# Chapter VII: Ex-Servicemen Contributory Health Scheme (ECHS)

**Audit Objective**
**To assess whether:**
- **Infrastructure as planned was created.**
- **Norms governing manpower and availability of medical equipment were adhered to; and**
- **Satisfactory supply of drugs was ensured.**

## 7.1 About ECHS

Ministry of Defence sanctioned, in December 2002, a health care scheme, namely "Ex-Servicemen Contributory Health Scheme (ECHS)" to cater for medicare of all ex-servicemen in receipt of pension, including disability and family pension, as also their dependents including wife/husband, legitimate children and wholly dependent parents. The scheme came into effect from 1 April 2003.


The scheme envisages medicare by establishing new Armed Forces Polyclinics and Augmented Armed Forces Clinics at 227 stations spread across the country with a view to reducing the work load in treatment of ex-servicemen/dependents on Service hospitals.

The total membership under the scheme as on 31 March 2011 was 11,58,559 and the beneficiaries were 36,59,263. The contribution received from members for the period 2006-07 to 2010-11 was ₹258.57 crore.

The workload of ex-servicemen (ESM) and their dependents with reference to OPD and admissions in service hospitals during the year 2008 and 2009 was as under:

**Table-70: Workload of ex-servicemen & their dependents**

| | OPD attendance | | Admissions | |
|---|---|---|---|---|
| **Services** | **2008** | **2009** | **2008** | **2009** |
| **Army** | 22,58,464 | 21,21,962 | 1,22,460 | 1,16,547 |
| **Navy** | 1,22,047 | 84,027 | 3,893 | 6,402 |
| **Air Force** | 1,77,152 | 1,77,622 | 2,962 | 5,609 |

The overall expenditure under revenue and capital heads during last five years amounted to ₹3390.44 crore and ₹46.17 crore respectively as per details given below:

**Table-71: Allotment and expenditure under revenue head**

(₹in crore)

| Code Head | 2006-07 | | 2007-08 | | 2008-09 | | 2009-10 | | 2010-11 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Allotment | Expenditure | Allotment | Expenditure | Allotment | Expenditure | Allotment | Expenditure | Allotment | Expenditure |
| Pay & Allowance | 23.40 | 23.50 | 25.92 | 26.09 | 27.31 | 27.41 | 38.90 | 38.94 | 59.00 | 45.95 |
| Medicines | 104.99 | 106.37 | 185.69 | 189.64 | 236.93 | 239.80 | 305.00 | 307.60 | 350.00 | 346.50 |
| Medical Treatment | 188.49 | 187.19 | 263.11 | 260.85 | 368.76 | 365.29 | 539.60 | 540.40 | 626.54 | 657.34 |
| Others | 7.26 | 4.54 | 15.19 | 6.24 | 7.14 | 6.25 | 6.42 | 5.02 | 25.50 | 5.52 |
| Total | 324.14 | 321.60 | 489.91 | 482.82 | 640.14 | 638.75 | 889.92 | 891.96 | 1061.04 | 1055.31 |

**Table-72: Allotment and expenditure under capital head**

(₹in crore)

| Code Head | 2006-07 | | 2007-08 | | 2008-09 | | 2009-10 | | 2010-11 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Allotment | Expenditure | Allotment | Expenditure | Allotment | Expenditure | Allotment | Expenditure | Allotment | Expenditure |
| Purchase of Land | 0.20 | 0.07 | 0.10 | 0.64 | 1.50 | 1.42 | 0.60 | 0.59 | 1.30 | 0.24 |
| Construction of building | 7.00 | 4.77 | 5.00 | 5.86 | 6.70 | 4.95 | 4.70 | 4.13 | 2.00 | 2.21 |
| Med equipment | 16.00 | 15.38 | 3.00 | 3.15 | 1.30 | 1.20 | 1.10 | 1.19 | 0.30 | 0.37 |
| **Total** | **23.20** | **20.22** | **8.10** | **9.65** | **9.50** | **7.57** | **6.40** | **5.91** | **3.60** | **2.82** |
| Funds surrendered | 20.80 | | 48.90 | | 50.50 | | 30.60 | | 33.40 | |
| Total funds available | 44.00 | | 57.00 | | 60.00 | | 37.00 | | 37.00 | |

