5.1 Chief Controlling Officer based audit of the Directorate of Health Services

Executive Summary

A Chief Controlling Officer (CCO) based audit of the Directorate of Health Services (Directorate) was conducted by examining records of 12 Drawing and Disbursing Officers including 50 dispensaries covering the period from 2007-08 to 2011-12. The audit covered areas of financial management, human resource management, Drug Policy of Delhi, procurement policies, procedures and practices followed in the Directorate.

No construction work had started at any of the land sites (August 2012), allotted at the cost of ₹13.13 crore between 1997 and 2008 for construction of 10 hospitals with proposed bed capacity ranging from 60 to 700.

The Directorate had not documented procedures and practices for procurement of materials and supplies. Assessment of requirements was based on assumptions. As the rates quoted by the suppliers were directly linked with the estimated quantities to be supplied, Central Procurement Agency (CPA) could not take advantage of competitive rates for bulk quantities of drugs and surgical items to achieve economies of scale as envisaged in drug policy. Purchases of medicines/drugs were made much in advance of the actual requirements,resulting in significant unused balances at the end of the year.

There was no mechanism in place to analyse the market rates of drugs during the extended period of rate contracts. This resulted in financial benefit to suppliers as the rates of drugs reduced in this period, resulting in an avoidable loss of ₹ 1.46 crore in purchase of drugs made by the Central Store alone.

Testing of CPA drugs and surgical items were carried out in a routine manner and there was no tracking of supplies at CPA and the Central Store level to ensure that testing of all batches was carried out. Further, in case of non-CPA procurement, the indenting units were relying only on the in-house test reports of the drugs submitted by the supplier which is an anomaly.

No Management Information System, either manual or computerized, was devised at the Directorate, CPA and Central Store level for planning and managing procurements and supplies.

There was an abrupt variation in consumption of medicines with reference to the number of patients attended to under the jurisdiction of the Directorate.

Public Health Standards approved by the Delhi Cabinet in 2010 to address the confusion caused by existence of heterogeneous primary healthcare facilities provided by multiple agencies have not yet been implemented.

No post for pathologist/lab technician was ever sanctioned by the Department for any of the 39 mother labs. Moreover, the *percentage* of referral cases in all the mother labs was as low as 8.43 *per cent* of the total cases.

To run the mobile clinics, 18 to 24 *per cent* of staff was arranged from the Government hospitals and dispensaries, besides using the services of NGOs to the extent of 34 to 48 *per cent*. Further, it did not have any alternative arrangement in place to make up for the absence of departmental doctors. Insufficient monitoring and diversion of mobile clinics were also noticed.

5.1 Introduction

The Department of Health and Family Welfare (the Department) of the Government of NCT of Delhi (Government) caters to health needs of population of Delhi and neighbouring states. The Directorate of Health Services (Directorate) of the Government of Delhi is the major agency with the Department, responsible for health care facilities at primary and secondary level through various types of health outlets, spread all over Delhi like Dispensaries and Health Centres, School Health Clinics and Mobile Health Clinics.

5.1.1 Organizational set up and functions

The Directorate is headed by the Director (Health Services), Government of Delhi, who is assisted by an Additional Director (Administration), an Additional Director (Medical) and Programme Officers. The organizational set up of the Directorate is given at **Annexure-5.1**. To streamline the functioning of the dispensaries and other public health activities under the Directorate, Delhi has been divided into eight districts which are headed by Chief District Medical Officers (CDMOs). Central Procurement Agency (CPA) is responsible for procurement of essential drugs and surgical items through tendering for all institutions/hospitals of the Government of Delhi. The Store and Purchase Branch (Central Store) at the Directorate (Hqrs) carries out procurement of medicines which are not covered under the rate contract of CPA and is also responsible for storage and distribution of equipment, medicines and consumables for its subordinate offices, health centers and dispensaries.

5.2 Scope and methodology of audit

The Directoratecoordinates implementation of various National and State health programmes through a network of 247 dispensaries and regulates the health services provided by registered private nursing homes. The CCO based audit coveredthe Drug Policy, 1994 of theGovernment of Delhi, procurement policies, procedures and practices followed in the Directorate and its subordinate offices i.e. CPA and Central Store for the period from 2007-08 to 2011-12. All the 12 Drawing and Disbursing Officers were selected for test check. In addition, 50 out of 247 dispensaries were also selected for test check on the basis of random sampling. An entry conference was held (22 May2012) with the Director, DHS to explain and discuss audit objectives and criteria. Audit findings, conclusion and recommendations were communicated to the Department and also discussed in an exit conference (28.2.2013).

5.2.1 Audit criteria

The audit criteria adopted as benchmarks to assess the performance of the Directorate was derived from the following:

- Bio Medical Waste Management (BMW) Act, 1998,
- Cigarette and Tobacco Products - Prohibition of Advertisement and Regulation Act, 2003,
- Nursing Home Registration Act, 1953,
- Government policies, directives, orders and guidelines on health in Delhi, and
- Guidelines, strategic goals, objectives and the targets to be achieved for various plan schemes.

5.2.2 Human Resources Management of the Directorate

Health is a field where availability of adequate qualified staff is of paramount importance. The staff position of the Directorate as on 31 March 2012 is given in **Table 5.1.**

Table 5.1: Staff position of the Directorate as on 31 March 2012

Sl. No	Category	Sanctioned posts	Filled	Vacant posts	*Percentage*
1.	Medical Staff	718	522	196	27.30
2.	Nursing Staff	569	471	98	17.22
3.	Paramedical Staff	933	849	84	9.00
4.	Administrative Staff	307	224	83	27.04
5.	Group – D staff	1477	1171	306	20.72
	Total	**4004**	**3237**	**767**	**19.16**

Source: Information provided by the Directorate

As can be seen from the above table, there were shortages of staff in every cadre, ranging from nine to 27.30 *per cent*. The shortage in medical and nursing cadre was particularly of concern as it adversely affected the working of the department in discharging its mandated responsibilities.

5.2.3 Overall Internal Control Mechanism of the Directorate

5.2.3.1 System of internal control procedure and internal audit system

To achieve the objectives, Directorate needs to devise a Management Information System (MIS) either in manual or computerized environment for receiving returns/reports from indenting units for tracking status of supply orders, performance of equipments, inventory, stock-outs of essential drugs, performance of suppliers, quality assurance by testing

laboratories and enforcing penalty clauses in case of non-performance of rate contract at any level. However, it was noticed that due to lack of effective internal control mechanism, the objectives were not achieved optimally as brought out in succeeding paragraphs.

Further, internal audit is an integral part of Internal Control Mechanism. To obtain reasonable assurance about its functioning, the Directorate is required to establish a free and independent internal audit. The Directorate did not have an internal audit wing of its own, but the Directorate of Audit, Government of Delhi conducts internal audit of the Department. It was noticed that 44 inspection reports containing 449 audit paragraphs were outstanding as of March 2012.

5.2.3.2 Other issues under Internal Control

Directorate undertakes various activities at each level of hierarchy in order to discharge its responsibility with regard to the primary health which inter-alia entail functional knowledge at every stage, i.e. procurement, storage and distribution of medicines/drugs, equipments, etc. Audit noticed that no laid down procurement procedures, guidelines were being maintained.

5.2.3.3 Accountability mechanism

A three tier system viz. Head office, Chief District Medical Officers and Dispensaries exists in the Directorate for implementing and monitoring the activities relating to the provision of primary health care. However, lack of coordination among the aforesaid three levels was noticed as elaborated in the subsequent paragraphs of the report.

5.2.3.4 Response to statutory Audit

The Comptroller and Auditor General of India conducts audit of the Drawing and Disbursing Officer (DDO) at the Directorate (Hqrs) as well as 11 other DDOs under its jurisdiction. No mechanism had been developed by the Directorate to monitor the compliance on the audit observations. It was noticed that 37 Inspection Reports containing 145 paragraphs covering the period 1999-00 to 2011-12 were outstanding as of December 2012.

A Performance Audit Report of the Directorate was printed in the Report of the Comptroller and Auditor General of India for the year ended March 2008. However, Action Taken Note (ATN) was awaited as of November 2012.

