CHAPTER XI : MINISTRY OF HEALTH AND FAMILY WELFARE

Family Welfare Training & Research Centre, Mumbai

11.1 Avoidable time and cost over run due to poor fund management

Failure of Ministry to release funds in timely manner for the construction of Family Welfare Training and Research Centre, Mumbai, contributed to avoidable cost escalation of ₹ 12.44 crore, non-completion of works even after eleven years and avoidable additional payments of ₹ 30.91 lakh and increase in lease premium.

The Family Welfare Training and Research Centre, (FWTRC) Mumbai, a premier Central Training Institute under the Ministry of Health and Family Welfare (Ministry), purchased on lease from CIDCO[1], in January and December 2005, three plots of land together measuring 6749.80 sq. m., for ₹ 1.04 crore for construction of institutional complex (office and hostel) and residential quarters.

Ministry issued administrative approval of ₹ 9.69 crore for the institutional complex only in February 2007 (more than one year after purchase of land), but did not release any funds. The project was scheduled to be completed by March 2009. Though the Central Public Works Department (CPWD), which was the implementing agency, raised demand for funds in April 2007, Ministry released ₹ One crore only one year later, on 25 March 2008, which lapsed as it was received at the fag end of the financial year. Again, after one more year, the Ministry released ₹ 2.50 crore on 25 March 2009, which also lapsed. Thereafter, the Ministry released ₹ 3.00 crore in July 2009. By this time, the validity of the tenders raised by CPWD in July 2007 (in anticipation of release of funds by Ministry) for an estimated cost of ₹ 3.39 crore also lapsed, and CPWD called for fresh tenders, which were awarded in August 2009 for ₹ 7.39 crore (an increased cost of ₹ 4.00 crore arising on account of Ministry's delay of more than three years in releasing funds).

Since the Ministry had released funds by the second quarter of the financial year (July 2009), the contractor finished work amounting to ₹ 1.59 crore between August 2009 and March 2010, and the balance of ₹ 1.41 crore was surrendered at the end of the financial year. Thereafter, Ministry failed to release funds during the entire financial year 2010-11, and released ₹ 1.1 crore

[1] The City and Industrial Development Corporation of Maharashtra is a city planning organization created by the Government of Maharashtra.

only in August 2011, followed by a further release of ₹ One crore on 31 March 2012 (i.e., on the last day of the financial year), of which, ₹ 0.91 crore was immediately surrendered after payment of pending bills. By the time the Ministry again released ₹ 0.91 crore in September 2012, the contractor, who had begun slowing down work since May 2011 due to continued delayed release of funds, requested the contract be foreclosed. The contract was foreclosed (30 November 2012) and ₹ 0.79 crore was surrendered after paying pending bills.

Though the foreclosure of the contract necessitated immediate submission of fresh estimates, the CPWD took more than one year to furnish (November 2013), fresh estimates for ₹ 13.72 crore in terms of DPAR[2] 2012 submitted to Ministry. During the process of examination in the Ministry, the Planning Commission and the Department of Expenditure, it was observed (May 2014) that the estimates needed to be updated in light of DPAR 2014, since notified. CPWD sent the revised estimates in January 2015. The Ministry finally sanctioned the revised estimates of ₹ 22.13 crore in February 2016, and released ₹ 0.99 crore on 28 March 2016, which also lapsed with the closing of the financial year.

Thus, persistent inaction of the Ministry in releasing funds has delayed and rendered incomplete a project scheduled to be completed in March 2009, and resulted in escalation of estimated costs for the institutional complex from ₹ 9.69 crore to ₹ 22.13 crore. The work on construction of residential quarters has not yet been conceived, and the land acquired for this purpose remains unutilised. Apart from this, CIDCO has been paid additional lease premium of ₹ 30.91 lakh (₹ 22.51 lakh for institutional complex + ₹ 8.40 lakh) for extension of construction period up to January 2018. Such additional lease premiums are likely to be paid in future also, in view of non-completion of construction.

Audit noted that though the Integrated Finance Division (IFD) had observed (December 2012) that despite orders to ensure signing of MoU/agreement with CPWD prior to release of funds by the Training Division which was to be done timely, these orders were not followed, for which responsibility was to be fixed. In their response, Training Division absolved themselves of all responsibility, and instead blamed CPWD for not signing the MOU, IFD for not concurring with release of funds for want of clarifications, and FWTRC for not submitting audited UCs and for weak monitoring. Against this background, no action was taken to fix responsibility. Audit is of the view that non-signing of MOU may not be a primary contributor for delay, since even in

[2] Department Plinth Area Rates

the absence of MOU funds continued to be released and work continued (although sporadically) and DPAR 2014 was approved. It is the responsibility of the Training Division to offer clarifications to IFD as warranted and to pursue non submission of audited UCs and ensure effective monitoring. It would further appear that the Ministry failed to learn any lessons from this futile exercise to fix responsibility, since even consequent to its approval based on revised DPAR 2016, an amount of ₹ 0.99 crore was released on 28 March 2016 when there was no possibility of its being utilised before the end of the financial year, and no further releases have been made till date (November 2016).

The draft paragraph was issued to the Ministry in October 2015 and September 2016. In their reply (February 2016), the Ministry continued to blame the CPWD and assumed no responsibility themselves. The Ministry further stated (October 2016) that the payment of additional lease premium of ₹ 22.51 lakh for extension of construction period up to January 2018 have been paid in September 2016. The reply is not acceptable since Training Division had not conducted the exercise of signing MoU with CPWD and fixing responsibility for delays, despite orders of IFD.

