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THE FEASIBILITY OF LEAN POLYCLINICS: CRITICAL ANALYSIS OF ECHS

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Abstract

Ex-servicemen Contributory Health Scheme (ECHS) is similar to the Central Government Health Scheme (CGHS), meant for meeting the medical requirements of the uniformed retired Defence personnel from the Army, Navy, and Air Force. The scheme covers almost 67 Lakhs of the retired as of now. The management of the scheme is controlled by Central Organisation at the apex, Regional Centres, and Polyclinics as the service providers. The medical cover is provided by services medical facilities, empanelled civil facilities, and Polyclinics. The strength of the beneficiary gets incremented by approximately 60,000 every year. The study is to research the actual requirements of staff at Polyclinics towards the conduct of an efficient and economically viable management system. ECHS is a copy-paste of the CGHS with some modifications. The policymakers of the ECHS, while formulating the scheme had a thought process of providing a second career for the retired Defence fraternity while formulating the manning of this scheme. When you look at the scheme the activities of Polyclinics are a duplication of the activities undertaken at the services hospitals (Military). After spending almost 20 years of the new scheme for defence veterans, it is time to introspect and to see whether the earmarked allocation of the yearly budget is being spent for the core purpose or not. The prioritisation is to be decided to see whether the scheme spends a larger portion of the budget on paying the salaries or to be spent on core medical expenditure. The Central Organization and Regional Centres' are managed by the serving Defence population and Polyclinics are managed by contractual employees. The other components of the scheme are Station Cells, Senior Executive Medical Officer, Bill Processing Agency (BPA) and the Principle Controller of Defence Accounts (PCDA). The government sanction towards allocation of vacancies for different types of Polyclinics, categorized based on the registered members in the demarcated geographical area of responsibility, was done on an adhoc basis. In the last 20 years, the task and role of the scheme have grown so much that there is a critical need for revision of the scale, especially in the non-medical categories. Such additional expenditure from the limited yearly budget of the ECHS will harm the expenditure for medical treatment.

Keywords: ex-servicemen, polyclinic, treatment, Defense, medical, reimbursement.

Introduction

The Ex-Servicemen Contributory Health Scheme (ECHS) was launched in April 2003 to provide quality medical care to the Ex-servicemen and their dependents by utilizing the existing medical infrastructure of the Armed Forces and the Civil/Government Hospitals [1]. It was a mammoth task to conceptualise, plan and execute this scheme. The scheme today has rapidly gained credibility and has made phenomenal progress over the past 19 years from 13 Regional Centres and 227 Policlinics to 30 Regional Centres and 433 Polyclinics with a total beneficiary base of approximately 67 lakhs [2]. The scheme is also extended to Gorkha Domiciles for Nepal. The scheme is dependent on a large number of agencies for its day-to-day functioning, which includes the command structure of the three Services, facilities of the Armed Forces Medical Services, ECHS Polyclinics, Regional Centres and Central Organisation ECHS, apart from the PsCDA, DG Defence Estates and Empanelled Medical facilities.

Background of the research

The research was primarily necessitated due to the increase in clientele every year (approximately 60,000 additions every year), escalation of the cost of medical treatment and the budgetary constraints of the government. When we have 60,000 defence retirees joining the scheme every year, the financial addition to the scheme is through the one-time contribution that the beneficiaries make at the time of their retirement.

As per the policy, certain classes of beneficiaries are exempted from paying the subscription like war widows, the disabled etc [4,5,6]. If we take the average contribution as Rs 70,000/-(which may not be correct, since it depends on the number of people of each category retiring in a year), the subscription every year will be Rs 42 Cr. This amount is only a small fraction of the yearly budget for ECHS, which is approximately 6500 Crs in a year. So the question is that" How long the government Will be able to support the scheme" also should the limited budget be primarily spent on treatment, other than spending on salary for the contractual employees?

While forming the ECHS, an aspect of a second career for the retirees of the Defence Forces was also considered [7]. That is why there is a reservation of 60% for the Officers cadre and 70 % for the other categories while engaging the contractual employees. When you look at the ECHS scheme, it has a lot of similarities with that of CGHS. Hence, keeping the constraints of the government budget, and the ever-increasing list of beneficiaries, the following needs to be analysed Need for the scheme to majorly focus on the medical treatment protocol Outsourcing the provision of supply of medicines Streamlining the present function of Polyclinic

Need for a separate medical scheme for the Defence retirees

The free medical care for the defence retirees is one of the conditions of the recruitment towards joining the Defence services. It is a contractual obligation as per the terms and conditions of the Defence services. That is, an individual joining the Defence services will be provided with free medical cover while in service and also after retirement. This medical service as per the terms of engagement is supposed to be free by the central government. To make this scheme a participative model, nominal charges are paid by the retirees at the time of retirement. The medical services while in active service and after retirement not only cater for the pensioner but also covers the spouses, dependent children, parents, and widowed sisters who are fulfilling the financial sealing specified in each category.