5.2.3.5 Vulnerability to fraud and corruption

Directorate is responsible for the primary level health activities for the population of Delhi through its network of 247 dispensaries and

implementation of different schemes like Mobile Health Scheme, School Health Clinics, etc. Audit noticed that the large quantum of procurement of medicines/surgical items, absence of documented procedures for procurement and lack of effective internal control, makes the Directorate vulnerable to fraud and corruption with the risk of undue benefits to the suppliers, procurement at higher prices, and pilferage of medicines/drugs in the distribution system.

5.2.4 Overall monitoring mechanism

Audit observed that:

- No effective monitoring mechanism was in place as reflected by poor budgetary control in terms of unrealistic budget projection, rush of expenditure in the month of March, non-settlement of Abstract contingent advances and proper utilisation of the grants given to other agencies/hospitals etc., and
- No periodical returns for ensuring regular and timely supply of essential drugs/surgical items and its stock out position were submitted to CPA/Central Store. There was no computerized system for monitoring the performance of suppliers, inventory of essential drugs/surgical items and status of functional equipments.

Audit findings

5.3 Financial management

Year-wise budget allocation and expenditure incurred by the Directorate during 2007-08 to 2011-12 is given in **Table 5.2.**

Table 5.2: Budget provision and actual expenditure

(₹ in crore)

Year	Plan		Non Plan		Total	
	Budget Allocation	Actual expenditure	Budget allocation	Actual Expenditure	Budget allocation	Actual Expenditure
2007-08	48.82	46.44	77.69	67.45	126.51	113.89
2008-09	58.87	53.90	98.23	93.35	157.10	147.25
2009-10	68.19	64.92	130.28	125.58	198.47	190.50
2010-11	100.50	91.50	150.88	147.25	251.38	238.75
2011-12	203.65	186.24	174.20	151.86	377.85	338.10

Source: - figures provided by the Directorate

From the above table, it is evident that the expenditure fell short of original budget allocation resulting in savings.

The Directorate stated (January 2013) that the reasons for the savings were non-approval of competent authority for inserting advertisements due to

MCD elections and finalisation of tenders for procurement of general items only in March 2012.This indicates absence of proper planning for timely procurement of medicines and other items.

5.3.1 Rush of expenditure

According to Rule 56 (3) of General Financial Rules, rush of expenditure, particularly in the closing months of the financial year, shall be regarded as a breach of financial propriety and shall be avoided. Scrutiny revealed that major expenditure of the Directorate was on 'Material and Supplies' followed by expenditure on schemes.The details of the expenditure under the head-'Material and Supplies' in the month of March of last five years is given in **Table 5.3.**

Table 5.3: Details of expenditure in the month of March

(₹ in crore)

Year	Total expenditure	Expenditure in March	Percentage of expenditure in March
2007-08	10.74	1.56	14.53
2008-09	12.75	2.61	20.47
2009-10	20.00	5.00	25.00
2010-11	25.98	11.00	42.34
2011-12	19.67	2.45	12.46

Source: Figures provided by Directorate of Health Services

From the above table, it is clear that the percentage of expenditure incurred during March under the head 'Material and Supplies' ranged between 12.46 and 42.34 *per cent*.

The Department in its reply (March 2013), stated that the approvals as well as sanctions were received in the month of March, for the period 2007-08 to 2011-12, due to which bills were drawn on 31March during the above said period. Facts remain that provisions of the GFR were not followed.

5.4 Directorate of Health Services (Hqrs.)

5.4.1 Non compliance of mandatory provisions on the website as per the Right to Information Act, 2005 (RTI Act)

Except the particulars of the organisation, functions, duties and the details of the dispensaries along with the introduction of some schemes, no information regarding the policies, budget, purchases, availability of medicines, subsidy programmes, etc. were available on the website of the Directorate which are mandatory under Section 4 of RTI Act, 2005. Thus,

citizens of the Delhi were deprived of their right to information due to non availability of such basic information on the website of the Directorate.

The Department had accepted the facts in its reply (March 2013) and noted for compliance.

5.4.2 Improper accounting treatment of penalties

Rule 9 of the General Financial Rules (GFR), 2005 states that it is the duty of the Department concerned to ensure that the receipts and dues of the Government are correctly and promptly assessed, collected and duly credited to the Consolidated Fund or Public Account as the case may be.

Audit scrutiny revealed that during 2007-12, the Directorate imposed penalty of `96.46 lakh on suppliers for delayed supplies. While making payment to the suppliers, the amount of penalty was deducted from the gross amount of the bills, instead of depositing the amount in the government account.

The Department accepted (March 2013) the facts and assured that penalties would be booked as departmental receipt from the year 2012-13.

5.4.3 Irregular payment of conveyance allowance of ₹ 3.79 crore to medical officers

Audit scrutiny revealed that all the doctors had claimed conveyance allowance for (i) visiting the hospital outside normal duty hours,(ii) visiting the patients at their residences, and (iii) performing other official duties as per prescribed rates. As per the clarification given by the Department of Health and Family Welfare, it was the responsibility of the supervisory officer who is, counter signing the certificate regarding visits made, to ensure that the claims are made on factual basis. However, it was noted that claims amounting to ₹ 3.79 crore were passed on the self certification of individual doctors without the counter signature of the supervisory officer. This resulted in irregular payment to the tune of ₹3.79 crore.

The Department admitted (March 2013) this as procedural lapse and ensured that the bills would be passed only after verification of the supervising officer.

5.4.4 Non-adjustment of Abstract Contingent (AC) advances of ₹ 1.90 crore

Rule 118 of Receipt and Payment Rules stipulates that money drawn on abstract contingent bills for payment of advances to suppliers should be adjusted within one month from the date of drawal. During the scrutiny of records, it was revealed that an amount of ₹1.90 crore (**Annexure-5.2**) of

contingent advances given to different officials/suppliers during the years 2010-11 and 2011-12 was not adjusted as of October 2012.

The Department stated (March 2013) that out of ₹1.90 crore, ₹ 1.31 crore of AC bill had been settled and for the rest of the amount, reminders had been issued for early action. The Directorate may take timely action to adjust the outstanding amount of AC advances.

5.4.5 Inadequate monitoring of receipt of Utilisation Certificates

Scrutiny of records revealed that 78 Utilization Certificates amounting to ₹447.40 crore due in respect of grants paid up to 2010-11were outstanding as of March 2012. Year wise position of outstanding utilization certificates is given in **Table 5.4.**

Table 5.4:Outstanding Utilization Certificates

(₹in crore)

Year	Utilization certificate due		Utilization certificates outstanding	
	No.	Amount	No	Amount
Up to 2008-09	50	8.28	50	8.28
2009-10	1	13.01	1	13.01
2010-11	27	426.11	27	426.11
Total	**78**	**447.40**	**78**	**447.40**

Source:Figures provided by Directorate of Health Services

The above table shows that an amount of ₹447.40 crore was still outstanding.

The outstanding balances ofutilisation certificates worth ₹ 447.40 crore showed that the internal control mechanism for monitoring the utilization of grants was inadequate in the Directorate.

The Department stated (March 2013) that utilisation certificates amounting to ₹ 201.44 crore had been settled and for remaining utilization certificates, reminders had been issued. The system of monitoring of timely receipt of utilization certificates may be improved.

5.4.6 Blockade of funds to the tune of ₹ 13.13 crore

The Directorate is responsible for establishment of new hospitals and dispensaries in Delhi. Scrutiny of records of construction of new hospitals and dispensaries revealed that the land at various places was allotted between 1997 and 2008 for construction of 10 hospitals with proposed bed capacity ranging from 60 to 700. An amount of ₹13.13 crore has been spent on account of purchase of land and construction of boundary walls.

The work was entrusted to various agencies. However, the records available with DHS revealed that no construction work had started on any of the sites (August 2012), except construction of boundary walls in some cases. Consequently, while funds of ₹ 13.13 crore remained blocked ,the people of Delhi were deprived of intended health services.

The Department stated (March 2013) that facts and figures were correct. The construction was delayed because of involvement of multiple-agencies. Further, with the passage of time, appreciation of cost of land was actually a gainful investment in capital assets by the Government. Reply is not acceptable as the prime objective of the Government was to provide health services to the targeted population of Delhi, instead of capital gain investment.