### Working arrangements between the Service hospitals and ECHS polyclinics

The Scheme stipulates the working arrangements between the Service hospitals and ECHS polyclinics to be as under:-

(a) Subject to load of authorised personnel, all facilities in Military, Naval and Air Force hospitals in the same station or the nearest or any other station will be utilised;

(b) Subject to existing facilities and load, referrals will be permitted for consultation, diagnostic tests and treatment at empanelled medical centres/ polyclinics/ hospitals/nursing homes;

(c) Additional requirement of medicines/drugs/expendables will be provided to Armed Forces clinics/hospitals through the scheme; and

(d) Free out-patient treatment will be made available through Augmented Armed Forces Clinics and Armed Forces Polyclinics.

### Reimbursement

Under the scheme, reimbursements for costs of medicines, etc. are provided to the patients where services are obtained from the empanelled Diagnostic Centres/Nursing Homes/Hospitals. In case of emergency, the beneficiary can report to the nearest Government hospital/ empanelled hospital for treatment under the scheme, the cost of which will be fully reimbursed. In case of accident and trauma cases, where time is crucial for life saving, an ESM may go to any Nursing Home/Hospital; ex-post-facto

sanction for reimbursement for such cases will be accorded by the Headquarters at Delhi.

### Management structure of the scheme

The scheme was to be implemented by a project organisation with a three tier structure, comprising of a Headquarters located at Delhi and 12 Regional Centres to oversee the functioning of 227 polyclinics. Army, Navy and Air Force were to provide manpower to the administrative organisation at HQ and Regional Centres from within their existing resources. The polyclinics to be set up and those set up till 31 March 2011 under the Scheme are as under:-

**Table- 73: Details of polyclinics**

| Type of Station | Polyclinics to be set up | Polyclinics set up |
|---|---|---|
| **Military Stations** | 104 | 106 |
| **Non Military Stations** | 123 | 121 |

The OPD attendance of ESM beneficiaries at ECHS polyclinics during 2006-07 to 2009-10 has consistently increased as shown below:

**Table- 74: Patients seen at ECHS and referred to Service hospitals**

| Year | Total patients seen at ECHS | Patients referred to Service hospitals |
|---|---|---|
| 2006-07 | 4200102 | 140575 |
| 2007-08 | 6496115 | 341345 |
| 2008-09 | 7756531 | 319623 |
| 2009-10 | 7842728 | 318416 |

It can be seen that the ECHS, which was set up as a new scheme, has gained popularity as evident from the steady increase in patients' attendance, thereby underlining the need to further strengthen and augment it with the entire necessary infrastructure and reduce referrals to Service Hospitals.

## 7.2 Creation of infrastructure

As per the scheme sanctioned, the infrastructure for 104 clinics in military stations was to be created within four years and for 123 polyclinics in non military stations within five years from the launch of the scheme. The infrastructure was to be completed at the earliest but not later than March 2008. In execution of the scheme the requirement of polyclinics was, however, revised to 106 in military stations and 121 in non-military stations. The scheme also provided that in respect of 121 polyclinics suitable accommodation for establishing these polyclinics will be rented till such time as the new buildings for these were constructed. As of February 2011, approximately 114 polyclinics were operating out of rented or re-appropriated buildings.

We observed that land and/or building for 171 polyclinics (106 military and 65 non military) was available and in respect of the balance 56 polyclinics (46 *per cent*) in non-military stations acquisition of land was in progress.

Construction of building was complete in respect of 95 out of 106 military stations where land had been acquired. In respect of 6 stations, construction was in progress while in the remaining 5 stations construction was yet to commence. Of the 65 non-military stations where polyclinics were to be constructed, in 47 stations construction had not commenced. This was despite the fact that money was available for undertaking the above activities under the capital outlay each year but was eventually surrendered as depicted in Table 72.

MD ECHS stated that in order to expedite creation of infrastructure at non military stations, a new comprehensive policy on hiring of buildings, acquisition of land and construction of polyclinic buildings was under examination. Sanction was also being sought to engage private/Government agencies for construction of polyclinics at non military stations where MES cover did not exist.

Thus, while the scheme has nearly met the objective of creating infrastructure in military stations, in respect of 85 *per cent* of the non-military stations, the infrastructure was yet to be established.