Thus, failure of Ministry in ensuring timely release of funds and non-fixing of responsibility has delayed the project by more than eleven years, resulted in escalation of estimated costs for the institutional complex from ₹ 9.69 crore to ₹ 22.13 crore, apart from unnecessary payment of lease premium totalling to Rs. 30.91 lakh (₹. 8.40 lakh + ₹ 22.51 lakh) which is likely to further increase. In addition, the work on construction of residential quarters has not even reached the design stage.

National AIDS Control Organisation (NACO)

11.2 Extra expenditure on purchase of ZLN tablets

Failure of National AIDS Control Organisation (NACO) to follow the financial rules in the procurement of ZLN tablets led to extra expenditure of ₹ 2.06 crore.

Rules[3] stipulate that all government purchases should be made in a transparent, competitive and fair manner so as to secure best value for money. Further, each schedule of requirement incorporated in the tender enquiry document is to be covered on the lowest responsive tenderer for that schedule without dividing the same. However, there may be special occasions of

[3] Rule 160 of GFR 2005 and Para 11.7.5 of Manual of Policies and Procedures for purchase of goods (issued by Ministry of Finance in 2006)

purchase of very large quantities of goods which are beyond the capacity of a single tenderer and the lowest responsive tenderer is unable to undertake the supply of the entire tendered quantity. In such cases, the remaining quantity may be ordered on the second lowest responsive tenderer (L2) at the rates offered by the lowest responsive tenders (L1), as far as feasible and for this purpose negotiation may be held with the above tenderer (*viz*., L2). In such cases, it may also become necessary to divide the requirement under a schedule by placing multiple contracts for part quantities on more than two responsive tenderers. Such eventuality should normally be foreseen and provided for in the notice inviting tenders.

The National AIDS Control Organisation (NACO) invited tenders (June 2013)[4] for procurement of ZLN tablets[5] in two equal schedules (i.e., Schedule-I and Schedule-II) of 16,84,80,900 tablets each. After evaluation of tender, supply orders of ZLN tablets for both schedules were issued (September 2013) to respective L1s as per details below:

Schedule	Agency declared L1	Quantity	Unit Price[6] (₹)	Total value (₹ in crore)
Schedule-I	M/s Mylan Labs Ltd.	16,84,80,900	7.90	133.10
Schedule-II	M/s Hetero Labs Ltd	16,84,80,900	8.01	134.95

Audit observed that since all the processes for both the procurement orders, including floating of bid, recommendation of the Bid Evaluation Committee (BEC) and award of the contract occurred in the same time frame, there was no requirement to split the order into two schedules. By doing so, and by not negotiating with M/s Hetero Labs to bring their prices down in tune with the prices of M/s Mylan Labs, NACO unnecessarily incurred extra expenditure of ₹ 1.86 crore.

On the other hand, on a subsequent occasion in 2014-15, even while NACO continued to split the required quantity of the same drug (ZLN tablets) into two schedules, they negotiated with L1 under the second schedule to reduce the prices. NACO however, thereafter failed to negotiate with L1 under the first schedule to reduce their prices to match the new price quoted by L1 under the second schedule. Consequently, NACO incurred extra expenditure of ₹ 20.38 lakh on the procurement under Schedule I, as per details below:

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4 Through RITES, a Public Sector Undertaking under the Ministry of Railways, primarily engaged in consultancy in the fields of transport, infrastructure and related technologies

5 Zidovudine +Lamivudine +Nevirapine (300+150+200) mg

6 All prices are exclusive of Central Sales Tax

Schedule	Agency declared L1	Quantity	Unit price quoted (₹)	Unit price after negotiation (₹)
Schedule-I	M/s Mylan Labs Ltd.	20,37,91,860	8.25	8.25
Schedule-II	M/s Hetero Labs Ltd	20,37,91,860	8.42	8.24

Ministry replied (November 2016) to Audit as under:

a. The procurements were governed by the World Bank guidelines;

b. Expenditure was not met from domestic funds;

c. The World Bank had informed in 2010 that negotiations can be allowed only if the conditions in the guidelines are met (*sic*, should be not met), *viz*., either the scope is reduced or risk and responsibility reallocated;

d. CVC had confirmed that their guidelines would not be applicable in projects funded by international agencies, if found in conflict with the applicable procurement rules of the funding agencies;

e. The World Bank guidelines on rejection of all bids are applicable only in certain situations that are not applicable here;

f. The checklist comparing national competitive bidding procedure and World Bank Policy forbid price negotiations except in certain situations that are not applicable here.

Ministry's replies are misleading and/or irrelevant for the following reasons:

a. World Bank guidelines do not contradict the GFR ; consequently, the CVC guidelines are also not in conflict;

b. Clause 1.2 of the World Bank guidelines stipulate the responsibility for the implementation of the project, and therefore the award and administration of contracts under the project, rests with the Borrower. One of the considerations guiding the World Bank's requirements is the need for economy and efficiency in the implementation of the project, including the procurement of the goods;

c. It is immaterial whether the expenditure is met out of World Bank funds/borrowings or from the Consolidated Fund of India. The Ministry has a fiduciary duty to ensure that funds entrusted to it are not wasted or misspent;

d. The World Bank clarification of 2010 was with reference to a specific situation arising at that time out of procurement relating to ELISA kits and does not apply in this case;

e. Similarly, Ministry's reference to the guidelines relating to the rejection of bids are not relevant to the present case which refers not to rejection of bids, but to negotiation with the lowest bidder;

f. The checklist cited by the Ministry relates to the banning of post tender negotiations with L1, who by definition is the lowest responsive tenderer to a bid offer. This ban is in tune with the CVC guidelines of March 2007. It is Audit's contention that Ministry should not have split the requirement of the same drug into separate schedules within the same bid, as a result of which, the determination of L1 itself becomes questionable.

g. The separate schedules splitting the total quantity are contrary to the spirit of World Bank guidelines and checklist, which *inter alia*, refer to attracting the interest of both small firms and encouraging competition. Considering the large size of the requirement (33.70 crore ZLN tablets), had Ministry invited eligible manufacturers to bid as per their individual capacity within the total quantity, both smaller and larger firms would have submitted bid, resulting in better prices.

h. As mentioned in the second case referred above, NACO had negotiated with the L1 under the second schedule. Hence the argument that negotiation is not permissible, it not valid.