5.4.7 Ineffective monitoring at the Directorate (Hqrs)

The Directorate has not devised any Management Information System (MIS) either in manual or in computerized form for monitoring and tracking the status of supply orders, performance of equipments, inventory, stock-outs of essential drugs, performance of suppliers, quality assurance by testing laboratories and enforcing penalty clauses in cases of non-performance of rate contract at any level. It was observed that dispensaries were sending manual reports and returns to the Directorate (Hqrs.) through CDMOs about OPD attendance, staff strength, stock-outs, status of lab equipments, etc. The Directorate (Hqrs.) was neither analysing these returns nor sending them to the Central Store and CPA, which were responsible for procurement of drugs and awarding maintenance contracts for lab equipments in dispensaries. As such, they were not kept informed about stock-outs of essential drugs and status of lab equipments. Audit observed that absence of an effective monitoring system for drugs and equipments resulted in stock outs of essential drugs ranging from 58 days to 390 days at Central Stores **(Annexure- 5.3**).

The Department stated (March 2013) that the MIS was likely to be established by April 2013, whichwould enable proper monitoring of the supply at various levels. Further, CDMOs had also been advised to monitor the stock outs, functioning of lab equipment, etc.

5.5 Central Procurement Agency

In pursuant to the Drug Policy of the Government of Delhi, Central Procurement Agency (CPA) was established in 1994, with the objective of procuring high quality drugs and other medical store items at affordable prices in all Delhi Government hospitals and health centres through a pooled procurement programme.

5.5.1 Goal not achieved due to low performance

The pooled procurement programme by the CPA is to be implemented in three phases. In the first phase, preparation of a rate contract of different drugs for procurement is to be undertaken. In the second phase, order for all drugs required in various hospitals is to be placed centrally but delivered directly to the hospitals. In the third phase, drugs are to be ordered by the CPA, procured, stored and distributed to different hospitals in the State by the CPA only. Further, as per the programme, modern techniques of drug storage and inventory control would be introduced so that at any point of time, the Central Unit is aware of the availability of different drugs at different hospitals and health care facilities.

Audit noticed that CPA is currently in second phase of implementation. As a result, any imbalance such as shortage of a particular drug, at any hospital, and availability of unused stocks at another hospital, cannot be identified. Further, no corrective measures can be taken and probability of pitfalls of multi-point purchasing of drugs can also not be overruled.

The Department accepted the facts and stated (March 2013) that now the computerization of supplies was being done through a software programme called 'Nirantar', which was effective in monitoring the supply and demand position. However, the Department assured that 'Nirantar' was likely to be fully functional from the year 2013-14.

5.5.2 Essential Drug List (EDL)

As per the Drug Policy EDL is to be prepared annually by a special committee, consisting of eminent experts from different hospitals in the state and other leading specialists to ensure proper and rational use of drugs, for decreasing unnecessary expenditure on medicines.EDL represents a list of minimum generic drugs needed for a basic health care system, listing the most efficacious, safe and cost-effective drugs for priority conditions with the objective of providing drugs to maximum number of patients. Audit scrutiny of records revealed that EDL was prepared in 2007 and again in 2011, after a gap of four years instead of every year. Records such as minutes of the meeting of the committee, justification for the addition or deletion of medicines, criteria for finalisation of EDL and approval of the competent authority were not provided to audit.

The Department stated (March 2013) that EDL committee now would have a mandatory meeting every January to take a stock of developments in pharmaceuticals and medical practices and the revisions of EDL, if required.

5.5.3 Procurement manual and guidelines not documented/ prepared

As per the Rule 135 of GFR, all department and organizations are required to prepare codified purchase manuals and instructions containing detailed purchase procedures, guidelines and also proper delegation of financial powers so that there is a transparent, systematic and uniform approach in decision-making. Audit noticed that Directorate had not documented written procedures and practices on procurement of materials and supplies. There were no guidelines for preparing estimated requirements of emergency procurement either. Due to absence of guidelines, supply orders for non-CPA drugs were placed directly with the suppliers of rate contracts, finalized by the hospitals and Central Store. There was no mechanism in place to ensure that procurement of these drugs was done economically by the Central Store by ascertaining and comparing the rate contracts of all hospitals. Hence, ad-hoc procurement system was being followed by these two procurement agencies of the Directorate.

The Department stated (March 2013) that preparation of procurement manual and guidelines started three years back but could not be finalised as various options available in supply chain management module of Nirantarhad not yet been selected.

5.5.4 Expenditure on non-CPA procurement exceeded the prescribed limit

As per the Drug Policy of the Delhi Government, only 10 *per cent* of total budget for 'Material and Supplies' can be spent on procurement of non-CPA drugs. Audit scrutiny of the Central Store records, however, revealed that expenditure incurred on non-CPA drugs was ranging from 23.09 to 37.12*per cent* as given in **Table 5.5.**

Table 5.5: Expenditure on procurement of non-CPA drugs

(₹ in crore)

Year	Total Budget of Material and Supplies	Total expenditure	Expenditure on non- CPA procurement	%age of non-CPA exp. against total expenditure
2007-08	10.74	10.74	2.48	23.09
2008-09	13.80	12.75	4.34	31.45
2009-10	20.00	20.00	5.54	27.70
2010-11	26.00	25.98	9.65	37.12
2011-12	25.00	19.67	2.47	9.88

Source: figures from the stock register of Central Store

The Department accepted the facts and stated (March 2013) that now efforts were being made to increase the coverage of drugs in rate contract and limit the non- CPA procurement within the range of 10 per cent.

5.5.5 Purchase of medicines short of permissible shelf life

To guard against loss in potency of medicines before the actual date of expiry, the terms and conditions of purchase of medicines stipulate that supplier should ensure that not more than 1/6 of shelf life had passed from the date of manufacturing at the time of supply, which is considered to be permissible shelf life. Audit observed that Central Store failed to enforce this provision, as it had accepted 64 supplies of various medicines/vaccines beyond permissible shelf life during the last five years **(Annexure-5.4)**.

The Department stated (February 2013) that in case of emergency and sometimes for smooth functioning of Central Store, drugs/medicines were received with impermissible shelf life. Further, due care was being taken for future, to avoid such a situation. The reply was not acceptable as timely action for procurement of drugs/medicines was lacking.

5.5.6 Inadequate estimation of quantities

Rule 137 of General Financial Rules stipulates that purchases should be made in the most economical manner in accordance with the definite requirement of the public service and care should be taken not to purchase stores much in advance of actual requirement. In order to achieve economies of scale, there was a need to assess the requirement properly after getting feedback from all the indenting units.

- Audit analysis of NITs 2007, 2008 and 2011 for procurement of drugs indicated that assessment of requirements was based on assumptions as CPA was not maintaining any database/details of quantities of drugs and surgical items procured, and actually consumed. Scrutiny of drug tender documents revealed that quantities for 426 and 377 drug codes were given against 622 and 709 drug codes, for2007 and 2008 respectively. Column for quantity of 196 drug codes in tender- 2007 and 332 drug codes in tender-2008 were left blank. As the rates quoted by the supplier firms were directly linked with the estimated quantity to be supplied, CPA could not take advantage of competitive rates for bulk quantities of drugs and surgical items, to achieve economies of scale as envisaged in the Drug Policy.
- Test check of records of the Central Store revealed that purchase of medicines/drugs was made much in advance of the actual requirements, resulting in huge balances at the end of the year.

The Department stated (March 2013) that Directorate had already initiated reforms in tender process in 2011.Reply of the Department was not acceptable as documentary evidence in support of the reforms stated to have been initiated in the tender process was neither been given to audit nor attached with the reply.

