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PUBLIC ACCOUNTS COMMITTEE
(2012-2013)

ANDHRA PRADESH LEGISLATURE

REPORT (THIRTEENTH)

ON

THE REPORT OF THE COMPTROLLER AND AUDITOR GENERAL OF INDIA (CIVIL) FOR THE YEAR 2010-2011 PERTAINING TO HEALTH MEDICAL AND FAMILY WELFARE DEPARTMENT

(Presented to the Legislature on 21-06-2013)

ANDHRA PRADESH LEGISLATURE (P.A.C.) SECRETARIAT,
PUBLIC GARDENS, HYDERABAD – 500 004.

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Committee on Public Accounts
(2012-13)
(Constituted on 20.01.2012)

1.	Sri R. Prakash Reddy	**Chairman**
2.	Sri K. Rambhupal Reddy	Member from Assembly
*3.	Dr. Daggubati Venkateshwara Rao	,,
4.	Sri Anam Vivekananda Reddy	,,
5.	Sri C.K. Jayachandra Reddy	,,
**6.	Sri Perni Venkatramaiah	,,
**7.	Sri T. Jaya Prakash Reddy	,,
**8.	Sri Dronamraju Srinivasa Rao	,,
**9.	Sri A. Mohan	,,
10.	Sri Devineni Uma Maheswara Rao	,,
11.	Sri B. Durga Prasad Rao	,,
12.	Sri G. Jaipal Yadav	,,
13.	Sri B.K. Partha Sarathi	,,
14.	Sri K. Kannababu	,,
15.	Sri Etala Rajender	,,
*16.	Sri Vasireddy Varada Rama Rao	Member from Council (upto 01.05.2012)
*17.	Sri V. Bhoopal Reddy	,,
*18.	Sri Rudraraju Padma Raju	,, (upto 08.02.2012)
*19.	Sri Nimmakayala China Rajappa	,, (upto 01.05.2013)
*20.	Sri Chukka Ramaiah	" (upto 29.03.2013)
***21.	Sri T. Bhanuprasada Rao	,,
****22.	Sri Ponguleti Sudhakar Reddy	Spl. Invitee from Council
****23.	Sri B. Changal Rayudu	,,
****24.	Sri K. Yadava Reddy	,,
****25.	Sri Y.V.B. Rajendra Prasad	,, (upto 29.03.2013)
*****26.	Sri Akbaruddin Owaisi	Spl. Invitee from Assembly
*****27.	Sri E. Lakshmi Narayana	,,

LEGISLATURE SECRETARIAT :

1.	Dr. S. Raja Sadaram,	Secretary
2.	Sri P. Balakrishnamacharyulu,	Deputy Secretary
3.	Sri H.A. Shafi,	Assistant Secretary
4.	Sri K.V.V. Satyanarayana,	Section Officer

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*w.e.f. 28.01.2012

**upto 09.02.2012

***w.e.f. 10.10.2012

****w.e.f. 10.10.2012

*****w.e.f. 26.11.2012

INTRODUCTION

I, the Chairman of the Committee on Public Accounts (2012-2013) having been authorised by the Committee to present the Thirteenth Report, on their behalf, do present this report on the Report of the Comptroller and Auditor General of India (Civil) for the year 2010-2011 pertaining to Health, Medical and Family Welfare Department.

2. The Report of the Comptroller and Auditor General of India (Civil) for the year 2010-2011 were laid on the Table of the House on 29-03-2012 respectively.

3. The Committee examined the report of the Comptroller and Auditor General of India (Civil) for the year 2010-2011 pertaining to Health, Medical and Family Welfare Department at their sittings held on 17.10.2012, 10.04.2013 and 23.04.2013.

4. A statement showing the Summary of Observations / Recommendations of the Committee is appended to this Report.

5. A record of proceedings of the sittings of the Committee, which has been maintained forms part of this Report.

6. The Committee placed on record their appreciation of the assistance rendered to them by the Principal Accountant General (G&S.S.A.), Andhra Pradesh and their Officers and Staff, Secretary to State Legislature and their Officers and Staff in examination and preparation of the Report. The Committee would like to express their thanks to the Officers of Health, Medical and Family Welfare Department and other Officers and Staff of the Government of Andhra Pradesh for the co-operation in giving information to the Committee.

Hyderabad,
Dated: 18-06-2013.

REVURI PRAKASH REDDY,
Chairman,
Public Accounts Committee.

Report of the Public Accounts Committee on the Reports of the Comptroller and Auditor General of India for the year 2010-11 (Civil) –

Government of Andhra Pradesh

Health, Medical and Family Welfare Department

PAC had discussed the matters relating to the Department on 17 October 2012, 10 April 2013 and 23 April 2013.

1. Para 5.2 Page 50 of Audit Report 2010-11

Functioning of Blood banks

1.1 Blood banks[1] are regulated by Drugs and Cosmetics Act, 1940 (Act) and relevant rules made there under. Government of India formulated the National Blood Policy (NBP) in April 2002 to bring about a "comprehensive, efficient and a total quality management approach" to functioning of blood banks throughout the country to ensure easy access to adequate and safe blood.

There were 233 blood banks[2] in Andhra Pradesh as of May 2010. We reviewed, during July - December 2010, the functioning of 45 (out of 126) blood banks in eight districts[3] over a period of three years (2007-10). Our findings in this regard are given in the succeeding paragraphs:

Para 5.2.1 Absence of relevant data

The State Level Committee (SLC) constituted in May 2010 for suggesting measures for strengthening the management of blood banks, estimated the demand for blood in the State at eight lakh units per annum. As against this, the existing 233 blood banks[4] are able to collect only seven

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[1] Blood bank means a place/organization/unit/institution or other arrangement made by them for carrying out all or any of the operations for collection, apheresis, storage and distribution of blood components or as whole human blood

[2] Adilabad: 6; Anantapur: 6; Chittoor: 10; East Godavari: 13; Guntur: 16; Hyderabad: 62; Karimnagar: 9; Khammam: 7; Krihna: 15; Kurnool: 6; Mahboobnagar: 5; Medak: 4; Nalgonda: 5; Nizamabad: 5; Prakasam: 5; Ranga Reddy: 12; SPS Nellore: 4; Srikakulam: 2; Visakhapatnam: 13; Vizianagaram: 5; Warangal: 7; West Godavari: 9 and YSR: r. Of these, 66 blood banks are under control of Government and 167 private

[3] Anantapur (5), Chittoor (10), Guntur (8), Hyderabad (8), Krishna (4), Kurnool (6), Medak (1) and YSR (3); (Government: 23 and Private: 22)

[4] Governm[illegible]t - 66, Red cross - 38, Voluntary/Charitable - 53 and Private hospitals - 76

[5] Citrate - Phosphate - Dextrose - Adenine

lakh units per annum. Considering this gap in demand and supply, there is an imperative need to utilise the available resources efficiently. However, the State does not have a centralised online database indicating the availability of various groups of blood at the blood bank level, district level and at the State level.

Blood collected is to be preserved in CPDA[5] solution at temperatures between 4° C and 6° C and utilised within 35 days of its collection. Audit scrutiny revealed that blood units in certain cases collected in all the 45 sampled blood banks had to be discarded due to their non-utilisation within the specified time. The concerned blood banks attributed this to low demand for blood in the neighbouring hospitals. This situation could have been ave rted had there been a centralised database of blood in the districts and the State as a whole, as the needy hospitals/patients in adjoining areas could have used it to the benefit of their patients.

The SLC had recommended (June 2010) setting up a well knit regionally coordinated blood banking system with structured blood transfusion services and an inbuilt mandatory quality assurance mechanism through the establishment of Mother Blood banks to ensure availability of screened safe blood, by upgrading one Government Blood bank per district to be called Mother Blood banks. However, no such blood banks had been established in the State so far (August 2011).

Blood banks are required to maintain the details of blood donors in a register, indicating vital details such as date of collection of blood, name of the donor, address, age, weight, percentage of hemoglobin (Hb), blood group, etc. Proper labeling should also be done on the blood packets to ensure that blood was collected from a physically fit and willing donor. This procedure was prescribed to ensure that blood is not collected from ineligible donors and to protect the donor. Further, this will ensure that the blood stock that does not conform to the prescribed standard is destroyed so that infections don't get carried through blood transfusion. It was noticed that, in 24 out of 45 blood banks test checked, this vital data was not captured/recorded in the blood donors register in respect of as many as 22,995 donors[6]. Further, in the blood bank at Government Hospital, Anantapur, crucial information which was very essential for supply of blood, viz., **blood group,** was not recorded in the donors register in respect of blood collected (2009-10) from 240 donors.

