.	Muzaffarpur
2.	Vishakapatnam	36.	Danapur (Patna)
3.	Guntur	37.	Chhapra
4.	Secunderabad	38.	Darbhanga
5.	Secunderabad (2nd)	39.	Gaya
6.	Chittoor	40.	Katihar
7.	Giddalur	41.	Motihari
8.	Golconda	42.	Vaishali
9.	Kakinada	43.	Buxar
10.	Vijayawada	44.	Siwan
11.	Srikakulam	45.	Sitamarhi
12.	Eluru	46.	Sasaram
13.	Kurnool	47.	Bhagalpur
14.	Karimnagar	48.	Samastipur
15.	Ananthapur	49.	Madhubani
16.	Cuddapah	50.	Khagaria
17.	Khammam	51.	Munger
18.	Nellore	**Chandigarh (01)**	
19.	Mehbubnagar	52.	Chandigarh
Arunachal Pradesh (02)			
20.	**Tezu***	**Chhatisgarh (04)**	
21.	**Along***	53.	Raipur
Assam (12)		54.	Bilaspur
22.	Jorhat	55.	Jagdalpur
23.	Guwahati	56.	Raigarh (Jashpur)
24.	Masimpur	**Delhi (06)**	
25.	Misamari	57.	Delhi Cantt (BHDC)
26.	Dibrugarh	58.	Lodhi Road (New Delhi)
27.	Tezpur	59.	Khanpur
28.	Tinsukia	60.	Timarpur
29.	Bongaigaon	61.	Shakurbasti
30.	Dhubri	62.	**East Delhi Area***
31.	Lakhimpur	**Goa (02)**	
32.	Goalpara	63.	Panaji
33.	**Lanka***	64.	Vasco-da-gama

Gujarat (06)		**Himachal Pradesh (19)**	
65.	Ahmedabad	105.	Bakloh
66.	Jamnagar	106.	Yol
67.	Vadodra	107.	Mandi
68.	Bhuj	108.	Hamirpur
69.	Rajkot	109.	Bilaspur
70.	Surat	110.	Una
Haryana (34)		111.	Solan
71.	Chandimandir	112.	Shimla
72.	Faridabad	113.	Chamba
73.	Karnal	114.	Palampur
74.	Ambala	115.	Kullu
75.	Sonepat	116.	Jogindernagar
76.	Panipat	117.	Sarakaghat
77.	Yamunanagar	118.	Shahpur
78.	Kaithal	119.	Deragopipur
79.	Kurukshetra	120.	Nahan
80.	Gurgaon	121.	Barsar
81.	Sirsa	122.	Ghumarvin
82.	Jhajjar	123.	**Rampur***
83.	Rewari	**Jammu & Kashmir (14)**	
84.	Rohtak	124.	Akhnoor
85.	Jind	125.	Leh
86.	Narnaul	126.	Udhampur
87.	Bhiwani	127.	Rajouri
88.	Hissar	128.	Srinagar
89.	Fatehabad	129.	Samba
90.	Loharu	130.	Jammu
91.	Dharuhera	131.	Junglot (Kathua)
92.	Gurgaon (Sohana Road)	132.	Baramulla
93.	Kosli	133.	Doda
94.	Charki Dadri	134.	Poonch
95.	Gohana	135.	Nagrota (Gujroo)
96.	Palwal	136.	Baribrahmna
97.	Kharkhoda	137.	Khanabal
98.	Narayangarh	**Jharkhand (07)**	
99.	Mahendragarh	138.	Ranchi
100.	Narwana	139.	Jamshedpur
101.	Bahadurgarh	140.	Daltonganj
102.	Meham	141.	Deogarh
103.	Sampla	142.	Chaibasa
104.	**Nuh***	143.	Gumla
		144.	Dhanbad

Karnataka (17)		**Madhya Pradesh (12)**	
145.	Bangalore (Urban)	185.	Jabalpur
146.	Yelahanka (Bangalore)	186.	Rewa
147.	Madekeri	187.	Mhow
148.	Mangalore	188.	Bhopal
149.	Mysore	189.	Bhind
150.	Belgaum	190.	Gwalior
151.	Bijapur	191.	Morena
152.	Dharwad	192.	Sagaur
153.	Karwar	193.	Amla
154.	Bidar	194.	Pachmarhi
155.	Kolar	195.	Satna
156.	Tumkur	196.	Ujjain
157.	Hassan	**Maharashtra (30)**	
158.	Shimoga	197.	Nagpur
159.	Virarajendrapet	198.	Solapur
160.	MEG Bangalore	199.	Ahmednagar
161.	Gulbarga	200.	Osmanabad
Kerala (23)		201.	Latur
162.	Palakkad	202.	Aurangabad
163.	Kochi	203.	Buldana
164.	Kannur	204.	Jalgaon
165.	Kozhikode (Calicut)	205.	Devlali
166.	Perinthalmanna	206.	Mumbai (Navy)
167.	Alleppey (Alapuzha)	207.	Mumbai (Upnagar)
168.	Thrissur	208.	Satara
169.	Kottayam	209.	Kolhapur
170.	Trivandrum	210.	Miraj (Sangli)
171.	Pathanamthitta	211.	Chiplun
172.	Kollam	212.	Sindhudurg
173.	Moovattupuzha	213.	Thane (Nerul)
174.	Kanhagad	214.	Mahad
175.	Iritti	215.	Akola
176.	Changanacherry	216.	Amravati
177.	Kalpetta	217.	Pune
178.	Mavelikara	218.	Wardha
179.	Trivandrum (Med College)	219.	Dhule
180.	Painavu	220.	Khadki (Pune)
181.	Kunnamkulam	221.	Karad
182.	Kottarakara	222.	South Pune (Lohegaon)
183.	Ranni	223.	Nanded
184.	Kilimanur	224.	Beed
		225.	Mumbai (COD Kandivali)
		226.	**Yavatmal***

Manipur (02)		**Punjab (Continued)**	
227.	Imphal (Leimakhong)	261.	Mansa
228.	Churachandpur	262.	Barnala
Meghalaya (01)		263.	Ajnala
229.	Shillong	264.	Tarantaran/Patti
Mizoram (02)		265.	Beas
230.	Aizwal	266.	Batala
231.	**Lunglei***	267.	Suranassi
Nagaland (03)		268.	Nawansahar
232.	Dimapur	269.	Samana
233.	Zakhama (Kohima)	270.	Nabha
234.	Mokokchung	271.	Uchi Bassi
Orissa (09)		272.	Talwara
235.	Behrampur	273.	Mohali
236.	Bhubaneswar	274.	Mahalpur (Garhshankar)
237.	Balasore	275.	Sri Hargovindpur
238.	Dhenkanal	276.	Abohar
239.	Puri	277.	Sultanpur Lodhi
240.	Sambalpur	278.	Phagwara
241.	Angul	279.	Doraha
242.	Koraput	280.	Jagraon
243.	Bhawanipatna	281.	Samrala
Puducherry (01)		**Rajasthan (30)**	
244.	Puducherry	282.	Bikaner
Punjab (37)		283.	Sriganganagar
245.	Pathankot	284.	Alwar
246.	Amritsar	285.	Bharatpur
247.	Ropar	286.	Jhunjhunu
248.	Faridkot	287.	Jaipur
249.	Ferozpur	288.	Sikar
250.	Moga	289.	Churu
251.	Gurdaspur	290.	Nagaur
252.	Hoshiarpur	291.	Kota
253.	Jalandhar	292.	Hindaun City (District Karrauli)
254.	Kapurthala	293.	Ajmer
255.	Ludhiana	294.	Barmer (Jalipa)
256.	Sangrur	295.	Jaisalmer
257.	Patiala	296.	Jodhpur
258.	Muktsar	297.	Pali
259.	Fatehgarh Sahib	298.	Udaipur
260.	Bhatinda	299.	Shergarh

Rajasthan (Continued)		**Tripura (01)**	
300.	Chirawa	340.	Agartala
301.	Dausa	**Uttrakhand (21)**	
302.	Sanganer (Vidhyadhar Nagar)	341.	Dehradun
303.	Bhuwana	342.	Karanprayag (Gopeshwar)
304.	Behror	343.	Kotdwara
305.	Didwana	344.	Pauri Garhwal
306.	Bhilwara	345.	Haldwani
307.	Rajgarh	346.	Pithoragarh
308.	Dungarpur	347.	Roorkee
309.	Rajsamand	348.	Almora
310.	Nim Ka Thana	349.	Vikasnagar
311.	Suratgarh	350.	Rudrapur
312.	Gangtok	351.	Joshimath
Tamilnadu (27)		352.	Rudraprayag
313.	Vellore	353.	Landsdowne
314.	Chennai	354.	Banbasa
315.	Avadi	355.	Dharchula
316.	Kanchipuram	356.	Raiwala
317.	Cuddalore	357.	Hempur
318.	Villupuram	358.	Uttarkashi
319.	Coimbatore	359.	Ranikhet
320.	Krishnagiri	360.	Bageshwar
321.	Salem	361.	Tehri
322.	Srivilliputtur	**Uttar Pradesh (49)**	
323.	Dindigul	362.	Ghaziabad
324.	Madurai	363.	Noida
325.	Tiruchirapalli	364.	Kanpur
326.	Nagapattinam	365.	Agra
327.	Thanjavur	366.	Etawah
328.	Theni	367.	Mainpuri
329.	Tirunelveli	368.	Firozabad
330.	Nagarcoil	369.	Etah
331.	Tuticorin	370.	Bulandshahr
332.	Wellington	371.	Bareilly
333.	Thiruvannamalai	372.	Badaun
334.	Chennai (Island Ground)	373.	Fatehgarh
	Kumbakonum	374.	Akbarpur Matti (Kanpur Dehat)
336.	Tambram	375.	Lucknow
337.	Ramnathapuram	376.	Raebareli
338.	335.	377.	Mathura
339.	Erode	378.	Aligarh

