CHAPTER VIII
DISCUSSION AND CONCLUSION

Our review on the evolution of Labour, Welfare and Social Security Legislation in the country reflects that the powerful Indian Bourgeoisie resisted the enactment of labour laws at every stage. They realised that proper implementation of labour laws would directly affect their profit margins. Concerted efforts by Trade Unions however ensured that the working class got some relief in the form of Social Security legislations.

The earliest legislation to protect workers interest was the Workmen’s Compensation Act. This provided for lumpsum compensation for Occupational Diseases and Injuries, and the employer was solely held responsible for paying the same. However, this Act was criticised on the grounds interalia, that long procedural delays prevented workers from getting timely and adequate compensation. The employers lobby too wanted that the responsibility for compensation should be “shared” by all parties.

As a result, at around Independence, the ESI Act replaced the Workmen’s Compensation Act primarily in the organised sector. This led to the creation of an autonomous ESI Corporation, which became a tripartite body run and financed by the Government, the employers and the employees. Though on paper, all the three parties have equal power, but the history of labour legislation has shown that the employers by virtue of their capital very often forced Governments’ to accept their conditions. Thus, the power equation in this tripartite body is not necessarily in a state of equilibrium conducive to workers welfare.

The ESI Corporation made rules and regulations for giving compensation to employees sustaining Occupational Diseases and Injuries, in the form of periodic payments. Another ‘glamorous’ benefit of free medical care to workers and their families was also provided by this autonomous corporation. We thus see that what was essentially an Occupational Health Service became saddled with the task of provisioning General Health Services as well. In addition, the State took over a significant share of responsibility for the provision of health care. In the process two things seemed to have happened. Firstly, the State which even normally providing basic health services to the people shifted some of
its resources from the general health care services to the ESIS. Secondly, the expansion of
the health care system within the ESIS covered up quantitatively the failure of this system
to build an adequate occupational diseases component. As a result its prevention, treatment
and compensation were neglected. In a way the States intervention, not only provided
monetary relief to the industrialists but also protected him from investing heavily into
control of occupational diseases and injuries.

Our attempt to evaluate the efficiency of the ESIS in providing comprehensive
health services to the working class in Faridabad district, has not only provided insights
into the working of the System and its correlates but has brought to fore some serious
issues for discussion. For analytical purposes it is important to first highlight the features of
the context in which the ESI System is located. As we have argued earlier, our Systems
Approach enables us to highlight the limits of intervention in the core system without
touching the supportive components and the contextual domain. In the present discussion,
we attempt to show how delineating the larger issue of the socio-political framework, that
influences the functioning of the core ESI System, is critical in any effort to improve ESI
services.

We begin by discussing the external factors viz the power and politics of
occupational diseases and injuries, vested interests of the principal players in the ESIS,
their class base and linkages with the Government administration, institutions and
legislation. These directly affect the working and also decide the priorities within the ESIS
system (both its core and supportive components). This is followed by a discussion on the
internal linkages of the ESIS that are critical for the working of the core and supportive
components of the ESIS. These are the administrative and executive links such as the
various ESI Institutions, the Medical Boards, the EI Courts, the Factory Inspectorate and
the District Health Services. Any lacunae within these hamper proper diagnosis, treatment,
prevention and compensation for occupational diseases and injuries, as emerges from our
data. Thereafter, we present important management issues concerning the ESI Health Care
system that prevent the workers and their families from getting satisfactory general health
services. Finally, we suggest some steps for systemic intervention, which in our view, will
help improve the efficiency of the ESIS in detecting, treating and compensating
occupational diseases and injuries, not only in Faridabad but in other districts as well.
EXTERNAL FACTORS INFLUENCING THE ESI SYSTEM

The socio-political context is determined by the balance of power between the principal players in the ESIS, viz the Government, the Industrialists and the workers. There is ample historical evidence discussed below, to prove that the balance in this power game has not remained constant. In other words, it has undergone changes over time.

Our review of literature, as presented in Chapter I, shows that the demand for compensation for occupational diseases and injuries was made by the workers as back as 1884 but nothing came out of it (Rafy, 1998, page 48). The earliest Social Security legislation, viz the Fatal Accident Act of 1885, remained merely on paper as to claim compensation under this Act, the heirs had to prove that the deceased worker had died due to the negligence of the employer (Govt of India, 1966, page 9). In fact in the initial periods of industrialisation, viz 1850 -1900, when labour was provided by the uprooted peasantry and tribal population, the legislation instead of being protective was primarily oppressive. The Plantation Act is an example. It was enacted in this period primarily to mobilise labour for plantations and mines and to keep them imprisoned on these places (Trivedi, 1987, page 185). In fact, up to the early twenties of the last century there was no statutory provision for assistance to any wage earner for even common accidents of life. No compensation was available for loss of wages during periods of interruption in his/her income due to unemployment, sickness, disability or maternity. Even in the event of an accident in course of, and arising out of employment, no relief was available (Mallick, 1995). The reasons for this were free availability of labour, lack of organization among workers, vested interests of the British and the tendency of the Government to avoid intervention in disputes between labour and industrialist (Gupta, 1984). Moreover, the employers opposed tooth and nail all social security legislation (Mody, 1935, page 2126).

The period 1900 - 1920 was one when no repressive legislations were introduced. In fact, certain Acts like the Factories Act and the Mines Act of 1901 were in the interests of labour. The statements made in the British Parliament and Associations of British Capitalists, however show that the enactment of these Acts was governed by the interest of the British capitalists who saw Indian industries with their cheap labour as competitors. It is important to note that, though these legislations were passed and provided for some
protection to workers in workplaces, the working conditions of labour remained poor or infact worsened. The reasons for non-implementation as well as poor coverage also becomes clear if we examine the evidence of interaction between the government machinery and the owners. Even the debates on the acts in the legislative assembly show that one major argument used by the supporters of Indian entrepreneurs was their economic inability to invest too much capital in welfare services. This stand was supported by the Government as is evident from the reports of the Factory Inspectorates and legislative assembly debates, all of which sympathised with the owners and agreed that they should not be harassed too much (Trivedi, 1987, page 186). This attitude of neglect of legislative measures to protect workers interests continued till the Second World War.