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[6] HB Percentage not recorded : 22,114 : Age, Weight etc. not recorded : 881.

Failure to record such vital details is not only fraught with the risk of transfusion of wrong blood to the patients, but may finally leave the blood unutilised and discarded and would result in wastage of a scarce resource defeating the very objective of the donors to save another precious life.

In the Explanatory Notes, Government stated as follows:

- ***7,29,843 units of blood was collected during the year 2011-12. Out of total blood collection, components were prepared from 5,50,859 units.***
- ***Blood information management system is under process in collaboration with Commissioner, Health and Family Welfare. AP State AIDS Control Society (APSACS) had provided required technical inputs for its development.***
- ***Blood storage centres are maintained by Indian Red Cross Society. The District IRCS blood banks/ Government hospital blood banks serve as mother blood banks. Safe blood is being supplied through mother blood banks to blood storage centres.***
- ***The Drug Control Authority is the regulating and monitoring authority with regard to the functioning of the blood banks.***

Para 5.2.2 Donor safety

As per the eligibility criteria fixed for blood donation under the Drugs and Cosmetics Rules, 1945 (Rules), the donor of blood should be in good health, mentally alert and physically fit. We observed the following violations of these standards in the test checked blood banks.

Conditions stipulated for drawal of blood	Audit findings
(1)	(3)
Age: Donor should be within the age group of 18 to 60 years.	In 23 out of 45 blood banks verified, blood was collected from 291 donors who are below the age of 18 years.
Weight: Weight of donor should not be less than 45 Kg	In 10 out of 45 blood banks verified, blood was collected from 71 donors whose weight was less than that specified.

(1)	(3)
Haemoglobin content: Haemoglobin content of donor's blood should should not be less than 12.5 gm/dl. Persons with haemoglobin less than this prescribed quantity cannot be treated as healthy person for blood donation. Further, blood weak in haemoglobin content does not help in carrying owygen to cells of the patient.	In 41 out of 45 blood banks checked, blood was collected from 3,617 donors (details given in *Appendix-5.1*) whose haemoglobin content was less, than prescribed rate i.e. 12.5 gm/dl, the lowest being 8.5 gm/dl.

As can be seen from the details tabulated above, donor safety was compromised by violating the eligibility criteria for blood donors.

In the Explanatory Notes, Government stated that APSACS would support the NACO supported blood banks in the form of supply of kits and consumables only, subject to availability of the same. Drug Control Authority is to regulate and monitor the records maintenance etc. If any irregularity/ deficiency is found by them, appropriate action would be taken by them.

Para 5.2.3 Extract of blood components

World Health Organisation (WHO) had emphasised the need for optimal utilisation of donated blood by use of specifically required components instead of whole blood. In view of the gap between demand and actual collection of blood units, conversion of blood into various components was an inherently effective way of overcoming the shortage of blood. In none of the 45 test checked blood banks, there was any evidence to prove that the blood banks had made any effort to extract blood components from the units collected. Thus, optimal utilisation of the scarce resource was not ensured.

In the Explanatory Notes, Government stated that the blood banks, which are having licence for components preparation, can only prepare blood components. All the blood banks are not licensed to do the components.

Para 5.2.4 Calibration of Equipment

Rules stipulate that the equipment used in collection, processing, testing, storage and sale/distribution of blood and its components should

be observed, standardised and calibrated at regular intervals as described in the Standard Operating Procedures Manual wherein details of frequency of calibration of various equipments are also prescribed. Though the prescribed equipment was available in adequate number in all the test checked blood banks, calibration of 102 equipments in 11 (out of 45) blood banks reviewed in audit had not been done.

In the absence of equipment calibration at regular intervals the risk of the results/ readings (obtained by using these equipments) not being accurate and reliable was ever present. Therefore, there was no assurance about the quality of the blood supplied by these blood banks.

In the Explanatory Notes, Government stated that Drug Control Authority is the regulating authority on blood banks to monitor the standards and operating procedures. Entering into AMC contracts with either the original equipment manufacturer or their authorized service agents for purpose of ensuring calibration of equipment is an option under consideration.

Para 5.2.5 Ineffective monitoring by Drug Inspectors

The Drugs Controller (India), Directorate General of Health Services, New Delhi issues licences to blood banks only after verifying it and carrying out a joint inspection along with the Director General, Drug Control Administration (DG, DCA).

Prior to issue of licence/renewal of licence to any blood bank for carrying out its operations, Drug Inspectors (Inspectors) working under the control of DG, DCA, are required to examine the premises and appliances/equipments, inspect the process of manufacture along with the means for operation of blood bank, processing of whole human blood for components, manufacture of blood products together with their testing facilities and also enquire into the professional qualification of the expert staff and other technical staff employed.

If the licensee fails to comply with any of the conditions of the licence or with any provisions of the Act or Rules there under, the licence

[7] District Hospital, Machilipatnam and Area Hospital, Gudiwada

may be cancelled or suspended. Licence to blood banks is valid for five years from the date of its issue and it has to be renewed thereafter from time to time. Rejected licensee can re-apply within six months after complying with.

We observed that:

- A majority of the Inspectors in the sampled districts have not complied with the above procedures. Monitoring of the blood bank operations/activities by the Inspectors was also found to be ineffective. Out of 45 blood banks verified, 22 had not been inspected by the licensing authority during 2008 and 2009.
- In case of two blood banks[7], we noticed that their licences had expired in 1999 and 2007. However, joint inspection was conducted belatedly only in January 2010. Thus, the blood banks functioned unauthorisedly during the intervening years. There were no recorded reasons for the inordinate delay in the conduct of joint inspection.

In the Explanatory Notes, Government stated that during the period 2006-12 there is a marked improvement in the monitoring by the Drug Inspectors as illustrated below:

Blood banks inspected: 960

Issue of show cause notices cum stop production orders: 122

Show causes issued: 233

Cancellation of blood bank licences: 32

Detection of unlicensed blood bank activities: 12

No. of convictions: 5

Special drive inspection of blood banks (4th to 5th October 2012): 217

Analysis of samples (4th to 5th October 2012): 286

Special Drive Inspection of blood banks conducted (09 December 2012): 222

Analysis of samples done (09 December 2012): 308

In addition to the above, joint inspections along with the officials of Central Drugs Standards Control Organization (CDSCO), GoI were also undertaken.

Para 5.2.6 Huge shortages of Drug Inspectors

The jurisdictional area of a Drug Inspector depends on the number of pharmaceutical units in the area and more than one Inspector may be required in a district.

We observed (August 2010) that there was acute shortage of 'Drug Inspectors' in the Department. There were only 24 Drug Inspectors against 558 posts required as per norms. Although, Government had sanctioned 75 additional posts during 2007-09, even these were not deployed as of August 2011. The Department stated (August 2010) that there were no eligible persons in the Department in respect of vacancies to be filled in through promotions and action was underway for direct recruitment.

⇒ *In the Explanatory Notes Government stated that, to augment the strength of the Drug Inspectors, the Government has sanctioned 75 Drug Inspector posts in the years 2008 and 2009. Out of the above, 52 Drug Inspectors posts have been filled up and recruitment process to fill up the remaining posts is on.*

Government also stated that, based on the recommendations of Audit, the following measures have been contemplated to improve the overall performance of the blood banks.

⇒ *Special training would be imparted with a specific aim to effectively enforce the provisions of Drugs and Cosmetics Act, 1940 by the respective blood banks.*

⇒ *The Drugs Control Administration would ensure that all the blood banks in the State would be inspected at least twice in a year though the statutory requirement is once in a year.*

⇒ *An officer of the rank of Deputy Director would be specifically entrusted to supervise the enforcement activities of the specially designated Drug Inspectors in the State for the blood banks and any irregularities in the blood banks would be dealt sternly.*

⇒ *Court cases with regard to the blood banks would be filed in the special courts and the speedy trial of the same would be ensured.*

⇒ *At least one percent of ready to use blood units/ blood components drawn from all the blood banks in the State would be sent for analysis for freedom from HIV, HbsAG, HCV, VDRL and Malaria at least once in a year.*

1.2 Initiating discussion on the Audit paragraphs, Principal Accountant General informed the Committee that there were 233 blood banks in the State and 45 were test-checked in Audit, which revealed many lapses.