Thus, by failing to negotiate with L1 (in respect of Schedule-II in the first case and in respect of Schedule-I in the second case), NACO incurred extra expenditure amounting to ₹ 2.06 crore.

Central Government Health Scheme (HQ)

11.3 Rent free accommodation to a commercial undertaking in violation of rules

Hindustan Latex Limited (HLL) provides diagnostic services to government and private patients in a building owned by the Central Government Health Scheme (CGHS) in RK Puram New Delhi. Apart from an inadequate discount of 10 *per cent* to CGHS beneficiaries, HLL does not pay rent in terms of extant orders resulting in loss of ₹ 1.72 crore during 2008-09 to December 2016.

Central Government Health Scheme (CGHS) executed (December 2007) a Memorandum of Understanding (MoU) with Hindustan Latex Limited (HLL) to set up a modern diagnostic centre (carpet area: 280.81 square metres) at CGHS Dispensary, RK Puram, New Delhi. In terms of the MoU, HLL provided diagnostic services to CGHS beneficiaries at CGHS rates (with a 10

per cent discount from April 2012), and was at liberty to serve private patients (non CGHS beneficiaries) at charges fixed by HLL.

Director of Estates under the Ministry of Urban Development (MoUD) is responsible for the administration and management of office buildings for various organisations of the Government of India. Directorate of Estates had fixed[7] the market rate of licence fee for allotting general pool office accommodation in Delhi to various non-entitled bodies (including non-eligible commercial organisations) at ₹ 65 per square metre of carpet area per month. Subsequently, the Director of Estates informed[8] that in cases where such accommodation is to be provided, the market rate is to be fixed in terms of the guidelines of 13 June 1985[9] according to which licence fee was to be revised every three years with escalation of 8 *per cent per annum* compounded on yearly basis. Though the orders dated 13 June 1985 deal with the leasing of private accommodation, they contain the inherent principles applicable to the leasing of government accommodation to non-entitled categories including the requirement of certificate of reasonableness of rent to be issued by the concerned Central Public Works Department (CPWD) officers/hiring committee in terms of reasonableness of rent based on factors like, prevailing market rate for comparable premises in the locality, etc.

CGHS did not follow the procedure enunciated by the CPWD/Director of Estates and assess the fair rent for the premises (in terms of the orders of 13 June 1985 and 16 March 1999), and it has not been possible in audit to assess the same. Despite this, Audit has assessed the license fee at ₹ 1.72 crore (in terms of the earlier orders of 29 January 1982 fixing it at ₹ 65 per square metre and orders of 1999 for increasing the rent at 8 *per cent* compounded annually). By giving HLL rent-free accommodation in a prime location, CGHS incurred a loss of ₹ 1.72 crore in license fees from 2008-09 till date (December 2016).

CGHS replied (June 2016) that HLL was a Government organisation and the MoU signed in December 2007 did not have any provision of rent. Further, HLL was extending 10 *per cent* discount on CGHS rates since April 2012, and the same arrangements of discount in lieu of rent was proposed to be continued in the new MoU which was under consideration.

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7 Directorate of Estates O.M. no. 18015(1)/80-Pol.IV dated 29th January 1982
8 Director of Estates O.M. no.18015/1/92-Pol-III dated 16th March 1999
9 CPWD O.M. no. 21/8/85-WI (DG) dated 13th June 1985

The reply is not acceptable. In terms of extant orders, CGHS is required to follow guidelines of the MoUD when allotting general pool office accommodation. The HLL centre at RK Puram, being located in a prime location in Delhi, enjoys considerable revenues from both CGHS beneficiaries (which is an assured business) and private patients. In any case, the suggestion to set off the amount of rent receivable from discount allowed by HLL is not valid in the absence of required provisions in the MoU and approval of MoUD.

The matter was reported to the Ministry in August 2016; their reply was awaited as of January 2017.

Jawaharlal Institute of Post Graduate Medical Education and Research, (JIPMER) Puducherry

11.4 Adequacy of Procurement Practices and Tertiary Health Care services in JIPMER

Despite engagement of specialised consultant, there was delay in installation of equipment and non-commissioning of laboratories. Tertiary health care services at JIPMER were lacking in infrastructure, human resources and services provided. Overcrowded OPDs, absence of screening in OPD, declining doctor-patient ratio in super speciality services, inadequate availability of nursing personnel, absence of specialised interventional pain management centre, inadequacies in OT, post-operative recovery unit, inadequacies of advanced imaging & lab services, dependence on private laboratories and scan centres were noticed.

Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER) originated as Ecole de Medicine de Pondicherry established by the French Government in the 1823, which was later converted into Dhanvantari Medical College[10]. Upgraded as JIPMER during 1964 and later declared to be an Institution of National Importance by an Act of Parliament on 14 July 2008, the Institute conducts undergraduate, post graduate and super specialty medical courses in addition to research in selected areas. There are 45[11] Departments in the Institute providing Inpatient and Outpatient services.

Audit was conducted (July 2016) covering the period 2012-13 to 2015-16 to examine the adequacy of procurement practices and tertiary health care

[10] At the time of de facto, transfer of Pondicherry to Government of India
[11] 2013-14 – 43 departments, 2014-15 and 2015-16 – 45 departments

services provided by JIPMER. The important findings are given in the following paragraphs:

11.4.2 Audit findings

11.4.2.1 Procurement, installation and utilisation of medical equipment

Ministry of Health and Family Welfare instructed (March 2009) JIPMER to engage HLL Life care Limited (HLL) as in-house consultant for construction of Women and Children Hospital (WCH), Academic Centre, New Hostel Complex and for timely procurement, installation and commissioning of medical equipment under Phase II development project[12].