The constant pressure from the workers, trade unions and the ILO - which at that time was dominated by the socialist countries of the erstwhile Eastern Bloc- and the first World War and its aftermath (Industrial production was required for political, economic and military considerations and hence strikes harmed the war effort), forced the Indian Government to enact the Workmen's Compensation Act 1923 (Trivedi; 1987; Elling,1986). This legislation (amended in 1926) provides for disablement and dependent benefit for occupational accidents and diseases, wherein the liability to pay the compensation is that of the employer (Mallick, 1995). It established the idea of absolute risk by abolishing the necessity for the workmen or their dependents to prove negligence or moral culpability on the part of the employer (Gupta, 1986).

The Indian Bourgeoisie however, tried its best to limit the compensation to the bare minimum. The functional problems in the working of the WCA arose principally out of the employers' resistance to pay liability towards compensation. The Indian Legislative assembly in the meantime, rejected the ILO convention of 1927 calling for adopting Health Insurance. We therefore see that during this period the Government, the bourgeoisie or the legislative body, which represented the emerging democratic process of future India, tried to use legislation to control the labour force. The concessions given to labour were negligible and even these ran into functional problems created by the industrialists.

During the Second World War the need to produce forced the Government to give up its laissez faire policy and take up strong interventive steps. The economic incentive
was strengthened by the political need as well. The Indian national movement started pressing the Government to give more and more attention to stabilise Indian economy and some rights to the workers for protection of their health (Trivedi, 1987, page 191). The workers also became organised into Trade Unions and so gained greater bargaining power.

The Government intervention into the economy in independent India was essentially for the evolution of a socialistic pattern of society. However, in reality the various Plans steered Indian economy on the capitalist path. Indian economy in fact offered much more substantial Government support to the capitalist than was otherwise possible. This was done by creating a public sector which provided infrastructural facilities and allowed resource transfer from the public to the private sector. In addition the Government also provided adequate subsidies to the private sector. Such a strategy for development consolidated an economic structure where inequality of classes became the very basis of growth (Bagchi, 1982). The Government considered peace in industry as a necessary condition for production and hence in the initial phases of planning attempted to achieve this by attempting to settle internal disputes, arbitration, education of workers, workers participation in management, unionisation and provision of social security measures.

The dawn of Independence thus saw the Industrial Truce Resolution in 1947 that emphasised that labour welfare was essential for industrial amity. However, the Indian Bourgeoisie ensured that even in independent India, despite the proclaimed aims of a welfare state and the socialistic pattern of society, the state power and planning process was mainly used by the employers for their benefit. Therefore, since the concerns of the bourgeoisie were overriding for the Indian State, the latter's self proclaimed goal of socialism could have had little meaning for the workers (Trivedi, 1987, page 116). Labour, which was an important factor in production was given a lot of lip service in the plans, but its real interest was secondary given the continuing nature of conflict between labour and capital. The emphasis on production continued and the logic that "betterment of labour lies in greater production" which was offered by the Government of India continued to be the guiding principles of Indian Planning.

It was in these socio political settings that the outcome of the Adarkar report, viz the ESI Act was passed. This Act provided for formation of an autonomous tripartite body
comprising the Government, the industrialist and the workers, to provide occupational and
general health services to the workers. A clear shift in priorities is evident in the funding
pattern of this Scheme. Whereas, in the case of WCA, the responsibility for compensation
was totally that of the industrialist, in the ESIS all three parties were made to contribute
towards the compensation amount. Beside, the composition of the higher executives of the
ESIS is a clear indication that the Government wants to have a firm control over the
running of this so called ‘autonomous’ scheme. Thus, the Government retains hold over the
day to day functioning of this so labelled “autonomous” Scheme by appointing directly the
Executive head (DGESI) and the Financial Commissioner. The other two parties are not
consulted in this appointment (Mallick, 1995). These two Government officials have to toe
the Government line as they are career IAS bureaucrats sweating for their next promotion
in their elite parent cadre. They are thus more concerned with protecting the fiscal health of
the Corporation. Detection, treatment and compensation for occupational diseases and
injuries are viewed as a drain on the finances of the ESI Corporation.

The Industrialists too by virtue of their capital might, are in a position to influence
the Government to take decisions that suit the former. As pointed out earlier, Indian
industrialists have viewed Workers Safety, Welfare and Health as events that directly
increase their production costs and thus reduce profits. They have therefore pressed upon
Governments to enact and enforce legislation that hampers detection and compensation of
occupational diseases and injuries. The guidelines regarding compensation for occupational
diseases and injuries framed by the Corporation, as revealed in our data, illustrate this
point. We discuss the same below.

Though the Workmen’s Compensation Act and the ESIS follow the same Schedules
for deciding quantum of compensation, the former gives one time compensation, whereas
the latter recommends periodic payments. This in effect means that the ESIS gives the
worker much less than even the interest (he would have earned on the lumpsum under the
Workmen’s Compensation Act), while retaining the capital permanently. Moreover, if the
disabled worker covered by the ESIS dies subsequently due to non occupational causes, his
family gets nothing. Therefore, the ESIS offers no “Social Security” when the family of an
occupationally disabled worker needs it most. Also a temporarily disabled worker is
entitled to only 70% of his normal wages as TDB. During this period, the employer pays
him no wage. This fact denies all logic of permanent employment. In addition, most lowly paid, unskilled and occupationally disabled workers have been dismissed by their employers in Faridabad by taking advantage of ESI General Regulations 98. These Regulations empower the employer to dismiss such workers if they have been getting TDB for more than 6 months or have been under treatment for an occupational injury for over 18 months. It is ironical to note that whereas on one hand, the employer has dismissed these workers on the grounds that the worker can no longer perform his original job due to his occupationally induced disability, on the other hand the ESI Medical Board at Faridabad has awarded an overwhelming majority of these workers “Nil- Loss of earning capacity” and hence no Permanent Disability Benefit. The worker has thus been literally thrown on the streets for no fault of his, whereas the employer has been allowed to take advantage of his own wrong. This attitude of the Corporation not only helps the industrialist to retain his huge assets but has also made the Corporation cash rich. As a result, the ESI Corporation has built a big corpus of Rs 399867 lacs as discussed on Page 246. These assets have many a time been used for purposes unconnected with workers welfare; at times to bail out the cash strapped Labour Ministry so that the latter can host International conferences (Page 247).