While in active service, all the medical requirements of the soldier and the dependants are looked at by the medical establishments under the Director General Armed Forces Medical Services (DGAFMS). DGAFMS at the apex has DsGAFMS for Army, Navy and Air Force. The medical services are provided by the Services Hospitals in terms of Military Hospitals (MHs), Command Hospitals (CHs), Base Hospitals, Services Hospitals of Army, Navy and Air Force and smaller medical establishments at the unit level.

Till the year 2002, the medical requirements of the retired fraternity were also being looked after by the same establishments. With the increase in the strength of retirees and limitations of such service hospitals to look after the retired, a need was felt to create a separate establishment for the retirees, Thus the formation of a separate scheme called ECHS [1].

The need for a separate scheme for the Defence retirees was thought primarily due to the conditions of the service (places of posting, weather conditions etc). The soldier who joins the forces at an early age spends their youth in the service of the nation. So they deserve special medical care at the fag end of their life. The soldier while joining the forces is a fit human being. The adversities which one undergoes make them succumb to various lifestyle- related medical problems. There cannot be any financial sealing or age limit for availing of the scheme for retired soldiers. Medical schemes (government/ private) always had financial limitations or upper sealing towards the expenditure. This could not have been possible without forming a separate scheme for the Defence retirees, since the provision of medical treatment in service and after retirement was the responsibility of the government as part of the terms and conditions of service.

Command and Control of ECHS

The 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 [8]. 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.

ECHS has a three-tiered structure, with the central body (Central Organisation) at its apex, regional bodies (Regional Centres) at the middle level and Polyclinics at the functional level. At present, Central Organisation, ECHS is headed by a Major General and Regional Centres by Colonels. The Central Organisation ECHS is located in Delhi and functions under the Chiefs of Staff Committee through the Adjutant General in the Integrated Headquarters of the Ministry of Defence (Army). At the regional level, 30 Regional Centres are functioning across the Country. Each Regional Centre on 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. 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, Physiotherapy treatment and dispensing of medicines. The entire staff at ECHS Polyclinic is employed on a contractual basis.

Organization of Central Organization (Cent Org)

The Cent Org, the apex body of the ECHS, is managed by the serving Defence staff from Army, Navy and Air Force. The subsections of this office have almost 8 departments headed by Colonel level officers and supporting staff. Since all these personnel are posted from the existing establishments of the Army, Navy and Air Force, the expenditure incurred on the day-to-day running of this establishment is not considered in this paper [8].

Organization Of Regional Centres

There are 30 Regional Centres under the Cent Org. Here again, the majority of the staff is posted from the existing establishment of the Army, Navy and Air Force. Few doctors dealing with billing and health services are hired on a contractual basis. The contractual employees working with the Regional Centres are in fact against the establishment of certain Polyclinics. Towards working out the expenditure of these establishments an average of 5 employees in each RCs can be considered. That itself makes the total contractual employees with RCs to approximately 150. This includes

doctors being paid a contractual fee of Rs 75,000/- per month and on average Rs 25,000/- for para and non-medical staff. This is a huge drain on the budget allocation of the ECHS [9].

To work out the expenditure outlay, it will be convenient to take a figure of 25 contractual employees on average. Thus the total contractual employees in Polyclinics altogether will be around 10,000 employees (includes employees hired under various welfare schemes also). The contractual fee will be ranging from Rs 1,00,000/- (specialist) to Rs 75,000/-(doctors) and an average of Rs 25,000/- towards para and non- medical staff per month. This expenditure is met from the annual allocation of the budget to the ECHS.

Supporting establishments of ECHS

In addition to the Cent Org, Regional Centres and the Polyclinics, establishments like Ex-servicemen Welfare wing of Ministry Of Defence, Station Cell at each Station headquarters of Army, navy and Air Force supporting each Polyclinic, Senior Executive Medical Officers and staff of each Polyclinic under the jurisdiction, the Bill Processing Agencies and the Principles Controller of Defence Accounts(PsCDA) are also engaged in the total ambit of the ECHS system. As per the existing policy directions on the subject, the people employed in all the above-quoted supporting establishments do get paid from their respective sub-departments and the total expenditure towards maintaining these is not directly accounted.
for in the budget for ECHS. In addition, the Military Engineering Services also pay a huge amount towards the maintenance of the infrastructure of the ECHS establishments [11, 12, 13].