Uttar Pradesh (Continued)		**Uttar Pradesh (Continued)**	
379.	Meerut	404.	Moradabad
380.	Muzaffarnagar	405.	Lakhimpur
381.	Saharanpur (Sarsawa)	406.	Bijnor
382.	Shahjahanpur	407.	Hathras
383.	Gorakhpur	408.	Rampur
384.	Allahabad	409.	Baghpat
385.	Fatehpur	410.	Jaunpur
386.	Pratapgarh	**West Bengal (16)**	
387.	Azamgarh	411.	Barrackpore
388.	Sultanpur	412.	Bengdubi
389.	Faizabad	413.	Lebong (Darjeeling)
390.	Deoria	414.	Krishnanagar
391.	Ghazipur	415.	Kolkata
392.	Varanasi	416.	Salt Lake
393.	Balia	417.	Midnapur
394.	Jhansi	418.	Burdwan
395.	Orai	419.	Cooch Behar
396.	Basti	420.	Behrampur
397.	Banda	421.	Binaguri
398.	Hardoi	422.	Kalimpong
399.	Barabanki	423.	Raiganj
400.	Unnao	424.	Baruipur
401.	Mirzapur	425.	Howrah
402.	Greater Noida	426.	Bankura
403.	Gonda	427	**Kathmandu (Nepal)**
		428	**Pokhra (Nepal)**
		429	**Dharan (Nepal)**
		430	**Mobile Polyclinic, Kathmandu (Nepal)***
		431	**Mobile Polyclinic, Pokhra (Nepal)***
		432	**Mobile Polyclinic, Dharan (Nepal)***

* Polyclinics yet to be made functional

Appendix - II
Para 2.35

TIME FRAME FOR PROCUREMENT
[UNDER SINGLE AND TWO-BID SYSTEM]

RECEIPT OF INDENT

S. No.	Activity	Under	
		Single Bid	Two-Bid
1	Vetting and Registration of Indent	1 week	1 week
2.	Vendor Selection and preparation of REF	1 week	1 week
3.	IFA's concurrence, CFA's approval and floating of RFP	2 weeks	2 weeks

PROCUREMENT ACTION

4.	Time allowed for submission of offers	1 to 3 weeks*	1 to 3 weeks*
5	Opening of technical bid and technical evaluation by TEC	NA	3 weeks
5 A	Opening of commercial bids, preparation of CST and vetting etc.	2 weeks	2 weeks
6	Submission of proposal for procurement or making counter offer or for holding negotiations with the concurrence of the IFA and approval of the proposal by the CFA	2 weeks	2 weeks
6A	Preparation of brief for the CNC, issuing notice for the CNC and actual conduct of CNC meeting	4 weeks	4 weeks
7.	Preparation of the minutes of the CNC meeting and obtaining of signatures of the members/chairman of the CNC	1 week	1 week
8.	IFA's concurrence and CFA's approval of the purchase proposal	2 weeks	2 weeks
9.	Preparation and dispatch of the Supply Order/signing of the contract	1 week	1 week
	Total	17 to 19 weeks	20 to 23 weeks

* This may vary as per the requirement.

Appendix - III
Para 2.43

No. 24(8)/03/US(WE)/D(Res)
Government of India
Ministry of Defence

New Delhi, the 19th Dec'2003

To,

The Chief of Army Staff
The Chief of Naval Staff
The Chief of Air Staff

Subject: Procedure for Payment and reimbursement of medical expenses under ECHS

Sir,

With reference to Govt. of India, Ministry of Defence letter No. 22(1)/01/US(WE)/D(Res) dated 30th Dec 2002 I am directed to convey the sanction of the President for adoption of the Procedure for payment and reimbursement of medical expenses under ECHS.

2. The procedure will be reviewed after one year or as and when required, whichever is earlier.

3. This issues with the concurrence of Ministry of Defence (Finance) vide their U.O No. 1363/PD/03 dated 17.12.2003.

Yours faithfully,

Sd/- xxx

(V.K. JAIN)
Under Secretary to the Govt. of India

Copy to:-

1. CGDA, New Delhi
2. SO to Defence Secretary
3. PPS to FA (DS)
4. PPS to AS (B) (Acquisition)
5. PPS to AS (T) / PPS to AS (I)
6. Addl FA (B) / Addl FA (Y)
7. JS (ESW)
8. JS (O/N)
9. Dir (Finance/AG)
10. Defence (Finance/AG/PD)
11. DFA (B) / DFA (N) / DFA (Air Force)
12. AFA (B-1)
13. D (Works) / D (Mov) / D (Med)

14. O&M Unit

Also to:-

15. DGAFMS
16. DGDE, New Delhi
17. DGD C&W
18. QMG
19. DGMS
20. DGMS (Air)
21. DGMS (Navy)
22. AOA
23. COP
24. MD Central Org ECHS
25. ADG C&W
26. DG (Works), E-in-C Branch
27. ADG (FP)
28. All Command Hedquarters
29. Navy Headquarters (PS Dte)
30. AG Branch / CW-3
31. Air Headquarters (PS & R)

Copies signed in ink :-

32. CDA (Army), Bangalore
33. CDA (WC), Chandigarh
34. CDA (Army), Patna
35. CDA (SC), Pune
36. CDA (Army), Meerut
37. CDA (NC), Jammu
38. CDA (Officers), Pune
39. CDA (Navy), Bombay
40. CDA (AF), Dehradun
41. CDA (Army), Jabalpur
42. CDA (Army), Secunderabad
43. CDA (Army), Lucknow
44. CDA (Army), Chennai
45. CDA (Army), Kolkata
46. CDA (AF), Delhi
47. CDA (Army), Guwahati
48. CDA (Army), Bombay
49. CDA (Army), Dehradun

EX-SERVICEMEN CONTRIBUTORY HEALTH SCHEME (ECHS) PROCEDURE ON PAYMENTS AND REIMBURSEMENTS FOR MEDICAL EXPENSES

AUTHORISATION

1. The authorization for payments to empanelled Hospitals, Nursing Homes, Diagnostic Centres and re- imbursement of medical expenses to Ex-Servicemen is as per para 2(j) of Govt of India letter No 22(1)/01/ US(WF)/D(Res) dated 30 Dec 2002.

REFERRAL TO HOSPITALS

2. **Military Stations:** Ex-Servicemen (ESM) and their dependents requiring hospital admission will, in normal course, be referred to Service hospitals, in the station. For this purpose Director General Armed Forces Medical Services (DGAFMS) will earmark a suitable proportion of beds in all Service hospitals for ECHS beneficiaries (except during war/ operational commitments). In case of non-availability of beds/facilities in service hospital, patients will be referred to empanelled hospitals for admission.

3. **Non Military Stations:** In non-military stations, ESM and their dependents will be referred to nearest service hospital/ empanelled hospitals by Medical Officer of ECHS Polyclinic.

PAYMENT TO EMPANELLED HOSPITALS/ NURSING HOMES/ DIAGNOSTIC CENTRES.

4. The payments by ECHS to the empanelled Hospitals, Nursing Homes and Diagnostic Centres will be governed by the following procedure:-

(a) **Referral to Empanelled Hospital/ Nursing Home/ Diagnostic Centre.** Payment of bills to empanelled concerns will only be authorised when patients are referred from ECHS Polyclinic for necessary treatment/ investigation. Hospitals will only treat patients for conditions for which they have been specifically referred from the ECHS Polyclinic, except in life saving /emergency situations.

(b) **Payment of charges to Empanelled Hospitals/Diagnostic centre.**

(i) The rates of payment to empanelled hospitals/Diagnostic centres in cities/towns covered under CGHS will be governed by the package deal rates as laid down for CGHS. The rates laid down for CGHS for various towns/cities will be applicable for ECHS Polyclinics located in corresponding/adjoining geographical areas.

(iv) For the polyclinics located in cities/towns not covered under CGHS, the rates of payment to the Empanelled Hospitals/Diagnostic centres will be negotiated and fixed by ECHS based on the facilities available and the prevailing market rates. The rates so fixed will, in any circumstances, not exceed the CGHS rates applicable to the nearest cities/towns covered under CGHS.

(iii) For diseases and conditions not in the list of CGHS package deals, the payment to the empanelled Hospital/Diagnostic centre would be at rates of AIIMS New Delhi or ***actuals, whichever is less.*** Where AIIMS rates are not available, the actual cost of drugs and room rent etc will be reimbursed.

(iv) The package deal rates will include all charges pertaining to a particular treatment/procedure including admission charges, accommodation charges, ICU/ICCU charges, monitoring charges, operation theatre charges, operation charges, anesthetic charges, procedural charges/Surgeons fee, cost of disposables, surgical charges and cost of medicines used during hospitalization, related routine investigations, physiotherapy charges etc.

(v) The package rate does not include diet, telephone charges, TV charges and cost of cosmetics, toiletry and tonics. Cost of these, if offered, on request of patient will be realized from individual patient and are not to be included in package charges.

(vi) The package deal includes

- 12 days for specialized procedure
- 7-8 days for other procedures
- 3 days for laparascopic surgery
- 1 day for day care/minor procedures (OPD)

(vii) If the beneficiary has to stay in the hospital for his/her recovery for more than the period covered in the package rate, the additional reimbursement will be limited to room rent as per entitlement, cost of prescribed medicines and investigations, doctors visits (not more than 2 times a day) for additional stay.

(viii) If one or more treatment procedures form part of a major treatment procedure, package charges would be made against the major procedures and only half of approved charges quoted for other procedures would be added to the package charges of the first major procedure.

(ix) The rates will be applicable only for allopathic system of medicine. No charges will be reimbursed for Homeopathic, Unani, Ayurveda or traditional systems of medicines.

(x) An empanelled hospital/ diagnostic centre whose rates for a procedure/test/facility are lower than the approved rates shall charge the beneficiaries as per actuals. Expenditure in excess of approved/package deal rates would be borne by the beneficiaries.

(xi) ***Any legal liability arising out of such services shall be dealt with by the empanelledhospital, nursing homes and diagnostic centres who shall alone be responsible.*** ECHS will not have any legal liability in such cases.

