Evolution of Veteran Medical Care Support System in India

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Abstract

The article gives out the evolution of the veteran healthcare of the Indian armed forces post-independence till the start of the Ex-servicemen (ESM) Contributory Health Scheme (ECHS) in 2003. Post-retirement benefits are part of terms of engagement of all militaries and are an incentive, as well as reward, for serving the country in difficult circumstances risking one's own life. In India post-independence, from almost no medical care except for disabled category, that too for selected few disabilities, the veteran medical care has passed through various stages like authorisation of medical treatment in service hospitals, Army Group Insurance (AGI) Medical Benefit Scheme covering high cost treatment not available in service hospitals and finally to ECHS which is a cashless and capless scheme and is one of the largest and efficient healthcare system for veterans in the in world.

Introduction

Post-retirement benefits are part of terms of engagement of all

militaries and are an incentive, as well as reward, for serving the country in difficult circumstances risking one's own life. Post 1962 Indo-China war, there was large-scale expansion of the army and the limited service hospitals were inadequate to provide medical care to veterans in addition to the expanded service clientele. Moreover, most of the service hospitals had few specialists and major costly treatment had to be undertaken

at private hospitals at very high cost. Case for introduction of special healthcare scheme for veterans was taken up repeatedly by the armed forces and veteran organisations. Various Committees were constituted by the government to examine the availability of medical facilities to veterans. However, it was not until 2003 that a viable and satisfactory Health Scheme (ECHS) was introduced for the Veterans.[1]

The Evolution of Veteran Health Care

The major stages in the evolution of veteran medical care support system in India are given below. These stages were not distinct and stand alone as some of them merged into the next stage.

(a) Medical Care through Public Health System (1947-1966).

(b) Medical Care through Service Hospitals (1966-2003).

(c) Army Group Insurance Medical Benefit Scheme (1991-2003).

(d) ESM contributory Health Scheme (since 2003).

Medical Care through Public Health System

In pre-independence India, the government took full responsibility for medical care of disabled veterans and also of their rehabilitation. Disabilities were categorised as follows:

(a) Loss of limb.

(b) General medical and surgical disability.

(c) Loss of speech.

(d) Deafness.

(e) Blindness and natural impairment of vision.

(f) Pulmonary tuberculosis.

(g) Mental diseases.

Post-independence, some of the above facilities were curtailed. No treatment was authorised for serious diseases, like pulmonary tuberculosis, leprosy and mental illness even if such diseases were attributable to military service if such treatment was not available from service sources. Veterans were to depend on public health system for medical care. The public health care system post-independence was at a nascent stage.

Considering the above data, veterans had virtually no medical care available. Moreover, it is to be borne in mind that most of the veterans were from rural areas and access to the very few existing public health facilities was very limited. Prevalence of communicable disease was very high at that time. Largely, there were no specific medical care facilities for veterans till 1966, when service medical facilities were made available to veterans with certain restrictions.

Medical Care through Service Hospitals (1966-2003)

In 1966, government liberalised the concessions towards veterans and their spouse for treatment from service hospitals.[2] Under these provisions, veterans and families, and families of deceased person drawing pension from defence estimates could avail free outpatient department (OPD) treatment and medicines from service hospitals. Sanction was also accorded for inpatient treatment subject to the following conditions:

(a) That the disease is not incurable.

(b) That the hospital accommodation could be made available from within the authorised number of beds and without detriment to the needs of serving personnel.

(c) That the treatment will be limited to the facilities locally available.

(d) No conveyance will be provided for journeys from the residence to the hospital and back.

(e) No special nursing would be admissible.

(f) It is specifically laid down that the above concessions will not include treatment for pulmonary tuberculosis, leprosy, mental diseases, malignant diseases or any other disease for which treatment is not ordinarily available from the local military sources.

Veterans were dependent on the public health system for medical care except in limited cases as under:

(a) Free medical treatment for specific disabilities in respect of ESM in receipt of disability pension.