M/s Larsen & Toubro Limited (L&T) was awarded the contract for both construction and 'procurement, supply, installation and commissioning' of 622 items of medical equipment at a cost of ₹ 334 crore[13] with completion period of 24 months from the date of Letter of Acceptance (LOA) (March 2010) on turnkey basis. JIPMER would finalise specifications within a period of 9 months (December 2010) from LOA[14]and JIPMER retained the right to vary the detailed specifications of medical equipment. Power supply/space for installation[15]were to be given to the M/s L&T by March 2012 by JIPMER.

Audit observed (July 2016) that though the buildings were handed over by April 2013, the equipment were installed within JIPMER premises in the new /old buildings with delay ranging from 1 to 59 months in several instances. Some cases noticed in audit are as under:

- Non provision of required space on the part of JIPMER resulted in delayed installation of 15 equipment supplied costing ₹ 9.49 crore. Delay ranged between 15 and 34 months.
- Delay in completion of civil renovation/electrical modification work by JIPMER resulted in delayed installation of 5 computed radiography equipment costing ₹ 2.28 crore[16] for the period between 12 and 37

[12] The project proposal consisted of setting up of Teaching Block, 400 bedded Women and Children Hospital, Hostel Complex and Doctors' Quarters. According to the contract agreement, HLL was responsible, *inter-alia*, for commissioning of all medical equipment and handing over to the entire satisfaction of the Client within the due date through EPC developer.

[13] Construction cost ₹ 208.75 crore and medical equipment cost ₹ 125.25 crore under Phase II project

[14] JIPMER approved the specification finally in January 2011 except equipment for Departments of Radio Diagnosis, Anaesthesiology and Psychiatry.

[15] Other than in WCH and Academic Centre

[16] Cost of each unit was ₹ 45.50 lakh.

months. The Ministry's reply (November 2016) also cited the delay of renovation work as affecting the installation of equipment.

- 199 medical equipment valuing ₹ 38.91 crore received during May 2010 to January 2013 were installed in Women and Children Hospital and Academic Centre between July 2012 and October 2015 with delay ranging between 4 and 39 months though the building for installation were ready in June 2012. Ministry's reply (November 2016) that the delay was due to delay in getting power supply is not acceptable as there was further delay in installation of equipment by 1 to 30 months even after the power supply was obtained in March 2013.
- Two equipment[17] purchased at a cost of ₹ 1.10 crore are still to be installed due to space constraint. Ministry accepted the audit observation.
- 17 equipment supplied from July 2011 to January 2013 at a cost of ₹ 2.74 crore remained uninstalled (November 2016) as the equipment were not of approved specification though 90 *per cent* cost i.e. ₹ 2.46 crore was paid. Though Ministry's reply (November 2016) indicates that the equipment were put to use, the departments informed that the equipment were yet to be installed (November 2016).
- Picture Archiving and Communication System (PACS) with Tele radiology software supplied to Radio Diagnostic Department in July 2012 at a cost of ₹ 5.69 crore could not be used for its intended purpose of patient care and digitalisation of hospital data management system owing to non-fulfilment of specifications and supply of lower version of software. Ministry's reply (November 2016) that state-of-the-art PACS has been established is silent about the intended purpose (including digitalisation of hospital management system) having been achieved even as on date.

Hence due to delay/non installation of equipment, the patient care services suffered.

[17] ENT Diagnostic cum Therapy Unit with Microscope amounting to ₹ 64.71 lakh supplied in December 2011 and Digital Panoramic & Cephalometric X-Ray Imaging unit amounting to ₹ 45.07 lakh supplied in January 2014.

11.4.2.2 Unwarranted procurement

Unwarranted procurement of L&T make anaesthesia monitors resulted in an unavoidable expenditure of ₹ 0.60 crore[18] as GE health care anaesthesia machine and L&T make anaesthesia monitor are not compatible for safe anaesthesia. Ministry stated (November 2016) that L&T make monitors were put into use with L&T machines procured in Phase I project. The reply supports the audit contention.

11.4.2.3 Non-functional laboratory services

Audit noted that Immunotherapy/Cytotherapy unit lab installed at a cost of ₹ 55.74 lakh[19] for treating patients using cell based therapy protocol was not functional due to fungus formation and water leakage. The Ministry replied (November 2016) that the unit is now functional after addressing the water leakage and fungus formation. However, the Department stated (November 2016) that the unit remains closed for repairs and renovation works.

In another case, infrastructure created at a cost of ₹ 1.03 crore[20] for the IVF laboratory remained idle as civil work was not done as per guidelines prescribed for establishing IVF laboratory. Ministry replied (November 2016) that the laboratory would be established shortly.

11.4.3 Patient care at Tertiary level

The Institute, with 45 departments provides medical care to patients through OPD and in private/general wards. The Institute also manages a 2131 bedded hospital as Super Specialty Tertiary Health Care besides its Rural Health Centre, Urban Health Centre and Outreach centres. Audit findings are as under:

11.4.4 Operation Theatre services

11.4.4.1 Inadequate OT schedule

Operation Theatre (OT) schedule allotted to each surgical department remained unchanged since 2014 due to shortage of nursing staff and post-operative recovery unit despite department's frequent requests to increase OT services/time to clear waiting time of patients. Ministry's reply (November

[18] Cost of 12 additional monitors purchased at the rate of ₹ 5.04 lakh.
[19] Equipment cost- cryo freezer ₹ 18.26 lakh and stem cell separator ₹ 37.48 lakh.
[20] Civil works ₹ 27.60 lakh plus equipment cost ₹ 75.84 lakh.