The era of ‘globalisation’ that swept the developing world since the 1990’s has provided a new concept in labour exploitation, viz, setting up of Export Promotion Zones (EPZ). India is shedding its trade barriers and opening up economies. The import substitution policies are giving way to export led growth. Thus, certain enclaves where free trade is allowed are being set up. These are called EPZ. 27 million people work in 850 such zones in the Third World. 80% comprise young and unmarried women with no rights. No labour laws are applicable to these EPZ, which by itself appears to be a gross violation of human rights. In developed countries, cost of production is high due to strict legislation. Employers are forced to provide good wages and other facilities to workers. But in these EPZ, in India, the Government is only interested in earning foreign exchange. State Governments are therefore advertising advantages of low cost labour and conflict free labour relations in these EPZ. They point out that as Trade Unions do not exist in these EPZ, entrepreneurs can easily get cheap unskilled labour. The managements therefore need not invest in Occupational Safety, Health or Labour Welfare since Inspectors are banned from visiting EPZ (Indian Labour Conference, 1999, page 11).
We thus observe that the workers have the least amount of say in the tripartite power game. The Trade Unions are unable to stand up to the combined might of the Government and the industrialist. By our interaction with Trade Union leaders in Faridabad, we came to the conclusion that proper compensation for occupational diseases and injuries is not on their agenda of demands at all. This is because they are totally involved in getting "basic human rights" for the workers, viz payment of full and timely wages and protection from retrenchment. Under these circumstances labour has been left to the vagaries of market forces. Workers admit that they do not mind working in inhuman conditions, even at grave risk to their lives, provided they get enough to keep body and soul together. The present era of "Globalisation" and "Privatization" has further loaded the dice in favour of the industrialist. In fact, now they are pressing for total removal of Labour Laws and Inspectorial Checks, under the garb of making the industrial atmosphere "investor friendly". (The Times of India, 29/9/2000). The Hind Mazdoor Sangh has stated, "Of concern is the eagerness displayed by various State Governments to advertise labour flexibility and cheap labour for attracting foreign direct investment as virtues for investing in their States" (Indian Labour Conference, 1999, page 11). Our data, presented in Chapter IV, shows that in Haryana under the garb of "elimination of Inspector Raj", Factory Inspectors have been directed by the State Government to minimize inspections. This has almost rendered defunct the statutory provisions under the Factories Act meant to protect labour.

The current trend in planning Health Service Systems is to shift to 'Privatization'. This is apparent in the recommendations of the Satyam Committee report, set up to review the ESIS Health Service System, and discussed in detail in Chapter III. The Satyam Committee has found a theoretical justification for restructuring of the ESIS medical care system by using workers dissatisfaction against the existing working of the ESIS, and underutilization of ESI hospitals, as the logic for privatization of ESI medical institutions (Government of India, 1999). At the same time it has chosen to be totally silent on the issue of addressing occupational diseases within the ESIS. Trade Unions have strongly opposed privatization of ESI hospitals and dispensaries as recommended by the Satyam Committee. They are of the opinion that privatization will hardly improve functioning, while increasing new vested interests. According to them, "It must be remembered that the ESI is a Social
Security scheme funded from workers wages. Social Security schemes should not be run on profit earning basis, which privatization will lead to. Infact, privatization may give further impetus to corruption and mismanagement with a view to earn even higher profits” (Indian Labour Conference, 1999). Since Trade Unions are one of the parties in the tripartite body called the ESIS, it was expected that their opinion will get due Weightage. However, the ESIC has initiated the process of privatization of ESI hospitals in Bibewadi and Kolhapur (Maharashtra) (The Sunday Times of India, 27 May, 2001). This is evidence that bargaining power of the workers is minimal in this tripartite organization.

The attitude of the higher executives and senior health professionals responsible for running the ESIS is indifferent, callous and antiworker. The appointment of a full time medical referee to oversee malingering among workers, as discussed on page 107-108, is one such example. The ESI higher-ups view workers as individuals out to make a fast buck, by feigning seriousness of their illnesses. Thus, “commuting accidents” are not taken into account as occupational accidents by the ESIC, as discussed in Chapter V. It is important to note that the Supreme Court arrived at this judgement because the ESIC went in appeal against an order of the Kerala High Court, which had directed them to grant compensation to workers sustaining injuries while commuting to work. Was it necessary for a Social Security agency to file such an appeal whose outcome could deny Social Security to the working class? The composition of the medical board in Faridabad wherein, the treating doctors are not associated with it on the ground that the latter can be “bribed” by the disabled worker is another example of the way the Corporation views workers. We observed in Faridabad, that workers are denied compensation for Employment Injury due to the rigid attitude of the ESI executives in interpreting whether an accident is occupational or otherwise. The decision is mostly against the disabled worker and it is left to the latter to prove “beyond all doubt” (not just “reasonable doubt”) that the accident arose due to his occupation. As a result, disabled workers have been left to fend for themselves on flimsy technical considerations. We also observed that as high as 25 % of dependents of workers killed in occupational accidents have not got dependent benefit. All of them were migratory labourers and their dependents were unaware of their entitlements. The Corporation has not made any aggressive attempts to track down these dependents and enlighten them about their dues. These cases are simply closed after procedural formalities.
The attitude of the members of the medical board is equally rigid. They examine the workers as if they are examining "cattle". Instead of being sensitive to the workers' problems, they treat them as "malingeringers" who are waiting to make a fast buck. They never read the opinion of the treating doctor or peruse the disability certificate given by the Chief Medical Officer of the district. In the case of Scheduled Injuries, the Board invariably ignores the note below the Second Schedule ESIS which reads: "Complete and permanent loss of the use of any limb or member (part of limb) referred in this Schedule shall be deemed to be equal to the loss of that limb or member". The Medical Board is unaware of the landmark judgements by various Courts, which call upon the Board to liberally apply the note below the Second Schedule. The situation is no better when it comes to non schedule injuries. The medical board gives no Weightage to subjective symptoms like pain, stiffness, etc, as it considers workers as "malingeringers". As a result, 90% cases of Occupational Injury in Faridabad in the last 5 years have been awarded disability percentages that are much lower than their legally entitled dues. Only 14% workers have been able to get more than 22% disability from the medical board at Faridabad. This is despite the fact that the Chief Inspector of Factories Haryana has officially reported a significant increase in the incidence of serious occupational accidents in Faridabad during the same period.