5.5.7 Variation in consumption of medicines with reference to number of patients attended

As per the Drug Policy, it is the objective of the CPA that all the necessary checks, counter checks (through computerized inventory system, modern accounting procedures) and surprise checks will be initiated to ensure that losses due to illegitimate activity are kept at the bare minimum. To see whether this objective was achieved, audit analysedthe consumption pattern of medicines of four groups* and compared this with the number of patients attendedto in the dispensaries during the period 2007-08 to 2011-12. As the selected four groups comprise of medicines of very general nature, which are used for common diseases, their consumption can be compared to the total number of patients attending the dispensaries **(Annexure.-5.5)**. Audit analysis revealed that :

- Treatment of patients declined by 3.34 *per cent* in 2009-10 from 2008-09, but the consumption of Group-I medicines decreased by 22.38 *per cent*. But the trend of consumption of medicines of group-II, III and IV was in reverse direction, as it increased by 67.11 *per cent*, 31.90 *per cent* and 24.80 *per cent* respectively.
- Though the treatment of patients in 2010-11, declined further by 0.01 *per cent* in comparison to 2009-10, consumption of medicines decreased at a comparatively steeper rate of 19.48 *per cent*, 10.74 *per cent*, 38.64 *per cent* and 21.94 *per cent,* for group-I, II, III and IV respectively.
- In 2011-12 number of patients decreased further by 7.22 *per cent* compared to 2010-11, however, the consumption of drugs indicated a mixed trend. While the medicines of group-I and IV were consumed less by 13.29 *per cent* and 20.38*per cent* respectively, the consumption of group-II and III increased by 11.78 *per cent* and 25.69 *per cent* respectively.

Thus, in comparison to decrease in patient numbers, there was an abrupt variation in consumption of medicines.

The Department stated (March 2013) that morbidity pattern of various diseases vary from year to year and season to season,therefore, thedisease

*1. Analgesics, Antipyretics and drugs for GOUT 2. Anti Protozoal drugs, 3. Antibacterial and 4. Antacid and other Anti ulcer drugs

profile could not be statistically compared with the consumption of medicines.

5.5.8 Deficiencies in rate contract management

5.5.8.1 Award of rate contract for drugs without obtaining competitive bids

Audit scrutiny revealed that rate contracts were finalised on single bid as detailed in **Table 5.6.**

Table 5.6: Details of medicines under rate contract

Particulars	Rate Contracts		
	2007	2008	2011
Total number of drugs for which tender invited	622	709	735
Total number of drugs for which rate contract awarded during a contract year	431	422	175
Total number of drugs for which rate contract could not be finalised	191	287	560
Total number of drugs for which rate contract awarded on the basis of single bid	98	162	Nil
%age of drugs for which rate contract awarded on the basis of single price bid	23	38	
Turnover criteria for eligibility of firm to submit a tender (₹ in crore)	35	35	40 to 80

Source: Figures provided by Central Procurement Agency

The rate contracts were awarded in case of 98 drugs in 2007 and 162 drugs in 2008, on single bid basis. Drug tender for the year 2011 was under process (October 2012).No study was conducted by the Directorate as to why CPA was not getting offers from more manufacturers for the supply of these drugs.

The Department stated (March 2013) that to study the poor participation in CPA tenders, meetings between prominent manufacturers and members of Special Purchase Committee in July 2012 and January 2013 were organised to address the issue. However, the outcome of these meeting was not provided to Audit.

5.5.8.2 Failure of CPA to initiate the process of next tender in time resulted in loss of ₹1.28 crore

Para 14.16 of chapter 14 of the Manual on 'Policies and Procedures for purchase of goods' stipulates that it should be ensured that new rate contracts are made operative right after the expiry of the existing rate contracts without any gap. In case, however, it is not possible to conclude new rate contracts due to some special reasons, timely steps should be taken to extend the existing rate contracts with same terms and conditions

etc. for a suitable period, not being more than three months. Also, while extending the existing rate contract, it should be ensured that the price trend is not on lower side.Audit scrutiny revealed that CPA finalised three tenders (2007, 2008 and 2011) for procurement of drugs and that period for finalization of these tenders ranged from 5 to 21 months. As CPA failed to initiate process of new tenders in time before completion of the validity of the existing contract, the existing rate contracts had to be extended frequently. Since the Directorate did not have any mechanism to analyse the market rates of drugs, extension of rate contracts by CPA resulted in financial benefit to suppliers, as the rates of drugs reduced in the intervening period (i.e., February 2007 to September 2007 and May 2011 to September 2011). Consequently, the Directorate suffered an avoidable loss of ₹ 1.28 crore in purchase of drugs made by the Central Store alone, during the period of extension ofcontracts as detailed below in **Table 5.7.**

Table5.7:Medicines procured at higher than market price

Year	No. of medicines procured	No. of medicines procured at higher price than market price	No. of medicines procured at lower price than market price	Net loss incurred (in ₹)
2005-07	91	60	31	6257765
2008-11	88	56	32	6534740
Total	**179**	**116**	**63**	**12792505**

Further, since all health institutions in Delhi were bound to procure drugs on the rate contracts finalised by the CPA, real loss would be much more which could not be quantified.

The Department stated (March 2013) that tender was floated timely in 2010, but had to be scraped owing to some complaints. In subsequent tender, prices of many drugs had gone up/down and, therefore, it was difficult to say that there was a loss to the Government because of extention of the tender. Reply was not acceptable as audit had taken a net figure by including all medicines procured during this period, irrespective of rates, for calculating the loss.

5.5.8.3 Non-enforcement of clause of extension of the contract

Clause-8 of the standard terms and conditions of the agreement stipulates that the tender may be extended for a further period as per the requirement or till the next tender is finalized, whichever is later. Audit scrutiny of agreements entered into between the Directorate and suppliers on supply of drugs, it was found that during 2007-08 to 2011-12, every time the existing contract was extended, decision was left to the discretion of the supplier, whether or not to supply the drugs. During the intervening period,

the suppliers supplied only those medicines to which they gave their consent and supply of remaining medicines were stopped till the finalization of next tender.

The Department stated (March 2013) that terms and conditions of the agreement were not clear as to whether purchaser could unilaterally extend the contract. Therefore, according to the Purchase Manual of Central Government, consent was sought before extension. Reply was not acceptable as it was clearly mentioned in the agreement that tender might be extended for a further period as per the requirement or till the next tender was finalized, whichever was later.

5.5.8.4 Non-issue of rate contract to eligible firms resulting in avoidable loss of ₹ 41.13 lakh

Audit scrutiny revealed that despite M/s M.J. Bio Pharma being declared as L1 out of four participating firms, the rate contract for Inj. Meropenem was issued to M/s Astra Zeneca on 28 April 2006. On representation made by M/s M J Bio Pharma, the rate contract of M/S Astra Zeneca was kept in abeyance and the matter was referred to an Enquiry Committee formed by the Directorate, which also declared M/S M.J.Pharma as L1. However, Special Purchase Committee decided that the clinical trial report of the drug might be asked from all the participating firms. None of the firms submitted the clinical trial report since it was not the pre-tender condition. In a meeting of Special Purchase Committee held in September 2006, it was suggested that samples of drug should be lifted from the open market. The vials should be coded, blinded and then sent for testing for (i) concentration of inj. Meropenum/ml of vials and its purity by laboratory analytical methods from the government approved labs and (ii) Microbiological opinion as regards testing of drug on bacterial growth. The Directorate could not conduct any such test as samples were neither provided by the firms nor lifted from the open market. During this period the injections were procured from the open market instead of placing order through rate contract. Audit collected the information relating to purchase of Meropenam Inj. from April 2006 to September 2007 from three hospitals and observed that due to non issue of rate contract to M/S M.J.Bio Pharma the Directorate suffered an avoidable loss of ₹ 37.13 lakh.

Similarly, in another case of rate contract of Injection-Enoxaparin (20mg and 40mg), the L-1 firm was not awarded the contract on flimsy ground of a complaint that was later found to be untrue. As a consequence, purchases were made from the previous supplier leading to avoidable loss of ₹ 4.00 lakh.

Thus, non-issue of rate contract to above two eligible firms resulted in avoidable loss of ₹41.13 lakh. Reasons for not issuing the rate contract to the lowest bidder were not furnished to audit.