2016) that all OT are utilised six days in a week from 8.00 am to 6.00 pm is not tenable since no order was issued allotting additional OT days and OT time.

Fully equipped Laparoscopic OT established (April 2013) in WCH Block and one Trauma OT (October 2014) in EMS Block were non-functional due to shortage of Anaesthetist. The Ministry's reply (November 2016) that 14 faculty posts could not be filled despite attempts to fill up the vacancies indicates the urgent need for renewed efforts to ensure that the infrastructure of available facilities is utilised at the earliest for the benefit of the patients.

Non-functional Laparoscopic OT

Medical Council of India (MCI) norms of one Minor OT for each surgical department in casualty/emergency unit was not available in Trauma critical care OT in Emergency Medical Service (EMS) block and in WCH block. The Ministry's reply (November 2016) that out of two OT tables available in each OT unit, one is being used as Minor OT is not acceptable since the infrastructures created was for major operations.

MCI norm that an OT Unit should have Post-Operative Recovery Unit with minimum of 10 beds was not complied with. Patients after surgery are directly transferred to the ward/ICU (other than in WCH-OG department which was provided with 5 bedded post-operative recovery unit). Ministry replied (November 2016) that post-operative recovery room would function after appointment of nursing personnel which is under process.

11.4.4.2 Deployment of Nursing Personnel

As per the Staff Inspection Unit (SIU)[21] norms of the Ministry of Health & Family Welfare, the requirement of nursing personnel[22] for 2131 bedded[23]

[21] SIU prescribes a bed to nurse ratio of 1:1.1.

[22] Nursing personnel consists of staff nurse, nursing sister, Assistant Nursing Superintendent, Deputy Nursing Superintendent, Nursing Superintendent and Chief Nursing Officer.

hospital works is 2344[24] whereas the present sanctioned strength and persons-in-position were 1450 and 1320 respectively. Consequently, JIPMER had a shortage of 1024 (2344-1320) as on June 2016. JIPMER recommended[25] creation of 815[26] additional nursing personnel posts. Closure of newly constructed/fully equipped Wards and ICUs were attributable to such shortage were observed as discussed below:

➢ Three wards (270, 271, 272) in paediatric ICU complex with 18 general beds, 6 isolation beds and 10 ICU beds and delivery room with 2 VIP suite established (April 2013) in WCH block with construction cost of ₹ 1.61 crore were not opened for patient care services since April 2013 resulting in creation of floor beds[27] and accommodating of new born infants on that floor beds.

New born infants accommodated in floor beds

Closed ward in PICU complex

➢ Two wards in SSB constructed at a cost of ₹ 23.75 lakh (approx.) were non-functional since 2009.

The Ministry stated (November 2016) that despite terrible shortage of nurses, ICU recovery rooms are opened with available staff. It further stated that all efforts are being made to operationalise the ward by January 2017.

11.4.4.3 Non-establishment of Interventional pain management centre

Standing Finance Committee (SFC) approved (November 2013) a proposal to establish an Interventional Pain Management Centre [28] but the same is yet to

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[23] Bed strength during 2012-13 and 2013-14 is 2059, 2014-15 is 2114 and 2015-16 is 2131
[24] Bed strength 2131 * 1.1 = 2344.
[25] Cadre restructuring report (2014-15) sent to Ministry, considering strength of 2059.
[26] Sanctioned bed strength (2059) multiplied by SIU norm (1:1.1) ie 2059*1.1 = 2265, 2265-1450 = 815.
[27] One hundred floor beds available.
[28] Estimated cost of ₹ 2.79 crore.

be established (July 2016). The patients suffering from terminal cancer, debilitating orthopaedic pain etc. require continuous multimodal approach of pain management but are currently given interventional blocks only once a week and not admitted in the Dept. of Anaesthesiology and Critical Care. The Ministry accepted (November 2016) the audit observation.

11.4.5 OPD Services

11.4.5.1 Establishment of specialised screening OPD

Around 7500 patients approach JIPMER daily including general/common, speciality and super speciality treatment. Screening OPD[29] approved in 2012[30] for patients to ensure the availability of services of specialties/super specialties to the most needy patients is yet to be made operational and OPDs remain overcrowded (November 2016). Ministry stated that the work would be completed during November 2016. However, JIPMER had informed that due to paucity of fund, the work would be completed only by September 2017.

11.4.5.2 Non-availability of amenities in OPD

Audit observed non-compliance of various norms prescribed under Indian Public Health Standards for patients in OPD services such as non-availability of X-ray view box, non-availability of complaint box, non-availability of patient calling system, non-availability of potable drinking water & toilets, inadequate seating arrangements, etc. in different department**.** Thus, JIPMER, a tertiary care hospital, was lacking in amenities for patients in OPD.

Ministry stated (November 2016) that the issues are being taken care of during modernisation programme. The facts remained that JIPMER failed to provide the required facilities as per the norms.

Overcrowded waiting area without seating arrangement in Nephrology OPD

[29] Screening OPD will provide consultations for surgery, medicine, ENT, ophthalmology, orthopaedics and dentistry along with laboratories and radiological services (X-ray, ECG, ECHO and Ultrasound etc.).

[30] The work to be completed within 24 months from the date of LOA. LOA was issued on 30 October 2013.