### Hiring of accommodation for polyclinics


The Ministry while sanctioning the scheme had stipulated the area of accommodation to be hired for different categories of polyclinics as under:-

**Table-75: Authorisation of built up area**

| Category of polyclinic | Built up area authorised (in Sq ft) |
|---|---|
| A | 5000 |
| B | 4000 |
| C | 2500 |
| D | 2000 |

As per records at MD ECHS, 92 polyclinics were functioning in hired accommodation. Data relating to area hired for polyclinics revealed that 41 polyclinics were functioning in prescribed area and 21 polyclinics were functioning in lesser area. We saw that nine polyclinics had deficient area of over 30 *per cent* and some clinics like Hoshiarpur, Pauri Gadhwal and Sonepat had more than 60 *per cent* deficient accommodation. For the balance 30 polyclinics the details of available area was not available.

While accepting the deficiency, MD ECHS clarified that critical deficiency of plinth area is mostly at rural/semi urban areas where large buildings were not available for hiring. All out efforts were being made to acquire land and speed up the construction of polyclinics. The entire process of hiring the buildings for polyclinics and acquisition of land was being simplified and strengthened for creation and upgradation of infrastructure.

## 7.3 Deficiency in manpower

The manpower for polyclinics at military and non-military stations was to be met through appointment on contractual basis. The norm governing the manpower to the four categories of polyclinics is as under:

**Table- 76: Authorisation of manpower**

| Sl. No. | Category | Mil Station | | | | Non Mil Station | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | A | B | C | D | A | B | C | D |
| 1 | Medical officer | 2 | 2 | 1 | 1 | 2 | 2 | 2 | 2 |
| 2 | Medical Specialist | 1 | 1 | - | - | 2 | 2 | 1 | 1 |
| 3 | Dental officer | 1 | 1 | 1 | 1 | 2 | 2 | 1 | 1 |
| 4 | Gynecologist | - | - | - | - | 1 | 1 | - | - |
| 5 | Officer in charge (non medical) | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 6 | Nursing Assistant/Nurse | 3 | 2 | 1 | 1 | 3 | 3 | 2 | 2 |
| 7 | Lab assistant | 2 | 3 | 1 | 1 | 2 | 2 | 1 | 1 |
| 8 | Dental hygienist | 1 | 1 | - | - | 1 | 1 | - | - |
| 9 | Female attendant | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 10 | Receptionist/Caretaker | - | - | - | - | 1 | 1 | - | - |

The scheme sanctioned in December 2002 did not provide Radiographer and Physiotherapist. In September 2003, this was corrected by including them in the category of Nursing Assistants.

Our scrutiny revealed that the manpower of medical officers actually held at the polyclinics during the period 2006-07 to 2010-11 was deficient when compared to the total authorisation as shown below.

**Table-77: Posted strength of manpower with reference to authorisation**

| Year | Medical Officer | | | Medical Specialist | | | Gynecologist | | | Percentage of deficiencies | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Auth | Posted | Def. | Auth | Posted | Def. | Auth | Posted | Def. | MO | MS | Gynec |
| 2006-07 | 375 | 306 | 69 | 176 | 73 | 103 | 28 | 11 | 17 | 18 | 59 | 61 |
| 2007-08 | 375 | 322 | 53 | 176 | 96 | 80 | 28 | 16 | 12 | 14 | 45 | 43 |
| 2008-09 | 375 | 313 | 62 | 177 | 103 | 74 | 29 | 19 | 10 | 17 | 42 | 34 |
| 2009-10 | 375 | 350 | 25 | 177 | 136 | 41 | 29 | 19 | 10 | 7 | 23 | 34 |
| 2010-11 | 375 | 348 | 27 | 177 | 130 | 47 | 29 | 20 | 9 | 7 | 27 | 31 |

The deficiency in each of the above categories had reduced over the period from 2006-07 to 2010-11. However, even though the scheme was in its eighth year of operation, the deficiency in respect of Medical Specialist and Gynecologist was as

high as 27 *per cent* and 31 *per cent* as of March 2011. The deficiency in respect of all categories of officers was more in the polyclinics located in non-military stations than in the military stations, adversely affecting the patient care as indicated below:-