5.5.8.5 Non-compliance of the fall clause of the agreement

As per CPA tender conditions, bidder is required to declare in its tender that rates quoted are not higher than rates quoted to other government/semi-government/autonomous/public sector hospitals/ institutions/organizations and that, if at any time during the execution of the contract, the controlled price becomes lower or the contractor reduces the sale price or sells or offers to sell such stores, as are covered under the contract, to any person/organisation including the purchaser or any organization including department of the Central Government or any department of the NCT Delhi, at lower price compared with rate in the contract, he was to notify such reduction to the purchaser and the price payable under the contract for the stores supplied after the date of coming into force of such reduction or sale or offer of sale shall stand correspondingly reduced. During test check of records audit noted that compliance to this clause was not being monitored by CPA. As an illustration, M/S Biodeal Laboratories Pvt. Ltd. was supplying Salbutamol Solution for Neubilizer (5mg/ml) at ₹13.80 against the rate of ₹6.76 fixed by 'National Pharmaceutical Pricing Authority', an organisation of the Government of India to enforce prices of medicines in the country under the Drugs (Price Control) Order,1995.

The Department accepted the facts and stated (March 2013) that M/s Bio Deal had deposited the excess amount.

5.5.8.6 Non enforcement of security deposit clause

As per the terms and conditions of the tender agreement, contractor should furnish a performance security deposit at the prescribed rate at the time of agreement with the CPA. It was noticed by audit that there was no centralized database for monitoring the security deposit in CPA. Audit test checked supply orders of six bulk drug supplying firms for rate contract for the year 2008 and observed that CPA was not enforcing this clause and failed to get deposits of ₹ 22.08 lakh **(Annexure-5.6)**.

The Directorate accepted the facts and stated (August 2012) that at present CPA was taking security deposit at the time of placing the supply order.

5.5.9 Improper maintenance of records of sample testing

During the scrutiny of records, it was noticed that CPA finalized two rate contracts with five NABL approved labs each for the years 2005 (extended up to December 2008) and 2008 (extended up to March 2012) to ensure testing of drugs/surgical items supplied to hospitals and the Central Store. However, no mechanism/system was evolved by CPA to ensure that sample of each batch of supply was tested before their distribution to patients. It was left to the Central Store, hospitals and institutes to send samples of the batches of drugs supply received in their stores.

The Directorate accepted the facts and stated (March 2013) that now each batch of the supply was getting tested. However, the Directorate did not produce any record to substantiate that samples of all batches of supply were tested before their distribution to patients.

5.5.9.1 No provision for penalising labs for incorrect reporting

During test check of records, audit observed that two drugs, namely Syp. Paracetamol IP and Syrup Promethazine, failed during the subsequent test of the same batch. The details are given in **Table 5.8** below.

Table 5.8: Details of lab test reports

Sl. No.	Name of drug	Name of Lab who conducted first test	Result of test and date of report	Name of Lab for subsequent test	Result of test and date of report
1.	Paracetamol Syp IP 125mg/5ml Batch No. WMS-1002	M/S ARBRO Pharmaceutical Ltd	Standard Quality 28.7.2006	M/S Sophisticated Industrial Materials Analytic Labs P. Ltd.	Not of standard quality 4.12.2006
2.	Promethazine Syp IP Batch No. PZS-1017	M/S Ashco Analytical Services	Standard Quality 19.5.2007	-do-	Not of standard quality 9.9.2007

Source: Information provided by Central Procurement Agency

In case of Syp. Paracetamol, the Directorate asked the firm to refund full payment of entire consignment, whereas in case of Syp. Promethazine, the firm was asked either to replace the drug or pay the full amount of the consignment. Thus, there was no uniform norm whether the failed drug is to be replaced or the cost of the drug is to be recovered from the suppliers, in case a drug failed in the test. There was no justification to arrive at the conclusion as to which of the two tests was correct, since one of the two test reports has to be incorrect. Enormity of impact of such drugs on health of patients, released on the basis of wrong test report cannot be quantified.

Further, there was no penalty clause incorporated in agreements signed with the labs, for furnishing incorrect test reports. Had there been a penalty clause, the Directorate could have, to some extent, ensured receipt of quality test reports and the instances of ambiguity in testing could have been avoided.

The Department accepted the facts and stated (March 2013) that penalty clause would be incorporated in future tenders.

5.5.10 Irregular expenditure of ₹ 1.62 crore on testing of samples of drug/surgical consumable items

As per Delegation of Financial Powers, Heads of the Department are empowered to incur recurring expenditure (not coming under the specified category) upto ₹ 2.00 lakh per annum. The expenditure under the head

"testing of drugs/medicines/surgical items samples" is of recurring nature and does not come under the specified category. Audit scrutiny of records revealed that during the last five years, an amount of ₹176.13 lakh was incurred on lab testing charges. However, expenditure sanction of ₹ 14.57 lakh had been obtained from the Finance Department for the period from December 2010 to March 2011. Thus, remaining expenditure of ₹161.56 lakh incurred by the CPA, beyond the competency of the Head of the Department, was irregular.

The Department accepted the facts and stated (March 2013) that this was being processed for regularization by the Finance Department.

5.6 Chief District Medical Offices

To streamline the functioning of the dispensaries and other public health activities under the Directorate, Delhi has been divided into eight districts which are the hub of all health related activities.

5.6.1 Non-implementation of Public Health Standards in Primary Urban Health Centers(PUHC)

In 2010, Public Health Standards were approved by the Delhi Cabinet to address the confusion caused by existence of multiple agencies providing primary healthcare with their respective units which are heterogeneous both in structure as well as services. Scrutiny of records vis-à-vis the standards revealed the following:

(i) Facility survey of the Primary Health Care Units

Facility survey of the Primary Health Centers belonging to different agencies was conducted in the year 2010 under National Rural Health Mission (NRHM) to identify existing facilities which can be upgraded to PUHC level. The Directorate surveyed 217 and 211 Allopathic dispensaries for infrastructure and services respectively. The detailed survey showed that even the basic services and infrastructure were not available in dispensaries **(Annexure-5.7)**. It was noticed in audit that no action was taken by the Directorate to remove the deficiency highlighted in the survey.

The Department stated (March 2013) that facility survey was conducted to objectively assess the gaps and several actions had been taken to rectify the gaps. The Reply was not acceptable as details of action taken by the authorities were not included in the reply.

(ii) Up gradation of identified units to the standards laid down

Once a PUHC has been identified, it should be upgraded to the standards laid down and recognized as such by a common insignia/board recognizing it as PUHC for the linked 50,000 population. However, it was observed in

audit that not even a single dispensary had been upgraded as of February 2013.

The Department stated (March 2013) that the process of up gradation to PUHC standards was not a onetime affair, and therefore, could not be implemented in one go, but was a continuous process, wherein the gaps were addressed in phases as per feasibility. The Reply was not acceptable as no document prepared by the Directorate in support of up gradation of dispensary was provided to justify their contention.

(iii) Facility wise population linkages

As per standards, the upgraded unit has to be mapped and linked to the assigned population through family health cards, which was not done (November 2012). These activities were to be carried out to strengthen all the identified units in terms of infrastructure/manpower. During the course of audit, it was noticed that no action was taken by the Directorate in this regard.

The Department stated (March 2013) that the task would be completed in near future with the cooperation from the Municipal Corporation of Delhi.

(iv) Referral services

As per the standards, maternity homes/hospitals for obstetric services/secondary/tertiary care centers should have been interlinked and displayed as such in the dispensaries as well as in the linked centre to ensure that the subsequent follow up of the referred cases and care as per the plan of action outlined by the consultant is possible. During audit it was noticed that no clear referral guidelines/protocols were available in the dispensaries.

The Department stated (March 2013) that the referral linkages had been established for provision of adequate mother and child health care, wherein dispensaries had been linked to higher centre for provision of maternal health care. Reply was not corroborated with the supporting documents.

(v) Community participation

(a) Rogi Kalyan Samiti

To ensure community participation in planning, implementation and monitoring of the activities in the dispensaries to make it more sensitive and responsive to the community needs and implementation of local level activities required for optimal functionalisation of the centre, the Rogi Kalyan Samitis were to be constituted. Audit scrutiny revealed that this objective has not yet been met.

The Department stated (March 2013)that this activity was exclusively being dealt by the Delhi State Health Mission and it was informed that the action to establish Jan Swasthaya Samiti in different dispensaries was in advance stage.