- The recommendations made by State level Committee that was constituted in May 2010 were not followed by blood banks.
- Blood samples were collected without observing the norms / prescribed standards
- Blood groups were not identified
- Blood samples were collected from lower age groups
- Blood components that were useful for many people were not extracted in full
- Blood banks were not being inspected by Drug inspectors

1.3 Director General, Drugs Control Administration (DG), while admitting the audit observations informed the Committee as follows:

⇒ There were only 25 Drug Inspectors (as of now there are 130 Inspectors) at the time of inspection. As of now, 60 Drug Inspector posts are vacant.

⇒ Recently, Government recruited 55 Drug Inspectors and recruitment of another 55 is in the pipeline and it will be completed by February 2012. As of now, of the 256 blood banks, 222 are functioning.

⇒ 55 Drug Inspectors posts were sanctioned without a single supporting staff. Each office runs with one Drug Inspector. The Department has forwarded the proposal to the Government to sanction at least one supporting staff for each Drug Inspector. After completion of the latest recruitment, the department is able to ensure inspection of every blood bank twice in a ye ar.

⇒ In the last month all the blood banks were inspected and certain deficiencies were noticed that included those observations made by Audit.

⇒ In one case, where the blood group was written differently on the record, notices were issued to all the blood banks to take corrective measures.

⇒ It was planning to take one per cent as the sample every year. The samples are being sent to other Laboratories (Private or Government) also to check whether the blood is genuine or not.

⇒ Two or three cases have happened last year like one death took place in Nellore. Efforts are being made to ensure that the blood collected is of proper quality.

1.4 The Committee noted that blood banks were to be inspected twice a year. Blood components were not being extracted from the samples collected. Blood was collected without conducting the prescribed checks. The Committee directed that blood should be tested for its group and the collection of blood should be done as per rules.

1.5 DG replied that basically their office is responsible with regard to the following aspects and their office gives notice for closure of the blood banks, if any deficiency is found:

⇒ to ensure safety and quality of blood collected

⇒ whether the blood banks are following the procedure or not

⇒ whether the blood banks have the proper equipment or not

⇒ whether the blood banks have the proper qualified technical staff or not

1.6 The Committee enquired about the administrative control of the staff.

1.7 DG replied that more than 50 per cent were on private side.

1.8 The Committee noted that 66 blood banks are being run by Government and the remaining by private establishments (Charitable trusts:53; Red cross:38; Private hospitals:76). The Committee enquired about the list of 45 blood banks verified by DG.

1.9 DG, Drug Control Administration informed the Committee that earlier, blood banks were being supervised only once in a year. Now, inspections are being conducted twice in a year. In September 2012, special

drive was conducted and 308 samples were collected. Show cause notices have been issued to all the blood banks that violated the rules and these blood banks would be visited again. 30 blood banks were ordered for stoppage of blood collection. Six blood banks were kept under suspension and licences had been cancelled in respect of three blood banks.

1.10 Director, Health and Family Welfare stated that their office gives training (new incumbents: 15 days; Medical Officers: 7 days) to Medical Officers and lab technicians regularly in the aspects viz., to conduct the screening, to do the blood grouping, identification of blood donors, donor safety and internal quality control. He also stated that Government is promoting voluntary blood donations and discouraging professional donors. The blood samples are sent to micro biology department for testing them for quality control.

1.11 The Committee expressed anguish over the lack of serious concern on the part of the blood banks and the department in observing the rules. The Committee pointed out about the detection of 6 cases of under age and one case of underweight in Government General Hospital, Anantapur, 2 cases in respect of under age and 8 cases of shortage of Haemoglobin in SVIMS, Tirupati.

Principal Secretary informed the Committee that 250 blood banks in the State have been inspected during April 2013 and furnished the following statistics in respect of the blood units collected during the year 2012-13

Total no. of Blood units collected during 2012-2013	Total no. of units collected from Under age (less than 18 years)	Total no. of units collected from under weight (less than 45 kgs)	Total no. of units which have less haemoglobin (less than 12.5 gms)
10,61,288	Nil	Nil	32

*

Sl. No.	Name and Address of the Blood Bank	Category	District	No.of blood units collected	Under age	Under weight	Less hemoglobin
1	Govt. Maternity Hospital Blood Bank, Near SVIMS Circle, Alipiri Road, Tirupati, Chittoor	Govt	Chittoor	3307	Nil	Nil	31
2	Indian Naval Hospital Ship kalyani Blood Bank, Gandhigram, Visakhapatnam	Central Govt.	Visakhapatnam	320	Nil	Nil	1

1.12 Director, Health and Family Welfare stated that the deviations pointed out by Audit have been rectified now.

1.13 Managing Director, NRHM stated that blood banks should maintain a minimum of seven unit's blood at any point of time. The MD promised that as suggested by Audit, online database would be maintained in six months time and training would be imparted to them.

1.14 The Committee noted that, of the 558 vacant posts of Drug Inspectors, 130 are posted and enquired about the sufficiency of staff for conducting regular inspections of blood banks.

1.15 Principal Secretary replied that a Parliamentary Committee that visited AP felt that the number should be 200. Proposals have been received from the Department for recruiting more number of Drug Inspectors. Finance Department was also informed of the position.

1.16 The Chairman enquired as to how the problem of shortage of Drug Inspectors would be resolved.

1.17 Principal Accountant General informed the Committee that GoI had appointed a Committee called Haki Committee in the year 1975 and Dr. Mashalkar Committee in the year 2003. They recommended one Drug Inspector for every 25 Drug Manufacturing Units and one Drug Inspector for every hundred outlet sales for more effective implementation. As per that order, the requirement of Drug Inspectors is worked out to 558 and this was also confirmed by the Assistant Director, Drugs Control.

1.18 Principal Secretary replied that Government is required to obtain the recommendations of all the States. A policy is being evolved by the Government to look at how far the recommendations can be implemented more effectively and what is the policy of the Government in this matter. As of now, there is no health policy in the State. He also stated that there is every need to focus on the public health and there should be public health policy. The recommendations of Dr. Mashalkar committee are ideal and were not circulated by GoI to all States. The recommendations should be adopted as a part of public health policy. The Parliamentary Committee observed that a geographical unit can be considered for every 55,000 shops. If we consider this, many numbers are required in Hyderabad. But it cannot be done.

1.19 The Committee pointed out that as per the data, all blood banks are licensed to prepare components.

1.20 The Committee sought to know about spreading of Dengue fever across the State. Referring to the newspaper reports, the Committee stated that neither diagnostic facilities nor medicines for dengue fever were available in Government hospitals. Due to non-availability of the required facilities, irrespective of rich or poor, everybody is approaching private hospitals. Taking advantage of this, the private hospitals are looting money.

1.21 Director of Public Health, while admitting this, stated that private hospitals are looting money by treating normal fever as dengue and misleading the public. Generally platelets are reduced even for strains also. Taking advantage of the ignorance (with regard to symptoms of dengue) of patients, private hospitals are exploiting. Even for normal viral fever also they are prescribing so many tests and fearing public. It is a fact that depending on the financial status of patients, hospitals are collecting thousands of rupees and even more than one lakh in some cases.

1.22 The Committee pointed out that the hospitals are collecting even up to Rs 3 lakh by fearing the patient that platelets had come done and if not restored it would be dangerous to the life of the patient. The Committee enquired as to why the Government is unable to control the menace.

1.23 While agreeing with the Committee, Director of Public Health stated that this was the problem in the whole country and not exclusively in our State. Recently, this issue with regard to controlling the private hospitals was discussed in a meeting held in Chennai. Keeping the World Health Organisation norms, action like blacklisting or closing of the hospitals had also come up for discussion and Government is waiting to reach out consensus on the issues and a decision would then be taken. The Director promised to take strict measures to control the private hospitals soon after receipt of Government guidelines in this regard.

