Ministry of Health and Family Welfare

Procurement of medicines and medical equipment

1. Introduction

Ministry of Health and Family Welfare procures medicines and equipment for the implementation of various disease control programmes, Central Government Health Scheme and for providing essential health care facilities to the people in Central Government Hospitals and research bodies and Institutes. Director General of Health Services which is an attached office of the Department of Health and Family Welfare implements Central Government Health Scheme (CGHS) through a network of 331[*] dispensaries, 19 polyclinics, 65 laboratories and 17 dental Units to provide comprehensive medical care to Central Government employees, pensioners and members of their families and other beneficiaries. The responsibility for procurement of drugs/ medicines for CGHS dispensaries in Delhi and under various disease control programmes was outsourced to various PSUs i.e. M/s Hospital Services Consultancy Corporation Ltd, M/s Bharat Immunologicals & Biological Corporation Ltd and Rail India Technical Economic Services Ltd. etc.

Expenditure on purchase of medicines and medical equipment constituted 13 to 16 *per cent* of the total expenditure of the Ministry during the years 2002-07. Out of the total expenditure of Rs. 6148.85 crore on supply of material and Rs. 1388.46 crore on purchase of medicines and medical equipment during 2002-07, the cost of medicines, materials and equipment procured through the Medical Store Organisation (MSO) and DGHS (Procurement Cell) was Rs. 171.05 crore and Rs. 75 crore, respectively during the corresponding period, which represented only three and five *per cent* of the total expenditure.

2. Organisational set-up

The Procurement Cell under DGHS constituted in January 1993, is primarily responsible for the procurement of machinery and equipment valued at Rs. 50 lakh and above. Machinery and equipment costing less than Rs. 50 lakh is procured by the respective hospitals and other subordinate offices, after necessary financial sanction is accorded by the competent authority. Ministry of Health and Family Welfare has also constituted a number of Purchase Committee/Purchase Advisory Committee(s) and review committees. Purchase committees are constituted for handling purchase of (a) drugs and medicines, (b) equipment and stores, (c) insecticides and larvaecides, (d) vaccines and contraceptives. All cases of purchase upto the value of Rs. 10 crores are decided by the respective Purchase Committees and cases in which the value of purchases exceeds Rs.10 crore, the recommendations of the Purchase Committee are considered by the Secretary (Health & Family Welfare) upto 20 crore and by MOS/ Minister in cases above Rs. 20 crore.

[*] Allopathic : 246; Ayurveda 32 and others 53

Medical Stores Organisation (MSO), an attached office of the Department is entrusted with the task of procurement of drugs and medicines required for health care and research in various Central Government hospitals and dispensaries and for implementation of various disease control programmes. MSO operates through seven medical store depots located at Mumbai, Kolkata, Chennai, Hyderabad, Guwahati, Karnal and New Delhi. In addition to procurement activity through the Procurement Cell of the Department and MSO, the Ministry has delegated powers to Central Government hospitals to procure drugs/medicines upto Rs. 50 lakh after a no objection certificate (NOC) is obtained from the Medical Store Organisation (MSO). No NOC is, however, required if the cost of drugs/ medicines to be procured is up to Rs. 5 lakh. Autonomous bodies functioning under the Ministry viz. AIIMS, PGI, NIMHANS etc. make purchase of medicines, drugs and medical equipment under a decentralized system.

3 Audit objectives

Performance audit of the procurement of medicines and medical equipment was taken up with a view to assessing whether:-

- operational procedures consistent with good pharmaceutical procurement were followed;
- a coordinated approach to the purchase of medical equipment taking into account needs and preferences of the end-users was followed with due regard to economy;
- the policies and procedures on bid document preparation, bidding process management, bid evaluation, award of contract and contract administration were efficient and effective; and
- the policies and procedures for pre-qualification process of vendors ensured transparent and appropriate evaluation.

4 Scope of Audit

The performance audit covered the procurement of medicines, equipment and other supplies during 2002-07 in the Ministry, DGHS, Central Government hospitals, institutions and CGHS dispensaries run by Director General of Health Services in NCT of Delhi and various states/UTs. Details of the offices covered in test-check are given in Annexure I and II.

Procurement outsourced to Hospital Services Consultancy Corporation Ltd., M/s. Hindustan Antibiotics Ltd. & M/s. Pure Pharmer Ltd, Rail India Technical Economic Services Ltd., M/s. Bharat Immunologicals and Biologicals Corporation Ltd., Bulandshar, Hindustan Latex Ltd., World Health Organisation and the award of rate contract by NCT for Generic drugs and adopted by the Ministry for MSO/ CGHS were not included within the scope of this performance audit.

5. Sample

The sample for test-check in audit constituted all contracts involving purchases of Rs. 5 crore and above, 50 per cent of contracts valuing between Rs. one crore to Rs. 5 crore and 25 per cent of the contracts with money value of less than Rs. one crore.

6 Budget allocation and expenditure

The budget estimates, revised estimates and actual expenditure during the years 2002-07 under "Supply & Materials" and "Machinery and Equipments" in respect of various attached/subordinate offices in the Department is given below:

(Rupees in crore)

Year	Supply & materials*			Machinery & equipments			Total expenditure
	Budget estimates	Revised estimates	Actual expenditure	Budget estimates	Revised estimates	Actual expenditure	
2002-03	1096.85	999.57	941.33	263.87	245.12	227.55	1168.88
2003-04	1209.87	1068.91	1056.84	291.54	290.96	227.13	1283.97
2004-05	1455.92	1346.19	1371.25	352.07	366.79	234.76	1606.01
2005-06	1601.18	1508.01	1309.83	477.93	459.17	365.61	1675.44
2006-07	1739.05	1571.88	1469.60	486.61	484.40	333.41	1803.01
Total			**6148.85**			**1388.46**	**7537.31**

Note: The table excludes the BEs, REs and Actual expenditure on purchase of drugs/medicines and machinery and equipment by Autonomous bodies and Institutes i.e. AIIMS; PGI Chandigarh; NIMHANS Bangalore etc.

As would be seen, the expenditure on supply & material and machinery & equipment increased from Rs. 941.33 crore and Rs. 227.55 crore in 2002-03 to Rs. 1469.60 crore and Rs. 333.41 crore respectively in 2006-07 registering a growth rate of 56 and 47 per cent over these years.

The above position indicates that the Revised Estimates were unrealistic and projected on the higher side by around 10 *per cent*.

The reasons for short utilisation of funds though called for were not received as of August 2007.

7. Audit findings

7.1 Pharmaceutical procurement

The procedures followed by the Ministry for pharmaceutical procurement have been assessed and reviewed against the good pharmaceutical practices. These procedures should include a well defined and documented establishment of needs, identification of equipment and pharmaceutical products that would meet these needs,

* Includes consumables e.g. cotton, syringes etc. as expenditure on purchase of medicines and drugs separately was not monitored or maintained

including, wherever practicable, the identification of generic over proprietary pharmaceuticals and framing of procurement documentation in a manner that is consistent with these. The procedures should also lead to identification of reliable suppliers including pre and post delivery inspections and qualification and encourage wide competition and a variety of suppliers.

The adequacy of procedures were also audited against criteria laid down in Rule 137 of the General Financial Rules of the Government of India which stipulate that each authority exercising financial powers in respect of procurement would be responsible and accountable for efficiency, economy and transparency in matters relating to public procurement and for fair and equitable treatment of suppliers and promotion of competition in public procurement.

7.1.1 Procurement Manual

In order to ensure the operationalisation of good procurement practices, it is necessary that the organizations concerned prepare detailed guidelines and procedures including, wherever applicable, standardized forms. Such documentation would also facilitate transparency in the process. In this connection, the Central Vigilance Commission (CVC) had directed that all organizations should prepare codified purchase manuals containing the detailed purchase procedures, guidelines and also proper delegation of powers, so that there is a systematic and uniform approach in decision-making. None of the major hospital/Institutes or other purchasing agencies in the Department had documented written procedures and practices on procurement. Government Medical Store Depot Manual prepared in the year 1979 has become outdated. There was no road map for various stages or activities of a procurement process. In the absence of a uniform and comprehensive Procurement policy, guidelines and Purchase Manual, the system of procurement was quite often ad-hoc and there was no uniformity in the procedures followed by various subordinate offices, as discussed in succeeding paragraphs. The Ministry stated (August 2007) that it was following written procedures for all its procurement activities and that work of revision of the Medical Stores Depot Manual, 1980 was in the final stages. Ministry has now taken up preparation of its own Manual of purchase procedure.