(b) Citizen charter

The Citizen Charter of a health organisation should have details to inform the beneficiaries about the health facility, its structure, its mandate, the services available in the centre, the entitlements of the beneficiary and the responsibilities of the beneficiaries. However, Citizen Charter of the Directorate does not contain the above information.

The Department in its reply (March 2013) stated that it was available in the dispensaries for public view and also available on the web site. However, the audit contention was that it lacked vital information to which the department did not reply.

5.6.2 Requirement of staff as per the standards of Primary Urban Health Centre

In April 2010, Public Health Standards were approved by the Cabinet. As per these standards, requirement of staff had been defined for providing health services, laboratory services, convergence with related sectors, referral linkages, prevention, etc. Accordingly, 6768 officials of different categories were required in the Primary Urban Health Centres (PUHCs) against which only 2858 officials were available **(Annexure-5.8)**. There was a shortage of 3910 officials (58 per cent) which had an impact on the working of the Directorate in discharging its mandated responsibilities.

The Department stated (March 2013) that the matter was under consideration of Administrative Reforms (AR) Department for creation of various posts.

5.6.3 Improper maintenance of OPD Register

As per the guidelines issued by the Directorate, the Medical Officer Incharge and the medical officers of the dispensary/Mobile Health unit should maintain the OPD register and should write clearly the name, sex, age and address of the patient.

Audit scrutiny of records related to the 50 selected dispensaries, however, revealed that the address of the patient was not entered in any of the dispensaries due to which the genuineness of the entries made in the register could not be verified in audit. In the absence of such details, follow up on the case and future investigation to control spread of diseases, if the need arises, would become difficult.

The Department accepted the facts and stated (March 2013) that the instructions had been issued to maintain OPD register and other relevant data, according to the guidelines.

5.6.4 Discrepancies in stock registers

(i) Audit scrutiny of records at 50 selected dispensaries revealed that stock register did not contain the batch number/lot number of the medicines received from the Central Store. Similarly, dates of manufacture and expiry were also not mentioned in the stock register. Though, the physical verification of stores had been done regularly, it was not clear as to how the same was done in the absence of basic information.

The Directorate accepted the facts and stated (February 2013) that it had issued necessary instructions in this regard.

(ii) During the audit of Baljeet Nagar Dispensary, it was noticed that the indents for medicines were given by OPD pharmacist and the same were recorded in the balance register. The daily consumption and balance of various medicines received from the dispensary store was to be recorded in the balance register, which was not being maintained by the dispensary since last ten years. As the dispensary did not maintain the actual consumption record, consumption of medicines could not be verified in audit.

The Department accepted the facts and stated (March 2013) that indent books and consumption registers for the period January 2007 to March 2012 had been prepared.

(iii) During the test check of records of Sagarpur Dispensary, it was revealed that instead of calculating the daily consumption of the medicines, only weekly totals of medicines were mentioned in the stock register during the period April 2007 to January 2009. Moreover, the medicines consumed were shown in the stock register as more than 119 to 420 *per cent* of actual consumption arrived on the basis of daily consumption register.

The Department stated (March 2013) that it was an inadvertent mistake of arithmetic calculation by pharmacist and all concerned have been advised, to be careful in future. The Reply was not acceptable as these mistakes were not pointed out even in the physical verification report.

5.6.5 Unauthorized destruction of government records

During audit of the dispensary at BholaNath Nagar it was observed that the records i.e. stock register, vouchers, indent books, balance register and distribution/consumption register for the period April 2005 to March 2010 had been destroyed due to termite infestation. However, the information

about the termite infestation and subsequent destruction of records was not given to the office of the CDMO (E). Thus, all records relating to the functioning of the dispensary were destroyed without the prior approval /proper authorization of the competent authority. As such, audit was not able to verify the receipt and consumption of medicines during this period.

The Department accepted the facts and stated (March 2013) that necessary instructions had been issued.

5.6.6 Anti Quackery Scheme

The Directorate in a meeting(March 2012) directed all the CDMOs to constitute teams for taking intensive tours of their respective districts to identify quacks, for immediate necessary action to be taken by referring the matter to the respective Council and also the police. An awareness campaign was also to be launched in slum areas to educate people about the threats posed by the quacks and also the implications of taking treatment from them. During the audit, it was noticed that no team was formed for the identification of quacks and no awareness campaign was launched.

The Department stated (March 2013) that Anti Quackery cell was unaware of such a meeting and no minutes of the meeting in this regard were traceable either in this cell or in DHS office. Reply is not acceptable as the meeting was held on 22 March 2012, under the chairmanship of Pr. Secretary of the Department, wherein all the CDMOs were directed to constitute the teams for taking intense tour of their respective district to identify the quacks and thereafter,necessary action.

5.6.7 Opening of Mother Laboratories without the requisite specialised staff

All primary health facilities should be able to provide diagnostic services, especially which can be managed at the dispensary level. Laboratories (Labs.) and mother laboratories were established by the Directorate in the year 2006. Audit scrutiny of records of 24 mother labs revealed that the basic requirements, essential to run these labs,were deficient. Details are:

No post of pathologist/lab technicians was ever sanctioned for any of these 39 Laboratories by the Directorate. The authenticity of the diagnostic tests conducted by Lab Assistant in these mother labs could not be ascertained in audit. Opening of mother labs without sanctioning/making available pathologist and lab technicians defeats the very purpose of the intended diagnostic services to the people.

The Department stated (March 2013) that a consolidated proposal for creation of various posts under DHS including that for mother labs, had

been moved and was under consideration of the Administrative Reforms Department.

(ii) The basic kits in mother labs were not available for a period ranging from four to 60 months during the period 2007-08 to 2011-12 as these were not available in Central Store.

The Department admitted the facts and stated (March 2013) that the problem of irregular supply of kits had been addressed by the Directorate.

5.6.8 Under utilization of facilities at mother labs

As per PUHC standard, all primary health facilities should be able to provide diagnostic services especially for conditions which can be managed at the PUHC level to avoid patients being referred to higher level facility centre. The mother labs were established with the purpose of providing doorstep delivery of the lab facilities for special investigations to public so that their visits to various government hospitals, which are already overburdened, could be restricted. These mother labs provide various diagnostic investigations like Haemoglobin (HB), Total Leucocytes Count (TLC), Differential Leucocytes Count (DLC), Erythrocyte Sedimentation Rate (ESR), Serum Widal, Urine Pregnancy Test (UPT), Blood Grouping, Blood Sugar, HIV Testrom, etc.

Audit analysis of the data of lab tests for the period 2011-12 revealed that the number of cases referred by doctors of dispensaries coming under the jurisdiction of a Mother lab of each district ranged from 0.80 to 17.63 *per cent*. The percentage of referral cases in all the mother labs was 8.43 *per cent* of total cases. In view of the poor per cent of referral cases, the Directorate should have ensured that all investigation cases are referred to mother labs by the dispensaries under the jurisdiction of an individual mother lab.

Therefore, the objective of establishing mother labs, to ensure decongestion of overburdened hospitals could not be fulfilled.

The Department stated (March 2013) that the matter was discussed for better utilization of diagnostic services and was hopeful that the patients would be motivated to use these services.

5.7 Mobile Health Scheme (MHS)

To provide basic health care to the residents at their door-step, it was decided to start the Mobile Health Scheme in the year 1989 in which a fleet of 20 mobile dispensaries was launched to cover different Jhuggi Jhopari clusters all over Delhi on weekly basis. Due to paucity of resources and keen interest shown by some NGOs, MHS invited NGOs to participate in the scheme and as a result, a fleet of 89 mobile dispensaries

started providing health care to Jhuggi Jhopari clusters/construction sites. One mobile dispensary visits two clusters in a day.

5.7.1 Manpower management in Mobile Health Scheme

The Directorate of Health Services hired vehicles from external agencies for running the scheme. The details of number of vehicles hired, along with the details of their deputation in NGOs and departmental zones (four zones) in Mobile Health Scheme are given in **Table 5.9.**

Table 5.9: Details of vans hired for MHS

Year	No. of vehicles hired	Mobile Van run by zones	Mobile Vans run by NGOs	Mobile Vans run by Govt.hospitals & dispensaries	Percentage of vans run by NGOs	Percentage of vans run by Govt. hospitals &dispensaries
2007-08	68	29	23	16	34	24
2008-09	74	29	29	16	39	22
2009-10	87	29	42	16	48	18
2010-11	86	29	41	16	48	19
2011-12	89	28	43	16	48	18

Source: Information provided by Mobile Health Scheme

Audit noticed that MHS was using the services of staff of other Government hospitals and dispensaries to run is mobile vans (18 to 24 *per cent*) at the cost of services to be offered in these hospitals and dispensaries. This further showed that the services in the hospitals and dispensaries were also compromised with to that extent.