(b) Other Armed Forces pensioners could be admitted to Service hospitals only if accommodation was available and the Officer Commanding Station/Administrative Authority sanctioned admission. Specified hospital stoppages were to be paid. No out-door treatment was available to such pensioners.

(c) Families of ESM were not entitled to any treatment out-door or indoor from service hospitals.

In 1983, Regulations for the Medical Services of the Armed Forces were framed superseding the Regulations for the Medical Services of the Armed Forces, 1962. Para 296 of the Regulation provides for 'Entitlement to Medial Attendance'. Relevant aspects of the entitlements are given below:

(a) Ex-service personnel in receipt of a disability pension and ESM of the Indian State Forces in receipt of a disability pension from the Defence Services Estimates for a disability accepted as attributable to or aggravated by service with the Indian Armed Forces are entitled treatment as out-patient or in-patient in service hospitals.[3] Treatment is authorised only for the disabilities for which pension has been granted excluding cases of pulmonary tuberculosis, leprosy and mental diseases and patients requiring any special treatment not ordinarily available from service sources, such as radiotherapy. Admission may be authorised for the purpose of observation to enable the medical authorities to arrive at a correct assessment of the degree of disability.

(b) Ex-service personnel invalidated out of service on account of pulmonary tuberculosis (TB) which has been accepted as attributable to/aggravated by service, and for which disability pension has been granted' may be admitted in Military Hospital (Cardio Thoracic Centre), Pune, if surgical intervention is required, on the recommendation of OC of an armed forces hospital, if a bed out of the ten TB beds reserved for this category of personnel were available.

Ex-service pensioners and the families of deceased service personnel drawing pension from defence estimates are entitled to free outpatient treatment in the nearest Armed Forces Hospital including the supply of medicine necessary for their treatment. In-patient treatment in Armed Forces Hospital being subject to the following conditions:

(a) That the disease is not incurable.

(b) The hospital accommodation could be made available within the authorised number of beds and without detriment to the needs of service personnel.

(c) That the treatment will be limited to the facilities available locally.

(d) No conveyance will be provided for journeys from the residence to the hospital and back.

(e) No special nursing would be admissible.

(f) For inpatient treatment, hospital stoppages as laid down will be paid.

(g) The scope of the above concessions will not include treatment for pulmonary tuberculosis, leprosy, mental disease, malignant disease or any other disease for which treatment is not ordinarily available from local military sources.

(h) These concessions will not be admissible to the service pensioners who are re-employed in Government/Semi-Government departments or other

public or private sector undertaking which provides medical facilities to their employees.

(i) For this purpose, family includes wife and unmarried children/step children/adopted children under 18 years of age who are dependent on the pensioners.[4]

In 1966, there were around 31 service hospitals all of which were located in the garrisons. The numbers of service hospitals have now increased to more than 100. There are various types of service hospitals depending on the dependency of the establishment. Various types of service hospitals are:

(a) **Section Hospitals.** Bed strength varying between 10 beds and 24 beds.

(b) **Peripheral Hospitals.** Bed strength varying between 25 and 99 beds calculated as 0.8% of the Garrison strength, generally without specialist facilities.

(c) **Mid Zone Hospitals.** Military Hospitals with a few basic specialties. Bed strength varies from 100 - 200 calculated as 1.5% of the Garrison strength plus 0.3% of the strength of dependent peripheral and mid zonal stations to cater for specialist beds.

(d) **Zonal Hospital.** At selected stations with Garrison strength of about 10,000 and above where specialist in the certain broad discipline such as Eye, ENT, Dermatology and Paediatric may also be available. The bed strength in such cases is generally upwards of 300 calculated as 1.5% of the Garrison strength as per KLP of the station plus 0.3% of the strength of dependent peripheral and mid zonal stations to cater for specialist beds.

(e) **Command Hospitals.** A Command Hospital, in addition to catering to the needs of local garrison, provides facilities for treatment in all the allied discipline such as Cardiology, Neurology and Nephrology. The bed strength of the hospital is calculated as 1.5% of the Garrison strength as per KLP of the station plus 0.2% of the

strength of all garrisons in the AOR of Command to provide for the specialist beds in all disciplines.