Recommendation

- **The Department should develop a manual/written procedures and follow them for all procurement activities.**

7.1.2 Formulary of drugs & medicines

A health care system can ill-afford to purchase drugs mentioned under different proprietary brands at widely varying prices. A limited list of essential drugs also referred to as a drug formulary defines which drugs will be regularly purchased. At the core of the concept is the objective that procurement should be limited to drugs that are economically priced but safe and effective. The use of a limited number of carefully selected medicines based on agreed clinical guidelines leads to a better supply of medicines, rational prescription, controls expenditure on drugs and allows the health system to procure drugs most economically. This in turn leads to more

competitive drug prices and also simplified supply management procedures. A review of the procedures followed revealed the following:-

(a) Essential list of proprietary medicines

Based on the recommendation of a Committee of Specialists, DGHS adopted in March 1996 a list of 317 essential proprietary medicines, valid for two years for procurement of proprietary medicines by Medical Stores Organization. This list was extended from time to time up to 2004-05. A committee of experts constituted in 2004 under the Chairmanship of the then Addl. DGHS, recommended a list of 504 proprietary drugs, which was approved as a combined formulary for CGHS and Medical Store Organisation (MSO). The number of medicines actually procured out of the essential list for CGHS scheme implemented in Delhi during 2003-04 to 2005-06 was 121, 113 and 390 items respectively. Procurement of a small number of medicines particularly during 2003-04 and 2004-05 indicated that either the essential list of medicines was not comprehensive as all the medicines were not indented by the indenting department or these medicines were procured through local purchases.

(b) Essential list of generic medicines

Director General of Health Services notified in February 2002 a formulary of 507 generic medicines which was kept in abeyance for further detailed examination. It was decided in December 2002 that pending final decision, 177 drugs/medicines common in the 'vocabulary of medical stores 1999', 'model drug list of WHO 2002' and 'drug list 2001 of N.C.T Delhi' would be adopted for procurement of generic medicines. Subsequently in June 2005, the Ministry adopted national essential drug list of 626 medicines notified by the Drug Controller General DGHS, as a generic formulary for MSO and CGHS. Only 93 generic drugs were procured out of the approved drug formulary for CGHS Delhi during the year 2004-05 for which records were test checked. Ministry had not analysed the reasons for the indenting Departments placing indents for a very small number of tested medicines, which could be either due to drug list being unrealistic or because the purchases of these medicines were being made locally.

(c) Separate formulary lists for hospitals and autonomous bodies

Lady Harding Medical College (LHMC) Hospital, Kalawati Saran Children Hospital (KSCH) Delhi and JIPMER (Pondicherry) had prepared their own combined select list of 552 and 400 drugs and medicines. Dr Ram Manohar Lohia Hospital (RML) and Safdarjang Hospital (SJH) did not have any essential list of drugs and these hospitals indented for or purchased medicines directly on the basis of drug lists compiled every year on the basis of requisitions made by the Departmental heads. Similarly, autonomous bodies like AIIMS prepared separate formularies of 1176 medicines. The select drug list of JIPMER had not been updated after 2001. The Ministry stated (August 2007) that it may not be proper to have a common formulary list for Government hospitals and autonomous bodies because of the functional autonomy of the later. It further stated that even amongst the Government hospitals, the formulary may not be common depending on the speciality of the hospitals.

The reply is not tenable as the concept of a list of essential medicines is central to any drug procurementpolicy and this does not affect the functional autonomy of the autonomous bodies as essential drug list are finalised after wide discussions and consultations. Further essential drug list includes medicines required under all groups and departments including various specialities and super specialities. As per WHO policy perspectives on medicines, the use of national lists of essential medicines has contributed to an improvement in the quality of health care and considerable economy in case of medicines. Moreover, the exception procedures should be able to fulfill the isolated special requirements.

(d) Wide variations in select essential drug lists

A comparison of the select lists of essential drug lists revealed wide inter-se variations between the number and type of drugs included in these lists. A detailed comparison under four groups i.e. anesthesia, cardiovascular, gastro intestinal and hormones & anti hormones revealed the following position:

Group	No. of drugs included in Formulary			
	DGHS	AIIMS	LHMC	Number of common drugs
Anesthetic	23	26	40	5
Cardiovascular	70	106	44	10
Gastro Intestinal	30	76	24	06
Hormones, Anti Hormones	30	84	**23**	1

(e) Large scale purchase of medicines outside formulary of medicines

CGHS dispensaries, Central Government hospitals and other organisations purchased large quantities of medicines as listed below which are only illustrative:

Sl.No.	Name of medicines not in the list of Generic formulary but purchased by the Safdarjung and RML Hospital in 2006-07	Quantity
1	Inj Amoxycillin 125 mg + Clavufanic Acid 25 mg	30000 Vials
2	Tab Trifluoperazine 5 mg + Trihexyphenidyl	220000 tab
3	Tab Theophyline 23 mg + Etophylline 77 mg	400000 tab
4	Betamethosone Valerate 0.12% + Neomycine Sulpha 0.5% (15 mg tube) Ointment	40800 tube
5	Tab Sulphamethoxazole 800 mg + Trimethoprim 160 mg	160000 tab
6	Inj Etophylline 169.4 mg + Theophylline 50.6 mg per 2 ml	65000 vial
7	Tab Asprin 350 mg + Cal carbonate 105 mg + Anhydrous Citric Acid 35 mg	450000 tab
8	Tab Antaacid (Dried Alum Hydroxy Gel 300 mg + Mag Alum silicate 50 mg + Mag Hydro 25 mg + Methyl polysiloxane 10 mg)	400000 tab
9	Susp Amoxycillin 125 mg+ clavulanic Acid 31.25 mg per 5 ml (50 ml bottle)	100 bottles
10	Syp Ampicillin 125 mg + Cloxacillin 125 mg per 5 ml (60 ml bottle)	500 bottles

These medicines were not included in the essential drug list. The purchase of medicines outside the essential list were made as a matter of routine rather than as exceptions. Thus the formularies of drugs and medicines adopted by various institutions did not serve the intended purpose of economical and efficient procurement of medicines as they failed to include pharmaceuticals that were routinely required by medical practitioners.

Recommendations

- **With a view to making lists of essential medicines a tool for improving pharmaceutical procurement, a common realistic list of essential drug should be prepared by the Ministry, and procurement should be generally within the formulary list.**

- **The purchase of medicines outside the list of essential medicines for addressing special needs should be permitted in a transparent manner as exceptions to the Rule. Internal controls for seeking compliance with procurement within the essential list should be instituted.**

The Ministry stated (August 2007) that recommendations of audit regarding medicines purchased outside the list of essential medicines for addressing special needs and instituting internal controls to follow the essential list had been noted for necessary action.

7.1.3 Inadmissible expenditure of Rs. 14.48 crore

Under the provision of Civil Services (Medical Attendance) Rules 1944, preparations/medicines such as cosmetics and toiletry items and primary foods, tonics, expensive drugs and laxatives etc as specified in Schedule I and II of these rules are inadmissible and are not to be prescribed or reimbursed. The items specified in Schedule I and II are to be treated as illustrative only and the AMAs have to take the decision whether a particular preparation/ medicine falls under any of the broad categories specified in these schedules.

MSO and CGHS Delhi made irregular and unauthorised purchase of cosmetics and toiletry items such as creams, lotions, mouth washes etc amounting to Rs. 0.90 crore during 2003-04 to 2005-06 and issued these to CGHS beneficiaries. Further, an expenditure of Rs. 6.38 crore and 7.20 crore was made by MSO and CGHS (Delhi) during the same period on purchase of inadmissible tonics, vitamins and minerals in violation of the above provisions. This resulted in irregular expenditure of Rs. 14.48 crore.

The Ministry stated (August 2007) that Medical Attendance rules were not applicable to CGHS beneficiaries.

The reply is at variance with the facts as relevant provisions of the Medical Attendance rules relating to inadmissible medicines have been adopted in toto in CGHS rules vide Appendix VI- List of inadmissible medicines.