1.24 The Committee also pointed out that, due to lack of sanitation facilities, frequently, rural public are suffering from fevers like malaria, typhoid, viral, etc. and Government hospitals are not equipped with either diagnostic facilities or the medicines for such fevers.

1.25 The Committee also mentioned that with regard to sanitation, there is no difference between rural and urban. In Vijayawada, around 400 metric tonnes of waste is generated every day and that waste is being stacked on roads leading to spread of mosquitoes, causing fevers to public. Due to lack of facilities in Government hospitals, public are approaching private hospitals and the hospitals are thus making money. The Committee directed that Government should address this problem at once.

1.26 The Committee expressed serious concern of the fact that the situation in Tribal areas is very alarming and felt that Government should educate them about various seasonal deceases to eliminate fear psychosis in them. The Committee also desired that Government educate public with regard to Swine-flu also.

1.27 The Principal Secretary, Finance stated that, in medical terminology Swine-flu is called H1N1. Generally, when immunity comes down human body is attacked with fever. Now-a-days every fever is being called swine-flu. Four years back there was no swine-flu in our country and it had spread from other countries in the year 2009. Some pharmaceutical companies created fear psychosis in the public so as to market their medicines. Wide publicity should be given to create awareness in the public about these deceases.

The Committee expressed serious concern with regard to the manner in which the blood banks are functioning in the State and decided to make the **following recommendations:**

1.28 Government should initiate immediate steps for creating a centralised online database of the availability of various blood groups to facilitate efficient use of this scarce resource.

1.29 Government should ensure that all the blood banks in the State invariably capture vital details like name, blood group, age, weight, address, etc. of the donors to eliminate the risk of transfusion of wrong blood to the patients and avoid wastage.

1.30 Measures should be initiated to ensure that equipment used in collection, processing, testing, storage and distribution of blood is calibrated at regular intervals to ensure that the readings are accurate and reliable.

1.31 Government needs to address the problem of huge shortage of Drug Inspectors at the earliest to ensure effective monitoring of blood banks.

1.32 Government should ensure regular inspection of all the blood banks in the State. Remedial measures with regard to the quality standards should also be taken wherever necessary.

1.33 Government should take appropriate action to create awareness in public with regard to seasonal fevers viz., Dengue, Swine-flu and viral fevers.

1.34 Government should periodically review the functioning of corporate hospitals and stringent action should be taken against the hospitals that are collecting huge amounts from patients in violation of norms.

1.35 Based on the recommendations of Dr. Mashalkar committee, a public health policy should be formulated by Government.

2. Para 5.3 page 54 of the Audit Report

Functioning of Trauma Care Centres

Para 5.3.1 Introduction

2.1 The scheme involved provision of financial assistance for upgradation and strengthening of emergency facilities in State hospitals located on National Highways. The hospitals designated by the GoI envisaged (November State Government and approved by GoI, were to be upgraded to Levels I to IV within a period of twelve months from the date of sanction. 1999) a scheme for developing a network of Trauma Care Centres (TCCs) along the Golden Quadrilateral, to provide emergency treatment to accident victims. The grants covered various components like civil works, equipment, manpower, communication systems, training, legal

[8] Level-II: 2004-05: Government General Hospital, Kurnool; 2005-06: King George Hospital, Visakhapatnam; 2006-07: District Hospital, Srikakulam; 2007-08: District Hospital, Rajahmundry; Government General Hospital, Guntur; District Hospital, SPS Nellore; 2008-09: RIMS, Adilabad; District Hospital, Nizamabad; and Government General Hospital Anantapur
Level-III: 2006-07: District Hospital, Eluru; 2007-08: Area Hospital, Tuni; Area Hospital, Tekkali; District Hospital, Ongole; CHC, Nayudupeta; 2008-09: Area Hospital, Kamareddy; District Hospital, Mahboobnagar and CHC, Penukonda, Anantapur

[9] 9.65 crore each for nine Level-II TCCs and 4.80 crore each for eight Level-III TCCs

[10] construction activities: 12.04 crore; equipment: 31.55 crore; manpower: 4.98 crore; other minor items like training, legal assistance, etc.: 0.51 crore)

assistance, etc. depending on the level of up gradation of a particular hospital.

In Andhra Pradesh, 17 hospitals[8] (Level-II: 9; Level-III: 8) were selected (2004-09) for up gradation as TCCs at a cost of ₹ 125.25 crore[9]. As of August 2011, GoI released ₹ 49.08 crore [10] to these hospitals.

GoI sanction had stipulated specific time frame within which the released funds were to be utilised as follows:

- Tendering for equipments should be completed within a period of 10 days of receipt of sanction letter.
- Manpower required should be finalised within 30 days for each of the Trauma Care Centre (TCC), etc.
- The expenditure statement, utilisation certificate should be submitted to GoI within 12 months for considering further release of funds.

Audit scrutiny (April/May and October 2010) of the relevant records of the hospitals concerned revealed that none of the 17 TCCs were fully operational as of August 2011 due to non-completion of civil works or, where the civil works had been completed, equipment had not been procured or, required manpower had not been put in place.

Para 5.3.2 Execution of civil works

The scheme envisaged renovation of existing hospital buildings[11] for Trauma Care. In the hospitals which were to be upgraded to Level-II and Level-III, certain civil works for operationalisation of Trauma Care Centres were to be taken up and completed. As per the scheme guidelines, all the civil works were to be completed within a maximum period of 12 months of the sanction.

The hospitals placed the amounts intended for civil works with the Andhra Pradesh Health and Medical Housing and Infrastructure Development Corporation (APHMHIDC), the nodal agency created (May 1987) by the State Government for construction of buildings, procurement and supply of equipment for all the Medical institutions in the State. Hospital-wise details of the amounts released during January 2005 to April 2010 for civil works, amounts deposited with APHMHIDC, stage of completion, etc. are given in *Appendix-5.2.*

We observed that:

- Civil works were completed (August 2011) only in seven hospitals[12] (expenditure: ' 4.71 crore) and delays in completion of works ranged from three months to as high as three years;
- In seven out of 17 other hospitals[13], civil works had not been completed. In Government General Hospital, Anantapur, even the land required for construction had not been identified; and
- In three other hospitals, viz., Rajiv Institute of Medical Sciences (RIMS), Srikakulam; Government General Hospital, Guntur and RIMS, Adilabad, civil works of TCC building was clubbed with civil works being executed in other buildings of the same hospitals. Since these buildings were at various stages of execution, civil works of TCC buildings was also delayed.

Tardy progress in completion of the buildings to house TCCs resulted in release of further funds amounting to ₹ 76.17 crore by GoI, towards other components like equipment, etc. being put on hold, as discussed in the subsequent paragraphs.

In the Explanatory Notes, Government stated that a total of 17 Trauma Care Centres were sanctioned in the State. Of these 9 will have level II facilities and 8 level III facilities. It was also stated that out of 17 centres, 15 have been completed and 2 centres are in advanced stage of completion. Against the amount of Rs 11.84 crore released, an amount Rs 10.21 crore has been incurred so far towards Civil works (Rs 5.57 crore for level II facilities and balance of Rs 4.64 crore for level III facilities)

Eight centres have been equipped either fully/partly with necessary equipment valued Rs 17.85 crore (level II centres: Rs 16.43 crore and level III: Rs 1.42 crore) out of Rs 37.57 crore released. In respect of other cases, the process of procurement of needed equipment is on.

11 Projected Cost/Sanction accorded: Level II: 80 lakh; Level III: 63 lakh/65 lakh
12 King George Hospital, Visakhapatnam; District Hospital, Rajahmundry, East Godavari; Government General Hospital, Kurnool; District Hospital, Tekkali, Srikakulam; Area Hospital, Tuni, Easxt Godavari; District Hospital, Eluru, West Godavari and RIMS, Ongole, Prakasam
13 District Hospital, SPS Nellore, Government General Hospital, Anantapur, District Hospital, Nizamabad, Community Health Centre, Area Hospital, Kamareddy, Nizamabad, District Hospital, Mahboobnagar and Community Health Centre, Penukonda, Anantapur

Para 5.3.3 Procurement of equipment

GoI's sanction stipulated that tendering for equipments[14] should be completed within a period of 10 days of receipt of sanction. On finalisation of tenders and after receipt of these documents in the Ministry, the next instalment of 40 *per cent* would be considered for release. The remaining 10 *per cent* would be released after placement of supply order. Thus, there was an inherent need to complete the process of procurement of equipment at the earliest. As most of the basic and essential equipment was already available with the identified institutions, assistance for equipment was restricted (by GoI) to ₹ 5 crore in respect of Level II TCC and ₹ 2 crore in respect of Level III TCC. This would imply that the hospitals were to identify/select only such of the vital equipments which are very critical to trauma care centres. We observed that such an exercise was lacking in all the test checked hospitals.