(f) **Army Hospital.** There is one Army Hospital which is meant for Research and Referral. In this kind of a hospital, in addition to the facilities available to Command hospital, a number of super specialists are also available.

Army Group Insurance Medical Benefit Scheme (1991-2003)

As given above, veterans were eligible for medical care from service hospitals since 1966. Though the scheme was meant to benefit all, only a few could avail the facility as service hospitals were very few and located in garrisons. In addition, a number of high cost medical treatment were not available in service hospitals and veterans had to spend a large amount of money which was usually unaffordable. There was an urgent need to cater for such high cost treatment. Some distress grant was available on case-to-case basis by AGI Fund (AGIF) and Kendriya Sainik Board (KSB) to cater for certain cases. But these funds were available only for few cases and re-imbursement was cumbersome, and often delayed, and wherein re-imbursement was granted, it was limited to a fraction of the actual expenditure. Though the case was being taken up regularly with the Government, there was no progress.

In order to address this dire need, the AGIF conceived a medical care scheme called Army Group Insurance Medical Benefit Scheme [AGI (MBS)]. In the absence of any progress to introduce healthcare scheme for veterans by the government, Army introduced AGI (MBS) in 1991. This scheme was contributory in nature and covered high cost treatment up to a specified amount at approved hospitals.

Third party insurers like General Insurance Corporation (GIC) were approached to work out a tailor-made scheme for the AGI members, but no one was willing to take up such a scheme without any experience. The Consulting Actuary also expressed their reservations on the scheme without any past experience or data. The pattern of anticipated payouts could not be clearly estimated due to far too many variables involved

in the operation without significant experience and data. A number of existing similar scheme run by various organisations like GIC, CGHS, Apollo Health Scheme, SAIL, Railways and Cancer Society were studied and incorporating best suitable practices, AGI (MBS) was formalised. The scheme was to be implemented with effect from 01 April 1991.

The following diseases involving high cost treatment/surgery were covered under scheme:

(a) Cardiology Treatment including Angiography, Angioplasty, By-pass surgery, Valve Surgery/replacement, Insertion of Pace Maker.

(b) Cancer Treatment including investigative procedure leading to definitive diagnosis and treatment, Chemotherapy, Radiotherapy, Surgery, Combination of any of the above.

(c) Kidney Transplant, including such preliminary treatment procedure to make the patient fit to undergo transplantation. Donor was to be arranged by recipient.

The MBS covered all service pensioners retiring after 01 April 1991 and their spouse. All members who were retiring with service pension only were made eligible to join the scheme. The scheme did not apply to retiring personnel of DSC and TA.

The members were entitled for the following maximum benefits for both member and spouse under the scheme:

(a) Heart Disease - Rs 75,000/-

(b) Cancer - Rs 50,000/-

(c) Kidney Transplant - Rs 1,00,000/-

(d) Maximum benefit available together for member and spouse during the entire period of validity was Rs 1 lakh.

The member was entitled to avail the benefit of the Scheme for a period of 15 years from the date of retirement or up to the age of 70 years whichever was earlier. Should a member die during the period of validity, the spouse would

continue to be entitled to draw the benefits of the scheme till the period of validity of the member as shown in the Identity Card. The major portion of the cost of surgery/treatment as laid by AGIF was borne by the AGIF; a small percentage of cost is to be borne by the member as under:

		AGIF	**Member or Spouse**
(a)	Officers	85%	15%
(b)	JCOs	90%	10%
(c)	OR	95%	5%

Amount given below was recovered by AGIF as one-time non-refundable subscription from the members from their maturity benefits at the time of retirement:

(a)	Officers	-	Rs 3,000/-
(b)	JCOs/OR	-	Rs 1,500/-

The existing medical facilities being provided in the Service Hospitals were to be continued for ESM as the scheme was catering for high cost surgery/treatment in Heart, Cancer and Renal diseases only and that too for service pensioners retiring after 01 Apr 91.