**Table- 78: Deficiency of manpower at military and non-military stations**

| Station | Med Officers | | | Med Specialists | | | Gynecologist | | |
|---|---|---|---|---|---|---|---|---|---|
| | Auth. | Posted | Def. | Auth. | Posted | Def. | Auth. | Posted | Def. |
| Mil Station | 132 | 127 | 5 | 27 | 24 | 3 | 0 | 0 | - |
| Non Mil Station | 243 | 221 | 22 | 150 | 106 | 44 | 29 | 20 | 9 |
| Total | 375 | 348 | 27 | 177 | 130 | 47 | 29 | 20 | 9 |

While accepting the non-availability of Medical Specialists and Gynecologists as a matter of concern, MD ECHS clarified that existence of vacancies is due to lesser contractual remuneration compared to that of the Central Government Health Scheme and that the matter was under examination at the Ministry. It was also stated that the deficiency of Medical Officers/ Medical Specialists/ Gynecologists in rural/semi urban areas was a malaise prevalent all over the country which could only be addressed with special compensatory allowance as an incentive for serving in rural/remote areas.

**Recommendation No 15**

**Effective steps may be taken to improve the availability of infrastructure and manpower, particularly in non-military stations, to ensure manning of equipment as well as for providing adequate patient care.**

While agreeing with the recommendation, the Ministry stated (July 2012) that necessary action for carrying out remedial action was under consideration.

## 7.4 Equipment

**Procurement of equipment without ensuring manpower**

Government sanction provided for medical equipment to polyclinics as under:

**Table- 79: Authorisation of equipment**

| Sl. No. | Medical Equipment | Military Station | | | | Non-military Station | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | A | B | C | D | A | B | C | D |
| 1 | X-ray machine | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 2 | Ultrasound | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 3 | Lab Autoanalyser | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 4 | Dental equipment set (including chair) | 1 | 1 | 1 | 1 | 2 | 2 | 1 | 1 |
| 5 | Physiotherapy (standard set) | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 6 | ECG machine | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 7 | Monitor Defibrillator | 1 | 1 | - | - | 1 | 1 | - | - |
| 8 | Ambulances | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |

The table shows that whereas X-ray machines and Ultrasound machines were provisioned in all the 227 polyclinics, the radiographers required to operate them had not been sanctioned for 79 polyclinics in C & D categories. In the polyclinics located at Lucknow, Chandimandir, Jabalpur and Shillong where only one Nursing Assistant (inclusive of radiographer) was authorized, X-ray machines were not utilized for want of manpower and therefore transferred to Military hospitals. At polyclinic Agra the machine was idle due to non availability of a radiographer.

The deficiency in other equipment such as Microscope complete, Wax bath, Instrument table, Gynec examination table was also observed at the polyclinics at Chandigarh, Ropar, Kapurthala, Kolhapur, Salem, Tirunelveli and Bhubaneswar.

MD ECHS stated that case for authorisation of deficient manpower was under consideration.

### Downtime of medical equipment

Scrutiny of records at MD ECHS revealed that 36 equipment remained un-serviceable at 18 polyclinics intermittently during 2008-09 and 2009-10 for periods ranging from 1 to 36 months in polyclinics for want of accessories and repairs as detailed below:

**Table- 80: Downtime of equipment**

| Equipment not functional | 2008-09 | 2009-10 | Name of equipment |
|---|---|---|---|
| Up to 3 months | 5 | 14 | (9)Dental chairs, (7) X-ray machines, ECG Machine, Ultrasound machine and Auto analyser. |
| 4 to 6 months | 1 | 3 | (3)Dental Chairs and X Ray machine. |
| 7 to 9 months | 3 | 1 | X Ray, (2) Dental Chairs and ECG Machine. |
| 10 to 12 months | - | - | |
| > 12 months | 5 | 4 | (4)Dental Chairs, (2) X-ray machines, (2) Air compressor and ECG Machine. |
| Total | 14 | 22 | |

The downtime exceeding 12 months in 2008-09 related to one equipment each at the polyclinics at Shahjahanpur, Jaipur, Agartala and two at Darjeeling. For 2009-10, of the four equipment that had downtime of over 12 months, one was at Barmer and three at Bengdubi.