(c) **Allied Charges**

(i) **Diet Charges.** ECHS beneficiaries having basic pension upto Rs.2025/- per month will be entitled to free diet during hospitalization in empanelled hospitals. In case suffering from T.B. or mental diseases, beneficiaries with basic pension upto Rs.3000/- per month will be entitled to free diet during hospitalization.

(ii) **Special Nursing/ Attendant charges**. Special nursing charges and/or Attendant charges will be admissible when such nursing/attendance is essential for recovery/prevention of serious deterioration of the patient as certified by the Medical Officer in-charge of the case. The approval of SEMO/SMO/PMO will be obtained through the concerned Polyclinic in all such cases. The rate ceiling for Special nursing andAttendant will be as per guidelines of the CGHS. Special nursing /Attendant will be applicable only for patients admitted in hospitals/nursing homes and will not be applicable in residence.

(iii) **Entitlement for indoor treatment**. Charges as applicable to CGHS will apply. With effect from the issue of this letter the ECHS beneficiaries shall be entitled to General/Semi Private/Private Ward facility in empaneled hospitals according to their rank structure as under :-

	Rank	Entitlement of Accommodation Hospitals
Officers		Private Ward
JCOs	(Nb Sub to Sub Maj including Hony Ranks of Lt/Capt and Equivalent)	Semi Private Ward
NCOs	(Sep to Hav including Hony Ranks of Nb Subedar and Equivalent)	General Ward

[Amended vide GOI MoD letter No. 22(16)/05/US(WE)/D(Res) dated 19 Jul 05) with the concurrence of Ministry of Defence (Finance) vide UO No. 717/AG/PD dated 14.07.05]

(iv) **AC Charges**. AC Charges will be included in rate for ICU/ICCU patients, private ward patients and speciality treatment patients. In all other conditions where AC is absolutely essential for treatment of the patient, such charges will be included with a necessary certificate from the treating physician.

(d) **Bills. The bills from the empanelled hospital will include the following:-**

(i) Medical advance drawn, if any.
(ii) Referral slip from Polyclinic & photocopy of ECHS card.
(iii) Copy of admission and discharge slip
(iv) Summary of the case, including outcome
(v) Consultation charges/ Diagnostic/ Package Charges as applicable.
(vi) Other charges if any, not included above (to be specified).

(e) **Mode of Payment**. Bills and connected documents will be submitted by Hospitals, Nursing homes and Diagnostic Centres to the Polyclinic from where the patient was referred. Officer In-Charge (OIC) Polyclinic will authenticate the bills and forward to concerned Senior Executive Medical Officer (SEMO)/ Principal Medical Officer (PMO)/ Senior Medical Officer (SMO) for scrutiny and onward despatch to Station Headquarters for payment. Payment will be made by cheque and will be subject to post-audit.

(f) **Treatment at Military Hospitals**. Hospital Stoppage Rolls and any other charges expended for treatment in Military Hospitals will be paid in full by the member and is not reimbursable.

SPECIALITY TREATMENT

5. The procedure for referral and reimbursement for speciality procedures will be as follows:-

(a) **Specialised tests and treatment**

(i) **Referral Procedure.** Ex-Servicemen or dependents will only be referred to the empanelled hospitals/diagnostic centres for specialized tests and treatment by the specialist at Polyclinic, specialist of Service hospital or specialist at empanelled hospitals/diagnostic centre. Only in case of emergencies and life threatening situations will a non specialist medical officer of the Polyclinic refer a patient directly for specialized tests and treatment. In such cases, a certificate to this effect will be endorsed by the referring medical officer. Payment to empanelled specialists/super specialist will be made as per procedure laid down.

(ii) **Speciality Treatment.** For treatment procedures in Cardiology Nephrology, Oncology, Joint Replacement and other expensive speciality treatment/ surgery, payment will be governed by the CGHS Rates for various procedures as revised from time to time. When the CGHS rates

for treatment are not available, rates of AIIMS ***or actuals whichever is less will be applicable***. Where the AIIMS rates are not available, the actual cost of drugs and room rent etc will be reimbursed.

(b) **Treatment at Medical Institutes of National Repute** - Certain Hospitals/ Institutes do not accept post-payment. Such Institutes will not ordinarily be empanelled under the ECHS. However admission/ treatment in the Institutes of National repute listed below will be permitted. In case ESM or their dependents are referred by ECHS Medical Officer Specialist to any of the Institutes mentioned below, an advance in the form of a crossed cheque payable to the concerned hospital will be drawn by the patient from the concerned Station Headquarter after submitting the referral form by an ECHS Polyclinic and estimate from the concerned hospital. The hospitals where such an arrangement will be permitted will be:-

(i) All India Institute of Medical Sciences, New Delhi
(ii) Post Graduate Institute, Chandigarh.
(iii) Sanjay Gandhi Post Graduate Institute, Lucknow.
(iv) National Institute of Mental Health and Neurosciences, Bangalore.
(v) Tata Memorial Hospital, Mumbai (for Oncology)
(vi) JIPMER, Pondicherry.
(vii) Christian Medical College, Vellore.
(viii) Shankar Nethralaya, Chennai.
(ix) Medical Colleges and Hospitals under the Central or State Governments.

6. Under certain special circumstances reimbursement of cost of medicines will be permitted only if the patient was referred by Polyclinic for speciality treatment and the medicines were prescribed to be taken with immediate effect on discharge. The special circumstances are:-

(a) Post operative cases of major Cardiac Surgery/Interventional Cardiology
(b) Oncology.
(c) Post operative organ transplant cases.
(d) Post operative joint replacement cases.
(e) Post operative major Neurosurgical/ Neurology cases.

7. The ex-serviceman should present the suitable prescriptions for medicines for above conditions to the O I/C Polyclinic immediately after dischage. A special demand for medicines will be raised by the O I/C Polyclinic, through usual channels to the AFMSD. The drugs will be procured from AFMSD under the normal procedures. Drugs will be procured from concerned SEMO if ' Not Available' at AFMSD. In the interim, drug purchased by ex-servicemen, is reimbursable, The period of reimbursement in such cases will be limited to one month after date of discharge from Hospital or date of issue of medicines from Polyclinic which ever is earlier

EMERGENCY TREATMENT

8. In emergencies and life threatening conditions, when patients may not be able to follow the normal refeiral procedure, the patients may report to the nearest hospital, preferably empanelled.

(a) Empanelled Hospital – Immediate emergency treatment in any Empanelled hospital will be rendered to ESM on confirmation of ECHS membership from the ECHS card. Payment for such treatment will be regulated as under:-

(i) Empanelled hospital will inform ECHS Polyclinic about the emergency admission at the earliest but not later than 24 hrs.

(ii) The empanelled hospital will not collect payment from ECHS member.

(iii) The actual cost incurred for emergency procedure will be payable by ECHS. Bill for emergency treatment will be forwarded to concerned Polyclinic for payment as per normal procedure. Such bills will be superscribed with 'EMERGENCY TREATMENT' written in Block capitals in Red.

(iv) On learning about admission of an ECHS member in an Empanelled hospital, the O I/C Polyclinic will make arrangements for verification of the facts.

(v) If, during the course of investigations/treatment a specific diagnosis is established requiring further management, the facts will be verified by concerned O I/C Polyclinic and the patient referred for the same formally.

(vi) In case of malpractice, unethical practices or medical negligence by an empanelled Hospital or Nursing home particularly in management of emergencies necessary action will be taken by the Station Commander to dis-empanel the Hospital or Nursing Home.

(b) **Non- Empanelled Hospital** – Ex-serviceman or his representative should inform nearest Polyclinic within 48 hrs of such admission. The responsibility for clearing bills will rest with the Ex- Serviceman. He/she will submit the bills alongwith summary of the case to the concerned Polyclinic. The sanction for reimbursement as per approved rates, will be accorded by Central Org, ECHS. Such bills will be submitted within a period of one month from the date of discharge from hospital.

(c) The Empanelled or Non-Empanelled Hospital will be liable to pay damages beneficiaries in case of medical negligence in emergencies, and the Hospital/Nursing Hom... shall deal with legal liabilities, if any. ECHS will not have any legal liability in such cases.

OTHER CONDITIONS

9. In cases where facilities for treatment are not available in Armed Forces Hospitals and in certain special conditions, the procedure for referral and treatment will be as follows:-

(a) **TB & Leprosy.** No OPD Charges will be reimbursable. TB and Leprosy will be treated through National programmes at District level. However when the patients require admission for the condition, rates of CGHS as applicable to LRS Institute of TB and Allied Disease will be applicable for hospitalization.

(b) **Hearing Aids.** The equipment will be entitled to patients based on the recommendations of ENT Specialist after clinical and audiometric justification The OIC Polyclinic, will procure the Hearing Aid in consultation with the SEMO, and issue to ESM. Replacement is permitted after a minimum 5 years life of the Hearing Aid, based on a condemnation certificate and approval of ENT specialist. Digital Hearing Aid will only be given on recommendations of three ENT specialists including at least one service specialist. Actual cost of hearing aid or CGHS rates whichever is lesser will apply.

(c) **Mental Diseases.** In all Mental illness cases the patient will be referred to Service Psychiatrist/ empanelled hospitals for OPD consultation. Drugs issued for the patient will be procured by the OIC Polyclinics / SEMO through special demand. Cases requiring hospital admission will be referred to authorized empanelled/Govt hospitals only. Provisions of Mental Health Act, 1987, as amended, will be applicable for all such hospital admissions. Payment will be made in full for admission to Govt hospitals and prescribed rates of CGHS will apply for empanelled hospitals.

(d) **HIV/ AIDS.** Ex-service pensioners boarded out of service due to AIDS will be provided treatment as prescribed by Armed Forces Centres for such treatment, at the time of discharge. Treatment will be made available to such individuals with effect from two months after the date of discharge. Fresh cases of HIV/ AIDS amongst members of ECHS, including dependents will be referred to nearest Armed Forces Immuno-deficiency Centres, and treatment as prescribed from these Centres only will be made available.