The Special Medical Board for Occupational Diseases has also gone about its job in a mechanical manner. Harpal Singh, the only worker to get compensation for an occupational disease in Faridabad in the last 5 years was initially rejected on the grounds that he is not suffering from Byssinosisis. The Special Medical Board did not even bother to ascertain that Harpal Singh did not work in a cotton mill and so the question of Byssinosisis did not arise. His dogged perseverance, grit and determination and a certificate from Safdurjung Hospital (unequivocally stating his disease as "Aluminium Induced Interstitial Fibrosis") was solely responsible for getting him his entitled compensation, albeit in the second attempt. Late Pati Ram, the only other case who was allowed to appear before the Special Medical Board in Faridabad in the last 5 years, was not so lucky. Despite, epidemiological, clinical and radiological evidence of Byssinosisis, the case of this man was rejected as he was repeatedly misdiagnosed as "TB". Similarly, though a referral Occupational Diseases Centre has been setup in Delhi, but the Dy Dir ESI has not taken
pains to communicate the same to the ESI health professionals working in Haryana. As a result, this ODC has not detected a single case of occupational disease from Haryana.

The indifferent Government attitude towards labour is apparent from the fact that no Medical Appellate Tribunal has been setup in Haryana, despite 50 years of implementation of ESIS in the State. Infact, no proposal exists to ever set up such a Tribunal. At the appellate stage the Corporation makes all attempts to ‘win’ the case against the workers in the EI Courts by ‘hook or crook’. Thus, medical board members are ‘briefed’ by the ESI Lawyer as to what to give as evidence while appearing before the EI Court, as discussed in Chapter VI. Also, year after year the Dy Dir ESI Haryana surrenders the budget under the head “Drugs and Dressings” due to bureaucratic indifference, while workers in Faridabad do not get adequate drugs form the ESI medical institutions.

To sum up, we see that the socio political milieu in which the ESIS is located has generated an ethos of indifference and callousness towards Occupational diseases in specific and general health services in particular. This is because the dominant players in the ESI, viz the Government and the industrialist have reduced the status of the third player viz, the worker to that of an underdog. These external factors have conveyed a clear-cut message to the health professionals of the ESIS and the Factory Inspectors to adopt procedures and attitudes that hamper detection, treatment, compensation and prevention of occupational diseases and accidents. The core and supportive components of the ESI system are bound to respond to the explicit external influences and mould themselves according to the implicit directions of the controlling masters. We now proceed to discuss the impact of the external influences on the core and supportive systems.

CORE AND SUPPORTIVE COMPONENTS

A major critique of the Workmen’s Compensation Act was that it was unable to provide adequate compensation to workers as they got entangled into legal complications. Also, it lacked a system for detection, diagnosis and treatment of Employment Injury. Since the ESIS replaced the above, it was natural to expect that the former would give priority to Occupational Health. Our data in Chapter III however, reveals that the priorities of the ESI Health Service System are as follows:

The reasons for the low priority given to Occupational Health by this premier occupational social security legislation are apparent. We have already discussed in the last section that both the industrialists and the top ESI Executives (representing the Government) view compensation of occupational injuries and diseases as a drain on the fiscal resources. Directives issued by the ESI Corporation to its health professionals preventing proper diagnosis of occupational diseases (Page 129-130) and lengthy procedures for obtaining compensation (Chapter V), as revealed in our data, illustrate this point.

We observe that the Third Schedule ESIS which lays down the list of occupational diseases is too technical. Common occupational diseases like TB do not find mention in this Schedule. The ESI Corporation insists that a technical diagnosis under this Schedule be made for the workers to get compensation for an occupational disease.

ESI doctors are not trained or equipped to list out technical diagnosis of occupational diseases as mentioned in the Third Schedule. As a result, negligible numbers of occupational diseases get compensation. In fact, in Haryana only one worker (Harpal Singh) has got compensation for an occupational disease in the last five years.

The ESI Scheme directives regarding diagnosis of Occupational Diseases ensure that their doctors do not even attempt to diagnose occupational diseases. The ESI Medical Manual, which is the bible of practice for ESI doctors states, "The Insurance Medical Officer/ Insurance Medical Practitioner should nowhere indicate that he (the worker) is a case of Employment Injury (the term includes Occupational diseases). They must clearly understand that the doctor is not the one to decide if it is a case of Employment Injury. This is the duty of the Regional Office/ Local Office" (ESI Corporation, 1983). The ploy to suppress Occupational diseases is apparent. Occupational history taking is the first step to the diagnosis of an occupational disease. When a doctor is prohibited from even recording an Occupational disease then how can the poor worker be expected to initiate the
cumbersome procedure of claiming compensation? Moreover, the Factories Act makes it mandatory for all doctors to notify occupational diseases. Doesn't the ESI Medical Manual therefore direct its doctors to violate the Factories Act? Our data reveals that in Faridabad the ESI doctors are scared to record a specific diagnosis of Occupational Disease due to the above directions given to them in the ESI Medical Manual.

Another evidence for the low priority accorded to occupational health can be adduced from the non availability of occupational injuries statistics in the ESIS. The ESIS has a centralized proforma for collection and compilation of morbidity data. This proforma has clubbed, 'Accidents, poisoning and violence' in one category. There is thus no way that one can find out the incidence of Occupational Injuries either at the local or at national level from this data. The ESI Corporation claims to have adopted this classification from the WHO entitled "The Statistical Classification of Diseases, Injuries and Causes of Death for Social Security purposes" to give it respectability. In the original WHO Classification the Cause Group 50 ('accidents, poisoning and violence') has been subdivided into two distinct categories viz (a) Occupational accidents and (b) Other accidents. If the same had been adopted in its entirety by the ESIS, the statistics on Occupational Injuries would have been automatically available. The ESIS however chose to club the two subdivisions into one category in its reporting proforma on the grounds (ESI Corporation, 1983):

"The subdivision of cause group 50 into Occupational Accidents and other accidents (as done by WHO) has been eliminated to avoid any misreporting of other accidents as cause of Employment Injury."