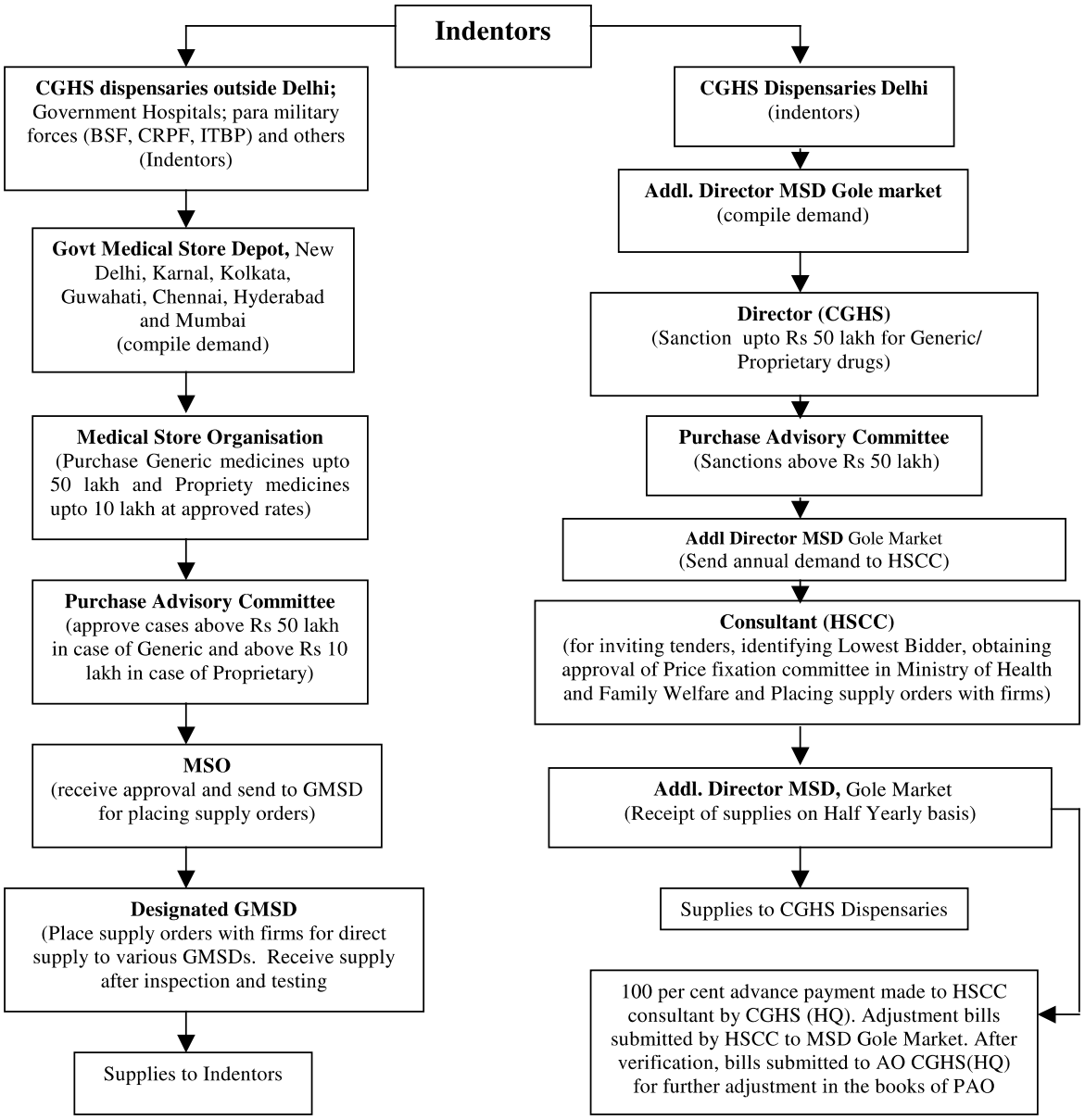
Recommendation

- **Internal controls and monitoring system needs to be strengthened. Accountability may be determined for irregular purchases.**

7.1.4 Medical Stores Organisation

The main objective of establishing Medical Store Organisation (MSO) was to meet the needs of various indentors including other Ministries in respect of medicines, surgical equipment and other medical supplies and manufacture drugs/ medicines, as far as possible, in manufacturing units under MSO. A flow chart indicating various indenting and procurement processes under DGHS is given below: -

Flow chart in respect of Procurement of Drugs/ Medicines



Against the total expenditure of Rs. 6148.85 crore by the Ministry on supply of materials during 2002-07, the contribution of MSO in these purchases was only Rs. 171.05 crore which constituted about three per cent of the total expenditure. This indicates under utilisation of the manpower and physical resources provided to the MSO. MSO has, by and large, failed to meet these objectives as its role over the years was limited to procurement of small quantities of drugs/ medicines indented by CGHS dispensaries outside Delhi, Central Government hospitals and for para military forces (viz CRPF. BSF, ITBP etc).

More significantly it showed that the systematic and orderly procedure for procurement and stocking of material that the setting up of the MSO was intended to achieve was not realised. A significant reason for poor performance by MSO in the procurement of drugs and medicines was the absence of a documented system for placing indents, consolidation of indents, issue of supply orders, procurement and supply etc. Though the indents for supplies were to be received in MSO from various indenting agencies by December of the preceding year, the indents were actually received after delays ranging from three to nine months as indicated in the following table:-

Table showing delay in receipt of indents by MSO from various indentors

Name of the Hospital	Delay in submission of Indent to MSO				
	2001-02	**2002-03**	**2003-04**	**2004-05**	**2005-06**
Safdarjung Hospital	3 months	7 months	3 and 8 months	3, 5and 8 months	4 and 6 months
RML Hospital	4 months	4 months	8 months	no delay	4 months
LHMC	No delay	5 months	9 months	8 months	4 month
KSCH	4 month	No indent	No delay	5 months	3, 7 and 9 months

Moreover, the medicines indented by various hospitals and dispensaries included items which were outside the essential drug list approved by DGHS. Scrutiny revealed that the medicines indented by the various hospitals and CGHS dispensaries could not be fully supplied by MSO and the actual supply ranged between nil to 71 *per cent* during the year 2001-02 to 2005-06. GMSDs Kolkata, Chennai & Mumbai did not also fully supply drugs/ medicines to various indentors including All India Institute of Hygiene and Public Health (AIIHPH), Kolkata and the actual supply ranged between nil to 91 per cent during the year 2002-03 to 2006-07. Due to the failure of MSO to supply indented medicines to various CGHS dispensaries and Central Government hospitals, local purchase of medicines were made on a very large scale at higher rates by these institutions as discussed in the following paragraph.

The Ministry stated (August 2007) that the issue of computerisation of procurement activities in all GMSDs and MSO has been taken up with the National Informatics Centre for inventory management, better linkage and transparency.

The MSO had established two pharmaceutical factories at Mumbai and Chennai with the objective of manufacturing common drug formulations and other medical supplies for supply to Government hospitals/ dispensaries. Though these factories were closed in June 1999 in the wake of Vaidyanathan Committee's

recommendations, 79 employees (Chennai 41 & Mumbai 38) continued to be posted in these two closed manufacturing units as of August 2007. Salary aggregating Rs. 8.21 crore was disbursed to the idle staff during the period July 1999 to January 2007.

The Ministry stated (August 2007) that the services of 79 employees were being utilised against vacant posts. The reply does not address the issue of redundancy of such utilisation of staff meant for pharmaceutical manufacturing against other vacant posts in MSO, as pointed out in the preceding paragraph.

Recommendation

- **The decline in the functioning of the MSO and outsourcing of procurement functions to the consultants should be reviewed for ensuring economies of scale and increasing supplier's interest in bidding. The possibility of obtaining divided deliveries over a period of time and to multiple delivery points could be examined.**

The Ministry stated (August 2007) that recommendations had been taken note of for necessary action.