As against the release of ₹ 31.55 crore[15] by GoI towards procurement of equipment to nine hospitals, the hospitals had placed ₹28.37 crore with APHMHIDC (details are given in *Appendix-5.3*) for supply of equipment. As of August 2011, APHMHIDC had supplied equipment worth only ₹ 13.20 crore leaving ₹ 15.17 crore unutilised with them. In response to an audit enquiry, APHMHIDC stated (September 2011) that tenders in respect of the equipment indented for TCCs were still under process. It was further observed that,

- Except Government General Hospital (GGH), Kurnool, none of the other eight hospitals could fully utilise the funds meant for procurement of equipment. While GGH, Kurnool, utilised the entire amount of ₹ 5.27 crore, five hospitals[16] had received only equipment valuing ₹ 7.93 crore as against ₹ 16.35 crore released for the purpose to APHMHIDC. Some of this equipment thus procured was not as prescribed by GoI for upgradation of TCCs.

14 Cost involved: 12.80 crore for Level II TCC; 2.53 crore for Level III TCC
15 King George Hospital, Visakhapatnam: 5.01 crore; RIMS, Srikakulam: 2.94 crore; District Hospital, Rajahmundry: 2.85 crore: Government General Hospital, Guntur: 5.00 crore; District Hospital, SPS Nellore: 4.95 crore; Government General Hospital, Kurnool: 5.02 crore; Area Hospital, Tuni, East Godavari: 2.17 crore; District Hospital, Eluru, West Godavari: 1.61 crore and RIMS, Ongole, Prakasam: 2.00 crore
16 King George Hospital, Visakhapatnam: 3.80 crore; RIMS, Srikakulam: 0.41 crore; District Hospital, Rajahmundry, East Godavari: 0.51 crore; District Hospital, SPS Nellore: 2.76 crore; District Hospital, Eluru, West Godavari: 0.45 crore

- Two hospitals viz., (a) Government General Hospital, Guntur and (b) District Hospital (RIMS) Ongole, were not supplied any equipment by APHMHIDC though necessary funds (₹ 7 crore) were placed at its disposal in December 2010/January 2011. Reasons for delay were not available with the hospitals.
- In Area Hospital, Tuni, ₹ 2.17 crore intended for purchase of equipment, were kept by the hospital in fixed bank deposits instead of transferring it to APHMHIDC. Specific reasons for non-utilisation of the amount were not furnished by the hospital authorities.
- In case of both Level-II and Level-III TCCs, the assistance in respect of General Surgical equipments was restricted to 2 sets (total cost limited to ₹ 4 lakh) only. We observed in King George Hospital, Visakhapatnam that, some of the important equipments such as Ultra Sound Scan, 500 MA X-Ray machine and CT Scan Multi-slice could not be procured by the hospital, where general surgical equipments had been purchased in excess. The Superintendent of the hospital contended (May 2010) that, as the hospital has the potential to emerge as Level-I centre (from existing Level-II), more number of sets of surgical equipment required for a full fledged Level-I centre were procured. The reply is not acceptable as procurement of more sets of general surgical equipment should not be at the cost of vital trauma care equipment viz., Ultra Sound Scan, 500MA X-ray machine and CT Scan Multi-slice required for effective functioning as a Level-II Trauma care centre.

Thus, while APHMHIDC was ineffective in speedy procurement and supply of equipment, the Superintendents of the hospitals also had failed to monitor this aspect vigorously resulting in non-receipt of the indented equipment even after the lapse of considerable time after placing the indents with APHMHIDC and funds remaining unused.

Para 5.3.4 Manpower

As per the Scheme guidelines, GoI would meet the expenditure on manpower necessary for the Trauma Care Centres during the first five years of their existence. GoI accordingly released (March 2008 – October 2010) ₹ 4.98 crore (for one year) to the State at the rate of ₹ 0.76 crore for six [17] Level-II hospitals and ₹ 0.42 crore to one [18] level-III hospital. Although the State Government was to finalise the required manpower for each TCC within the stipulated period of 30 days of receipt of sanction of the grant, it accorded sanction for recruitment of staff for the TCCs, that too only for 10 (out of 17) hospitals in March 2009.

We observed that,

- the staff sanctioned was not as per the approved norms applicable for Level-II and Level-III TCCs (as detailed in *Appendix 5.4*).
- Even in the hospitals where manpower was sanctioned, as against the prescribed norm of 84 for Level-II hospitals and 75 for Level-III hospitals, staff actually recruited was far lower and ranged between three to seventeen.
- Further, the hospital authorities recruited only Data Entry Operators and staff nurses, that too only partially, while other technical staff like General Surgeon, Orthopedic Surgeon, Anesthetist, Medical/Para Medical staff critical for TCCs were not recruited.
- In Government General Hospital, Kurnool where the upgradation of the hospital to TCC had been sanctioned way back in the year 2004 and where the required building had already come up and the required equipment had been procured, no staff had been sanctioned by the State Government as of August 2011, despite the lapse of over five years.

Thus, Government's failure in planning and managing the activity of recruitment and deployment of technical manpower to the hospitals resulted in non-execution of the project within the prescribed timelines.

The hospital authorities contended (June 2011) that, the TCCs were extending treatment to accident victims with the existing staff. The contention is not acceptable, because in the absence of specialised staff as envisaged in GoI's sanction the TCCs cannot be considered fully operational.

In the Explanatory Notes Government stated that, pending provision of full strength, these centres are functioning with the existing

[17] District Hospital, SPS Nellore, District Hospital, Rajahmundry; GGH, Guntur; GGH, Kurnool; KGH Visakhapatnam; and RIMS Srikakulam
[18] District Hospital (RIMS), Ongole

manpower. The recruitment process has suffered due to poor response from qualified and talented medical professionals.

Para 5.3.5 Utilisation Certificates

We analysed the reasons as to why the funds (₹ 125.25 crore) sanctioned were not released in full by GoI to the hospitals. While releasing funds, GoI stipulated that, Utilisation Certificates (UCs) along with the audited accounts of the funds sanctioned should be submitted to the Ministry within 12 months of release of funds to ensure further releases. We observed that, except King George Hospital, Visakhapatnam, none of the other 16 hospitals had utilised the funds as detailed above, nor furnished as of April 2011 UCs for the full amounts received. As against ₹ 49.08 crore released by GoI, UCs for ₹ 31.72 crore were yet to be furnished by the hospitals and non-compliance of this requirement resulted in further release of funds (₹ 76.17 crore) by GoI being withheld, as mentioned in para *supra*.

2.2 Initiating discussion on the audit paragraph, the Principal Secretary stated that overall 17 Trauma Care Centres (TCCs)were sanctioned. Of these, 9 were having level II facilities and 8 having level III. 15 TCCs have been completed and the remaining two are in advanced stage of completion. Procurement of equipment has been done in many of these cenres.

2.3 The Commissioner AP Vaidhya Vidhana Parishad stated that there are three types of centres. Level I is only one Centre in the State in NIMS. Level – II centres are in teaching Hospitals and Level-III are at the District and PHC level. Trauma Care Centres have been proposed in Nandigama, Suryapeta and Tandur and in the highway of Zaheerabad to Machilipatnam.

2.4 The Committee enquired about the details of funds received from GoI during the years 2011-12 to 2012-13 vis-à-vis expenditure incurred thereon.