The above logic appears mischievous to say the least. After all the ESI Scheme is the outcome of an Occupational Health Legislation. A definite procedure is laid down by the ESIS for confirmation of Occupational Injuries (DGESIC, 1988). Only after the report by an employer, examination by an ESI doctor, and enquiry by an ESI LO Manager does the Corporation arrives at the conclusion whether an accident is Occupational or otherwise. Then how can misreporting take place and where is the need to make this modification in the WHO Classification? The deliberate design to suppress data on Occupational Injuries is therefore apparent. Such a modification is indeed a thinly veiled yet highly effective attempt to avoid transparency in compensation proceedings and thus deny the worker his legitimate dues.
Similarly, the decision to set up four ESI Occupational Diseases Centres in the four metros was expected to provide the impetus for proper detection, treatment, compensation and prevention of occupational diseases. However, our data reveals that no case of Faridabad (or for that matter Haryana) has ever been referred to this Hospital. This is because the ESI Health Service System in Haryana is unaware of this referral chain. It is indeed a startling revelation. In due course, this communication gap may be bridged. But after observing the functioning of the Occupational Diseases Centre at New Delhi, we do not expect that the quality of compensation for occupational diseases in Faridabad will improve, even if ESI doctors in Faridabad start referring cases to their designated ODC. We came to this conclusion because the ODC functions like any other normal curative super speciality hospital. No record is made of the cases of occupational diseases diagnosed and compensated due to the existence of this ODC. It is therefore not surprising that despite, 5 years of existence the ODC has been unable to generate any epidemiological data on the incidence of occupational diseases among workers in their referral area.

A simplistic approach would be to blame the ESIS doctors and allied staff for the low prioritisation of occupational health in the overall ESI Scheme. However, the above evidence suggests that this is not true. The doctors and inspectors are simply pawns who can be easily manoeuvred by the kingpins of the system. After all they are merely employees of the Corporation or the Government and have to obey its directives. As a result, the ESI doctors do not visit factories and hence are unaware of occupational diseases prevalent in their area. These doctors do not carry out placement or periodic medical examination of workers. They are not even made aware of the referral chain for sending cases of occupational diseases. There is no epidemiological database generated on the incidence of occupational diseases as the proforma of morbidity reporting gives no Weightage to such diseases. Dispensary doctors do not take pains to fill up the ‘Occupational Injuries’ proforma introduced by the Haryana ESIS. This portion is left blank. As a consequence, the Health Information System does not generate any data on the quantum of occupational injuries treated in the ESI medical institutions.

The three agencies which should interact frequently viz the ESI Health Service System (responsible for detecting, diagnosing and treating Employment Injury), the ESI
Medical Boards (responsible for fixing quantum of compensation for Employment Injury) and the District Factory Inspectorate (responsible for prevention of Employment Injury by enforcing Safety and Health regulations at the work place), function as independent water tight compartments. There is no coordination whatsoever between them.

The composition of the medical board is such that the treating ESI doctors are in no way associated with them. Thus, the opinion of the doctor who diagnoses and treats the Employment Injury is given no Weightage by the compensation board. This in effect means that the worker has to prove his case 'de novo' before the compensation board. Moreover, the Form 16 (to be raised by the management in case of occupational accident) is required to be sent to both the ESI and the Factory Inspectorate. If there is coordination between the two, cross checking can be done. Thus, the ESIS can compensate the worker and the Factory Inspector can prosecute the errant employer for violation of safety and health provisions at the workplace. The latter will serve as a deterrent and prevent future accidents, thereby decreasing the workload of the ESIS. However, we observed that in Faridabad, the ESIS and the Factory Inspectorate never share information with each other. While this lack of coordination helps the errant employer in escaping prosecution, it also prevents the worker from getting his entitled dues.

The working of the supportive components like their core counterparts are also equally influenced by the socio-political context. The functioning of the preventive component viz the Factory Inspectorate is seriously affected. The Factories Act 1948 was passed with the aim of regulating Safety, Health and Welfare conditions at the workplace. It called for punitive action against defaulting employees. Factory Inspectors were appointed to visit factories to oversee the implementation of the Act. However, we find in Haryana and Faridabad that there has been a conscious downsizing of the Inspectorate staff by the Government with the aim of attracting “Capital” into the State. The Government has officially banned visit of Factory Inspectors to industrial establishments covered under Rural Industrial Segment and Small Sector Units under the garb of “elimination of Inspector Raj”. At present the strength of the Factory Inspectorate is so low that an Inspector can at best visit a factory once in 3 years. As a result only 32.22 % factories get visited every year.
Our data show that all the above has led to gross under reporting of non fatal accidents in Faridabad. This is corroborated by the fact that only 33.14% of the factories submit statutory returns. This is despite the fact that Faridabad has 668 hazardous units and there has been a major spurt in industrial accidents since 1996. Since there is no check on the employers, the conditions of Safety and Health on the factory floors in Faridabad are extremely poor. As a result 94% of workers faced unsafe conditions at the workplace, as revealed by our User survey (Chapter VII).

A significant supportive component of the ESI System viz the legal adjudication system has been made insensitive by the lopsided power equation between the principal players of the ESIS. The Government of Haryana lacks the political will to set up a Medical Appellate Tribunal, to speed up cases of appeal against the decisions of the ESI Medical Boards. It has also failed to set up exclusive EI Courts. Presently, the so called EI Court hears all other civil and criminal suits also. As a result cases of workers are decided at an agonizingly slow pace of 4-5 years.

Due to the above delay and prohibitive cost of litigation (payment to lawyers), aggrieved workers seldom file cases in the EI Court. Their agony is aggravated by the fact that if a worker does pick up courage, the ESI Corporation fights tooth and nail to defeat the worker. No provision has been made to provide free legal support to the aggrieved, impoverished and disabled worker in this legal battle amongst inequal. It is a classical example of using “workers money against the workers”.

The judiciary has often come to the rescue of a courageous worker by being benevolent, liberal and humane while giving judgements. These landmark decisions should serve as guiding principles, for the ESIS so the subsequent workers get their entitled dues without resorting to litigation. Our data reveals that, the ESIS does not follow the spirit behind past judgements, forcing new workers to agitate before Courts on issues well decided in earlier judgements.

We can thus see that the ESI Corporation (though an autonomous body) has placed such hurdles before its own doctors that the only way a worker can get compensation is to approach an NGO or a receptive Union Leader. Therefore, merely setting up of four costly
ESI Occupational Disease Centres in the four metros (hailed as a conceptual breakthrough in the ESI Scheme) will hardly help in improving the state of the insured workers (ESI Corporation, 1997b). Instead of spending so much on a large technology based infrastructure, the ESI Scheme should first remove the regulations that prevent detection of Occupational diseases and then concentrate on creating and utilizing existing resources and facilities to medically examine the workers at periodic intervals so that Occupational diseases can be detected at the early stage itself. The latter was recommended by the second ESI Review Committee (Hoshings) way back in 1983, but then worker oriented recommendations are rarely implemented in a capitalist dominated society.