7.1.5. Local purchase of medicines made by CGHS dispensaries and hospitals

With a view to fill the gaps in the availability of the prescribed medicines at the dispensaries, the system of purchasing of medicines from Authorised Local Chemist (ALC) was introduced in April 1991. Under the system, the ALC who were appointed for a term of two years were to be local chemists, preferably within a distance of 2-5 kms from the dispensary. The process of selection of ALC is through open tender and one of the major criteria for selection of the chemist is the maximum discount offered on maximum retail price (MRP). The position of drugs and medicines supplied to CGHS dispensaries by MSO/contracted agency and value of medicines purchased locally from designated local chemists during 2002-07 was as under:

(Rupees in crore)

Unit/Period **(1)**	**Total expenditure on procurement of medicines** **(2)**	**Value of medicines procured through MSO/ consultant** **(3)**	**Value of medicines purchased from local chemists** **(4)**	**Percentage of (4) to (2)** **(5)**
CGHS Delhi (2002-06)	459.21	92.88	366.33	80
CGHS Hyderabad (2002-07)	102.36	9.17	93.19	91
CGHS Bangalore (2002-07)	39.33	9.88	29.45	75
CGHS Allahabad (2002-07)	95.11	24.26	70.85	75
CGHS Patna (2002-07)	8.81	1.53	7.28	83
CGHS Kolkata (2002-07)	47.86	7.85	40.01	84
CGHS Mumbai (2002-07)	59.2	10.18	49.02	83
CGHS Pune (2002-07)	26.23	3.23	23.00	88

Unit/Period (1)	Total expenditure on procurement of medicines (2)	Value of medicines procured through MSO/ consultant (3)	Value of medicines purchased from local chemists (4)	Percentage of (4) to (2) (5)
CGHS Guwahati (2002-07)	8.32	2.20	6.12	74

It would be seen from the above that out of the total expenditure of Rs. 459.21 crore on purchase of medicines for **CGHS dispensaries at Delhi** during 2002-06, the value of medicines purchased through local chemists was Rs. 366.33 crore which constituted 80 per cent of the total purchases. Similarly the percentage of local purchase of medicines to total purchases in **CGHS Hyderabad, Bangalore, Allahabad, Patna, Kolkata, Mumbai, Pune** and **Guwahati** during the years 2002-07 ranged between 74 to 91 per cent respectively. The position in the two test checked hospitals, **Smt. Sucheta Kirplani Hospital** and **Ram Manohar Lohia Hospital** was similar as 77 to 97 per cent of the total purchases were made locally during 2002-2007.

As per paragraph 38 of GMSD Manual, the MSD is to prepare the estimated requirement carefully for each year to ensure adequate stock levels at all times to meet demands of the indentors without resorting to local purchase. Further, PAC had recommended in paragraph 1.25 of its 103rd Report (Fourth Lok Sabha) the scaling down of local purchase of medicines to the minimum since it was costlier than centralised purchase.

Despite these provisions and PAC recommendations, the basic objective of making procurement in larger quantities in order to achieve economies of scale was not achieved mainly due to defective and inadequate systems for assessment, consolidation and preparation of essential lists. CGHS dispensaries made extensive purchases of medicines from local chemists without regard to the quality and cost-effectiveness of these purchases. Under the centralized procurement system through MSO and consultants, the major suppliers were generally the well established large pharmaceutical companies who were allowing discounts upto 40 per cent on MRP against which the local purchases were made for medicines manufactured by small manufacturers and local chemists who allowed discounts generally up to three *per cent* and in isolated cases up to eight *per cent*. In **CGHS (Delhi)** alone, based on the variation of 11.25 per cent (20 - 8.75) in discount rates between the minimum discount rate of 20 per cent offered by the suppliers under the centralised purchases and maximum discount of 8.75 per cent offered by local chemists, the Department incurred extra avoidable expenditure of Rs.41.21 crore (@ 11.25 per cent of total payment of Rs. 366.33 crore made to ALCs during 2002-06) on account of the local purchases of medicines. Moreover, in the absence of a system of quality checks on the supply of medicines by ALCs, the quality of the locally purchased medicines are not ensured.

The Ministry stated (August 2007) that due to seasonal variation of diseases and changes in prescription pattern, CGHS has to procure medicines outside formulary and that audit observations had been noted and due care would be taken to

improve the availability of medicines in future. The Ministry further stated that loss worked out by audit was notional in view of need based medicines purchased for the patient in distress as per specialist doctor's prescription.

The reply is not tenable as list of essential medicines is developed on the basis of standard clinical guidelines for common diseases and emergence of seasonal epidemics etc. The contention of the Ministry that loss worked out by audit was notional is not correct as the value of medicines purchased through local chemists, instead of being an exception, constituted 80 per cent of the total purchases which resulted in loss due to low discount offered by local chemists as compared to discounts available for large scale procurement.

Recommendation

- **Reasons for very large local purchases exceeding 80 per cent should be identified and corrective measures to prevent bypassing of central procurement should be taken up to make pharmaceutical procurement economical and consistent with need for quality. MSO procurement system should also be strengthened.**

The Ministry stated (August 2007) that recommendations for minimizing local purchases and strengthening of MSO had been noted for necessary action.

7.1.6 Irregularities noticed in local purchases

On the basis of the irregularities and excess payment detected in audit in respect of indents, bills and records of 50 chemists for the month of April 2001, the then Secretary Health & Family Welfare was requested by the Comptroller and Auditor General in December 2002 to have the results of sample check looked into by the internal audit. The special audit of the payments made to the local chemists by the Internal audit wing of the Ministry had, *inter alia* brought out following irregularities:-

- Variation in the rates of discounts allowed by the local chemists to ESI and CGHS.

- Unauthorised and irregular reimbursement of 8 per cent sales tax over retail prices resulting in loss of crores of rupees to the Government;

- Possibility of spurious drugs being supplied in CGHS

- Leakage in the distribution system in CGHS; and

- Delay in processing the bills of local chemist.

The Ministry appointed during the year 2006, M/s. A F Ferguson & Company a consulting company for carrying out a review of the CGHS Scheme. The consultant in its interim report of December 2006 had *inter alia* pointed out suspected formation of cartels of the local chemists, absence of a mechanism to track drugs procured from

them but not issued to beneficiaries and delays of about six months in settlement of individual claims of the chemists.

During the review of the system in audit all the above irregularities were not only found to be still persisting but the situation had become worse as delays in settlement of claims of chemists had increased to nine months. 90 per cent of selected ALCs offered a discount of 3 to 4.50 per cent during the period May 2003 to December 2007 in **CGHS (Delhi)**. This trend strongly points to the possibility of the local chemists forming a cartel. Apart from this, routinely delayed payments can lead to offer of very low discounts leading to loss. Review of the ALC Scheme in the states revealed following further points:-

- In **CGHS (Delhi),** contrary to the policy of the Department to award, one group/ area to one chemist located within 2-5 kms of the dispensary, firm namely: M/s Alankit Life care Ltd, Ashok Vihar (North Delhi) was allotted five dispensary groups spread over areas spanning from South Delhi to Faridabad and Noida.

- Some of ALCs in **CGHS (Delhi)** had offered higher discounts subject to the condition that their payments were released within four to six weeks of submission of their bills. The Department has not taken appropriate measures to meet this demand of the chemists, which could result in significant economy.

- In **CGHS (Kolkata)**, dispensaries had been divided into four groups and separate tenders were invited for each group. Bidders were permitted to bid for only one group in which these commercial establishment were located. But it was observed that discount obtained in the zones varied widely rates ranging from 5 to 13.5 per cent during 2004-05 to 2006-07.

- **CGHS (Lucknow)** had reimbursed an amount of Rs. 68.01 lakh during 2002-07 to the CGHS beneficiaries directly on account of purchase of life saving drugs.

- The **CGHS (Chennai)** adopted a different system and instead of appointing local chemists, it reimbursed the cost of medicines to CGHS beneficiaries directly. The Department had reimbursed an amount of Rs. 8.62 crore to pensioners and Rs. 0.57 crore to CGHS beneficiaries during 2005-06 to 2006-07. As a result the discount offered by ALC's was not availed of.

- **CGHS (Patna)** had procured life saving drugs/ medicines amounting to Rs. 56.11 lakh during 2005-06 from a chemist offering lower discount rate of 12.5 per cent instead from another chemist who had offered 22 per cent discount. This resulted in extra expenditure of Rs. 1.74 lakh.

- Under a stop gap arrangement in **CGHS (Delhi)** during the period 2003-05, certain groups of dispensaries were allotted to chemists offering lower discount rates ignoring chemists who had offered higher discount rates.

The Ministry stated (August 2007) that delays in settlement of claims were procedural and for minimizing these delays the powers to pass claims of local chemists had been decentralized and delegated to zonal Additional Directors. It further stated that four dispensaries had been withdrawn from M/s Alankit Life care Ltd through retendering process.