11.4.5.3 Decline in doctor- patient ratio in super speciality OPDs

Adequate manpower in medical services is a critical component having a direct bearing on patient care. Audit observed that number of patients attended per specialist was on an increasing trend (6 *per cent* to 585 *per cent*) every year in different super speciality departments during the period from 2013-14 to 2015-16 **(Annex-I)**. It was observed that the increase was more than 100 *per cent* in five[31] departments and more than 200 *per cent* in two[32] departments. While the patient attendance was increasing every year, the super specialist doctors' strength was decreasing. The doctor patient ratio which was 1:5998 in 2013-14 worsened to 1:12094 in 2015-16. Four super speciality departments *viz*. Endocrinology, Medical Oncology, Nephrology and Medical Gastroenterology were functioning without a regular professor from 2013-14 onwards. The only patient satisfaction survey conducted (cardiology department in 2015-16) so far by the Institute revealed that the patients were unable to get enough time from the doctors in the OPDs due to huge patient load. Further, JIPMER is yet to conduct the study on Maximum Handling Capacity of any of the OPD to ascertain the quality of care received by the patients in the OPDs.

In reply, the Ministry stated (November 2016) that there is a proposal to create 100 more faculty posts but repeated attempts to fill up even sanctioned post have proved futile because of corporate sector hospitals. The reply support the audit contention of shortage of doctors in super specialties.

11.4.6 IPD services

11.4.6.1 Functional beds not optimally utilised

Details of sanctioned beds and functional beds[33] for the period from 2012-13 to 2015-16 indicates that though the number of functional bed strength[34] increased every year, it did not reach the sanctioned bed strength (2059) for the year 2012-13. Further 285020 bed days were unutilised **(Annex-II)** resulting in referring patients waiting for surgery, to other health centres. Acknowledging that some beds are non-functional, the Ministry informed that

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[31] Cardiology, CTVS, Neurosurgery, Endocrinology and Medical Oncology.
[32] Surgical Gastroenterology and Surgical Oncology.
[33] A bed is considered to be functional bed if the bed is actually setup, staffed, equipped and available for patient care.
[34] 1618 in 2012- 13 to 2044 in 2015-16.

however, number of inpatients far exceeds the sanctioned bed strength. The reply is silent about the reasons for functional beds remaining unutilised.

11.4.6.2 Patients awaiting surgery

OTs are scheduled for half day generally in JIPMER. The waiting time for patients awaiting surgery ranged between 2 weeks to 36 months **(Annex-III)** excluding the likely waiting time for taking Ultra Sound Scan (upto two months), C.T. Scan (upto 20 days), MRI Scan (upto 5 months) etc. The Cardiothoracic & Vascular Surgery (CTVS) department stated that the waiting period had direct bearing on the patient's condition and would have impact on the overall outcome of the treatment and around 200 patients in the waiting list die every year for want of timely treatment. Departments stated that the waiting list was due to non-availability of OTs beds and increased hours would be possible only if staff strength is doubled. Ministry stated (November 2016) that intense efforts are being made to bring down the waiting period.

11.4.7 Multi organ transplant programme in JIPMER

Organ transplant is recognised as an effective method to save the lives of persons suffering from end stage organ failure.

11.4.7.1 Non-availability of transplant coordinator

Section 11 of the Transplantation of Human Organ (Amendment) Act (THOA) 2011 stipulates the appointment of Transplant coordinator[35] by hospitals involved in organ transplant. National Organ Transplant Programme (NOTP) which promotes deceased organ transplantation to protect vulnerable poor from organ trafficking provides financial assistance to the hospitals to appoint transplant coordinators.

Audit observed that JIPMER, without appointing a dedicated transplant co-ordinator, started the deceased (cadaver) donor organ harvesting programme in December 2013 and harvested only 20 cadavers out of 559 deaths during 2013-14 to 2015-16 in EMS/Trauma care centre. The nodal officer, appointed on 06.11.2015 for the purpose of interacting and organising all aspects of organ/tissue transplantation activities, stated that out of 559 death cases, 56 to 84 (10 *per cent* to 15 *per cent*) cases could be potential

[35] Transplant Coordinator (section 5 of THOA 2011) - a person appointed by the hospital for co-ordinating all matters relating to removal or transplantation of human organs or tissues or both and for assisting/coordinating between treating team and transplant team, handle medico-legal formalities, counsel family members of diseased donor.

deceased donors for harvesting organs. Thus, the non-availability of dedicated transplant coordinator contributed to the low harvesting of organs during above period. Ministry accepted the audit observation.(November 2016)

11.4.7.2 Inadequate progress in organ harvesting

A deceased donor can donate organs[36] and tissues[37] provided they are in medically fit condition. As per the guiding principles of NOTP issued by DGHS, all organs should be utilised and wastages avoided as organs are scarce and can save lives. Audit observed that unlike in other institutes of national importance,[38] JIPMER had established facility for transplantation of only three organs *viz*. kidney, liver and cornea and performed average number of 20 kidney transplantation in a year (2012-15) which is significantly lower than the average number of 200 and 150 transplantations performed by PGIMER Chandigarh and AIIMS New Delhi.

Audit observed that number of patients awaiting kidney transplantation as on July 2016 is 82. JIPMER attributed the long wait to severe shortage of faculty and senior residents, lack of beds/space as well as lack of dedicated operation theatre for kidney transplantation.

Further, Audit observed that even though JIPMER had formulated a policy for organ sharing, it had not established any organ sharing arrangement with any hospital. In the absence of such organ sharing arrangement, JIPMER could not ensure optimal harvesting. The Ministry accepted the audit observation (November 2016).

11.4.8 Cancer treatment facility

Cancer has emerged as a major public health challenge in India. It is one of the leading causes of death.

11.4.8.1 Regional Cancer Centre not functioning as a separate unit

Department of Radiotherapy was granted Regional Cancer Centre (RCC) status to provide a comprehensive cancer treatment at tertiary level under one

[36] Organs- kidneys, liver, heart, lungs, intestine, pancreas
[37] Tissues- two corneas, skin, heart valves, cartilage/ligaments, bones/tendons, vessels.
[38] PGIMER, Chandigarh established facility for seven organ transplantation and AIIMS, New Delhi for five organs.

roof[39] and a separate block was constructed during 2008. At present, RCC has three main branches of Oncology, *viz*. Radiation Oncology, Medical Oncology and Surgical Oncology.