Under these circumstances, it is not definite that coverage by the ESIS of the Pali Mohabattabad stone crusher belt, will improve the quality of Occupational Health Services in this area. While occupational injuries may start getting compensation if the Scheme is notified, but our data from Faridabad district shows that extent of diagnosis, treatment and compensation for occupational diseases will continue to be negligible. A parallel can be drawn to the Slate Pencil industry at Mandsaur (MP), where the ESI Scheme has been in operation for over two decades. Though surveys done in different occupational groups by the ICMR from 1981-86 in this area show prevalence of Silicosis ranging from 16-57%, yet the ESIS has not diagnosed a single case of Silicosis during the same period in the same area (Chakravarty, undated).

There is also a myth prevailing among certain Executives of the Corporation that workers themselves are responsible for non detection of occupational diseases, since they are unaware of the fact that they have contracted the same. Such a thought process has been translated into official action by launching of Safety and Health campaigns to educate 'workers' about occupational diseases (Labour Bureau, Annual Indian Labour Year Books). While conceptualizing the National Tuberculosis Programme, Banerji has shown that there is enough awareness about the symptoms of Tuberculosis even among the rural people (Banerji, 1963). The same is true for Occupational diseases. Our User Survey (Chapter VII) brings out that workers in Faridabad, no matter how illiterate, come to know whenever they get symptoms of any occupational disease by their own experience and interaction with their peers, but are forced to accept them as a 'fait accomplie' because the system (dictated by the powerful employer lobby) creates hurdles in detection, diagnosis,
treatment and compensation of Occupational diseases. As a corollary, the need of the hour is not expensive ‘education campaigns’ but creation of a free, flexible, sensitive and functional system that encourages detection, compensation and prevention of occupational diseases.

HEALTH CARE SERVICES

The ESIS provides General Health Care services to the workers and their families. Our data however reveals that the quality of General Health Care provided by the ESIS in Faridabad is poor.

The ESI dispensaries and hospitals are in a poor state of cleanliness and have erratic water supply and electricity. The medical equipment in hospitals though adequate, is in a poor state of maintenance and repair. The medical and paramedical staff has no accountability towards their clientele or superiors. Doctors spend just two hours attending to the OPD and ‘specialists on call’ rarely turn up to attend to emergencies in non working hours. Referral of patients to referral hospitals is done not necessarily due to technical considerations but due to administrative reasons. The medical staff decides their own work schedules. Private practice among ESI doctors is rampant, despite their drawing Non Practising Allowance. Neither, the MS of the Hospital nor the ESI executives take any action against errant staff. There is thus a total breakdown of administration in the ESI medical institutions in Faridabad. As a result of this, many workers in Faridabad avoid using the ESI hospitals and dispensaries. This is reflected in the poor OPD attendances and low bed occupancy rate of ESI medical institutions located in Faridabad.

The morbidity reports generated by the ESI Health Service System in Faridabad show that a significant number of diseases fall under the final diagnosis of “ill defined diseases”. The ESI medical Institutions in Faridabad have all facilities for proper diagnosis and treatment of diseases. Despite this, too many vague diagnosis of “ill defined diseases” reflects poorly on the competence of the treating doctors. Moreover, the fact that the administration has chosen to turn a blind eye to this, shows the administrative staff in poor light.
The guidelines for referral of serious patients laid down by the ESI Corporation for Faridabad have been made without considering ground realities. Faridabad is a part of the National Capital Region and practically part of Delhi. There is a 600 bedded ESI Hospital cum Occupational Diseases Centre in New Delhi. This is equipped with practically all super specialist infrastructure. However, it has not been designated as a referral centre for Faridabad in respect of non occupational diseases. Instead patients are sent to non ESI medical institutions in Delhi, where they have to spend considerable amount of money and undergo the routine harassment, typical of overloaded and understaffed Government hospitals.

The ESI Dispensaries are the ‘first contact point’ between the ESI Health Service System and the workers. This ‘first contact’ should always be a pleasant experience, so that the clientele have faith in the system. However, in Faridabad, the picture is dismal. The dispensaries are ill equipped. They do not have oxygen cylinders or an anti anaphylactic tray to cater to emergencies. There is no minor Operation Theatre. No antibiotics are available in the drug store. The doctors are seldom found in the dispensaries during evening hours. Dispensary doctors have no powers to locally purchase drugs. Therefore, even routine cases are referred to the hospital. To sum up, the ESI dispensaries can at best be described as “upgraded first aid posts”.

The above point to the fact that ESI administrative authorities have done little to make the ESI Health Service System “user friendly”. On the contrary, the system has created so many bottlenecks, within itself that it discourages workers from utilising the system. This is apparent from our User Survey wherein, an overwhelming majority of workers expressed gross dissatisfaction with the ESI Medical Institutions.

The ESI Health Service System in Haryana has bureaucratic hurdles and bottlenecks that impede its smooth functioning. We have already discussed that the system does not allow the doctors in the dispensaries to purchase even essential non available drugs. Besides, Trade Unions have repeatedly represented in meetings to the ESIS that drugs are not available in the ESI hospitals and dispensaries in Faridabad. The MS of the hospital has on record, stated in these meetings that the shortage of drugs is due to non availability of funds from the ESI directorate in Chandigarh.
Under these circumstances, it is ironical to note that the ESIS in Haryana has been consistently surrendering a substantial part of its budgetary allocation under the head “Drugs and Dressings”. The expenditure on drugs and dressings in this State has not only been much below the ceiling prescribed by the ESI Corporation but also among the lowest in the country. This situation has come about because the State bureaucracy has been unable to coordinate between its multiple wings. As a result, while on one hand the budget lapses, on the other hand the workers are denied ‘essential drugs’.

This situation of “famine amongst abundance” has also proved fatal to a few workers. Since funds are not released in time for super specialist treatment of serious ailments like Cancer, Heart Disease, etc, workers like Sheesh Nath Tewari and Kaushal Kumar Pande (Pages 100-101) have lost their lives as the disease process worked faster on their bodies than the speed with which the ESIS processed their claims for advance for super specialist treatment. Thus, this “Social Security Scheme” holds up the workers “Security” due to red tape when the latter needs it most.