### Non-functional of equipment

As of March 2011, 18 equipment (seven X-ray machines, nine Dental chairs and two Semi auto analyzers) were non functional since January 2010 at 17 polyclinics located at non military stations. MD ECHS in reply stated that case regarding non-functioning of the equipment had been taken up with the firms and DGAFMS. SOP for repair and maintenance of medical equipment was stated to be under revision.

The serviceability of the equipment at polyclinics could not be verified as log books required to be maintained for all the non-expendable medical stores costing ₹10,000 and above were not maintained. As a result quantum of actual downtime and unserviceability of equipment could not be ascertained.

Regarding downtime/non-functioning of equipment, MD ECHS stated that necessary corrective measures were being examined in consultation with DGAFMS.

### Monitoring of availability of drugs in polyclinics

Directorate General Financial Planning (DGFP) (AHQ) allots funds to MD ECHS who in turn issues the funds to DGAFMS for allotment to AFMSDs and respective hospitals for local purchase of drugs and consumables for the polyclinics.

In September 2007, MD ECHS issued instructions to all Regional Centres to obtain monthly report on availability of drugs and consumable from polyclinics in their jurisdiction and forward a quarterly report to the Headquarters.

We, however, observed that instructions issued by MD ECHS were not adhered to by the Regional Centres as three out of 13 Regional Centers, namely, Danapur, Delhi and Jabalpur, never submitted the reports. The reports, where rendered, were irregular**.** In respect of other 10 Regional Centres, only 45 out of 153 reports due were rendered i.e. 29 *per cent*.

The reports from Regional Centres of Kolkata and Pune indicated that the lead time taken for materialisation of supplies from the AFMSDs was far more when compared to lead time allowed under DGLP. The lead time in certain cases was even up to six months to one year indicating low priority accorded to ECHS. Moreover, there was no evidence of any tangible action taken to bring down the lead time.

In reply, it was stated that the feedback system took time to develop depending on various problems faced. It was also stated that time taken for procurement of medicines is as per the existing procurement procedure and instructions were being issued to render the report.

Thus the Management Information system designed to assess availability of drugs in polyclinics is defunct and needs to be made operative at all Regional Centres to ensure proper monitoring by MD ECHS given the fact that materialisation of supplies from AFMSD to ECHS needs to improve.

### Low compliance of medical stores

The ECHS Polyclinics are dependent on AFMSDs as well as nearest service hospitals for drawal of medical stores. In August 2009, the DGAFMS circulated list of 67 drugs which were identified as ‘vital’ & ‘essential’ and advised all the ECHS Polyclinics to ensure maximum availability of these medicines at all times.

The AFMSD Mumbai, however, did not hold stock of 35 vital and essential drugs (52 *per cent*) and stock of nine drugs (13 *per cent*) was less than the MMF. The AFMSD Delhi Cantt did not hold stock of 10 essential drugs (15 *per cent*) and for 24 drugs (36 *per cent*) the stock held was less than MMF.

Thus the depots were unable to provide the vital and essential drugs to ECHS polyclinics affecting the medicare to ESM.

Besides the essential category of drugs, the compliance rate of the drugs in general was examined at ECHS polyclinics located at military and non-military stations during 2006-07 to 2010-11. In 10 military stations the compliance rate ranged from 17 *per cent* (Ambala) to 84 *per cent* (Mumbai). In 20 non-military stations it ranged from 11 *per cent* (Ara) to 76 *per cent* (Fatehpur).

Accepting the non availability of drugs as a matter of concern, MD ECHS stated that various measures to obviate the same were under examination. The Regional Centres were also stated to have been instructed to obtain monthly report on availability of drugs etc., and to apprise the Central organisation quarterly.

**Recommendation No 16**

**Availability of drugs in ECHS polyclinics should be improved at the earliest. The management tool devised to ascertain availability of drugs in polyclinics should be strengthened to ensure correct reporting.**

Agreeing to the recommendations, the Ministry stated (July 2012) that all-out efforts were being made to ensure that necessary drugs are available.

## 7.5 Inadequacy of empanelled hospitals

ESM and their dependents requiring hospital admission are normally referred to Service hospitals and, in case of non-availability of beds/ facilities in Service hospitals, to empanelled civil hospitals for treatment. For this purpose, a Board of Officers at a station scrutinizes the applications received from the hospitals in a station for empanelment. Evaluation of hospitals is then carried out by the Board as regards their reputation, accessibility, availability of professional services and reasonability of rates before making recommendation. The hospitals are then recommended to the Empowered Committee for approval under the Chairmanship of Additional Secretary in the Ministry. On approval, the hospitals are initially empanelled for a period of two years generally and agreements are then signed by the Station HQ with the hospitals to provide for treatment to the ESM.