The Commissioner, APVVP furnished the details of funds released by GoI during 2012-13 for Trauma Care Centres ***vis-à-vis*** the expenditure, as follows:

Name of the Centre	₹ (in crore)
King George Hospital, Visakhapatnam	5.60
District Hospital, Rajahmundry	2.97
Area Hospital, Tuni	2.65
District Hospital, Eluru	1.48
Area Hospital, Tekkali	2.65
Government General Hospital, Guntur	5.84
RIMS, Srikakulam	2.75
RIMS, Ongole	2.65
GGH, Kurnool	4.97
RIMS, Adilabad	3.30
GGH, Naidupeta	0.65
District Hospital, Nellore	2.11
District Hospital, Nizamabad	0.80
Area Hospital, Kamareddy	2.65
District Hospital, Mahbubnagar	0.65
GGH, Anantapur	0.65
CHC, Penugonda	0.65

2.5 The Committee noted as follows:

- For upgradation of the 17 centres, GoI had released only ₹ 49.08 crore as against the sanctioned amount of ₹ 125.25 crore.
- While releasing funds, GoI stipulated that, Utilisation Certificates (UCs) along with the audited accounts of the funds sanctioned should be submitted to the Ministry within 12 months of release of funds to

ensure further releases. Non-compliance of this requirement resulted in **withholding of further release of funds (₹ 76.17 crore) by GoI.**

- Except in King George Hospital, Visakhapatnam, none of the other 16 hospitals had utilised the funds, nor furnished UCs for the full amounts received.

- GoI had prescribed specific time schedule for three components viz., civil works, equipment and manpower. Tendering of equipment should be completed within a period of 10 days. The required manpower for each Trauma Care Centre was to be filled within 30 days of receipt of sanction of the grant. All the tendering process should be completed within 30 days.

2.6 The Committee asked whether all the funds sanctioned by GoI have been received and whether the amounts received have been utilised for the purpose.

2.7 Principal Secretary replied that there were three stages for release for funds in the programme. First stage is for construction, second stage is for equipment and the third stage is for manpower. He also stated that funds were released directly to Hospitals.

2.8 The Committee felt unhappy that, due to non-furnishing of UCs, State Government had not received funds in full from GoI and asked whether any efforts are being made by the Government for release of funds by GoI. If funds are not released it is huge loss to the State Government, as so many people are losing their lives in the accidents occurred on National Highways because of lack of treatment facilities in the hospitals.

2.9 Principal Secretary admitted the inordinate delay in implementation of the programme and explained the reasons. There were around 15,000 deaths per annum on the road accidents and it was highest in India. Keeping in view this alarming situation, Ministry of Transport had formulated the programme in consultation with Health, Police and Transport Departments. The implementation was brought under the control of Health Department, as it requires hospital facilities. Funds are being released by GoI directly to the Superintendents of the Level II and Level III hospitals. He also stated that the Doctors have no knowledge about the accountancy and thereby there was a delay in furnishing the details for preparation of UCs. Equipments are lying idle where civil constructions lagged behind. There shall be synchronization between civil construction and the arrival of

equipment. The Department is not also equipped with necessary skills for college management issues.

2.10 The Committee enquired about the preparation of the project and asked the reasons for non-completion of the construction of two centres. The Committee asked as to how the 15 centres could be completed, incurring only Rs 49.08 crore (as initially released by GoI) without the release of remaining funds by GoI.

2.11 Principal Secretary replied that in the areas where civil constructions were completed, Government is unable to recruit the specialist doctors. Regular doctors are to be posted. The main reason for non-completion of the project is non-availability of human resource viz., Neurosurgeon, Pediatrician, Gynecologist, Anesthesian, etc and functioning of a Trauma Care Centre is very difficult without an Anesthesian.

Principal Secretary also stated that the funds are not lapsable. It is unfortunate that the works were delayed very badly due to lack of coordination and absence of fixing responsibility. GoI promised to release the balance funds based on the implementation of the project. Besides this, GoI sought proposals for establishing more centres.

2.12 The Committee felt that immediate response is required when a person meets with an accident. If such response /dedicated doctors are not available it cannot be construed that the centres are completed.

2.13 Principal Secretary admitted that there is no dedicated staff for these centres. He also stated that it is major concern that the State has not derived better results of this programme. Principal Secretary also stated that no doctor is coming forward to work for ₹ 30,000 fixed by Government. GoI had fixed ₹ 20,000 per orthopedic surgeon. When interviews were conducted for the posts of orthopedic surgeon, no candidate had turned up. In this scenario, GoI had been requested to increase the pay scales for the doctors and this has been accepted.

2.14 The Committee expressed doubts over the completion (and functioning of) of 15 centres with the meagre initial release of ₹ 49 crore as against the sanction of ₹ 125.25 crore (for civil works, equipment and man power) by GoI. The Committee also expressed doubts with regard to obtaining of the remaining funds of ₹ 76 crore from GoI since the State has badly delayed the initial process of construction, procurement of

equipment, etc. The Committee therefore directed the Principal Secretary to furnish year-wise details of amounts received from GoI for the programme and item-wise expenditure incurred by the State Government.

2.15 In the meeting held on 23 April 2013, the Principal Secretary has furnished the following details.

(a) Year-wise amounts received and utilized:

(Rupees in crore)

Year	Released	Utilised
2005-06	4.50	4.50
2006-07	4.14	4.14
2007-08	3.40	3.40
2008-09	19.65	13.29
2009-10	7.00	4.84
2010-11	8.22	5.13
2011-12	8.59	3.47
Total:	**55.50**	**38.77**

An amount of ₹ 69.75 crore is yet to be received from GoI.

(b) The status of civil works, equipment and HR are as follows:

Civil works: While works have been completed in respect of 13 centres, work is nearing completion in respect of 4 centres and so far ₹ 10.08 crore has been spent.

Equipment: The Grant in aid received in respect of 8 centres has been fully utilized, while in respect of 4 centres procurement is in process. In respect of 5 centres grant is awaited. The total expenditure incurred was ₹ 27.54 crore.

HR: In respect of 7 centres the grant received has been utilised, while in respect of 2 centres action to fill up the posts is on. Grant in respect of 8 centres is awaited. So far, an amount of Rs 1.15 crore has been spent.

(c) Of the 17 centres, 7 are fully functional (Level II: 5; Level III: 2) and 10 are partially functional (Level II: 4; Level III: 6)

(d) In 2006, proposals were also submitted to GoI for sanction of establishment of 27 centres at selected places in different districts in the State. This was followed up by another proposal submitted in 2012 for 10 more centres. Besides, two more centres (one at Tandoor and the other at Rajampet) are proposed at State level. The sanction of GoI for these 37 centres is still awaited which is being pursued for expediting the approval.

2.16 Principal Secretary also stated that hospitals should maintain trauma care emergency medicine and the hospitals cannot deny treatment for accident cases brought to them, by taking shelter on the ground of non-availability of trauma care. Each area hospital must have an orthopedician, anesthetist and physician, and they must attend trauma care and poly trauma care cases. It is very difficult to find out a neurosurgeon and we must improve the situation to establish neurosurgery units. It is very unfortunate that neurosurgeons are not available in the medical colleges where trauma care centres were established. He also stated that, with a view to providing emergency medical services without depending on GoI, upgradation has been proposed in three departments viz., Emergency Medicine, Transfusion medicine and Hospital administration in KGH / Visakhapatnam, Vijayawada, Guntur, Hyderabad and Warangal. This upgradation consists of 20 critical care units for respiratory intensive care, 10 neurosurgery units for neuro intensive care, 100 intensive critical care units in every teaching hospital and to provide nurses in the ratio of 1:1 for each bed.

2.17 The Committee felt that trauma care is emergency service and the programme should have been implemented on war footing basis. The Committee while expressing displeasure over non-functioning of all the trauma care centres even after 4 years of sanction (2008), felt that, besides

proposing new centres, action should be taken immediately for functioning of all the trauma care centres already sanctioned.

2.18 The Committee also felt that the proposals already sent for establishing TCCs were not based on a scientific approach and directed that centres should be allocated across the State in a scientific manner duly considering the data with regard to occurrence of accidents, casualties and the survivals in various places of the State.

2.19 The Committee also discussed about various accident cases and deaths occurred in the recent past, and the experiences faced by the Hon'ble Members due to non-responsiveness of the doctors in the hospitals concerned even for admitting the patients. The Committee also pointed out non-availability of gas, oxygen, medical kits and necessary medical equipment in the hospitals. The Committee quoted some instances where the duty doctors were not responding when the accident cases are taken to the nearest hospitals particularly in the night times. Most of the Members felt unhappy that the doctors concerned are not responding even on humanitarian grounds.