There is a palpable lack of commitment on the part of majority of medical personnel working in the ESIS in Faridabad. This is apparent from the way doctors have exercised their options regarding continuing in the ESI Health Service System or shifting to the General Health Service System. These are weighed purely by personal considerations. Those who have opted for the ESIS have done so only because they want to avoid rural service. This being the sole consideration, it is unlikely that creation of a separate ESI Medical cadre in Haryana will help in improving the efficiency of the ESI Health Service System.

The ESI Health infrastructure in Haryana and Faridabad, unlike that of the General Health Service System of the country, is adequate. Our data shows that an ESI doctor on an average sees significantly less number of patients than the norms prescribed by the ESIS. The bed occupancy rate of ESI hospitals is also around 50% only. Despite this, there is widespread ‘User dissatisfaction’. This is because doctors are not committed towards their duties. Our time activity study revealed that doctors spend almost 50% of the working hours in social activities unconnected with patient care. They also make no attempt to
record an ‘aetiological diagnosis’. Infact, in 32% of the cases the doctors do not write any
diagnosis. The radiologist does not record his opinion on X Rays. No follow up is carried
out with the referral hospital. An alarmingly large number of TB patients have been
labelled as “defaulters” despite the fact that they stopped coming for treatment due to non
availability of anti TB drugs in the ESI Hospitals.

As a result of the above attitude, though the incidence of work related diseases like
TB, cough with expectoration, allergic dermatitis, etc is high, these get reflected as non
occupational diseases. Therefore, the procedure for compensation of occupational diseases
is not set into motion at all. This is apparent from the fact that in the last 5 years no ESI
doctor in Faridabad (or for that matter Haryana) has ever diagnosed any occupational
disease.

Moreover, the ESI Health Service System has been needlessly burdened to carry
out National Health Programmes, not only for the workers but also for the general
population. This is supposed to be done under the coordination of the local programme
officers working under the District Health Services. This dual control hampers running of
these programmes. Logically, the State General Health Services should run these
programmes, as it is the duty of the State to extend these facilities to the entire population
in the district. Resources paid for by the workers should not be diverted to running health
programmes for the district administration.

The ESI Health Information System is also in a poor state. The pharmacists compile
morbidity data at all levels. Since ESI doctors generally do not write a diagnosis, it is the
pharmacist who works out a diagnosis based on the treatment prescribed. Thus, the
statistics generated at the primary level itself is faulty. No attempt is made by the Medical
officer incharge dispensary/ MS hospital/ Dy Dir ESI (medical) to check the authenticity of
this vital data. They merely function as post offices for mechanical compilation and onward
transmission. No epidemiological analysis is carried out by medical personnel at hospital/
district or state level. Even at the national level this faulty and inaccurate data merely gets
published in the ESI Annual Report. Such an exercise serves no public health purpose.
To sum up, the data points to a polarisation of the ESI population between a technically powerful small privileged class at one extreme (the Health Care Delivery System of the ESIS) and the large mass of underprivileged beneficiaries with little knowledge or power at the other end. There is no attempt to sensitise the doctors to the problems of the working class. The doctors and paramedical staff come from the upper and middle strata of society respectively. They treat the workers who hail from the lower strata of society as ‘third rate citizens’. The entire ESIS system protects the provider’s interests as against that of the workers. This is akin to the stratification observed in the General Health Service System of the country (Qadeer, 1985; Banerji, 1982; 1985).

We observe that the quality of general health care provided by the ESIS is no better than that provided by the State to the general population. This is apparent from the widespread User dissatisfaction in Faridabad, as revealed by our data presented in Chapter VII. In the western world, it is the National Health Service that takes care of providing general health services to the entire population (including workers) (Elling, 1986). The Occupational Health Service thus is able to concentrate on detection, treatment, compensation, and prevention of Occupational diseases and injuries. However, in India the ESIS has diluted its focus on Occupational Health by broadening its mandate to provide General Health services to the working class. As a result, Occupational health has been almost entirely elbowed out in the overall ESI Scheme.

In short, occupational health has become a victim of the failure of a system (ESIS) that is overtly influenced by the external power and the political might wielded jointly by the industrialist and the Government.

POINTS OF INTERVENTION

Our data has shown that the ESI Scheme has failed to provide satisfactory Occupational Health Services to the working class. In addition, workers are completely disenchanted with the General Health Services provided by its Health Care Delivery System. Any alternative system will not succeed unless some semblance of a balance in the power equation between the three principal players viz Govt, industrialists and workers is created. This is the major cause for the inefficiency of the ESI System not only in
Faridabad but also in the entire country. We now suggest some feasible interventions to improve upon the existing system.

Any intervention for change will have to take into account the readiness of the system and the political conditions within which it operates (Dutta, 1994; page 354). We are therefore suggesting the following two types of interventions: (a) Interventions within the prevailing conditions that help in removing bottlenecks; (b) Broader interventions that involve changes at political and policy planning levels. These we feel may improve the overall capacity of the ESI system to diagnose, detect, treat and compensate occupational diseases and injuries.

Interventions within prevailing conditions

1. The provision of recovery of damages by the ESI Scheme from the employer, in case it is proved that he has failed to provide statutory safety measures (that led to Employment Injury) in his factory needs to be restored. This will not only improve revenue collections of the ESI Scheme but also force employers to enforce all preventive safeguards (statutorily required under the Factories Act) in their factories.

2. The compensation medical board for Occupational Diseases & Injuries should comprise of local ESI doctors and be presided over by the senior Medical Superintendent of the local ESI Hospitals. The Medical Referee (representative of the ESI Corporation) and a Trade Union representative should be in attendance. The treating doctor’s report should be the baseline for awarding compensation and this vital document should be a part of the overall report prepared by the medical board. The board can meet once a month, preferably at the ESI Hospital.

3. The first instalment of compensation payment should be handed over to the workers immediately on conclusion of the medical board. A 'single window clearance system' needs to be put in place.

4. The Temporary Disability Benefit (TDB) rates should be enhanced from the present, 70% of wages to full wages, as the worker gets no wage when he gets TDB. Also, the workers should continue to get TDB even after his injury has stabilized. TDB should only be stopped after the worker’s case is decided by the
medical board. This will put pressure on the ESI Corporation to finalise cases faster.