JIPMER informed that an ideal cancer centre should have all major modalities such as surgery, radiotherapy, medical oncology, anaesthesia, radio diagnosis, nuclear medicine, palliative care, pathology, psychological support centre etc. under one roof. Audit noticed that even though there is a separate block for RCC, only two of the above sections *viz*. Radio Therapy and Medical Oncology are functioning there and all other sections are functioning in different blocks in different locations leading to hardships for the patients.

Further, for running RCC as a separate Institute and also to achieve the objectives of RCC such as treatment, early diagnosis and prevention of cancer, JIPMER had created the post of Director, RCC. However, RCC is functioning without a Director for the last two years (2014-15 and 2015-16). Although the Ministry stated (November 2016) that the unit is part of JIPMER and not a regional cancer centre but Audit noted that the Government of India had already decided (January 2002) to develop JIPMER's Department of Radiotherapy as a Regional Cancer Centre.

11.4.8.2 Comprehensive cancer treatment facility

As per guidelines of NPCDCS[40], a tertiary cancer centre shall provide comprehensive cancer care which includes cancer prevention, early detection, diagnosis, provision of therapy, after care, palliative care and rehabilitation. Such comprehensive cancer treatment facilities were not available as detailed below:

- **Preventive Oncology**

Preventive Oncology, which paves the way for prevention and early detection of cancer, is not available in JIPMER although 65 to 75 *per cent* of patients coming to RCC are in the advanced stage (III and IV) patients.

Ministry stated (November 2016) that proposal has been submitted to establish comprehensive preventive oncology unit in the Phase-3 expansion of RCC.

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[39] JIPMER's website

[40] National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases & Stroke.

- **Absence of Comprehensive Palliative Care Centre**

Nearly 70 *per cent* of the cancer patients attending RCC are in advanced stage of disease, for whom palliative care would be the predominant form of treatment. Audit observed that such a comprehensive palliative care centre is not available in JIPMER. Ministry replied (November 2016) that the same has been envisaged in Phase 3 expansion of RCC.

- **Absence of therapeutic nuclear medicine procedures in cancer treatment.**

Therapeutic nuclear medicine plays a vital role in cancer treatment by affording different type of therapies.[41]It was seen that these therapies are not being done due to non-availability of isolation ward though specialised faculties are available from March 2010. Ministry stated (November 2016) that action is being taken to convert the existing ward into an isolation ward.

11.4.8.3 Non-availability of leukaemia isolation ward

Leukaemia patients/febrile neutropenia patients require isolation as they are at high risk of developing fatal infection. Due to non-availability of leukaemia induction isolation ward, these patients are being treated in open general wards leading to risk of high induction mortality among such patients. Ministry stated (November 2016) that it is being considered in Phase 3 expansion of RCC.

11.4.9 Advanced investigations and imaging services

Tertiary care is a specialised consultative health care, usually provided for inpatients following referral from primary or secondary health professionals to an institution that has personnel and facilities for advanced laboratory and imaging investigations as well as for highly skilled clinical management.[42]

11.4.9.1 Non-availability of advanced lab investigations

Audit observed that many advanced laboratory investigations in Biochemistry, Clinical, Immunology, Microbiology, Pathology and Anatomy Departments were not available due to shortage of consumables and technicians. "Non-availability" certificates are being issued despite availability of well-equipped

[41] 1311 therapy,1311 MIBG therapy, 177Lu DOTA therapy, 177 Lu EDTMP therapy.

[42] Report of Planning Commission's Working Group on Tertiary Care Institutions for 12th Five Year Plan.

departments and laboratories. Hence, the patients are compelled to approach private labs. Ministry's response (November 2016) that the fund position has since improved and advanced investigations are being done was not in line with the response of departmental heads (November 2016) that these investigations were currently not being done.

11.4.9.2 Absence of advanced imaging services

(i) PET/CT scan

While X-ray and Ultra Sound Scanners are essential diagnostic equipment for providing quality medical care to patients, a PET/CT scan is more advanced and more accurate in evaluating cancer patients. Unlike in other Institutes of National Importance,[43]JIPMER did not have PET/CT scan despite sanction of ₹ 16.53 crore for its establishment in January 2012. Hence, JIPMER was referring patients to private lab centres for taking PET/CT scan where the patients had to pay different rates for similar scans[44]. Audit noted that this goes against JIPMER's Vision and Mission to be a model for health care systems in India and to provide service of the highest order. The Ministry attributed the absence to difficulties experienced in complying with tender requirements.

(ii) OPG X-ray

The facility was not provided due to non-commissioning of the newly purchased equipment. Ministry attributed delay in installation to modernisation of the ground floor.

(iii) Tesla MRI

Equipment essential for performing imaging and interventional procedures was not available although it was available in other institutes of national importance.[45] Ministry informed that the same would be installed before April 2017.

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[43] AIIMS New Delhi and PGIMER Chandigarh.

[44] In one case one of the private lab charged ₹ 9,000. In another case another private lab charged ₹ 25,000 and subsequently allowed a rebate of ₹ 9000 and the same lab charged ₹ 15,000 from another patient.

[45] AIIMS, PGIMER, NIMHANS and six newly established AIIMS.