Recommendation

- **The scheme of appointing local chemists needs to be reviewed and rationalised to ensure fair selection with maximum economy in procurement. Delay in payment to ALCs also need to be curbed as these can have undesirable consequences.**

The Ministry stated that audit recommendations had been noted for necessary action.

7.1.7 Excess procurement of medicines and loss due to expiry of drugs

As per the standing instructions of the Department, the buffer stock in stores at any given time should not exceed four months requirements of any item.

Test check of a sample of 20 purchase contracts in **CGHS (Delhi)** pertaining to 2005-06 revealed that in 10 cases (50 per cent), the quantity of the medicines purchased was sufficient to meet the average requirement of the CGHS for periods ranging from 8 to 16 months. A further comparison of the indents with bin cards of five medicines purchased during 2003-04 revealed that orders for procurements of these medicines were placed by **CGHS (Delhi)** with HSCC far in excess of actual requirements. This subsequently resulted in huge stockpiling of medicines worth Rs. 51.69 lakh with short shelf life at the close of the year 2003-04. In order to liquidate the huge stock of medicines with short shelf life, circulars were issued from time to time to all the dispensaries directing them to lift the stocks by placing indents. Audit scrutiny revealed that bulk of these medicines were dispatched to various dispensaries between April 2004 to July 2004 by CGHS (Delhi). Scrutiny of the records of 17 dispensaries to which the excess quantity of medicines was unilaterally supplied revealed that quantity of the medicines supplied during that period exceeded the previous year stocks and consumption of these medicines manifold.

Further, in seven Medical Store Depots and two CGHS stores, failure of the Department to periodically assess procurement requirements reasonably and accurately resulted in unwanted medicines worth Rs. 5.87 crore becoming time expired at the end of January 2007. The Ministry stated (August 2007) that due care was being taken now in assessing the requirements on the basis of consumption pattern during the relevant period and therefore, there may not be any excess procurement of medicines and resultant expiry of drugs in future.

Recommendation

- **Based on past consumption of individual drugs or VEN techniques (vital, essential and non-essential drugs) suitable method of estimating the**

requirements for procurement should be employed for arriving at proper figures for procurement.

7.1.8 Quality assurance

Scrutiny of records revealed that a formal system of pre and post-qualification of the prospective suppliers to ensure procurement from suppliers of quality products was not in place. As per the standing instructions of the Ministry, only pre-tested medicines were to be accepted from the MSO/ HSCC. Since, about 80 per cent of the medicines were purchased from local chemists/ suppliers in CGHS dispensaries and Central Government hospitals, these instructions had become redundant as drawing of samples of drugs for testing and follow up were not in vogue in local purchases.

In cases where specific complaints about the quality of drugs were received, the Ministry issued instruction for sending samples to Government approved laboratories for testing. Audit scrutiny revealed that during the years from 2001-02 to 2006-07 in **CGHS (Delhi), CGHS (Pune), CGHS (Kolkata)** and **GMSD (Kolkata),** 35 items of medicines were sent for laboratory testing on the basis of complaints received from Chief Medical Officers and individuals. The laboratory testing reports had confirmed that these drugs were of sub standard quality. In two cases the test report was submitted after a lapse of one year by which date the drugs/ medicines had already been prescribed and administered to the 'beneficiaries'. Similarly, in 20 other cases, more than 70 per cent of the medicine had been administered to the beneficiaries before test results could be received.

The instructions of the Ministry further stipulated that random samples of drugs from the supplies received were to be drawn by CGHS and MSD and sent to Central Indian Pharmocopial Laboratory (CIPL), Ghaziabad for testing. The Central Government hospitals and AIIMS had not drawn any samples for testing by CIPL as these organisation were relying on the laboratory test reports of the supplier.

Recommendation

- **Local purchases from ALCs should be discouraged and reduced and samples of drugs/medicines purchased should be subjected to timely test.**

The Ministry stated (August 2007) that major hospitals like Ram Manohar Lohia and Safdarjung rely upon tests conducted at the government approved laboratories or CIPL, Ghaziabad before accepting medicines from suppliers. However, the quality control assurance proposal in respect of supply of day to day emergency medicines to individual patients through local chemist received by the respective dispensaries was under active consideration of DGHS / Ministry.

7.1.9 Appointment of contractors for procurement of drugs & medicines

According to the guidelines issued in February 1999 by the Central Vigilance Commission, consultants need to be appointed only when it is felt absolutely essential. Appointment of consultants has to be done in a transparent manner and after following the competitive tendering system. The consultants' role has to be well

defined and they are to assist departmental officers because of perceived lack of expertise. Further, the consultants are to be engaged for minimum period necessary subject to the overall ceiling of two years.

The department has engaged consultants from time to time for procurement of drugs and medicines required for CGHS dispensaries in Delhi and other national disease control programme including externally aided projects. Even though these agencies are termed consultants, they are in fact contracted to carry out procurements. These agencies have been appointed despite the existence of MSO, which was required to carry out the function of procuring, stocking and supplying pharmaceutical supplies. The details of programmes implemented and consultants appointed for procurement of stores is indicated in the following table:-

Sl. No.	Unit/ Programme	Procurement Agency
1.	CGHS, Delhi	Hospital Services Consultancy Corporation Ltd.
2.	Integrated Disease Surveillance Project	Hospital Services Consultancy Corporation Ltd.
3.	National AIDS Control Programme	Hospital Services Consultancy Corporation Ltd.
4.	Food & Drug Capacity Building Project	Hospital Services Consultancy Corporation Ltd.
5.	T.B. Control Programme	M/s. Hindustan Antibiotics Ltd. & M/s. Pure Pharmer Ltd.
6.	Enhanced Malaria Control Programme (NVBDCP)	Rail India Technical Economic Services Ltd.
7.	Immunisation Strengthening Project PPI	M/s. Bharat Immunologicals and Biologicals Corporation Ltd., Bulandshar
8.	Reproductive & Child Health Programme	Hospital Services Consultancy Corporation Ltd. & Hindustan Latex Ltd.
9.	National Leprosy Control Programme (NLEP)	World Health Organisation

The services of Medical Store Organisation, New Delhi for procurement of drugs and medicines for CGHS units in Delhi was dispensed with in March 2003 and this work was assigned to M/s Hospital Services Consultancy Corporation (HSCC) India, Noida for the year 2002-03 and onwards. The Department entered into an agreement with M/s HSCC from November 2002 appointing it as consultant for procurement of drugs/medicines on a consultancy fee of 4.5 per cent of the value of drugs procured. The term of the contract has been extended from time to time upto November 2008.

The reasonableness of consultancy fee of 4.5 per cent paid was also doubtful as the Purchase Advisory Committee (PAC) of the Ministry had in their meeting held in July, 2005 observed that commission claimed by M/s HSCC was on a very high side and should have been 1 to 2 per cent in view of the job done by procurement agency. The PAC had also observed that the Consultant had no major contribution to make and its job was only to make enquiry from the manufacturers and place orders on them. Joint Secretary (VC) had also instructed (November 2005) Director CGHS to take up the matter for reducing the consulting fee to 2 per cent at the time of renewal of contract from December 2005. However, the fee was never reviewed or revised. Rs. 9.03 crore (Rs.4.15 crore for CGHS Delhi and Rs.4.88 crore for various

National programmes was paid to the consultant (HSCC) as consultancy fee for the services of procuring drugs during 2002-03 to 2006-07.

Recommendations

- **The consultants should be appointed in conformity with the guidelines and instructions issued by the CVC.**

- **The consultancy fee paid should be reviewed and revised keeping in view the limited services provided as observed by the Purchase Advisory Committee and recommendations of the PAC.**

The Ministry stated (August 2007) that consultants were appointed keeping in view the difficulties in supplies of drugs and medicines by MSO to CGHS Delhi and other National disease control programme network throughout the country. The reply is not tenable as Organisational structure of Ministry provided for the specialised Medical Store Organisation which was responsible for procurement of medicines and equipment. Instead of activating the Medical Store Organisation, the Ministry hired consultants which impacted the economical operation of the Department due to underutilization of the existing infrastructure of Medical Store Organistion and avoidable payment of consultancy fee. The Ministry further stated that the matter of reducing consultation fee to 2 per cent had been initiated and the same would be considered at the time of extension of contract with HSCC.