(e) **Artificial Limbs/Appliances.** Artificial Limbs/Appliances will be reimbursed in full when procured and fitted at Artificial Limb Centre (ALC) Pune, and Artificial Limb Sub Centres in the AFMS hospitals. CGHS rates will apply in other cases treated in empanelled hospitals.

(f) **Rehabilitation/Terminal Care** - Rehabilitation/Terminal care will be provided in empanelled rehabilitative homes and hospices. Patients admitted to Service hospitals or empanelled hospitals/nursing homes where the finality of treatment has been reached and definitive medical treatment has run its course, will be referred to rehabilitative homes/hospices for nursing care and rehabilitation. The conditions for which rehabilitative care will be admissible will be paraplegia, quadriplegia, Alzheimers disease, cerebro- vascular accidents, other neurological and degenerative disorders, amputations, cancer terminal care and other such medical conditions when duly referred by treating specialists. Approval of SEMO/SMO/ PMO will be obtained for these referrals. The payments for such cases will be regulated as under :

(i) Rates of payment for rehabilitation/terminal care cases will be limited to maximum rates permissible under CGHS for Special Nursing/Aya/Attendant charges PLUS char ges for medical treatment as per CGHS rules. Where the rates of CGHS are not laid down, AIIMS charges ***or actuals which ever is less*** will be applicable. In case rates have not been defined by AIIMS, the actuals will be reimbursed. Rehabilitative care/terminal care does not include old age homes.

(ii) Reimbursement will be limited to maximum period of 6 months. Thereafter cost of such care has to be borne by the patient.

(g) **Medical Equipment for Residences** - Medical Equipment including nebulisers, CIPAP /BIPAP machines and glucometers etc as authorized under the CGHS will be issued to members, when use of such equipment is considered absolutely essential on medical grounds, on recommendations of the Specialist and approved by the Senior Advisor and Consultant of the concerned speciality under whose jurisdiction the Polyclinic is located. The equipment will be procured through a special demand by the O I/C Polyclinic. Consumables for the equipment will be issued under arrangements of O I/C polyclinic. Cost on repair and annual maintenance contracts will be borne by the member themselves and will not be reimbursable.

(h) **Medical Examination/Health check up/Screening tests** – The ECHS beneficiaries may undergo medical examination/health check up at the Polyclinic once a year. The medical examination/ health check up will be limited to facilities available in the Polyclinic. Referrals to empanelled institutes for Medical examination/Health check up/ Screening tests are not permissible. Such Medical Examinations would be permitted only after all 227 Polyclinics have been established and made fully functional.

(j) **Dental Treatment** – Dental treatment including referrals will be as per laid down procedures for other medical cases. Dentures will be permitted only if advised by Dental officer at ECHS Polyclinic or Service Dental officer. A particular type of partial/complete denture will be permitted on one time basis only for each member/dependent of the scheme as per CGHS rates.

(k) **Intra Ocular Lens** – Intra ocular lens (IOL) implantation will be provided to ECHS members preferably at nearest service eye center . In case of IOL implantation undertaken at Civil hospitals,

payment will be limited to prevailing CGHS rates. Type/make of IOL implanted will be specified in the bills by empanelled hospital.

(l) **Spectacles** - Spectacles will not be provided under ECHS except post operatively in cases of conventional operation of cataract. Cost of spectacles in such cases will be limited to Rs 200/- only. Replacement of Spectacles will be admissible once in three years provided the same is undertaken on the advice of the Medical Officers of the Polyclinic or empanelled Consultant.

(m) - **Plastic Surgery** - Reimbursements, payments for Plastic surgery will not be permissible under ECHS except for therapeutic reasons and in post traumatic cases on recommendations of SEMO/SMO/ PMO. Provisions of CGHS and package deal rates/ceilings will apply

Appendix - IV
Para-3.1

No. 24(14)/03/US(WE)/D(Res)
Government of India Ministry of Defence
Deptt of Ex-ServicemenWelfare
New Delhi, Dated the 31 January, 2005

To,

The Chief of the Army Staff
The Chief of the Navy Staff
The Chief of the Air Staff

Subject:- Procedure for procurement of land in Non-military stations for Ex-Servicemen Contributory Health Scheme, (ECHS)

Sir,

1. With reference to Govt. of India, Ministry of Defence letter No. 22(1)/01/US(WE)/D(Res) dated 30 Dec 02. I am directed to convey the sanction of the Government for 'Procedure for procurement of land in non military stations, listed in Appendix A to this letter for Ex-Servicemen Contributory Health Scheme (ECHS) with immediate effect.

2. This procedure will be effective for a period of three years from the date of issue of this letter.

3. This issues with the concurrence of Ministry of Defence (Finance) vide their U.O. No 61/DFA/DS/W/05 dated 28.1.05.

Yours faithfully,

Sd/- x x x x

(V.K JAIN)
Under Secretary to the Govt of India

Copy lo:-

1. CGDA, New Delhi
2. SO to Defence Secretary
3. PPS to Secretary .
4. PPS to AS (B) (Acquisition)
5. PPS to AS (T) *I* PPS to AS (I)
6. Addl. FA (M) *I* Addl FA (K)

7. JS (ESW)

8. JS (0/N)

9. Dir (Finance/AG)

10. Dir (Fin/AG)

11. Defence (Finance/AG!PD)

12. DFA (B) *I* DFA (N) *I* DFA (Air Force)

13. AFA (B-1)

14. D (Works) *I D* (Mov) *I D* (Med)

15. O&M Unit

Also to:-

16. DGAFMS

17. DODE, New Delhi

18. DOD C&W

19. QMG

20. DGMS

21. DGMS (Air)

22. DGMS (Navy)

23. AOA

24. COP

25. MD Central Org ECHS

26. ADO C&W

27. ADO (FP)

28. All Command Headquarters

29. Navy Headquarters (PS Dte)

30. AG Branch / CW-3

31. Naval Headquarters

(PS Dte) Copies signed in ink. :-

32. CDA (Army), Bangalore

33. CDA {WC), Chandigarh

34. CDA (Army), Patna

35. CDA (SC), Pune

36. CDA (Army), Meerut

37. CDA (NC), Jammu

38. CDA (Officers), Pune

39. CDA (Navy), Bombay

40. CDA (AF), Dehradun

41. CDA (Army), Jabalpur
42. CDA (Army), Secunderabad
43. CDA (Army), Lucknow
44. CDA(Army), Chennai
45. CDA (Army), Kolkata
46. CDA (AF), Delhi
47. CDA (Army), Guwahati
48. CDA (Army), Pune
49. CDA(Army), Bombay
50. CDA (Army), Dehradaun

PROCEDURE FOR PROCUREMENT OF LAND FORECHS POLYCLINICS IN NON MILITARY STATIONS

Requirement of Land and Authority

Govt of India MOD letter No 22(1)/01/US(WE)/D(Res) dated 30 Dec, 02 accorded approval for acquiring land in non-military stations as per Appendix F para l (a) as follows:-

Type of Polyclinic	A	B	C	D
Area of Land (in sq yards)	1200	1200	700	700

Procedure to be adopted

2. Based on the list approved by the Government of India, a list of Polyclinics identified for development in Non Military Stations for a particular year will be made available by the Central Organisation, ECHS to respective Commands.

3. The HQ Commands/Area/Sub Area thereafter will forward a list of such stations to the concerned Defence Estates Officer (DEO). The DEO will identify and forward details of suitable Defence Land, if available, in these stations.

4. The suitability of the lai1d will be assessed by the respective Station HQs on the basis of area, accessibility for ESM, connectivity through road and rail links, location within town etc. If the land is found suitable, the construction of ECHS Polyclinic will be done as per procedure laid down for construction of Polyclinics.

5. If Defence land is not available or found un-suitable than simultaneous efforts will be made to look for land belonging to any other Central Government Department/State Government/Local Housing Body/Development Authority etc.

6. After adequate efforts have been made to identity land as stated in paragraph 5 above and if these efforts fail, action will be taken to purchase land by inviting tenders from the interested sellers through open newspaper advertisements. Tender will be invited in double envelopes. The first envelope will carry the details with regard to the location, description and suitability of land. The second envelope will consist of the financial
offer. A purchase committee shall be constituted at Headquarters Command level whose composition will be as follows:-

i)	An officer not below the rank of Brig or equivalent .	-Chairman
ii)	Commander Works Engineer or his representative	-Member
iii)	Senior Executive Medical Officer or his representative	-Member
iv)	Representative of Regional CDA	-Member
v)	DEO/ADEO	-Member

7. The Purchase Committee will open the first envelope and decide the suitability of offers received . The second envelope consisting of the financial offer will be opened only in those cases where the plot of land offered for sale has been found 'suitable for the purpose of locating the polyclinic. Based on the offers received, representatives of Command Headquarters will make comparative statement of offers and depending upon the prevailing land value rates, the purchase committee, wherever consider essential, will negotiate the rates with the lowest tender and arrive t a negotiate price of land.

8.

8. The Committee will obtain a certificate of cost reasonability from the competent revenue authority. General Officer Commanding-in-Chief of the Command will have powers to approve purchase of land upto a value of Rs. 5.00 Lakh (Rupees Five Lakhs). If the land value is more than Rs. 5.00 lakhs, the case will be routed through Central Organization, ECHS, AG's Branch Army Headquarters to Ministry of Defence.

9. Before submitting the case, the Purchase Committee will ensure the following points:-

(a) While fixing the land value, rate given by the Revenue authorities shall be kept in view
(b) I n case the price agreed by the Purchase Committee exceeds the rate suggested by the Collector/ Revenue Authorities, reasons for accepting the higher price will have to be recorded in writingby the Committee.
(c) The Purchase Committee will examine and confirm the right and title of the land owner over the land proposed for purchase.
(d) Recommendations of the Committee will be submitted to the Central Organization, ECHS through the Command Headquarters
(e) The Central Organization, ECHS will submit the case to MOD who will in consultation with MOD (Fin) issue the Government sanction expeditiously On the approval having been accorded by the MOD/GOC-in-C all documentation including the transfer/sale deed will be prepared by the concerned DEO.