Against sanctioned posts of 35, availability of doctors in MHS during the period of 2007-12 is given in **Table 5.10.**

Table 5.10:Availability of doctors against sanctioned posts

Year	Sanctioned post	Filled	Vacant	Posted at Hqrs (in charge)	Posted in field (mobile vans)	Mobile Van deputed at zones
2007-08	35	27	8	1	26	29
2008-09	35	24	11	1	23	29
2009-10	35	23	12	1	22	29
2010-11	35	23	12	1	22	29
2011-12	35	29	6	1	28	28

Source: Information provided by Mobile Health Scheme

A comparison of the doctors posted in the field with number of vans deputed in the zones clearly shows that three, six, seven, seven vehicles during the year 2007-11 respectively were in the field without doctors.

Further, scrutiny of Service books of 19 doctors revealed that there was an absence of doctors for 366, 279, 338, 248, and 239 days on account of leave during the year 2007-12.

MHS did not have any alternative arrangement in place to make up for absence of doctors; as a result, patient care was directly affected.

The Department accepted the facts and stated (March 2013) that besides routine services, the mobile vans also catered to the services like preventive services, family planning services and health education and promotions despite shortage of doctors.

5.7.2 Diversion of Mobile Vans

The services of mobile health clinics/vans along with the entire medical team were diverted on a large scale and on regular basis to other places/programmes like Sant Nirankari Samagam, Kawars camps, etc. for which no financial sanctions were issued by the Government of Delhi to MHS. The frequent diversions of mobile vans not only resulted in diversion of funds of MHS but also deprived the Jhuggi Jhopari (JJ) clusters of the services of the mobile vans.

5.7.3 Non-accountal of unutilised medicines during different events ranging from 43 to 78 *per cent*

During the course of audit in the West district, it was observed that for each public event separate records were maintained for receipt and distribution of medicines, surgical and non-surgical consumables (in the area under jurisdiction of the district) where services of mobile vans were utilised. All India Congress Committee convention was held from 15 December 2010 to 20 December 2010 in Burari Ground, Delhi. Scrutiny of OPD distribution registers revealed that out of 400 crepe bandages received from main store, only 33 were distributed during the event. The balance stock of 367 crepe bandages was neither carried forward to the stock register maintained for the next event nor shown as balance/stock in hand in the next and subsequent indents for requisition of medicine/non-surgical consumables from the Central Store.

Similarly, scrutiny of the records maintained for Nirankari Satsang held in November 2010 in Burari Ground, Delhi, revealed that huge balances of medicines which remained unutilized after the event were not accounted for,in the subsequent events. Furthermore, 43 to 78 per cent of the medicines indented remained unutilized which points to the projection of inflated requirement of medicines by the district.

Moreover, the expenditure on medicines/surgical items for such events, tantamount to diversion of funds from the budget allocated for MHS, as the objective of the scheme is to provide medical facilities at Jhuggi Jhopari clusters and construction sites.

The Department stated (March 2013) that as regard to crepe bandage, remaining balance was distributed to the WZ-I and WZ-III teams and was consumed in the allotted area. The reply was not acceptable as no documentary evidence to this effect was furnished with reply. No reply in respect of unutilized medicines in Nirankari Satsang event was furnished.

5.7.4 Difference in number of OPD slips issued and number of patients attended under Mobile Health Scheme

Guidelines issued by the Directorate state that after examination and diagnosis of the patients, the doctor should give the necessary medical advise on prescription slips. As per the information provided to audit, 121.01 lakh patients were attended to under the scheme, whereas only 27.12 lakh blank OPD slips were issued by the store to the Mobile Vans during the period 2007-08 to 2011-12. It is evident that either OPD slips were not issued to 93.88 lakh patients (77.6 *per cent*) or figures for patient attendance have been inflated.

The Departmentstated (March 2013) that the difference in the OPD slips was due to reasons that OPD slips were used for the first time and thereafter the prescriptions continued in old OPD slip. It further stated that in large gathering, they were unable to issue OPD slips to each and every person. Moreover, in view of the other preventive/promotive health education activities, prescription slips were not required. It was also stated that in the absence of OPD slips, cyclostyle slips were issued as an alternative. The reply was not tenable as the essentiality envisaged in the guidelines was not met, defeating the intended purpose of issuing prescription slip. Further, as per stock register, the stock of OPD slips had never been 'Nil' at any point of time.

5.7.5 Irregularities in the selection of NGOs for running Mobile Health Vans

Rule 206 (b) of GFRs clearly state that the voluntary organizations or non government organisations carrying out activities which promote the welfare schemes and programmes of the Government, should be selected on the basis of well defined criteria regarding financial and other resources, credibility and type of activities undertaken. The MHS invites applications on prescribed proforma from registered voluntary organisation/NGOs/private hospitals to participate in MHS to provide basic health care including immunization and family planning services to residents of Jhuggi Jhopari clusters and construction sites all over Delhi.

Audit scrutiny revealed that three NGO's were selected for running the mobile dispensaries for the period 2011-13 despite all the three NGOs were not found suitable. But, on subsequent physical verification, they were declared suitable and mobile units were allotted to them. Moreover, one NGO was selected inspite of expressing its inability to disburse the salary of staff.

From the above, it is clear that MHS did not fix well defined criteria for selection of NGOs giving scope for arbitrary selection.

The Department stated (March 2013) that the deficiencies noticed by Audit would be incorporated in terms and conditions for the selection of the NGOs in future.

5.7.6 Purchase of medicines with less permissible shelf life

Scrutiny of records in respect of Mobile Health Scheme revealed that the relevant entry regarding date of manufacture of drug/medicine was not made in the stock register. Thus, it was difficult to ascertain whether the medicines were purchased with permissible shelf life.

The Department stated (March 2013) that now such entries were being made on online programme 'Nirantar'.

5.7.7 Monitoring

Zonal in-charges of all four zones of Mobile Health Scheme are required to conduct inspections of mobile vans deputed in their respective zones and submit the inspection reports at MHS (Hqrs). However, there were no benchmarks set for the inspection of mobile clinics by the zonal incharges. It was noticed that only 138 inspections in four zones were conducted during April 2009 to May 2012. Audit scrutiny of inspection reports revealed that:

- Targets for inspection were not fixed,
- In six cases, the registration numbers of vehicles inspected, as per the monitoring report, were different from those for which the claim was raised by the service provider,
- In three cases, the Jhuggi Jhopari clusters shown as inspected by the zonal in-charge was different from the cluster covered by the mobile van dispensary as recorded in the vehicle log book and verified by the controlling officer, and
- In six cases, the mobile van dispensaries (NGOs) were found absent and in seven cases (NGOs), the team/doctors were unavailable in the mobile van dispensary. In some cases memoranda were issued by the Directorate but no concrete actions was taken.

Though, there was no benchmark, an average of 3.6 inspections per month for 4576[†] available sites, can fairly be termed as insufficient monitoring for ensuring desired services to general public by these mobile van dispensaries

The Directorate stated (February 2013) that sometimes the vehicle was out of order, therefore, the vehicle number mentioned in the monitoring report did not match with the number mentioned in the bill. The reply was not acceptable as the bills were verified on the basis of log book of the particular vehicle by the competent authority.

5.8 School Health Scheme (SHS)

School Health Scheme provides comprehensive Integrated Health Care Services to school children. The services provided to school children include routine health checkup, immunization against Tetanus, health education, counseling and advising the school authorities for maintenance of healthy and safe environment.