7.1.10 Non-adjustment of advances

As per the terms of contract between Ministry of Health and Family Welfare (DGHS) and HSCC (I) Ltd. for procurement of medicines for CGHS Dispensaries, 100 per cent cost of the medicines was to be released by CGHS to HSCC on placement of orders to HSCC. The adjustment bills are to be submitted to CGHS within 3 months of the release of advance.

Audit scrutiny revealed that against the advances aggregating Rs. 74.92 crore released to HSSC during 2002-06 for procurement of medicines for CGHS dispensaries, adjustment accounts for Rs. 49.59 crore only had been rendered leaving an amount of Rs. 25.32 crore outstanding with HSCC as of February 2007.

Recommendation

- **Internal controls should be strengthened for monitoring of timely recovery of unadjusted advances along with interest.**

The Ministry stated (August 2007) that the audit observations has been noted for necessary action.

7.1.11 Management Information System

The department had not put in place any Management Information System(s) for tracking status of supply orders and payments to compile information on suppliers, inventory and stock outs etc either in a manual or computerised environment.

A reliable MIS should be developed as a tool for effective planning and managing procurement. The Ministry stated (August 2007) that with the proposed computerization of procurement activities, the issue of MIS was being addressed.

7.2 Acquisition of medical equipment

The responsibilities of Management for acquisition of medical equipment *inter-alia* include, planning for acquisition, selecting medical equipment and standardising medical equipment by type.

7.2.1 Planning the acquisition of medical equipment

A properly planned approach to the purchase of medical equipment taking into account the needs and preferences of professionals and end users whilst retaining consistency and control is needed if value for money is to be obtained. As per Chapter 10 (Planning, Organisation and Management techniques) of the Hospital Manual issued by DGHS, each hospital should prepare a prospective master plan, broken into phases and the plan should inter-alia include physical structure, building, equipment, furniture, manpower and consumables needed. The annual plan prepared by the hospital each year should be based upon the master plan and adhoc planning has to be avoided.

No long term and well documented plan for procurement of equipment had been prepared either centrally in the Ministry or at the level of individual hospitals test checked in audit. The hospitals have no documented systems for assessing the need to acquire and replace medical equipment by analysing demand and usage information from medical equipment inventories and other sources of information including estimates of the volume of clinical demand. All acquisition cases, irrespective of value, contained very few details and were not made on a formal basis. There was no evidence to demonstrate that purchase decisions were taken after assessing the needs of the patients and were economically sound and affordable.

The initial cost of a medical equipment is only a part of the total cost of medical equipment and other costs over the lifetime of equipment include operating costs, maintenance and training. None of the test-checked hospitals had used the life cycle costing approach to evaluate cost implications of medical equipment purchased. The hospitals/units were merely projecting the requirement of funds annually in an adhoc manner on the basis of requisitions projected by each departmental head. Absence of proper planning had resulted in deficiencies in the acquisition of medical equipments as discussed in succeeding paragraphs:

(a) Common use items of machinery & equipment not identified

There was no system in place for compiling and consolidation of information on commonly used items of Machinery and Equipment (M&E) in each hospital for their collective purchasing under one contract for obtaining economy from bulk purchase. Each unit was processing its purchase proposals costing up to Rs. 50 lakh separately. Similarly, the concept of medical equipment libraries for lower cost common items like infusion pumps, nebulisers, endoscopes and portable devices etc

was not developed by any of the hospitals, due to which the benefits of lower costs, standardisation, intensive use of equipment and improved access to equipment were not achieved. The Ministry stated (August 2007) that the issue of identifying common items in Government hospitals under a system of Joint purchase committee has been initiated and would be in place soon.

(b) Standardisation of Medical equipment and benchmark for holding medical equipment

Considerable saving and benefits in the form of lower costs of service, spares and training result if a single product model is used for a given application throughout various hospitals/units. In addition, medical equipment standardization gives greater flexibility in the clinical setting, allowing patients to be transferred between medical departments if necessary, facilitated by the availability of the same medical equipment in different units. The Ministry did not have a policy on standardisation of medical equipment.

It was noticed in audit that while Ram Manohar Lohia Hospital procured Colour Doppler Echo Cardiography System for Cardiology Department during 2003-04 for Rs. 47.05 lakh, Safdarjung Hospital procured the same equipment in the same year at a cost of Rs. 44.64 lakh. Similarly, Sarfdarjung Hospital procured ICU Ventilator for Anesthesia department in 2005-06 for Rs. 10.84 lakh and during the same year Lady Harding Medical College and Hospital procured two ICU Ventilators for Anesthesia department at a unit cost of Rs.5.95 lakh. The variation was due to different makes and models of medical equipment in use in different hospitals.

Test check revealed wide variation in the number of some of the medical equipment held by Radiology department of different hospitals as indicated in the following table:-

(In numbers)

Equipment installed in the Radiology department	Safdarjung Hospital (1531 beds)	Lady Harding Medical College & Hospital (877 beds)	All India Institute of Medical Sciences (1864 beds)	Ram Manohar Lohia Hospital (1000 beds)	Number of makes and models	
					Make	Model
MRI	1	Nil	3	1	2	4
CT Scan	2	1	7	1	4	10
Colour Doppler	1	2	12	1	5	12
Ultrasound	5	2	7	3	9	13
Digital Radiology	1	Nil	2	1	3	3
X-ray machine	11	8	12	7	5	26
Portable X Ray	16	4	22	13	5	24
Mammography	1	-	2	-	2	2

As would be seen from the table, the equipment held by the hospitals did not have a rational basis. Audit scrutiny further revealed that there was variation in the number of makes and models of these items of equipment. The suppliers technical information brochures and bulletins were mainly used for obtaining technical information about medical equipment and taking purchase decision. Since the suppliers of medical equipment have an interest in presenting the information about their models in a way designed to encourage a purchase, which manifests at times in

the departmental heads favouring technical specifications tailor made for a particular firm/ supplier, it is necessary to have some degree of standardisation in medical equipment procurement on the basis of a wider range of advice. The Ministry stated (August 2007) that DGHS had recently undertaken an exercise with the involvement of various Government Hospitals to generalize specification of general equipment required by various departments to maintain similarity in all central government hospitals.

A comparative and relational study of 'machinery and equipment available', 'Work load' and 'available Staff ' in Dr Ram Manohar Lohia Hospital in respect of Cardiology department revealed underutilisation of equipment and lack of skilled manpower as indicated in the following table:-

S. No.	Name of M&E Location	Qty	Capa-city of the machine to carry out number of tests	Actually tested on patients	Percentage utilisation	No of technicians actually required to operate at particular time	No of technicians in position	Waiting list
1	TMT Machine (NIC Lab)	2	4200	1330	32	2	1	2 weeks
2	Echo Machine (NIC Lab)	2	9000	5098	67	*	*	4 month
3	Holter Monitoring system	4	1200	419	35	*		1 week
4	ECG Machine	17	612000	63449	10	17	11	No waiting
5	Cath Lab	1	1044 (in 3 months)	261 (in 3 months)	25	4	1	1 week

These tests are performed by doctors themselves

The above table indicates that despite a list of waiting patients and availability of equipment, services could not be rendered due to lack of skilled manpower. There is thus a need for benchmarking the holding of equipment by each hospital after making allowance for difference in size of hospitals, patient load and case mix. The Ministry stated (August 2007) that under utilisation of equipment was due to non-availability of sufficient number of cardiologist and technical staff.

Recommendation

- **Procurement needs of various hospitals and autonomous bodies should be properly planned, consolidated and coordinated in order to take advantage of bulk purchase discounts. There is considerable scope for standardising makes and models of medical equipment.**

The Ministry stated (August 2007) that audit recommendations had been taken note of for necessary action.

(c) Hurried purchase of medical equipment at the end of financial year

Hurried and unstructured purchases at the end of financial year often precludes rational selection. It was noticed that in All India Institute of Medical Sciences expenditure of Rs. 1.54 crore, on procurement of M&E in 10 cases was made in the month of March of the financial year. In Central Research Institute, Kasauli 34 to 84 per cent of expenditure of Machinery & Equipment and Supply & Material was made during the last quarter of the financial year during the years 2002-03 to 2006-07. Similarly NIMHANS , Bangalore incurred expenditure ranging from 39 to 83 per cent of the total expenditure on procurement of Machinery & Equipment in the last quarter of the financial years 2002-03 to 2005-06.