8. The Central Organization, ECHS will earmark annual budgetary funds from Capital Head and allocate the same to the QMG's Branch from Major Head - 4076 Sub Major Head - 01 and ECHS Code Head 902/47.

ACCEPTANCE OF GIFTED LAND

Action at Headquarters Command Level

9. A Station Boa rd of Officers will be constituted by concerned Headquarters Command to examine the offer made by the concerned State Government/Non Government Organisation/Charitable Trust/Organisation/ Private Pa1ty/individual and assess suitability of establishing the ECHS polyclinic on the said land. Prior to the Board being ordered, the Headquarters Command will ensure the following:

(a) The offer has been made in writing.
(b) The offer must clearly give details of the land being made available.
(c) The land will be transferred irrevocably and will be handed over in an unencumbered manner
(d) ff the land is being offered on lease, the lease will not be for less than 30 years and shall be renewable with mutual consent. The te1ms and conditions shall be spelt out clearly.

The DEO shall carry out the documentation as per procedure already in vogue.

12. The Boa rd of Officers shall comprise the following:-

a) Presiding Officer - Officer nominated by Station Commander

Member
i) -Representative of Senior Executive Medical Officer
ii) -Representative of Commander Works Engineer
iii)

13. The Board shall examine suitability of the site, bearing the following aspects:-

a) Land is not under illegal occupation and should be free of all encumbrances.
b) Examine revenue records and enclose relevant extracts
c) Examine the site from accessibility to Ex-Servicemen
d) Proximity to other Medical facilities in the city
e) Proximity to Bus terminus/rail way station for conveyance of ECHS members

f) The area offered is as per the minimum size mentioned in Govt letter ibid. However Board isempowered to consider additional land if offered by Govt/ any agency, subject to meeting allabove conditions.

g) The donor will not impose restrictions like name of family members to be mentioned on the polyclinic building to gain popularity

h) The donor may not seek any benefits in lieu of the land being gifted to the Government.

j) There is no dispute over the gifted land which may lead to unnecessary litigation for Union of India.

14. The Board having satisfied itself of the suitability of the site will forward its proceedings with recommendations to Headquarters Command for approval of GOC-in-C through Principal Director of Defence Estate. Once approval of GOC-in-C has been accorded, suitable orders to that effect will be issued and the Defence Estate Department shall take over the land as per existing procedure, execute deeds and record mutation. Said land, lherealle1 will be taken over on charge of Military Land Record/Garrison Land Record and subsequently handed over to military authorities as per laid down procedure .

Budgetary Allocation

15. In case the land in question is gifted, no payment is required to be made except for Registration/Mutation and any other procedure. Amount shall be paid by the DE authorities from Revenue Head of expenditure from ECHS, Budget. Central Organisation, ECHS shall allocate fund for the same on demand from concerned Command Head quarters/DEO.

16. Where the land is obtained on long lease, necessary payment shall be made by DE authority as per existing procedure and amount debited to revenue head of expenditure of ECHS. Command Headquarters will obtain necessary annual allocation from ECHS Central Organisation.

Appendix-V
Para 3.3

(Ref comments of Central Org ECHS at Q.No. 4 (a))

LIST OF 191 ECHS POLYCLINICS WHERE LAND IS YET TO ACQUIRE

Ser No	Polyclinics	Type	Mill Non Mil	Stn HQ	Service/ Comd	State
1	Muktsar	C	Non Mil	Ferozpur	we	Punjab
2	Sonepat	B	Non Mil	Ambala	WC	Haryana
3	Panipat	C	Non Mil	Ambala	WC	Haryana
4	Noida	A	Non Mil	Delhi Gantt	WC	UP
5	Bhiwani	A	Non Mil	Hissar	SWC	Haryana
6	Etawah	C	Non Mil	Kanpur	CC	UP
7	Firozabad	D	Non Mil	Agra	CC	UP
8	Karanprayag (Gopeshwar)	B	Non Mil	Joshimath	CC	UK
9	Muzaffarnagar	D	Non Mil	Meerut	CC	UP
10	Pratapgarh	D	Non Mil	Allahabad	CC	UP
11	Azamgarh	D	Non Mil	Faizabad	CC	UP
12	Sultanpur	C	Non Mil	Faizabad	CC	UP
13	Deoria	C	Non Mil	Kunraghat	CC	UP
14	Ghazipur	B	Non Mil	Varanasi	CC	UP
15	Krishnanagar	C	Non Mil	Barrackpore	EC	WB
16	Burdwan	D	Non Mil	Panagarh	EC	WB
17	Pali	D	Non Mil	Jodhpur	SC	Rajasthan
18	Buldana	D	Non Mil	Bhusawal	SC	Maharashtra
19	Orai	D	Non Mil	Jhansi	SC	UP
20	Sangli	B	Non Mil	Kolhapur	SC	Maharashtra
21	Chiplun	C	Non Mil	*INS Angre, Mumbai*	*Navy*	Maharashtra
22	Amaravati	D	Non Mil	Pulgaon	SC	Maharashtra
23	Vellore	A	Non Mil	Chennai	SC	Tamilnadu
24	Kanchipuram	C	Non Mil	Chennai	SC	Tamilnadu
25	Cuddalore	D	Non Mil	Chennai	SC	Tamilnadu
26	Villupuram	D	Non Mil	Chennai	SC	Tamilnadu
27	Salem	C	Non Mil	Coimbatore	SC	Tamilnadu
28	Dindigul	D	Non Mil	Tiruchirapalli	SC	Tamilnadu
29	Madurai	C	Non Mil	Tiruchirapalli	SC	Tamilnadu
30	Nagapattinam	D	Non Mil	Tiruchirapalli	SC	Tamilnadu
31	Nagarcoil	D	Non Mil	Trivandrum	SG	Tamilnadu
32	Tuticorin	D	Non Mil	Trivandrum	SC	Tamilnadu
33	Thiruvannamalai	C	Non Mil	Chennai	SC	Tamilnadu

34	Madikeri	C	Non Mil	Stn HQ Cell ECHS, K & K Sub Area	SC	Karnataka
35	Bijapur	D	Non Mil	Belgaum	SC	Karnataka
36	Chittoor	C	Non Mil	Secunderabad	SC	AP
37	Giddalur	C	Non Mil	Secunderabad	SC	AP
38	Kakinada	D	Non Mil	INS Circars	Navy	AP
39	Viiavawada	D	Non Mil	Secunderabad	SC	AP
40	Pathanamthitta	B	Non Mil	Trivandrum	SC	Kerala
41	East Delhi Area	B	Non Mil	INS India	Navy	Delhi
42	Mumbai (COD Kandivali)	C	Mil	INS Hamla	Navy	Maharashtra
43	Srikakulam	D	Non Mil	INS Circars	Navy	AP
44	Sambalpur	D	Non Mil	Sambalpur	CC	Odisha
45	Angul	D	Non Mil	INS Chilka	Navy	Odisha
46	Dhenkanal	C	Non Mil	INS Chilka	Navy	Odisha
47	Puri	D	Non Mil	INS Chilka	Navy	Odfsha
48	Painavu (Thodupuzhal)	D	Non Mil	INS Vendurithy	Navy	Kerala
49	Muvattupuzha	D	Non Mil	INS Vendurithy	Navy	Kerala
50	Ramanathapuram	D	Non Mil	INS Purandu	Navy	Tamilnadu
51	Palwal	D	Non Mil	AF Stn, Faridabad	AF	Haryana
52	Tambram	D	Non Mil	413 AF Stn Tambram	AF	Tamilnadu
53	Barnala	D	Non Mil	501 SU, AF	AF	Punjab
54	Kolar	D	Non Mil	AF Stn Yelahanka (Bangalore)	AF	Karnataka
55	Tumkur	D	Non Mil	AF Stn, Jalahali	AF	Karnataka
56	Wardha	D	Non Mil	AF Stn, MC (U)	AF	Maharashtra
57	Yavatmal	D	Non Mil	AF Stn, MC (U)	AF	Maharashtra
58	Erode	D	Non Mil	AF Stn, Sulur	AF	Tamilnadu
59	Sivagangai	D	Non Mil	AF Stn, Thanjavur	AF	Tamilnadu
60	Bhilwara	D	Non Mil	Aimer	SC	Rajasthan
61	Dunqarpur	D	Non Mil	Udaipur	SC	Rajasthan
62	Raisamand	D	Non Mil	Udaipur	SC	Rajasthan
63	.Rajkot	D	Non Mil	Jamnagar	SC	Gujarat
64	Surat	D	Non Mil	Vadodara	SC	Gujarat
65	Nanded	D	Non Mil	Aurangabad	SC	Maharashtra
66	Dhule	D	Mil	Devlali	SC	Maharashtra
67	Beed .	D	Non Mil	Ahmednaqar	SC	Maharashtra