The Ministry had approved empanelment of 1054 hospitals till March 2011 whereas valid agreement was available with only 507 hospitals. In the balance 547 hospitals, agreements had expired and not renewed. The position of valid existing agreements

and those expired but not renewed as of March 2011 are as under:

**Table- 81: Position of empanelled hospitals**

| **Total hospitals approved for empanelment*** | | **Hospitals with valid agreements as on 31/03/2011**** | | **Hospitals where agreements had become invalid/expired as on 31/03/2011*** (*per cent* in bracket)** | |
|---|---|---|---|---|---|
| Military stations | Non-military stations | Military stations | Non-military stations | Military stations | Non-military stations |
| 601 | 312 | 276 | 157 | 325 (54 *per cent*) | 155 (50 *per cent*) |

**In the balance 141 hospitals, categorization as military or non-military station is not known as these empanelled hospitals are located at places other than military/ non-military policlinics.*
*** The remaining 74 hospitals have been empanelled at other than the polyclinic stations.*
****The remaining 67 hospitals pertain to other than polyclinic stations*

We observed that validity of agreements existed for 276 hospitals at 57 military stations and 157 hospitals at 60 non-military stations. We observed that as of March 2011 at 15 non-military stations out of 75 and an equal number out of 72 military stations where hospitals had been approved for empanelment by the Ministry, agreements with the empanelled hospitals had not been renewed. While in military stations the beneficiaries have the option of treatment in service hospital, in non-military stations the beneficiaries have to mostly rely on the empanelled hospital for treatment. Thus, in the absence of empanelled hospitals, the ESM in those non-military stations were put to the inconvenience of undertaking long journeys to the nearest Service hospitals for treatment.

At 18 'C' and 'D' polyclinic stations, having ESM dependency between 2500 and 10000, the number of hospitals empanelled was found more and in two cases as high as 15 (Lucknow and Nagpur) whereas at 18 'A' and 'B' polyclinic stations, where ESM dependency is 10000 and above, the availability of empanelled hospitals was low ranging between one and three**.**

MD ECHS stated that, in February 2011, ECHS had signed Memorandum of Understanding (MoU) with Quality Council of India (QCI), National Accreditation for Board of Hospitals (NABH) to further reduce the time taken for empanelment.

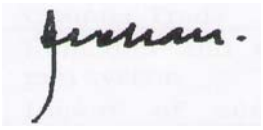
Thus non-availability of empanelled hospitals at non-military stations as well as availability of fewer numbers of empanelled hospitals for population of 10,000 and above would restrict the availability of treatment to ESM undermining the objective of the scheme. In other words the deficiency in availability of empanelled hospitals would restrict the accessibility of ESM.

## 7.6 Non-utilisation of Management Information System Software (MIS)

The MD ECHS concluded a contract in January 2004 for installation of Information Technology infrastructure for smart cards along with MIS software at ECHS HQ, Regional Centres and Polyclinics. Our scrutiny revealed that the infrastructure created in June 2006 was being used only for registration and referral of patients, though the MIS software had 32 modules. Thirty of the thirty two modules were not used due to non- availability of trained manpower. Thus, full benefits expected from the computerisation were not derived.

While agreeing with the inadequacy of the existing in-house efforts for automation, MD ECHS clarified that to overcome this deficiency a case for complete automation of ECHS with the assistance of National Institute for Smart Government was under finalization. In addition, an on-line bill processing system with the assistance of a Bill Processing Agency (BPA) viz. UTI-ITSL was being launched with effect from April 2012 to maintain the MIS of the scheme.

The Ministry stated (July 2012) that a proposal to augment and strengthen the automation process of ECHS was under finalisation.



**New Delhi**
**Dated: 26 November 2012**

**(Venkatesh Mohan)**
**Director General of Audit**
**Defence Services**

**Countersigned**

**New Delhi**
**Dated: 26 November 2012**

**(Vinod Rai)**
**Comptroller and Auditor General of India**