Principal Secretary replied that, training in neurosurgery is being imparted for some of the MBBS doctors. After training they are posted to trauma care centres. After becoming general surgeon they would be elevated as neurosurgeon and after becoming neurosurgeon, generally they are not showing interest to work at any places except Hyderabad.

2.20 The Committee asked about the survival rate of cases admitted in the trauma care centres.

2.21 Principal Secretary replied that medical care and surgery should be done immediately to the persons who met with accidents. For better transportation of these persons "108 ambulance scheme" had been introduced by the Government in 2007-08. About 815 ambulances are available in the State. Data analysis of the cases shows that the survival rate is about 25 per cent. The maximum survival cases relate to Poly trauma and orthopedic surgeries. The survival rate is very less in cases of neurosurgery. In head injury cases, the survival rate is very less. In this

context, the issue regarding collusion of '108 Ambulance services' staff with corporate hospitals has come up for discussion.

2.22 The Committee pointed out that persons who met with accidents are being transported to corporate hospitals by 108 service staff for making money in collusion with the corporate hospitals stating that the required facilities are not available in the Government hospital and that it would be dangerous to the patient if the patient is not taken to corporate hospital.

2.23 The Commissioner, H&FW stated that these incidents are galore in Krishna district and there were complaints from different quarters in this regard and in some cases, the staff working on the "108 services" had been removed. Similar cases were there in West Godavari, Parkasam and Nellore districts. The Commissioner however, stated that they cannot direct the ambulance staff not to take injured persons to corporate hospitals as it is a very sensitive, delicate and emotional issue. Any unethical practices being adopted by the staff working either on 108 or on 104 services should be nipped in the bud itself. For this purpose, the district administration in tandem with the District Medical and Health Officer should institute remedial measures for creation of awareness and enlightenment in the general public at large.

2.24 The Commissioner promised the Committee that appropriate steps would be taken in the right direction to create necessary awareness in public with regard to referring of accidental cases to Government Area Hospital/ District Primary Health Centres in the State for timely and first aid medical treatment.

2.25 Principal Secretary stated that instructions were given to the 108 services staff to take the patients first to the nearest Government hospitals and if the Government hospital concerned expressed its inability to take care of the patient due to non-availability of the required facilities then only the patient is to be taken to corporate hospital. The Principal Secretary also stated that poor people are getting treatment in corporate/ private hospitals by borrowing amounts from private parties.

2.26 The Committee felt that a facility for reimbursement of expenditure incurred by the patient should be given in respect of cases admitted in trauma care centres. Care should be taken to ensure that public perception

about trauma care centres is good unlike their poor perception about Government hospitals. The Committee also felt that the trauma care centres where more cases are registered should be strengthened by providing sufficient staff and equipment.

2.27 The Committee expressed anguish at the department's failure to implement the programme of Trauma Care Centres despite availability of central assistance, especially with regard to non-providing of required equipment and staff in Government hospitals.

2.28 The Committee felt unhappy to note that due to non-utilisation of the amount initially released, the State is also losing further assistance due from GOI. Therefore, the Committee decided to make the **following recommendations.**

2.29 ***The Committee noted that construction of trauma care centres was not synchronised with the purchase of equipment and recruitment of the required staff which have led to non-achievement of the objective of providing emergency care to accident victims. The Committee recommended that expeditious steps should be taken by the Department to complete the work relating to all the trauma care centres and operationalise them quickly by pursuing with the GoI to obtain the sanctioned grants.***

2.30 ***The Committee felt that the proposals sent by Government for sanction of new trauma care centres appear to have been based on the specific requests / pressures from such areas, without any rationale. The Committee therefore recommended that the proposals should be revised on a scientific basis by taking the required inputs from the departments concerned so that the centres are established in all the districts and locations along the National Highways across the State.***

2.31 ***The Committee recognized the problem with regard to recruitment of specialist doctors due to insufficient salaries offered by the Government. The Committee recommended that immediate steps should be taken to recruit the required specialist doctors by incentivising***

them and by offering, among others, increased salary packages to encourage them to work in Government sector.

2.32 ***The Committee, while observing that the required equipment for providing emergency services is not available in a majority of the Government hospitals in the State, particularly in the hospitals that are functioning nearer or adjacent to the Highway, recommended that immediate steps should be taken to provide sufficient equipment to provide emergency medical care in all such hospitals. Preference should be given to the Area hospitals / community hospitals /trauma care centres adjacent to National Highways.***

2.33 ***The Committee observed that many cases are being referred to NIMS, Hyderabad, due to lack of facilities in the other cities of the State and therefore recommended that necessary steps should be taken to upgrade the Government Hospitals in all cities of the State as Super Speciality Hospitals.***

2.34 ***The Committee found that, in many of the accident cases that were taken to the nearest hospitals, particularly at night times, the duty doctors are not responding and the patients are not being admitted even on humanitarian grounds. The Committee therefore recommended that Government should issue necessary instructions to all the hospitals in the State with regard to immediate response and extending necessary medical care.***

2.35 A toll free number should be provided and displayed in all the hospitals for making complaints against the staff who are non-responsive or misbehaved with the patients or their attendants.

3 Para 5.4 page 58 of the Report

Functioning of equipment in Medical colleges

3.1 Scrutiny of the records relating to utilisation of equipment in Government Medical College, Anantapur (November 2010) and Siddhartha Medical College, Vijayawada (June 2010) and the relevant records in the Office of the Director of Medical Education (DME) revealed the following.

Para 5.4.2 Government Medical College, Anantapur

Government Medical College, Anantapur, receives at least 50 cancer patients every month. GoI released (December 2005) ₹ 2 crore as one time grant to the college under National Cancer Control Programme (NCCP) for development of Oncology wing based on the proposals submitted (January 2004) by the College through the State Government.

For commissioning of Oncology wing, the following steps were to be taken:

- Purchase of necessary equipment
- Construction of bunker as per the norms prescribed by BARC[1] for installation of the equipment
- Deployment of technically qualified staff for manning the Oncology wing

Equipment consisting of treatment planning system, Cobalt Unit "60" tele-therapy system and source costing ₹ 2.12 crore[2] was received during July 2006 - December 2007. In order to put the equipment to use and commission the Oncology wing, simultaneous action was to be taken to ensure synchronization of all the above three activities. We however, found that such an exercise was not undertaken by the Medical College. Though requisite funds (₹ 41 lakh) for construction of bunker were placed at the disposal of APHMHIDC[3] in March 2006 itself, the site was handed over to the contractor belatedly in August 2007. As a result, bunker could be completed and the equipment was installed only by April 2008. Even after installation, calibration of the equipment, which is a pre-requisite for starting the treatment, was done only after a gap of one year i.e., in April 2009 owing to non-availability of technical staff[4]. Further, due to non-availability of technical staff, generation of field radiation survey reports was delayed which ultimately caused delay in obtaining necessary permission from BARC for commissioning the treatment. Further, even after receipt of BARC permission in September 2009 to commence treatment, the DME failed to deploy Oncologist to man the equipment. In the meantime, the warranty period of the equipment[5] and the two year period

19 Bhabha Atomic Research Centre
20 Treatment planning system (0.31 crore); Cobalt unit "60" tele-therapy system ('1.24 crore) and Source ('0.42) crore); Custom charges on the above equipemtn ('0.15) crore) funds over and above '2 crore met ffrom Hospital Development Society funds
21 AP Health and Medical Housing and Infrastructure Development Corporation Limited
22 Professor: 1; Assistant Professor: 2; and Tutor: 1 in the Department of Radio-Therapy
23 which was 15 months from the date of shipment or one year from the date of installlation whichever is earlier had expired

(after expiry of warranty) of free maintenance service, to be provided by the company, had expired. That apart, the hospital could not confirm the prospect of radio active cobalt unit serving its full life. As of August 2011, in the absence of an oncologist the equipment had not been put to use and no patients were being treated.

Thus, due to lack of synchronization of all the three activities of construction of bunker, installation of the equipment and deployment of technical staff, coupled with failure of the DME to deploy Oncologist to man the equipment, the equipment procured way back in 2006 remained idle even after the lapse of five years. This deprived the cancer patients of Anantapur and neighbouring districts of the benefit of advanced cancer treatmment.