ESM Contributory Health Scheme (2003 Onwards)

The government sanctioned ESM Contributory Health Scheme (ECHS) in 2003, a capless and cashless scheme meeting long time aspirations of veteran community and providing improved health care facilities.[5]

All the Committees and Commissions appointed to study the medical care of veterans brought out in their findings and recommendations that the medical care situation of veterans was grossly inadequate and recommended immediate improvement. Meanwhile, a number of ESM associations jointly knocked the doors of Supreme Court of India (WP No 210 of 1999) seeking direction to the government to provide full medical care to the veterans on the grounds of its being a fundamental right and also on the basis of the legally recognised doctrine of ‘Legitimate Expectation’ since they were

holistically cared for while in service and suddenly could not be deprived of such a facility without any viable alternative.

The Hon'ble Supreme Court held that the veterans did deserve a privileged treatment due to the nature of service that had been rendered by them. Extract of the ruling is reproduced below:

> "[…] The petitioners have rightly stated that they have served in the Army, Air Force and Navy of the Union of India during cream period of youth, putting their lives to high risks and improbabilities. As a mark of respect and gratitude, therefore, they must be provided medical services after retirement. It is indeed true that men and women in uniform are the pride of the nation and protectors of the country. It is because of their eternal vigil those ordinary citizens are able to sleep peacefully every night. For it is these men and women guarding the frontiers of our nation that makes our interiors safe. They, therefore, are entitled to privileged treatment […]."

After detailed deliberation, proposal for a contributory health scheme was placed before the cabinet. The scheme was to make maximum use of the existing resources of the armed forces including land and infrastructure. Medical care was to be provided to veterans, spouse and dependants. Each member was to pay a fixed one-time contribution. The proposal was referred by the cabinet to a Group of Ministers (GOM) comprising of Min of Defence (MoD), Finance, Health and External affairs. The summary of recommendations by GOM was as under:

> (a) GOM gave 'In Principle Approval' to provide medical care to ESM, their widows and next of kin of deceased soldiers. It also accepted the requirement of providing medical care facilities to the rural interiors where there is a sizable concentration of ESM. The GOM accepted the necessity and desired quick implementation of the ECHS at stations, to be decided by Army HQ, be made at the earliest.

(b) 120 Polyclinics/MI Rooms/ Authorised Medical Attendant (AMA) station wise were approved to be established ranging from Type “A’ to “E’ based on population of ESM. These were further increased later.

(c) The GOM stressed that stations where there are no medical facilities or negligible medical facilities be established on priority.

(d) It was proposed that a review be carried out by MoD two years after the successful implementation of the scheme as planned, for further expansion of the scheme in remaining stations and to carry out modification if found necessary.

(e) Central organisation be established at Army HQ and Regional organisation be created to function with the existing Static Headquarters in various stations to monitor the scheme.

(f) Civil medical facilities/Hospitals be empanelled for treatment of patients beyond the treatment capacity of polyclinics.

(g) Reimbursement of cost of investigation, diagnostics, medicines, hospitalisation incurred by patients referred by polyclinics.

(h) ECHS to be implemented by a project organisation, which will function under the MoD.

(i) Maximum possible use of existing resources including infrastructure and land and MoD be empowered to give such sanctions.

(j) ECHS will be contributory scheme and members would not be authorized Fixed Medical Allowance (FMA).

The cabinet approval to the recommendations of GOM was accorded in Oct 2001 and the Scheme came into being through a detailed Government Order. The salient aspects of the Government Order are given below[6] :

(a) The term beneficiaries included all ESM in receipt of pension, family pension, their dependents i.e. spouse, legitimate children and wholly dependent parents. Sons with permanent disability of any kind would also be eligible for lifelong medical treatment.