5.8.1 Targets not achieved

As per records, there was a steady increase in the number of schools and students, but there was no corresponding increase in the number of School Health Clinics. The targets and achievements there against under the scheme are given in **Table 5.11.**

Table 5.11: Targets and achievement of SHS

Data	2007-08	2008-09	2009-10	2010-11	2011-12
No. of SHS clinics	15	23	28	30	48
No. of teams	14	23	28	-	93
No. of schools allotted	140	190	208	-	939
No. of students enrolled	148574	225539	258434	-	1408500
No. of students covered	75869	119918	148824	-	196800
Percentage of students covered	51.06	53.16	57.58	-	13.97
Immunization (T.T.)	7413	36877	27046	-	0
Magic shows	0	0	122	-	0

Source: Information provided by the SHS

Audit analysis revealed that as per above table the School Health Scheme was not achieving its target. In 2007-08, the percentage of students covered under SHS was 51.06 per cent but in 2011-12, it decreased to

[†] (88 vans x 2 sites per day x 26 days in a month = 4576)

13.97 *per cent*, though there was a significant increase in the number of teams from 14 to 93 during 2007-08 to 2011-12. Immunization against Tetanus decreased by 26.65 *per cent* in 2009-10, whereas it came to zero *per cent* for the years 2010-11 and 2011-12.

The Department stated (March 2013) that earlier, the target was number of students enrolled in schools, catered by the School Health Clinics. In 2011-12, the target was the total number of students enrolled in all Delhi Government Schools. Thus, the percentage of students actually covered changed drastically. Thereply of the Department was not convincing as the average number of students covered by each team also reduced from 5419 to 2116 students, during the period from 2007-08 to 2011-12.

5.9 Bio-medical waste scheme

Delhi generates approximately 7000 metric tons of waste per day, out of which 70 tons are bio medical waste from various hospitals, clinics, and clinical laboratories. The treatment of bio medical waste and its disposal is of paramount importance for prevention of environmental pollution and hazardous diseases arising out of these substances. The government hospitals and some private hospitals have their own arrangement for treatment of bio medical waste, but small government dispensaries, private nursing homes/clinics cannot make their own arrangement for treating of bio medical waste due to high cost involved. Keeping in view the difficulties faced by these smaller health institutions, Government established two centralized bio-medical waste treatment facilities at Okhla and Nilothi in Delhi. The genuineness of the selection procedure for awarding the contract of the treatment plants could not be verified in audit as the Directorate expressed its inability to trace the records.

5.9.1 Non recovery of ₹ 1.41 crore from private contractor as monthly rent

Possession of land at Gazipur was taken over by the Directorate in June 2005 for a centralised bio-medical waste treatment plant. The Directorate entered into two agreements with M/s SMSL-Water Grace Products, the highest bidder, on 21 July 2006 and 7 August 2006 (the latter being part of

first agreement) for installation of centralized bio-medical waste treatment plant. The Delhi Pollution Control Committee (DPCC) inspected the site and the case was submitted to the Bio-Medical Waste Committee. This Committee in its meeting held on 31 May 2007, decided to refuse its consent for establishing the facility and the same was intimated to the contractor on 25 June 2007. Subsequently, the Directorate gave another site at Nilothi and entered into an Addendum Agreement with the same contractor on 4 November 2009 with the terms and conditions of previous agreements. Audit analysis revealed that:

a) No preliminary feasibility study was conducted before installation of new project with respect to technology to be used, the minimum waste to be disposed of and increase of quantum of waste during the project period, etc,

b) As per the condition 13 of the Addendum Agreement, all terms and conditions of the Agreements dated 21 July 2006 and 7 August 2006, other than those amended by this Addendum Agreement, together with all rights and obligations of the parties there under, shall continue to remain in full force and effect and shall be binding on both the parties, as before. In the Addendum Agreement, it was not mentioned that the period of agreement starts from the date of Addendum Agreement i.e. 4 November 2009, and M/s SMS Water Grace (Pvt.) Ltd would not pay the monthly rent as the land of Gazipur was declared unfit for establishing centralized bio medical waste treatment plant,

c) The contractor was to pay monthly charges of ₹4.32 lakh to GNCTD from the date of commencement of the facility or six months from the date of handing over/taking over of the land, whichever is earlier. The land at Gazipur was handed over to contractor on 7 August 2006 and the payment of monthly charges became due after six months i.e. from 7 February 2007 and was to be paid upto October 2009, the month after which land at Nilothi

was allotted. However, the Directorate did not recover the amount of ₹1.41[‡] crore against monthly charges, due from contractor.

The Department accepted the facts and stated (March 2013)that the then Principal Secretary(H&FW) gave directions to recover the due amount from the contractor.

5.9.2 Irregular Purchase of Bioster amounting to ₹62.92 lakh

BMW generated by dispensaries/hospitals is collected by M/s Synergy Waste Management and M/s SMW Water Grace Products. It was the responsibility of the contractors to collect, transport and dispose of the BMW after treating the same. Audit scrutiny revealed that the Directorate purchased Biosters amounting to ₹ 62.92 lakh for disinfection of bio-medical waste with the justification to disinfect the BMW generated in dispensaries /hospitals as there was a chance of infection during transit, whereas, the same activity was to be carried out by the agencies as an integral part of the agreement. Hence, the amount spent on purchase of Biosters to the tune of ₹62.92 lakh was unwarranted and unjustified because the BMW generated in Delhi by its dispensaries and the government hospitals was already less than the quantity treated free by the agencies.

The Departmentstated (February 2013) that no burn technology was preferred world over, therefore, Biosters were purchased as it used non-burn technology (High Frequency Microwave Disinfection) which cause less pollution, easy to use and cost effective etc.The reply was not acceptable as it was the responsibility of the contractor to collect, transport and dispose the waste as per the agreement and, thus, the Directorate incurred unwarranted expenditure.

Conclusion

In the absence of documented procurement procedures and instructions the Directorate resorted to procurement of drugs and medical equipment on adhoc basis. Improper assessment of actual requirements resulted in stock

[‡] (432000 x 32=1,3824000 and penalties for first 90 days@ ₹ 1000= 90000 and thereafter another 90 days @ ₹ 2000= 180000)

outs of essential life saving drugs and overstocking of few other medicines. This had adverse impact on delivery of health services in Delhi.

No system has been put in place for monitoring quality of drugs being supplied to hospitals and dispensaries. Testing of CPA drugs and surgical items were carried out in a routine manner. There was no tracking at CPA or the Central Store level to ensure that testing of all batches was carried out. Further, in the case of non-CPA procurement, the indenting units were only relying on in-house test reports of the drugs, submitted by the supplier, which was an anomaly, as there wereno testing reports of the drugs by CPA.

No Management Information System, either manual or computerized, was devised at the Directorate, CPA and Central Store level for planning and managing procurements and supplies.

Despite creation of infrastructure by the Directorate, for providing best health care facilities to population of the city, the objective of health care for the under-privileged has not been achieved.

Recommendations

- *Management Information System and monitoring mechanism need to be strengthened at all levels for effective decision making like assessment of actual requirements, monitoring of supplies and conforming with terms and conditions of agreements.*
- *In order to ensure operationalisation of good procurement practices, it is necessary that the Department, the Directorate, CPA, the Central Store and all indenting hospitals/institutes prepare detailed guidelines and procedures, in standardised forms. Such documentation would also facilitate transparency in the procurement process.*
- *An effective mechanism to capture fluctuations in the price trend of medicines/drugs in the open market may be developed to achieve maximum benefit in procurement of medicines.*

- *The Directorate needs to standardize clauses in standard bidding documents and agreements to ensure compliance to the Drug and Cosmetics Act, 1940.*
- *Procurement needs of all indenting hospitals/institutes need to be properly planned, consolidated and coordinated after properly assessing requirements in order to take advantage of bulk purchase discounts and to avoid stock out of essential and life saving drugs.*
- *Rate contract of all hospitals may be displayed on the Directorate's website for ensuring procurement of drugs economically and maintaining transparency.*
- *In order to make the system transparent, hospitals and dispensaries might consider displaying availability of drugs and surgical item on daily basis for convenience of patients.*

New Delhi
Dated:

(DOLLY CHAKRABARTY)
Principal Accountant General (Audit), Delhi

Countersigned

New Delhi
Dated:

(VINOD RAI)
Comptroller and Auditor General of India