Recommendation

- **Mechanism provided in rules for regular monitoring of the pattern of expenditure to avoid rush of expenditure at the end of the financial year should be followed and internal controls strengthened.**

The Ministry stated (August 2007) that audit recommendations had been taken note of for necessary action.

(d) Delay in installation of equipment

According to standing instructions the equipment & machinery received are to be installed and commissioned as per the time schedule prescribed in the contract. Scrutiny of records of various Central Government hospitals/ Autonomous bodies revealed that 39 items of equipment costing Rs. 31.94 crore received during 2004-05 to 2006-07 were installed after delays ranging from 2 to 23 months. In **NIMHANS, Bangalore** and **National Tuberculosis Institute (NTI), Bangalore,** equipment was installed after delays ranging from 10 to 54 months. Similarly, in March 2005, PGIMER Chandigarh procured attachment of Haemotology Analyzer at a cost of Rs. 18.37 lakh without procuring custom slides which are essential for operationalising the equipment. The equipment installed in August 2005 was lying idle as of May 2007.

Recommendation

- **MIS Procedures should be strengthened for monitoring installation of equipment within prescribed time schedule.**

The Ministry stated (August 2007) that audit recommendations had been taken note of for necessary action.

(e) Avoidable payments of Rs 69.86 lakh on account of Demurrage charges

Safdarjung Hospital, Dr RML Hospital and **Post Graduate Institute of Medical Education and Research (PGIMER), Chandigarh** make heavy purchase of imported machinery and equipment regularly for use in various departments. The consignments of imported items received at the airport are to be released by clearing

agents hired for the purpose by the hospitals. Scrutiny revealed that hospitals incurred an expenditure of Rs. 69.86 lakh (Rs. 31.66 lakh **(Safdarjang hospital)** + Rs. 18.73 lakh **(RML)** + 19.47 lakh **(PGIMER,Chandigarh)**) towards demurrage charges/ground rent charges to the airport authorities from 2002-03 to 2006-07 due to failure in releasing the consignments within the stipulated period. It was further observed that the demurrage charges were being paid as a matter of routine and the reason for delay[♣] in not ensuring timely release of consignments were not analysed.

Failure on the part of the Hospitals in ensuring necessary formalities being completed in time and getting the consignments released in time besides being indicative of deficient planning and monitoring, resulted in avoidable expenditure of Rs. 69.86 lakh paid towards demurrage charges from 2002-03 to 2006-07. The Ministry stated (August 2007) that the audit observation had been noted and efforts were being made to minimize the delay and to develop better coordination.

7.2.2 Unplanned purchases of medical equipment

(a) Tenders for procurement of 10 bedside monitors with central station were invited by Safdarjung Hospital on 5th August, 2002. The equipment of three out of five firms, which had responded, was found technically suitable. Joint Purchase Committee of the hospital in its meeting on 10th July 2003 under the chairmanship of Medical Superintendent approved the procurement of the equipment costing US$ 72659 plus freight, insurance and other clearing charges (INR Rs. 34.46 lakh). The equipment was received in October, 2003 and the HOD, Cardiology was requested to indent the equipment. HOD Cardiology in his note stated that he was not aware of any such purchase being requisitioned by the Department of Cardiology. It was further stated by the HOD Cardiology that the file relating to purchase of equipment was never shown to him. The equipment was installed in October 2004 in ICCU after a lapse of one year on the direction of Medical Superintendent. The Cardiology department was requested (April 2007) to intimate the status of the utilization of bedside monitors but this information was not provided to audit.

(b) The test check of the records of PGIMER**,** Chandigarh revealed that the hospital had to incur extra avoidable expenditure due to delay in initiating procurement process, uncoordinated approach and indecisiveness on the procurement of equipment which resulted in the acquisition of the same material subsequently at higher rates as detailed below: -

S. No.	Name of Equipment & quantity	Month/ year of Demand	Initial Purchase/ quoted rate & date	Higher purchased rate & date	Avoidable expenditure	Reasons
1.	Intracranial Pressure Monitor (2 Nos.)	December 2002 January 2003	Rs.16.70 lakh (Rs. 8.35 lakh per item) February 2004	Rs. 20.86 lakh March 2006	Rs. 4.17 lakh	Delay in procurement process

[♣] Failure of supplier to give timely intimation about dispatch of goods; delay in payment of custom duty; delay in providing information to clearing agent or failure of clearing agent to clear equipment in time.

S. No.	Name of Equipment & quantity	Month/ year of Demand	Initial Purchase/ quoted rate & date	Higher purchased rate & date	Avoidable expenditure	Reasons
2.	ICU Monitoring System (1 No)	October 2005	Rs. 69.70 lakh Feb 2006	Rs. 82.00 lakh Mar 2007	Rs. 12.30 lakh	Original tender scrapped for getting a better deal

(c) In view of increase in the number of road accidents in Delhi, the Dr RML hospital prepared a scheme for the establishment of trauma center in order to optimise utilization of the first hour, which is critical for the survival of the accident victims. In July 2001, the Ministry conveyed its approval for the construction of Trauma Building, purchase of medical equipment, consultancy and staff cars etc. at a cost of Rs. 28.13 crore (Rs. 10 crore for civil works; Rs. 18.13 crore for equipments etc.). The construction work was started in June 2003 with the target date of completion by December 2005.The construction work had, however, not been completed as of February 2007.

Scrutiny revealed that during the period October 2005 to January 2007 machinery and equipment costing Rs. 8.49 crore was purchased for Trauma Centre even though the construction of building and other physical infrastructure was incomplete. Machinery and equipment items costing Rs. 2.10 crore were issued to other departments of the hospital viz., Orthopaedics, Anesthesia, Surgery, Radiology etc purportedly for testing of quality of the machinery under working condition during the warranty period. The balance machinery and equipment items acquired for Rs. 6.39 crore were lying in the store awaiting installation as of March 2007. Purchase of costly equipment and machinery without ensuring availability of physical infrastructure resulted in idling of the equipment and attendant risks of damage during storage, loss of warranty benefits and obsolescence etc. This could have been avoided if the progress of the construction of buildings was monitored and proper coordination ensured between the authorities responsible for building construction and equipment procurement.

The Ministry stated (August 2007) that due to various technical reasons the trauma center has not yet been handed over to the hospital.

(d) Cobalt Therapy Machine and Low Energy Linear Accelerator Machine (LINEC) is a radiotherapy machine for cancer treatment. The Cobalt Therapy Machine is based on technology that is more than 33-year-old, and uses radioactive material (in this case cobalt 60) as a source of energy whereas Low Energy Linear Accelerator Machine is a new technology, which does not need a radioactive source.

In the meeting of Directors of Regional Cancer Centres under National Cancer Control programme held on 23rd December 2003 for taking a decision on phasing out of Cobalt machines in the country, it was held that low energy linear accelerator machines were superior to Cobalt machines in view of better technology and considerations of difficulties in procuring and disposal of radioactive material. Cobalt Unit was considered suitable only in small centres.

In another meeting of experts on 12th May 2004 held to take a decision on purchase of second cobalt machine at Safdarjung Hospital, the members were of the view that though the initial cost for Linear Accelerator Machine was more, in view of maintenance cost of cobalt technology which required source replacement after 7 to 8 years, per patient cost was same as that of Low Energy Linear Accelerator Machine. The Director JIPMER had also pointed out that Low Energy Linear Accelerator Machine was superior to Cobalt Machine for treatment of deep-seated tumours. Most of the experts were of the view that if Safdarjung Hospital already had one functional Cobalt Machine procured and installed in 1992, then new purchase should be of Low Energy Linear Accelerator Machine.

Notwithstanding these recommendation and the fact that one cobalt unit were already functional in the hospital, Safdarjang hospital purchased 2nd cobalt therapy unit in March 2005 at a cost of Rs. 2.10 crore. Reasons for purchasing 2nd Cobalt therapy machine despite recommendations of experts to the contrary were not on record. This resulted in depriving the patients of the benefits of improved/ new technology, apart from hazards of the radioactive source.