5. Legislation has to be introduced to ensure that no worker is removed from service for sustaining Occupational Diseases/Injuries till his case is finalised by the medical board. Even after finalisation of the case, the employer should not be permitted to dismiss workers awarded 50% or less disability as these workers have been ‘certified’ fit for work (under sheltered conditions) by the medical board. This will remove the anomaly, wherein on one account the medical board awards ‘Nil’ disability on the ground that the worker has no ‘loss of earning capacity’, and on the other ground the employer dismisses him as the latter feels that the worker’s disability prevents him from working in his present job.

6. Permanent Disability Benefit (PDB) for an Employment Injury should continue to be given to the dependents’ even if the worker subsequently dies due to non occupational causes.

7. A legislative amendment is to be made to ensure that commuting accidents (sustained while coming or returning from work) are treated as Employment Injury.

8. The priorities of ESI Health Service System need to be changed. The so called “backbone of the scheme” should not be ‘medical care services’ but ‘detection, treatment and compensation of occupational diseases and injuries’.

9. The ESI Medical Manual should have a clause inserted wherein, it would be mandatory for ESI doctors to detect, treat, diagnose and assist in compensation for occupational diseases and injuries.

10. All cases (whether occupational or otherwise) that cannot be managed in local ESI Institutions, should be referred to the ESI Occupational Diseases Centres cum Hospitals only. The Occupational Diseases Centre should stress on detection and treatment of Occupational Diseases and Injuries. They should be responsible for referring cases to Compensation Medical Boards.

11. The Health Information System should be designed in a manner that occupational diseases and injuries are segregated from non occupational ones.

12. During the induction training programme ESI doctors should be visit local factories and be sensitised to occupational diseases and injuries in their area. Attendance of a Trade Union representative during these programmes should be mandatory.

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13. A monthly meeting of ESI executives/doctors/Factory Inspectorate staff and Certifying Surgeon should be mandatory to cross check data and coordinate social security and health and safety measures.

14. The administrative machinery of ESI Health Service System needs to tighten up to ensure timely presence of doctors and paramedical staff in OPD and “on call”.

15. Recording of an ‘aetiological diagnosis’ on the prescription pads should be mandatory.

16. The equipments and drugs necessary at the ESI dispensary level should be made available, so that dispensaries can tackle medical emergencies.

17. The bureaucracy in Haryana has to remove ‘red tape’ to ensure that allotment for ‘drugs and dressing’ is judiciously and fully utilized. On no account should it be allowed to be surrendered.

18. Medical Board members need to be sensitized to:

   (a) Importance of Note below Second Schedule ESIS (Appx 1), which reads, “Complete and permanent loss of the use of any limb or member (part of the limb) referred to in this Schedule shall be deemed to be equivalent to the loss of that limb or member”

   (b) An important judgement of the MP High Court which reads, “In this era of benevolent enactments, and thinking of welfare state and an assurance of fundamental rights to citizens, all benevolent enactments have to be interpreted with a broader outlook. If anything is to be interpreted, if anything needs to be interpreted from the codified section, the interpretation should be always in favour of beneficiaries for whom the enactments have been indicated. The indicator of the interpretation should be always pointing towards the hapless, weaker sections of the society who are thrown in hazardous occupation.” (JG Chitre, MP (HC). Indian Factories Journal and Factories Journal Reports, Vol 94, Part 8, 19/2/99, page 122).

19. The fixed Occupational Diseases’ list prepared by the ESIS centrally should not be rigidly enforced. It should merely be supportive. Medical Board members may decide on whether a disease in arising due to or as a result of occupation, depending on each individual case. Similarly, the clause for a minimum period of continuous employment for being compensated for an occupational disease needs to be repealed.
20. ESI doctors should carry out placement medical examination and periodic medical examination (once in 3 yrs) in respect of all workers.

21. The notification regarding ‘Abolition of Inspector Raj’ in Haryana needs to be recalled. All vacancies of Inspectors under the Factories Act are to be filled up expeditiously so that regular Inspections as required under Factories Act are carried out.

22. The Industrial Hygiene Laboratory in Faridabad is to be made functional and the Certifying Surgeon provided with a functional X Ray machine and ambulance.

23. Regulation is required to be introduced to ensure that all Surveys conducted by CLI/DGFASLI/RLI are published.

24. MAT and exclusive EI Courts are to be set up immediately in all States. Cases pertaining to workers have to be decided in a time bound manner.

25. Past judgements of all ESI cases to be circulated to ESI executives/doctors.

26. Corporation should not contest cases purely on technical/legalistic grounds. A more humane approach is needed by the legal officials of the ESIS.

27. Law Courts should set precedents by giving jail sentences to employers who are convicted of violation of Labour Laws, ESI Act, Workmen’s Compensation Act and Factories Act.

Broader changes

We have seen that the purpose of replacing the ESI Act with the Workmen’s Compensation Act viz, to provide better Occupational Health Services and comprehensive health care to the working class, has not been achieved. Moreover, the ESI scheme has shifted its focus from delivering Occupational Health Services to becoming a “medicalised scheme” essentially providing General Health Services. From the 90’s onwards, we see that the process of globalisation is not only restating labour laws but also pushing into opening up to privatisation. This situation does not auger well for the occupational health of the workers.

To get back its focus, we feel therefore that the ESI Scheme has to delink itself from providing General Health Services. The General Health Services should be provided by the District Health Services of the district in which the worker and his family is located, as is already being done for all other residents of the district. The ESI Scheme preferably
should only provide facilities for diagnosis, detection, treatment, prevention and compensation of occupational diseases and injuries. The downsizing of ESI personnel and infrastructure, as a result of this structural change will help in boosting and conserving the revenue of the ESI Corporation (which is presently being ‘wasted’ in providing “unsatisfactory” General Health Services to an equally dissatisfied clientele). This revenue can be used effectively to ensure that the worker gets his entitled treatment and compensation for injuries sustained at the work place. Modalities for implementation of this proposed scheme can be worked out after consulting representatives of workers and industrialists.

We understand that the above expectation is contrary to the prevailing trend. However, if India is to retain the welfare nature of its State then its workers must occupy the central space in its concerns, as their Health is not only the objective of Planning but also a means of national Prosperity. A political will to discuss this restructuring is necessary if the democratic processes of building a welfare state have to be strengthened.
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