11.4.10 Support Services

11.4.10.1 Preparation of diet in unhealthy condition

The Department of Dietetics established in 1966 provides diet[46] to all inpatients as per dietary requirements. The main kitchen was built in 1964 to meet the need of 860 patients per meal. Now, due to increase of bed strength, the number of diets to be supplied also has increased to 1750 diet per meal. The department reported that the space for kitchen, and other facilities are inadequate to meet the present condition. Further, the Institute had no testing facilities for food items before supply to patients. Since the kitchen was not found to be suitable for remodelling, the department submitted a proposal (October 2013) for modernisation. But, no action has been taken (July 2016) either to construct a new modular kitchen or to renovate the existing one. Thus, the kitchen continues to operate with outmoded, unhealthy and unhygienic working conditions.

View of kitchen premises

Ministry stated (November 2016) that the work for modernisation of the kitchen is already underway and would be completed by December 2017.

11.4.11 Conclusion

Health care services at tertiary level in JIPMER were lacking in infrastructure, human resources and services being provided. There were delays in installation of equipment. Overcrowded OPDs, absence of screening OPD, declining doctor-patient ratio in super speciality services, inadequate availability of nursing personnel, absence of specialised interventional pain management centre, inadequacies in OT, minor OT, post-operative recovery unit, inadequacies of advanced imaging & lab services, dependence on private laboratories and scan centres were noticed.

[46] The diet covers normal diet for adult and children, liquid diet, high protein diet, high protein fluid diet, light diet (milk & bread), low protein diet, diabetic diet, bland diet (low residue diet) and high carbohydrate diet.

Indian Council of Medical Research

11.5 Irregular grant of benefits to the scientists

Irregular grant of promotions under Flexible Complementing Scheme to the scientists with retrospective effect led to irregular payment of arrear amounting to ₹ 2.35 crore in 101 cases.

Department of Personnel and Training (DoPT) issued (November 1998) instructions on modification of the existing Flexible Complementing Scheme (FCS) for in-situ promotion of scientists working in various scientific departments of Government of India. These instructions, issued consequent to Fifth Pay Commission recommendations, prescribed minimum residency period and assessment procedure for in-situ promotion of scientists and technical staff. FCS was applicable to all Scientific and Technological departments.

Further, DoPT, in response to references seeking clarification on the date from which such promotions were to be given, communicated (July 2002) that in-situ promotions under FCS should be effective from a prospective date after the competent authority approved the same. Subsequently, based on recommendations of Sixth Pay Commission, DoPT further modified (September 2010) FCS and introduced revised pay scales and assessment procedures. DoPT reiterated (September 2012) its earlier position regarding date of grant of promotion under FCS, clarifying that promotion cannot be made with retrospective effect. Thus, no promotions can be granted with retrospective effect under FCS.

Indian Council of Medical Research (ICMR), an autonomous body under Ministry of Health and Family Welfare, substantially financed from GoI grants, formulated its Health Research Scientists Cadre Rules, 2007 and made provision for promotion of scientists on the basis of FCS in accordance with the criteria prescribed for such promotions by Government vide DoPT OM dated 9 November, 1998 and as amended from time to time.

Out of 33 Institutes/Centres of ICMR including ICMR Hqrs., Audit test checked the cases of promotions of scientists under FCS in ICMR (Headquarters) and its three centres[47] located in Delhi/NCR and observed that

[47] National Institute of Medical Statistics(NIMS) Delhi, National Institute of Malaria Research (NIMR), Delhi, and Institute of Cytology and Preventive Oncology (ICPO), Noida, U.P.

in 466 cases, promotions in higher grade were granted to the Scientists posted in all the centres, by ICMR Headquarters during June 2013 to February 2016, by ante-dating the effective date of promotion by six months to 41 months from the date of promotion orders. Hence salaries and arrears were paid in contravention of extent policy circulars. The financial implication in 101 such cases pertaining to Scientists posted in ICMR Headquarters and three centres amounted to ₹ 2.35 crore.

The matter was reported to the Ministry in August 2016; their reply was awaited as of January 2017.

Regional Medical Research Centre, Dibrugarh

11.6 Poor fund management

Failure of Regional Medical Research Centre, Dibrugarh to adhere to the investment procedure of Indian Council of Medical Research in investing the surplus funds resulted in loss of opportunity to earn extra interest of ₹ 1.04 crore during 2011-15.

Regional Medical Research Centre (RMRC), Dibrugarh is one of the regional centres of Indian Council of Medical Research (ICMR) for carrying out Biomedical Research in eight states of the north-eastern region of India and is entirely funded by ICMR.

Handbook on Finance and Accounts (Handbook) of the ICMR provides that the RMRC may, based on assessment of the immediate requirement of funds, place the surplus funds in Short Term Deposits (STD) of 91 days/31 days with accredited bank. Further, the funds equal to the average monthly expenditure during the period from April to November of the previous year plus 10 *per cent* must be kept in the current account.

RMRC, Dibrugarh kept the fund received from ICMR in a current account (account) and made payment for day-to-day expenditure apart from investing money in STD from time to time. Audit noted (March 2016) that RMRC, Dibrugarh had not followed the investment procedure as stipulated in the Handbook after taking into consideration the necessity of fund. There were surplus funds ranging between ₹ 0.46 crore and ₹ 13.58 crore available for further investment after setting aside the minimum fund[48]. Had RMRC, Dibrugarh worked out the surplus fund in each month keeping in view the

[48] Ranging between ₹ 2.15 crore and ₹ 7.36

investment procedure stipulated in the Handbook and invested the surplus funds at least for 31 days, they could have earned additional interest of ₹ 1.04 crore during 2011-15.

Thus, failure of RMRC, Dibrugarh to adhere to the investment procedure of ICMR in investing the surplus funds resulted in loss of opportunity to earn extra interest of ₹ 1.04 crore during 2011-15.

RMRC, Dibrugarh stated (August 2016) that from September 2016 onwards the system for investment would be adopted as pointed out by audit.

The matter was reported to the Ministry in July 2016; their reply was awaited as of January 2017.