7.2.3 Non-adjustment of outstanding advances given to suppliers

Scrutiny of records of Safdarjung hospital, Dr. R.M.L. Hospital and NEIGRIHMS Hospital revealed that large amounts of outstanding advances given to suppliers for services rendered or supplies made from 1986-87 to 2006-07 remained unadjusted as indicated in the following table:

(Rupees in crore)

Advances outstanding	**Amount of advance outstanding**
Upto 5 years	51.11
6-10 years	1.90
11-15 years	0.31
Above 15 years	0.05
Total	**53.37**

The reasons for outstanding amounts for adjustments have been called for from the department. The Ministry stated (August 2007) that the outstanding advances would be adjusted shortly.

7.3 Bid document preparation and bidding process management etc.

7.3.1 Preparation of Bid document

Consequent upon decentralization of purchase activities by DGS&D, Ministry of Health & Family Welfare issued instructions (January 1993) regarding procedure to be followed for purchase of stores/equipments by various organizations including delegation of enhanced financial powers. As per these instructions, the tender set and the resultant contract was to be adopted as per DGS&D standard proforma including terms and conditions with some modifications. Scrutiny of the bid document preparation in the Ministry and its subordinate and attached offices showed that standard bidding documents as per DGS&D standard proforma was not adopted by

RML, LHMC, SSK Hospital and AIIMS and instead separate non-standard bid documents had been adopted by these hospitals.

Scrutiny of the non-standard bid document disclosed that in some cases important provisions relating to 'liquidated damages', 'document establishing bidder eligibility and qualification', 'force majeure', 'packing' etc had been left out. The 'levy of liquidated damage charges in case of late supply' and 'replacement of machinery & equipment in the case of non performance of the equipment within guarantee period' etc adopted by the AIIMS under sections II and III were not in accordance with the DGS&D standard bid documents. Further, various forms specified under section VII to XII of standard bidding documents relating to bid form & price schedule, bid security form, contract form, performance security form etc. were also not provided for in the non-standard bid documents. Similarly, the bid document of **National Tuberculosis Institute Bangalore** and **All India Institute of Speech and Hearing (AIISH) Mysore** did not provide for important clauses viz. 'performance security', 'warranty period', 'imposition of penalty for delay in supply and installation of equipments' and 'bid security'.

As the Hospitals are procuring high value equipment on regular basis, the clauses referred in the DGS&D standard bid documents are important for safeguarding the interest of the Government and also has indirect financial implication in the evaluation of offers and executing the contract. In 162 test-checked cases in CGHS, RML hospital, Safdarjang hospital, AIIMS and PGIMER, Chandigarh, supply of medicines and equipment had been delayed in 38 cases for periods ranging from 2 to 10 months. In the absence of liquidated damages clause in the bid, penalty of Rs. 37.08 lakh based on rate of 0.5 per cent of the delivered price of the delayed goods for each week of delay or part thereof until actual delivery upto a maximum of 10 per cent as per the terms and conditions of standard bid was not recovered.

Recommendation

- **The bidding documents should be reviewed and standardised in line with standard documents of the DGS&D across all the attached and subordinate offices of the Ministry.**

The Ministry stated (August 2007) that the bidding documents of the hospitals had now been standardised.

7.3.2 Bidding process management

The bid evaluation process should be fair and transparent and proceedings of the committees should be recorded in detail. Indent for procurement of equipment valuing Rs. 50 lakh and above are raised on the Procurement Cell of DGHS New Delhi by various hospitals/ institutions under Ministry of Health and Family Welfare. The Procurement Cell fixes the calendar of activities annually and informs the indentors so that indented equipments is procured as per schedule date and payments are made in the same financial year. In this regard following points were noticed in audit:

a) Delay in processing and award of contract

As per provision of Chapter 7.6 of DGS&D Manual and instructions dated 19th July 1999 of the department, the indent was to be raised by the indentors only after obtaining the administrative approval and financial sanction from the competent authority. In 15 test checked cases out of a total of 35 purchase cases processed in DGHS Procurement Cell during the period 2002-06, it was noticed that in 14 cases procurement process had not been completed according to the fixed schedule for the year, mainly because of delays ranging from 3 to 24 months in obtaining administrative approval and financial sanction from the competent authority. Similarly in 14 out of 15 cases test checked, there was delay ranging from 15 days to eight months in submission of indents by the indentors. In 14 cases, there was delay of three to 27 months from the date of receipt of indents in the award of contracts. Delay of 10 to 80 days in evaluation of technical bids by the Technical Evaluation Committee against the fixed schedule of 15 days from the date of sending technical bids were also noticed.

Thus, undue delay in obtaining the administrative approval and financial sanction, submission of indents and evaluation of bids resulted in delay in processing and award of contract. The Ministry stated that based on audit observation necessary instructions had been issued to all concerned departments for processing technical evaluation bids in a time-bound manner of 15 days.

b) Government hospitals were expected to complete the purchase process within six months from the date of invitation of bid. Delays were noticed in processing and award of work in the case of various hospitals as indicated below:-

(Rupees in lakh)

Hospital	Cases test checked	Delay in purchase of equipment									
		6 to12 months		12 to 18 months		18 to 24 months		24 to 36 months		More than 36 months	
		No.	Cost	No.	Cost	No.	Cost	No.	Cost	No.	Cost
R.M.L	10	--	--	8	118.16	-	-	2	24.86	-	-
Safdarjung	16	5	571.70	1	35.70	2	28.50	6	58.40	1	118.00
LHMC	5	2	46.96	-	-	1	16.38	1	9.79	--	--
BCGVL, Chennai	1	-	-	-	-	1	225.00	-	-	-	-

The main reason for delay in finalization of purchase process was delay in evaluating the technical and financial bids. The Ministry stated (August 2007) that instructions would be issued to all hospitals to complete the purchase process within six months from the date of invitation of bids.

(c) Undue haste in procurement

With a view to having wide, fair and adequate competition, it is important that sufficient time of say 4-6 weeks in case of advertised / global tenders and 3-4 weeks in case of limited tenders is allowed, except in cases of emergency wherein also a reasonable time should be permitted. The tender should preferably be kept open for sale till the date of tender opening or just one day prior to the date of opening.

It was observed in **AIIMS** that against the normal time of 4-6 weeks allowed for submission of tender, only 5 to 16 days was allowed in 8 test checked cases involving purchase value of Rs. 6.91 crore during 2005-06. It was further noticed that sale of tender was closed 7 to 17 days before opening of tender. The procurement was thus done in a manner, which limited competition.

8 Conclusion

Performance audit of Procurement of medicines and medical equipment in Ministry of Health and Family Welfare revealed that good procurement practices were by and large not followed and procurement processes were characterized by ad-hoc decisions. The basic requirement of developing formal written procedures, using explicit criteria or key performance indicators for making procurement decisions was not met. Similarly, a Management Information System for tracking demand and supply of medicines and medical equipment has not been set-up either in a manual or computerised environment for planning and managing procurement.

A common formulary or essential drug list had not been developed and there were wide variations between the number and type of drugs included in essential drug lists adopted by CGHS and some of the Government hospitals/ Institute. The Ministry had also failed to formulate any policy on standardisation of medical equipment and benchmarks for holding of medical equipment by each hospital based on the size of hospitals, patient load and case mix etc. As a result, wide variation in the number of makes and models of medical equipment held by various hospitals was noticed.

The irregularities of suspected cartel formation by local chemists, serious doubts about the quality of drugs supplied by chemists and delay in a few cases in settlement of the claims of chemists, brought out by internal and statutory audit in the years 2002, 2003 and by the consultant engaged by the Ministry for study of CGHS, persisted as effective corrective measures had not been taken. Medical Store Organisation failed to meet the needs of various indentors and only 3 per cent of the total requirement of medicines was supplied by them during 2002-07. Consequently, large local purchases ranging from 74 to 97 per cent were noticed due to which the basic objective of making procurement in larger quantities in order to achieve economies of scale was not achieved. Failure of the Department to make reasonably accurate estimate of procurement requirements from time to time resulted in medicines valued at Rs. 5.87 crore becoming time barred in Government Medical Store Depots and CGHS Store.

9 Acknowledgement

We acknowledge with thanks the interaction conference with the Secretary and the senior officers of the Ministry of Health and Family Welfare to discuss the audit objectives, areas of audit examination and to get the perception as well as suggestions of the Ministry.

(A.K. THAKUR)
New Delhi **Director General of Audit**
Dated **Central Revenues**

COUNTERSIGNED

New Delhi **(VIJAYENDRA N. KAUL)**
Dated **Comptroller and Auditor General of India**