(b) ECHS is a “Contributory” scheme. The scheme is voluntary for the pensioners who retired before 31 Mar 2003 and compulsory for those who would retire on or after 01 Apr 2003. Payment was envisaged as a onetime contribution. (For old retirees, provision of payment in the form of three installments was catered for). Retired personnel joining the scheme would cease to draw the FMA of Rs.100/- after joining the scheme.

(c) Medical care to be provided by way of setting up of New Polyclinics and Augmented Armed Forces Clinics at 227 stations in a phased manner.

(d) Subject to load of the authorised personnel, it was made mandatory that all available facilities in Services Hospital in the same station, nearest or any other station should be utilised. After exhausting the spare capacity of the Service Hospitals outsourcing to empanelled private/government facilities was to have been resorted to.

(e) Reimbursement will be admissible either directly to patients or to the facilities contracted for cost of medicine, Diagnostic Tests, consultation, hospitalisation.

(f) Emergency treatment can also be taken in any empanelled facility directly even without a referral from ECHS. The cost of such treatment will be fully reimbursed by the government to the concerned facility. In extreme emergency like accidental trauma etc. the patient could go to any facility which may/may not be empanelled. Ex post facto sanction of the same will be accorded by Central Organisation in New Delhi.

(g) The scheme is implemented by a project organisation comprising of a Central Organisation at Delhi and Regional

Organisation created out of existing resources of Army, Navy and Air Force at other pre-designated locations.

Fixed Medical Allowance

Fifth pay commission recommended a FMA of Rs 100 per month. The recommendation was accepted and veterans were given FMA of Rs 100/- per month w.e.f. 01 Jan 96.[7] With the introduction of ECHS in 2003, the FMA was stopped for ECHS members.[9] FMA has been reintroduced for ECHS members w.e.f. 01 Nov 18.[8] Members who do not have any ECHS polyclinic/Service Hospital/ Upgraded MI Room for treatment in their district will be eligible for opting for FMA. Once a member opts for drawing FMA, he will not be eligible for OPD treatment in polyclinics/ service hospitals/ MI Rooms. However, he will be eligible for IPD treatment. FMA has been increased to Rs 1000/- per month.[9]

Conclusion

Medical care for India's veterans evolved over the years to one of the largest and efficient healthcare system for veterans in the in world. From almost no medical care except for disabled category, that too for selected few disabilities, the veteran medical care has passed through various stages like authorisation of medical treatment in service hospitals, AGI Medical Benefit Scheme covering high cost treatment not available in service hospitals and finally to ECHS which is a cashless and capless scheme providing medical care to approximately 52 lakh veterans and their dependents; through a network of 30 Regional Centres, 427 Poly Clinics and more than 2000 empaneled medical facilities throughout the country besides the service hospitals. Persistent and continuous efforts have been made to improve and streamline ECHS by enhancement of capabilities and functionalities of the scheme by policy initiatives and infusion of technologies backed by sound budgetary support.

Endnotes

[1] Government of India Ministry of Defence letter No 22(1)/01/US(WE)/D(Res) dt 30 Dec 2002.

[2] Government of India Ministry of Defence letter No 16307/DGAFMS/DG-3A/D(AG-II) dt 14 Oct 1966.

[3] Regulations for Medical Services in the Armed Forces (RMSAF)-1983, Page 64, Para 296 (O).

[4] Regulations for Medical Services in the Armed Forces (RMSAF)-1983, Page 64, Para 296 (O) (C) (iii).

[5] Government of India Ministry of Defence letter No 22(1)/01/US(WE)/D(Res) dt 30 Dec 2002.

[6] Government Order No 22(1)/01/US(WE)/D (Res) dated 30 Dec 2002.

[7] Government of India Ministry of letter No 22(1)/01/ US (WE)/D(Res) dt 30 Dec 2002.

[8] Government of India Ministry of letter No 22 (01)/2011/WE/D (Res 1) dt 01 Nov 18.

[9] Government of India Ministry of letter No 1 (01)/2009-D (Pen/Policy) dt 29 Aug 2018.

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