Authorization of manpower in Polyclinics

The polyclinics, in general, are authorised by Officer in Charge, Specialist Medical Officer (depending on the category of Polyclinic), Medical Officer, Nursing Assistant, Laboratory Technician/ Assistant, Pharmacist, Physiotherapist and non-medical category which includes clerks, Receptionists, Information Technology Assistant, Peon, Chowkidar, Safaiwalla etc [14,15]. Each of the Polyclinics in Military parlance can be considered to be a lodger unit of the supporting station.

Functions of Polyclinics

The functions of the Polyclinics are dealing with routine sickness, where the doctor at the Polyclinics can diagnose the medical issues and issue medicines, issue regular monthly medicines (as prescribed by the respective specialists at empanelled medical facilities/ Service hospitals), the conduct of routine laboratory checks (all specialised pathological tests are referred to empanelled facilities), routine physiotherapy. Based on a survey conducted the various categories of the beneficiaries based on the regular functions of the Polyclinics can be summarised as: -
Collection of regular monthly medicines-60% Taking referrals for specialised treatment either from empanelled medical facility/ Service Hospital-25 % Regular monthly blood check (diabetic patients)- 5 % Diagnosis & treatment at Polyclinic- 10 %

ECHS vs CGHS

The Central Government Health Scheme is a very old medical scheme for the employees of the Central Government [16]. When one looks at the ECHS and CGHS, it is almost the same except in terms of management and manning. CGHS rules, regulations and policies are replicated when it comes to anything for ECHS. The guiding factors for ECHS emanate from the policies of CGHS.
The main difference between the CGHS and ECHS is the large number of employees contracted or working in the establishments meant to take care of the beneficiaries of ECHS. Otherwise, the treatment protocols, treatment with the empanelled facilities, the reimbursement claims, appointment of staff etc are the same in ECHS which is applicable for CGHS. In terms of the empanelment of the medical facilities, there is duplication. The CGHS and ECHS maintain separate empanelled facilities. Though the procedures and reimbursements are the same, the separate list of empanelled facilities makes the scheme more vulnerable when it comes to the ECHS.

The current medical insurance scenario

With the opening up of the insurance sector to private players and medical insurance schemes being made available up to one crore and the age limit getting extended to 99 years etc, there is a need to rework the administration of the ECHS scheme with more emphasis on the treatment protocol other than, this scheme being made as a second career option of the retirees of defense Forces. This is primarily due to the ever-increasing beneficiaries in the scheme. A study was undertaken to know the actual beneficiaries indicate that, 66 % of the beneficiaries are dependents. Other than the pensioner and the spouse, the scheme extends to male children up to the age of 25 years, girl children up to employment or marriage, disabled children for life, short service commissioned officers, dependent parents, widowed sisters etc. The list is very long. This results in the actual beneficiary not being able to get the desired treatment. After all the budget is limited and after the initial subscription, the treatment for life is free in the scheme. This scenario indicates the need for revisiting the scheme, not to find an alternative, but to make it economically viable, where the soldier who spent their youth for the nation get medical care at the later stage of their life.

Scope of the study

The study was conducted in only one region of the Maharashtra to find out ways and means of reducing the manpower by finding alternatives to the existing medical protocol without compromising the quality of medical services provided to the retired defiance personnel. Today it appears that there are duplicities involved in the total functioning of Polyclinics. Sometimes it gives a feeling that the Polyclinics are doing a post office job. The beneficiaries generally (60%) have medical issues related to cardiology, Hypertension, Diabetic, Cancer or Ortho related. There is no specialist and wherewith available at Polyclinics to deal with it. Hence they are either referred to the service specialist or specialist in empaneled facilities. Thus Polyclinics becomes a facilitator only. The other major category of beneficiaries falls under people who want to have their regular monthly medicines. In this case, also there is no value addition in the treatment protocol. Such beneficiaries at regular intervals follow up with the specialist doctors at a service hospital or empaneled facility. Towards collection of regular medicines, the beneficiaries have to come to Polyclinic and meet the Medical Officer, who, without making any addition or deletion recommends the same medicines prescribed by the specialist. If it is so, why do they have to come to Polyclinic? The alternative to collection of regular monthly medicines can be worked out; this will ease the life of the veterans by not coming to Polyclinic, especially for this purpose.

Hence it is felt that almost every activity in the chain of treatment protocol being presently done at Polyclinics is eighter a duplication or a kind of post office job. There may be a very small percentage of the population, who, once come to Polyclinic and the treatment protocol gets completed in the Polyclinic itself. This generally happens for beneficiaries who are affected with a common cough, cold, or fever. This category of beneficiaries comes to Polyclinic and gets treated at the Polyclinic. This category of beneficiaries is very limited.