68	Karad	D	Non Mil	Kolhapur	SC	Maharashtra
69	Eluru	D	Non Mil	Secunderabad	SC	AP
70	Ananthapur	D	Non Mil	Secunderabad	SC	AP
71	Kurnool	D	Non Mil	Secunderabad	SC	AP
72	Cuddapah	D	Non Mil	Secunderabad	SC	AP
73	Nellore	D	Non Mil	Secunderabad	SC	AP
74	Karimnaqar	D	Non Mil	Secunderabad	SC	Telanqana
75	Khammam	D	Non Mil	Secunderabad	SC	Telangana
76	Mehbubnagar	D	Non Mil	Secunderabad	SC	Telangana
77	Shimoqa	D	Non Mil	Bangalore	SC	Karnataka
78	Gulbarqa	D	Non Mil	Belgaum	SC	Karnataka
79	Virarajendrapet	D	Non Mil	Stn HQ ECHS K & K Sub Area	SC	Karnataka
80	Kanhagad	D	Non Mil	Kannur	SC	Kerala
81	lritti	0	Non Mil	Kannur	SC	Kerala
82	Kunnamkula Keralam	D	Non Mil	Kochi	SC	
83	Changanasserv	D	Non Mil	Trivandrum	SC	Kerala
84	Kumbakonum	D	Non Mil	Tiruchirappalli	SC	Tamilnadu
85	Kalpetta	D	Non Mil	Kannur	SC	Kerala
86	Mavelikara	D	Non Mil	Trivandrum	SC	Kerala
87	Trivandrum Kerala (Med Colleqe)	D	Non Mil	Trivandrum	SC	
88	Kottarakara	D	Non Mil	Trivandrum	SC	Kerala
89	Ranni	D	Non Mil	Trivandrum	SC	Kerala
90	Kilimanur	D	Non Mil	Trivandrum	SC	Kerala
91	Tehri	D	Non Mil	Raiwala	CC	UK
92	Uttarkashi	D	Non Mil	Joshimath	CC	UK
93	Rudrapur	D	Non Mil	Haldwani	CC	UK
94	Rudraprayag	D	Non Mil	Joshimath	CC	UK
95	Bageshwar	B	Non Mil	Ranikhet	CC	UK
96	Banbasa	D	Non Mil	Banbasa	CC	UK
97	Gonda	D	Non Mil	Faizabad	CC	UP
98	Basti	D	Non Mil	Kunraghat	CC	UP
99	Banda	D	Non Mil	Allahabad	CC	UP
100	Rampur	0	Non Mil	Bareilly	CC	UP
101	Lakhimpur Kheri	D	Non Mil	Lucknow.	CC	UP
102	Bijnore	D	Non Mil	Meerut	CC	UP
103	Baghpat	D	Non Mil	Meerut	CC	UP
104	Hathras	D	Non Mil	Mathura	CC	UP
105	Jaunpur	D	Non Mil	Varanasi	CC	UP
106	Mirzapur	D	Non Mil	Varanasi	CC	UP

107	Deoghar	D	Non Mil	Ramgarh ASHQ	CC	Jharkhand
108	Dhanbad	D	Non Mil	Ramgarh ASHQ	CC	Jharkhand
109	Bhaqalpur	D	Non Mil	Danapur	CC	Bihar
110	Motihari	D	Non Mil	Danapur	CC	Bihar
111	Siwan	D	Non Mil	Danapur	CC	Bihar
112	Samastipur	D	Non Mil	Danapur	CC	Bihar
113	Madhubani	D	Non Mil	Danapur	CC	Bihar
114	Vaishali (Hajipur)	D	Non Mil	Danapur	CC	Bihar
115	Khagaria	D	Non Mil	Danapur	CC	Bihar
116	Munger	D	Non Mil	Danapur	CC	Bihar
117	Sitamarhi	D	Non Mil	Danapur	CC	Bihar
118	Chaibasa	D	Non Mil	Ranchi	CC	Jharkhand
119	Gumla	D	Non Mil	Ranchi	CC	Jharkhand
120	Daltonganj	D	Non Mil	Ranchi	CC	Jharkhand
121	Sasaram	D	Non Mil	Gaya	CC	Bihar
122	Buxar	D	Non Mil	Gaya	CC	Bihar
123	Jaqdalpur	D	Non Mil.	Raipur	CC	Chhattisqarh
124	Bilashpur	D	Non Mil	Raipur	CC	Chhattisqarh
125	Jashpur (Raigarh)	D	Non Mil	Raipur	CC	Chhattisgarh
126	Ujjain	D	Non Mil	Bhopal	SC	MP
127	Koraput	D	Non Mil	Gopalpur	CC	Odisha
128	Bhawanipatna	D	Non Mil	Gopalpur	CC	Odisha
129	Narwana	D	Non Mil	Hissar	SWC	Harvana
130	Sampla	D	Non Mil	Hissar	SWC	Harvana
131	Meham	D	Non Mil	Hissar	SWC	Haryana
132	Loharu	D	Non Mil	Hissar	SWC	Haryana
133	Kosli	D	Non Mil	Hissar	SWC	Haryana
134	Charki Dadri	D	Non Mil	Hissar	SWC	Haryana
135	Mahendragarh	D	Non Mil	Alwar	SWC	Haryana
136	Didwana	D	Non Mil	Bikaner	SWC	Rajasthan
137	Dharuhera	D	Non Mil	Alwar	SWC	Harvana
138	Bahadurgarh	D	Non Mil	Hissar	SWC	Haryana
139	Behror	D	Non Mil	Alwar	SWC	Rajasthan
140	Raiaarh	D	Non Mil	Bikaner	SWC	Rajasthan
141	Chirawa Vidyadhar	D	Non Mil	Jaipur	SWC	Rajasthan
142	Nagar (Sanqaner)	D'	Non Mil	Jaipur	SWC	Rajasthan
143	Bhuwana	D	Non Mil	Jaipur	SWC	Rajasthan
144	Suratgarh (Hanumangarh)	D	Non Mil	Sri Ganganagar	SWC	Rajasthan
145	**Nagrota**	**D**	**Non Mil**	**Udhampur**	**NC**	**J&K (Gujroo)**
146	Baribrahmna	C	Non Mil	BO Bari	WC	J&K

				(Baribrahmna)		
147	Palampur	D	Mil	Palampur	WC	HP
148	Kullu	D	Non Mil	Palchan	WC	HP
149	Jogindernagar	D	Non Mil	Palampur	WC	HP
150	**SarkaQhat**	**D**	**Non Mil**	**Chandimandir**	**WC**	**HP**
151	Shahour	C	Non Mil	Dharamshala	WC	HP
152	Dehragopipur	D	Non Mil	Yol	WC	HP
153	Narainaarh	D	Non Mil	Ambala	WC	Haryana
154	Ainala	D	Non Mil	Amritsar	WC	Punjab
155	Tarantaran/					
156	Patti	D	Non Mil	Amritsar	WC	Punjab
156	Sri Hargobindpur	D	Non Mil	Gurdaspur	WC	Punjab
157	Batala	D	Non Mil	Gurdaspur	WC	Punjab
158	Ghumarvin	D	Non Mil	Jallandhar	WC	HP
159	Barsar	D	Non Mil	Jallandhar	WC	HP
160	Suranassi	D	Non Mil	Jallandhar	WC	Punjab
161	Garhshankar (Mahalour)	D	Non Mil	Jallandhar	WC	Punjab
162	**Nawansahar**	**D**	**Non Mil**	**Jallandhar**	**WC**	**Punjab**
163	Sultanpur	D	Non Mil	Kapurthala	WC	Punjab Lodhi
164	Phagwara	D	Non Mil	Jallandhar	WC	Punjab
165	Doraha	D	Non Mil	Ludhiana	WC	Punjab
166	Jagraon	D	Non Mil	Ludhiana	WC	Punjab
167	Samrala	D	Non Mil	Ludhiana	WC	Punjab
168	Samana	D	Non Mil	Patiala	WC	Punjab
169	Talwara	D	Non Mil	Uchi Bassi	WC	Punjab
170	Gohana	D	Non Mil	Ambala	WC	Haryana
171	Gurgaon Road)	B	Non Mil	Delhi Gantt	WC	Haryana (Sohana
172	Kharkhoda	D	Non-Mil	Ambala	WC	Haryana
173	Shakurbasti	B	Non Mil	Delhi Gantt	WC	Delhi
174	Greater Naida	A	Non Mil	Delhi Gantt	WC	UP
175	Nuh	D	Non Mil	Delhi Gantt	WC	Haryana
176	Cooch Behar WB	D	Non Mil	Cooch Behar ASHQ	EC	
177	RaiQanj	D	Non Mil	Bengdubi	EC	WB
178	Baruipur	D	Non Mil	Kolkata	EC	WB
179	Howrah	D	Non Mil	Kolkata	EC	WB
180	Bankura	D	Non Mil	Panagarh	EC	WB
181	Behrampur	D	Non Mil	Barrackpore	EC	WB
182	Lanka	D	Non Mil	Misacamp ASHQ	EC	Assam

183	Churachandpur	D	Non Mil	Leima.khong	EC	Manipur NE
184	Goaloara	D	Non Mil	Guwahati	EC	Assam
185	Dhubri	D	Non Mil	RanQiya	EC	Assam
186	MokokchunQ	D	Non Mil	Stn Cell Jorhat	EC	Nagaland NE
187	BoriaaiQaon	D	Non Mil	RanQiya	EC	Assam
188	Tezpur	D	Non Mil	Tezpur	EC	Assam
189	Tinsukia	D	Non Mil	Dinjan	EC	Assam
190	Lakhimour	D	Non Mil	Likabali	EC	Assam
191	Lunalei	D	Non Mil	Aizwal	EC	Mizoram NE

Appendix-VI
Para 3.19

UNIT WISE TOTAL ALLOTMENT :ECHS FUND
CODE HEAD 363/01 FY 2012-13, 2013-14 & 2014-15

(Rupees Inlakhs)