In the Explanatory Notes, Government stated that Radiation Oncologist and Radio Physicist have since been positioned at Government Medical College, Anantapur and the equipment is put to use for the intended purpose for the benefit of the patients.

Para 5.4.2 ***Siddhartha Medical College, Vijayawada***

The YVC Oncology Wing and Research Centre, Chinakakani (Hospital), attached to Siddhartha Medical College, Vijayawada was provided (October 1998) with Theratron Phoenix Cobalt Unit (Unit) worth ₹ 1 crore for treating cancer patients[6]. As of February 2009, the tele-cobalt source had completed two half lives and the output level neared minimum level[7] beyond which the Unit would not be permitted for usage until the new source is installed. The Unit was closed in October 2009 and no inpatients were admitted thereafter.

Audit scrutiny revealed the following.

For ensuring continued service by the unit for treatment of cancer patients, two activities were to be properly synchronized:

⇒ Periodical review of the availability of source so as to initiate action to seek funds in advance from Government for replacement of source, especially in the context that the GoI supplier firm (BRIT) takes about six months for supplying the source material, after full payment of the cost in advance.

24 235 cancer patients in the year 2008 and 127 cancer patients in the year 2009 were treated
25 Minimum level: 50 RMM; output level as of March 2011:53 RMM

⇒ Ensuring the availability of Medical Physicist and Radiological Safety Officer throughout for operating the Unit.

It was observed that such an exercise was lacking. Though the Principal of the Medical College took up the matter with the Director of Medical Education (DME) in February 2009 itself and followed it up regularly for replacement of tele-cobalt source with 200 RMM output, DME forwarded the proposals to Government seeking funds only in March 2011, i.e., after the lapse of more than two years. In the meantime, the cost of replacement of the source had escalated (September 2010) to ₹ 1.12 crore. State Government was yet to provide the estimated funds (August 2011) for the purchase of the source material.

Further, the posts of Medical Physicist and Radiological Safety Officer remained vacant since August 2009. Consequently, the Radio Therapy Unit had to be closed in October 2009 as directed by Atomic Energy Regulatory Board. The DME confirmed the audit observation.

Thus, failure of DME in not taking up the matter with the Government immediately after reporting by the Medical college for provision of funds, coupled with non-filling up of the vacancy of Medical Physicist resulted in the Radio Therapy Unit not functioning and lying idle for over one and half years depriving the cancer patients of the benefit of treatment.

In the Explanatory Notes Government stated that the 'Radiation source' got exhausted in the existing Cobalt equipment that outlived its life. Further, the technology also became outdated. In view of this, the Superintendent, Government General Hospital, Vijayawada has submitted (September 2011) fresh proposals for procurement of certain equipment valued Rs 15.55 crore that included one 'Duel Energy Linear Accelerator with MLC – (₹ 10.00 crore)' to replace the outdated Cobalt equipment. These proposals are under consideration of the Government and expeditious action will be taken for obtaining administrative approval duly following the prescribed procedure for procurement of the equipment either from the State budget or through the assistance from GoI.

3.2 Initiating discussion on the audit paragraphs, the Committee noted that Government had taken action with regard to the audit observation against Government Medical College, Anantapur. The Committee however, felt unhappy over the inaction for over 4 years on the part of the Director of Medical Education and the Government which resulted in the abnormal delay in supply of equipment and positioning the required manpower to man the Cobalt unit thereby depriving the treatment to cancer patients in both the Medical Colleges. Further, with regard to Siddhartha Medical College, Vijayawada, the Committee also sought explanation for the delay in taking action.

3.3 Principal Secretary admitted that, due to the delay in making the facility available, people were denied those services and the services were to be provided on urgent basis. As the existing equipment had outlived, the Government would go for modern equipment (Duel Energy Linear Accelerator) rather than old one.

3.4 The Committee while expressing displeasure over the delay in procurement of the required equipment to make the Cobalt unit functional in Siddhartha Medical College, Vijayawada, recommended that Government should take immediate steps to procure the modern equipment, as proposed by the Principal Secretary. The Committee also recommended that simultaneous action should be taken to position the required manpower by the time the equipment is installed to ensure restoring the improved medical services for the benefit of cancer patients.

3.5 The Committee also recommended that a report regarding the installation of the modern equipment and its functioning should be submitted to it within six months.

SUMMARY OF RECOMMENDATIONS

1. Government should initiate immediate steps for creating a centralised online database of the availability of various blood groups to facilitate efficient use of this scarce resource.

(Para No.1.28)

2. Government should ensure that all the blood banks in the State invariably capture vital details like name, blood group, age, weight, address, etc. of the donors to eliminate the risk of transfusion of wrong blood to the patients and avoid wastage.

(Para No.1.29)

3. Measures should be initiated to ensure that equipment used in collection, processing, testing, storage and distribution of blood is calibrated at regular intervals to ensure that the readings are accurate and reliable.

(Para No.1.30)

4. Government needs to address the problem of huge shortage of Drug Inspectors at the earliest to ensure effective monitoring of blood banks.

(Para No.1.31)

5. Government should ensure regular inspection of all the blood banks in the State. Remedial measures with regard to the quality standards should also be taken wherever necessary.

(Para No.1.32)

6. Government should take appropriate action to create awareness in public with regard to seasonal fevers viz., Dengue, Swine-flu and viral fevers.

(Para No.1.33)

7. Government should periodically review the functioning of corporate hospitals and stringent action should be taken against the hospitals that are collecting huge amounts from patients in violation of norms.

(Para No.1.34)

8. Based on the recommendations of Dr. Mashalkar committee, a public health policy should be formulated by Government.

(Para No.1.35)

9. The Committee noted that construction of trauma care centres was not synchronized with the purchase of equipment and recruitment of the required staff which have led to non-achievement of the objective of providing emergency care to accident victims. The Committee recommended that expeditious steps should be taken by the Department to complete the work relating to all the trauma care centres and operationalise them quickly by pursuing with the GoI to obtain the sanctioned grants.

(Para No.2.29)

10. The Committee felt that the proposals sent by Government for sanction of new trauma care centres appear to have been based on the specific requests / pressures from such areas, without any rationale. The Committee therefore recommended that the proposals should be revised on a scientific basis by taking the required inputs from the departments concerned so that the centres are established in all the districts and locations along the National Highways across the State.

(Para No.2.30)

11. The Committee recognized the problem with regard to recruitment of specialist doctors due to insufficient salaries offered by the Government. The Committee recommended that immediate steps should be taken to recruit the required specialist doctors by incentivising them and by offering, among others, increased salary packages to encourage them to work in Government sector.

(Para No.2.31)

12. The Committee, while observing that the required equipment for providing emergency services is not available in a majority of the Government hospitals in the State, particularly in the hospitals that are functioning nearer or adjacent to the Highway, recommended that immediate steps should be taken to provide sufficient equipment to provide emergency medical care in all such hospitals. Preference should be given to the Area hospitals / community hospitals /trauma care centres adjacent to National Highways.

(Para No.2.32)

13. The Committee observed that many cases are being referred to NIMS, Hyderabad, due to lack of facilities in the other cities of the State and therefore recommended that necessary steps should be taken to upgrade the Hospitals in all cities of the State to the level of NIMS.

(Para No.2.33)

14. The Committee found that, in many of the accident cases that were taken to the nearest hospitals, particularly at night times, the duty doctors are not responding and the patients are not being admitted even on humanitarian grounds. The Committee therefore recommended that Government should issue necessary instructions to all the hospitals in the State with regard to immediate response and extending necessary medical care. A toll free number should be provided and displayed in all the hospitals for making complaints against the staff who are non-responsive or misbehaved with the patients or their attendants.

(Para No.2.34)

15. The Committee while expressing displeasure over the delay in procurement of the required equipment to make the Cobalt unit functional in Siddhartha Medical College, Vijayawada, recommended that Government should take immediate steps to procure the modern equipment, as proposed by the Principal Secretary. The Committee also recommended that simultaneous action should be taken to position the required manpower by the time the equipment is installed to ensure restoring the improved medical services for the benefit of cancer patients.

(Para No.3.4)

16. The Committee also recommended that a report regarding the installation of the modern equipment and its functioning should be submitted to it within six months.

(Para No.3.5)

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