Method of Research

The research was carried out by the following methods In-depth interview
Stratified sampling survey

Conduct of in-depth interview and Focus Group:

The sample collected for this particular research was from total 100 respondents who are beneficiaries from various ranks and gender. It was a group of 6 comprising one officer, two Junior Commissioned Officers, one honorary rank officer, a lady wife of an Officer, and one from the other ranks. The composition of the qualitative research by way of the in-depth interview was to check on the feasibility of making the manning at Polyclinic to the bare minimum to utilize the funds consumed towards payment of salary to be better

utilized for treatment.

Category of participants	Interview/focus groups
Officers	O1
Hon. Officers	01
JCO's	02
Other Ranks	46
Dependents	50

Focus Group And Interview: Data Collection :

The sample size is 100 and the focus group were conducted for 46 respondents and fifty dependents. According to the availability of the respondents at given place. The main intention of the focus group was to know from the beneficiaries if the existing functions of the Polyclinic are reworked by having a lean Polyclinic, without compromising the quality of medical services and utilization of the budget allocation mainly towards the treatment aspects. The questions were mainly on the following issues: -

The main purpose of visiting the Polyclinic
Types of medical issues of the beneficiaries
Are the beneficiaries happy with the treatment protocol of Polyclinic?
The capability of Polyclinic to handle medical emergencies.
Opinion on empanelling the chemist for regular medicines Services of the dental department is Polyclinics treating the patient or a referral agency Opinion on direct reporting by patients to empanelled hospitals Direct reporting to MH/CH bypassing the Polyclinic Utility of Polyclinic Laboratory Outsourcing the lab facility.

The survey has helped to find the actual utility of the Polyclinic when it comes to the treatment of beneficiaries. It is observed that the actual medical treatment at Polyclinic is availed by 5 to 10 % of the population only. The rest of the treatment protocols being done at Polyclinic are a duplication of what is being done at MH/CH/Empanelled medical facilities.

Analysis

The qualitative analysis of in-depth interview conducted in a small group of approximately 6 to 10 . The opinions or answers received in the in- depth interview on various aspects of the functioning of the Polyclinic had the following options for ensuring the routine functions of the Polyclinic. The table below mentioned covered the important aspects related to the functions and suggestions largely raised during the focus group discussion and in-depth interviews: -

Functions of Polyclinic	**Present function**	**Suggestions/Alternate**
Reporting Sick	Report to Polyclinic, meet the treating doctor for disposal	Report to Polyclinic and take a slip to the MH/CH/Empaneled facility
Medicines	ECHS/ALC/Buy and claim	Direct collection from empanelled Chemist cashless
Laboratory	Some tests are done in Polyclinic others are referred to empanelled laboratories.	Totally from empanelled laboratories.
Ancillary Medical Equipment	ECHS procures and supplies to Beneficiary	Based on the recommendation of a specialist, buy it from empanelled dealer
Physiotherapy	Some at Polyclinic and remaining from the empanelled facility	Totally from the empanelled facility
Consultation	Totally at Polyclinic	Only minor consultation at

		Polyclinic
Reimbursement claims	Routing through Polyclinic	Direct uploading by the beneficiary

The survey results indicate the fact that the majority of the consultations, treatment etc are done at the MH/CH/ Empaneled Medical facilities. The function of the Polyclinic is as an intermediary to route the cases to respective appropriate facilities. There is no value addition by keeping the intermediary action at the Polyclinic level. If each of the activities is outsourced, it will reduce the manning of the Polyclinics very drastically. It will in turn have a lot of savings in terms of the contractual fees and salaries paid as of now. The function of the Polyclinic can then be reduced to a coordinating agency. This can be done by authenticating the genuineness of the beneficiary and then issuing certificates to this effect for the beneficiary to undertake the treatment, collect medicines etc. In the majority of the instances, the Polyclinic is duplicating the actions without any value addition. It is diverting the fund in terms of the salary to the staff, which could better be utilized for the actual treatment.

Conclusion

In today's scenario, Polyclinics are duplicating various functions of the treatment protocols without any value addition. In many cases, it is inducting certain avoidable days into the system of treatment. By adopting the principles of outsourcing and empanelment, a huge amount of the budget can be saved by reducing the present functional role of Polyclinics to that of a coordinator. Polyclinics which has an average of 25 staff can very well
be reduced drastically with one or two doctors and two to three medical staff. They will issue tokens to the respective empaneled medical facilities or MH/CH for all consultations/admissions/ collection of medicines/ pathological examinations. The reimbursement of emergency treatment bills can be made to be uploaded directly to the BPA by the beneficiary.

Hence under budget constraints and ever-increasing beneficiaries, the funds can better be utilized for the actual purpose of the treatment. Once the role and task of the Polyclinic are redesigned all other support services presently provided by the Station Cell, Senior Executive Medical Officer, Regional Centers and the Central Organization can be cut to the required size. This can further be reduced by utilization of the digital platform in future.

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