COMO	NAME OF UNIT	TOTAL ALLOTMEN-T FY2012-13	TOTAL ALLOTMENT FY 2013-14	TOTAL ALLOTMENT FY 2014-15
	AFMC BTD PUNE	0.00	0.00	0.00
	AFMSD DELHI CANTT	1850.84	2300.00	2650.00
	AFMSD LUCKNOW	1438.16	1526.00	1350.00
	AFMSD MUMBAI	1994.60	1723.00	2552.00
	AFMSD PUNE	34.84	7.95	5.83
	AFTC DELHI GANTT	30.46	26:45	28.00
	ALC PUNE	36.72	153.00	170.00
	Ola DGAFMS	15.58	0.00	375.31
	RESERVE WITH DGAFMS	0.00	0.00	0.00
	DGEME	24.62	23.75	41.25
NAVY	INHS SANEEVANI,	419.30	363.00	452.00
NAVY	INHS NIVARINI, CHILKA	164.16	174.00	221.40
NAVY	INH$ ASVINI	1896.38	1972.00	2579.00
NAVY	!NHS DHANVANTRI,	7.08	f3.50	20.00
NAVY	INHS JEEVANTI	10.70	15.00	35.00
NAVY	INHS KALYANI,	746.84	445.00	509.00
NAVY	INHS PATANJALI	25.36	22.08	30.00
NAVY	NIDS	7.38	6.30	6.90
AIR	AIR HQ	4495.92	4550.00	4722.11
SC	57 FMSD	0.00	0.00	0.00
SC	CH(SC)	1345.46	1373.00	1800.00
SC	185 MH	39.30	42.12	55.00
SC	177 MH	3.84	3.34	7.50
SC	MH WELLINGTON	450.90	490.00	542.00
SC	MH TRIVENDRUM	1124.28	1253.17	1515.00
SC	MH SECUNDERABAD	622.72	480.00	678.00
SC	MH SAUGOR	10.00	11.80	15.00
SC	MH PULGAON	25.00	21.70	21.70
SC	MH PANAJI	90.70	78.50	98.00
SC	MH NASIRABAD	63.00	59.60	59.60
SC	MH KIRKEE	422.72	383.00	512.00
SC	MH KHADAKWASLA	0.00	0.00	0.00
SC	MH KAMPTEE	6.84	6:02	6.02
SC	MH JODHPUR	170.60	118.00	182.00
SC	MH JHANSI	53.62	46.58	77.00
SC	MH JAMNAGAR	17.08	19.80	14.70
SG	MH GWALIOR	118.70	103.00	117.00
SC	MH GOLCONDA	107.38	138.25	228.00
SC	MH DHARANDHARA	0.54	1.97	2.50
SC	MH DEVLALI	99.54	101.40	164.00
SC	MH CHENNAI	607.30	654.00	760.00
SC	MH CANNANORE	364.10	365.00	401.00
SC	MH BHUJ	4.56	18.50	20.35
SC	MH BHOPAL	65.46	71.55	153.00
SC	MH BELGAUM	109.54	95.00	104.00

COMO	NAME OF UNIT	TOTAL ALLOTMENT FY2012-13	TOTAL ALLOTMENT FY 2013-14	TOTAL ALLOTMENT FY 2014-15
SC	MH BARODA	31.00	27.15	29.87
SC	MH SABINA	0.00	0.00	0.00
SC	MH AVADI	146.38	165.00	185.00
SC	MH AURANGABAD	96.54	63.75	115.00
SC	MH AHMEDNAGAR	181.84	187.75	215.00
SC	MH AHMEDABAD	59.30	51.50	85.00
SC	MH CTC	700.00	807.00	807.00
SC	MDC WELLINGTON	0.72	0.63	0.63
SC	MDC TRIVENDRUM	0.12	0.10	0.07
SC	MDC SECUNDERABAD	0.54	0.47	0.47
SC	MDC SAUGOR	0.30	0.26	0.26
SC	MDC PANAJI	0.66	1.57	1.57
SC	MDC NASIRABAD	0.90	0.78	0.78
SC	MDC NASIK ROAD	0.00	0.00	0.05
SC	MDC MEG B'LORE	0.30	0.27	0.27
SC	MDC MALAD	0.36	0.31	0.31
SC	MDC KIRKEE 0/IJ)	1.02	0.89	0.89
SC	MDC KIRKEE (CME)	0.54	0.47	0.47
SC	MDC KIRKEE	1.26	1.10	1.10
SC	MDC KHADAKWASLA	0.24	0.21	0.21
SC	MDC KAMPTEE	0.00	0.00	1.00
SC	MDC JODHPUR	0.18	0.16	0.16
SC	MDC JHANSI	0.18	0.16	0.16
SC	MDC GWALIOR	0.36	0.31	0.31
SC	MDC GOLCONDA	0.12	0.10	0.07
SC	MDC DEVLALI	0.06	0.05	0.03
SC	MDC CHENNAI	1.74	1.48	1.48
SC	MDC CANNANORE	1.26	1.10	1.10
SC	MDC BOLARAM	0.00	0.00	0.00
SC	MDC BHOPAL	0.06	0.05	0.04
SC	MDC BELGAUM	0.54	0.47	0.47
SC	MDC BARODA	0.30	0.26	0.26
SC	MDC AURANGABAD	0.30	0.26	0.26
SC	MDC AHMEDNAGAR	0.66	0.57	0.57
SC	CMDC PUNE	4.64	4.03	9.03
SC	21 CDU	0.42	0.36	0.36
SC	12 CDU	0.48	0.42	0.42
EC	151 BH	192.70	217.00	242.00
EC	154 GH	0.36	0.31	0.41
EC	155 BH	5.00	12.12	20.00
EC	158 BH	232.70	185.00	138.00
EC	160 MH	6.36	8.53	11.50
EC	162 MH	5.00	4.34	20.00
EC	163 MH	23.34	29.00	39.90
EC	164 MH	10.00	8.69	8.69
EC	165 MH	0.30	0.77	2.50
EC	178 MH GANGTOK	13.08	14.30	12.00
EC	179 MH	6.54	5.65	5.65
EC	180 MH	2.00	1.75	1.7
EC	38 AMSD	0.06	0.05	1.34
EC	56 FMSD	0.00	0.00	0.0
EC	58 FMSD	4.92	4.28	4.2

COMO	NAME OF UNIT	TOTAL ALLOTMENT FY2012-13	TOTAL ALLOTMENT FY 2013-14	TOTAL ALLOTMENT FY 2014-15
EC	EC (TC) KOLKATA	3.80	4.29	4.29
EC	181 MH	0.00	0.00	0.00
EC	182 MH	3.00	3.87	3.87

EC	183 MH	1.84	3.95	9.00
EC	BH B'PORE	99.98	119.70	112.00
EC	CH (EC) KOLKATA	688.16	597.00	906.70
EC	MH PANAGARH	41.00	35.50	71.05
EC	MH SHILLONG	20.92	8.15	11.00
EC	CMDC (EC) KOLKATA	5.36	4.67	4.80
EC	3 CDU	0.06	0.05	0.06
EC	4 CDU	0.18	0.16	1.12
EC	33 CDU	0.60	0.52	1.40
EC	201 MDC	0.06	0.05	0.04
EC	MDC B'PORE	2.04	1.76	2.05
EC	MDC BENGDUBI	0.36	0.31	0.73
EC	MDC HAPPY VALLEY	0.00	0.00	0.00
EC	MDC PANAGARH	0.30	0.27	0.30
EC	MDC SHILLONG	0.12	0.10	0.08
WC	AFC DELHI	1434.48	1644.00	2408.40
WC	MH AMBALA GANTT	253.62	280.00	325.00
WC	AH (R&R)	3555.48	3600.00	3600.00
WC	172 MH	126.38	109.50	122.00
WC	MH SHIMLA	55.58	48.38	55.00
WC	MH AMRITSAR	284.54	266.90	454.59
WC	MH KASAULI	45.70	39.86	31.85
WC	159 GH	79.00	68.50	78.50
WC	MH PATIALA	239.08	247.00	450.00
WC	59 FMSD	0.00	0.00	0.00
WC	60 FMSD	0.00	0.00	0.00
WC	CH (WC)	1231.04	1167.00	1525.00
WC	MH JALLANDHAR	808.16	530.00	647.00
WC	BH DELHI CANTT	2050.90	2384.00	2588.00
WC	167 MH	209.08	214.00	316.58
WC	MH PALAMPUR	80.70	125.00	192.50
WC	MH YOL	207.62	210.00	281.00
WC	MH BAKLOH	8.70	10.40	10.40
WC	MH DALHOUSIE	1.24	1.08	1.08
WC	171 MH	24.16	20.95	30.70
WC	173 MH	25.84	22.43	21.65
WC	MDC PALAMPUR	0.12	0.10	0.08
WC	9 CORPS DENTAL	0.12	0.35	1.25
WC	AFDC DELHI	3.90	8.40	6.30
WC	CMDC (WC)	6.38	5.55	7.55
WC	2 CDU	1.74	1.51	1.61
WC	11 CDU	1.80	1.56	2.15
WC	ADC (R&R)	12.98	11.24	18.50
WC	MDC DELHI GANTT	3.06	2.65	3.00
WC	MDC AMRITSAR	2.50	3.17	3.00
WC	MDC JALLANDHAR	0.42	0.36	0.36
WC	MDC SUBATHU	0.12	0.10	0.08
WC	MDC SHIMLA	0.30	0.27	0.30

COMO	NAME OF UNIT	TOTAL ALLOTMENT FY2012-13	TOTAL ALLOTMENT FY 2013-14	TOTAL ALLOTMENT FY 2014-15
WC	200 MDC	**5.38**	**3.67**	**3.67**
WC	202 MDC	**1.44**	**0.75**	**0.75**
cc	161 MH	**57.30**	**62.67**	**71.00**
cc	BH LUCKNOW	**170.00**	**207.25**	**250.00**
cc	CH (CC) LUCKNOW	**1215.54**	**1445.00**	**1683.00**
cc	MH AGRA	**141.84**	**133.00**	**171.00**
cc	MH ALLAHABAD	**162.70**	**180.00**	**228.00**
cc	MH BAREILLY	**170.00**	**177.25**	**283.00**
cc	MH DANAPUR	**157.30**	**186.55**	**260.00**

cc	MH DEHRADUN	**355.00**	**440.50**	**617.00**
cc	MH FAIZABAD	**62.16**	**63.75**	**146.00**
cc	MH FATEHGARH	**27.30**	**30.70**	**45.00**
Cc	MH GAYA	17.00	19.76	21.75
CC	JABALPUR	168.16	165.70	224.27
Cc	MH LANSDOWNE	39.00	33.93	70.50

cc	MH MEERUT	700.00	760.90	971.99
cc	MH MHOW	115.46	106.00	96.60
cc	MH NAMKUM	51.62	129.75	122.73
cc	MH PANCHMARI	0.00	0.00	0.00
cc	MH RAMGARH	25.00	21.71	16.00
cc	MH RANIKHET	34.30	44.80	44.80
cc	MH ROORKEE	93.16	88.85	87.00
cc	MH GOPALPUR	15.46	30.44	38.48
cc	MH VARANASI	63.62	67.35	67.35
cc	MH MATHURA	87.30	88.65	106.00
cc	CMDC LUCKNOW	4.52	3.99	3.99
cc	MDC ROORKEE	0.30	0.27	0.27
cc	MDC MEERUT	0.54	0.72	0.72
cc	MDC JABALPUR	2.10	2.12	2.12
cc	MDC ALLAHABAD	1.56	1.36	1.36
cc	MDC BAREILLY	0.42	0.46	0.46
cc	MDC DEHRADUN	0.54	0.47	0.47
cc	MDC AGRA	0.84	0.73	0.73
cc	MDC DANAPUR	1.08	0.94	0.94
cc	MDC FAIZABAD	0.66	0.57	0.57
cc	MDC FATEHGARH	0.48	0.42	0.42
cc	MDC GAYA	0.06	0.00	0.25
cc	MDC GOPALPUR	0.06	0.05	0.04
cc	MDC MHOW	0.90	0.78	0.78
cc	MDC NAMKUM	0.24	0.21	0.21
cc	MDC PITHORAGARH	0.12	0.10	0.08
cc	MDC PREMNAGAR	0.42	0.26	0.26
cc	MDC RAMGARH	0.00	0.00	0.00
cc	MDC RANIKHET	0.12	0.10	0.08
cc	MDC VARANASI	2.28	1.98	1.98
NC	92 BH	12.54	10.89	11.98
NC	37 AMSD	0.00	0.00	0.00
NC	CH (NC)	109.08	69.70	106.6'7
NC	150 GH	12.50	30.80	60.00
NC	153 GH	20.00	17.38	13.0
NC	166 MH	422.7(	438.00	510.00
NC	170 MH	60.46	75.42	88.50

COMD	NAME OF UNIT	TOTAL ALLOTMENT FY2012-13	TOTAL ALLOTMENT FY 2013-14	TOTAL ALLOTMENT FY 2014-15
NC	168 MH	0.00	0.00	0.00
NC	169 MH	0.00	0.00	0.00
NC	CMDC (NC) UDHAMPUR	3.68	3.20	3.20
NC	15 CDU	0.12	0.11	0.14
NC	16 CDU	0.54	0.47	0.47
NC	203 MDC	0.00	0.00	0.00
NC	14 CDU	0.30	0.77	1.00
NC	61 FMSD	0.06	0.05	0.05
NC	MH DODA	0.00	0;00	0.00
NC	MH KARGIL	0.00	0.00	0.00
SWC	MH ALWAR	151.84	146.77	206.45
SWC	MH JAIPUR	757.30	737.00	952.00
SWC	MH KOTA	53.84	46.72	51.39
SWC	176 MH	15.00	13.05	13.05
SWC	187 MH	58.30	50.67	60.00
SWC	55 FMSD	0.30	0.27	0.27
SWC	174 MH	149.1	149.50	149.50
SWC	175 MH	0.00	0.00	6.00
SWC	184 MH	0.00	0.00	6.00
SWC	MDC ALWAR	0.30	0.27	0.27
SWC	CMDC JAIPUR	5.30	4.85	4.85
SWC	MDC KOTA	0.30	0.27	0.27
SWC	1 CDU	0.10	0.09	0.07
SWC	10 CDU	0.84	0.74	0.74
SWC ·	MH HISSAR	231.84	190.60	250.00

TOTAL FUND ALLOCATION FROM CENTRAL ORGANISATION ECHS AND CGDA BOOKING EXPENDITURE

(Rupees In Crores)

Financial Year	Allocation	CGDA Expenditure Booking
2012-13	385.0000	385.6800
2013-14	393.6377	377.8308
2014-15	480.0985	471.9613

Appendix-VII
Para 3.20

FUNDS STATE OF LAST THREE YEARS : REVENUE

Financial Year	Projection	BE (Budget Estimate)	RE (Revised Estimate)	MA (Modified Appropriation)	Expenditure (CGDA)
2012-13	1860.00	1400.00	1473.86	1450.98	1444.43
2013-14	2082.95	1476.46	1776.46	1789.46	1781.38
2014-15	2489.21	1420.58	2470.58	2260 .58	2236.17
2015-16	3532.12	2639 .00	-	-	*714.61

FUNDS STATE OF LAST THREE YEARS : CAPITAL

Financial Year	Projection	BE (Budget Estimate)	RE (Revised Estimate)	MA (Modified Appropriation)	Expenditure (CGDA)
2012-13	37.00	37.00	6.50	5.43	4.33
2013-14	50.00	30.00	14.00	12.45	10.90
2014-15	50.00	20.41	5.91	5.11	#6.61
2015-t6	50.00	30.00	-	-	^1.48

* CGDA Booking upto 30 Sep 2015

^ CGDA Booking upto 30 Sep 2015

Over Booking by CGDA. Case taken up with CGDA.

Annexure - I

MINUTES OF SECOND SITTING OF THE SUB-COMMITTEE ON DEFENCE OF COMMITTEE ON ESTIMATES (2015-16)

The Sub-Committee sat on Friday, the 11th September, 2015 from 1500 hrs. to 1630 hrs. in Room No. '139', Parliament House Annexe, New Delhi.

PRESENT

Kalikesh N. Singh Deo – Convener

MEMBERS

2. Dr. Sanjay Jaiswal - Co-Convenor
3. Shri J.C. Divakar Reddy
4. Col. Sonaram Choudhary
5. Shri Ashwini Kumar Chobey
6. Shri P. Kumar
7. Shri Anil Shirole

SECRETARIAT

1. Shri Devender Singh – Additional Secretary
2. Shri Vipin Kumar – Director
3. Shri U. C. Bharadwaj – Deputy Secretary

REPRESENTATIVES OF THE MINISTRY OF DEFENCE

(DEPARTMENT OF EX-SERVICEMEN WELFARE)

1.	Shri Prabhu Dayal Meena,	Secretary, ESW
2.	Smt. K. Damayanthi,	Joint Secretary, ESW
3.	Maj. Gen. A.P. Bam,	MD, ECHS
4.	Maj. Gen. R. S. Grewal,	Rep. of DGAFMS
5.	Brig. Sadhan Sawhney,	DDG AFMS (Planning)

2. At the outset, the Convener welcomed the Members to the Second Sitting of the Sub-Committee on Defence of Committee on Estimates (2015-16). He then directed that the representatives of the Ministry of Defence (Department of Ex-Servicemen Welfare) be called in.

3. The Convener welcomed the representatives of the Ministry of Defence (Department of Ex-Servicemen Welfare) and drew their attention to Direction 55(1) of 'Directions by the Speaker, Lok Sabha' regarding confidentiality of the proceedings of the Committee.

4. Thereafter, a representative of Ministry of Defence (Department of Ex-Servicemen Welfare) made a Power Point Presentation (PPP) on the subject ‘Ex-Servicemen Contributory Health Scheme'. The main points covered under PPP related to the sanctioned strength both medical and non-medical and expansion plans for polyclinics for better services, issuing of new smart cards to beneficiaries, number of beneficiaries and their contributions for availing the scheme, deficiency of administrative manpower and doctors for ECHS, adequacy of equipment, availability of life saving drugs, modes of entry into Armed Forces Medical Service, need to increase in-take capacity of Armed Forces Medical Colleges, problem of land acquisition for poly clinics amongst others. The Members of the Committee sought clarification on various issues related to the subject in question and the representatives of the Ministry responded thereto. To the points to which representatives

could not readily respond, the Convener asked them to furnish detailed written replies to the Lok Sabha Secretariat at the earliest.

5. The verbatim proceedings of the Sub-Committee were kept on record.

The Committee then adjourned.

Annexure - II

MINUTES OF THIRTEENTH SITTING OF THE COMMITTEE ON ESTIMATES (2016-17)

The Committee sat on Wednesday, the 07 December, 2016 from 1500 hrs to 1605 hrs. in Committee Room 'D', Parliament House Annexe, New Delhi.

PRESENT

Dr. Murli Manohar Joshi – Chairperson

MEMBERS

2. Shri Sultan Ahmed
3. Shri George Baker
4. Shri Dushyant Chautala
5. Shri Ram Tahal Choudhary
6. Col. Sonaram Choudhary
7. Shri Ramen Deka
8. Shri Sanjay Dhotre
9. Shri P. C. Gaddigoudar
10. Smt. Kavitha Kalvakuntla
11. Shri K.H. Muniyappa
12. Shri Ravindra Kumar Pandey
13. Shri Raosaheb Danve Patil
14. Shri Md. Salim
15. Shri Arvind Sawant
16. Shri Jugal Kishore Sharma
17. Shri Anil Shirole
18. Shri Rajesh Verma

SECRETARIAT

1. Shri Devender Singh – Additional Secretary
2. Shri Vipin Kumar – Director
3. Shri Srinivasulu Gunda – Additional Director
4. Shri R.C. Sharma – Deputy Secretary

SECRETARIAT

2. At the outset, the Chairperson welcomed the Members to the Sitting of the Committee.

3. The Committee then took up for consideration the following draft Reports:-

(i) Draft Report on 'Ex-Servicemen Contributory Health Scheme' pertaining to to the Ministry of Defence (Department of Ex-Servicemen Welfare); and

(ii) ***** ***** ***** *****

4. The Committee adopted Reports at (i) ***** above with some modifications. They also authorized the Chairperson to finalize the Reports in the light of the modifications suggested and factual verification and present the same to Lok Sabha.

5. The Chairperson placed on record the cooperation and valuable suggestions of the Members in the work of the Committee. He also thanked the Secretariat for their cooperation and assistance rendered to the Committee.

The Committee then adjourned.