CHAPTER 5

Healthcare Infrastructure

5 Chapter Healthcare Infrastructure

Audit Objective: Whether the health sector had adequate infrastructure as per prescribed norms and whether these were utilised efficiently and effectively.

There were inadequate Primary Healthcare facilities (including Primary Health Centres), to serve the rural population throughout the State. Absence of requisite physical infrastructure was noticed in the existing primary healthcare facilities. Community Health Centres were running with less than the number of prescribed beds. Most of the Super Speciality Hospitals (SSHs) had failed to deliver super-speciality services. Intensive Care Units and Cardiac Care Units in SSHs were also found non-functional. Further, equipment, acquired at significant expenses, could not be traced during the tagging exercise and many items of equipment were found lying idle in SSHs. The newly set up Integrated AYUSH Hospital in Paschim Medinipur, had remained un-utilised.

Infrastructure

5.1 Inadequate Primary Healthcare facilities to serve rural population

As prescribed in the Indian Public Health Standards (IPHSs), there should be one Sub-Centre for every 5,000 population, one Primary Health Centre (PHC) for every 30,000 population and one Community Health Centre for every 1.20 lakh population for plain areas[122].

An assessment (based on the population figure of the 2011 census and conservatively considering the population criteria for plain areas only) of availability of the existing primary health facilities in the State, showed the following status:

Table 5.1: Availability of the existing primary health facilities in the State

Type of health facility	Population norm (in plain areas) for Healthcare facilities	Rural population of West Bengal as per 2011 census	Ideal number of facilities	Total number of facilities available	Shortage of health facilities	Shortage Percentage
Sub-Centre (SC)	1 SC per 5,000 population	6,21,83,113	12,437	10,368	2,069	16.64
PHC	1 PHC per 30,000 population		2,073	916	1,157	55.81
CHC	1 CHC per 1,20,000 population		518	348	170	32.84
Total:			**15,028**	**11,632**	**3,396**	**22.60**

Source: HMIS data and IPHS norms and data furnished by H&FW Department

It could be seen that there was considerable shortage of PHC facilities in the State, as against the norms laid down by the IPHS. Non-availability of PHCs in the State, (as high as 56 *per cent*) was alarming.

In reply, Department stated (February 2024) that 3,187 new Sub-centres had been sanctioned and made functional. However, scrutiny of HMIS data showed that only 2,305 SCs were added in HMIS as of April 2024. The reply remained silent about shortages in PHCs and CHCs in the State.

[122] *3,000 for SCs, 20,000 for PHCs and 80,000 for CHCs in hilly/ tribal/ desert areas*

A district and facility-wise shortage analysis ***(Appendix 5.1, Appendix 5.2 and Appendix 5.3)*** of healthcare facilities, showed the following position of shortages in Primary Healthcare facilities, across districts:

Table 5.2: Percentage of shortages in Healthcare facilities in the State

Shortage in Sub-Centres		Shortage in PHCs		Shortage in CHCs	
Districts	**Shortage *(percentage)***	**Districts**	**Shortage *(percentage)***	**Districts**	**Shortage *(percentage)***
Nadia	37.11	**Uttar Dinajpur**	79.58	**Uttar Dinajpur**	59.09
Uttar Dinajpur	34.97	**South 24 Pgs. & Diamond Harbour HD**	70.86	**Nadia**	45.16
Murshidabad	27.06	**Malda**	70.41	**Malda**	44.83
Malda	25.88	**Purba Medinipur & Nandigram HD**	66.02	**Murshidabad**	43.75
Purba Medinipur & Nandigram HD	21.61	**North 24-Parganas & Bashirhat HD**	64.93	**Coochbehar**	42.86
Birbhum & Rampurhat HD	20.73	**Murshidabad**	63.18	**South 24 Parganas & Diamond Harbour HD**	41.18
Coochbehar	19.75	**Nadia**	62.19	**Jalpaiguri & Alipurduar**	39.13
Purba & Paschim Bardhman	17.55	**Dakshin Dinajpur**	60.42	**North 24 Parganas & Bashirhat HD**	38.89
Paschim Medinipur & Jhargram	17.35	**Jalpaiguri & Alipurduar**	59.47	**Purba Medinipur & Nandigram HD**	36.84
Bankura & Bishnupur HD	14.47	**Coochbehar**	57.31	**Hooghly**	35.71
North 24 Parganas & Bashirhat HD	13.27	**Paschim Medinipur & Jhargram**	52.61	**Dakshin Dinajpur**	33.33
South 24 Parganas. & Diamond Harbour HD	12.09	**Hooghly**	46.91	**Paschim Medinipur & Jhargram**	32.56
Dakshin Dinajpur	11.11	**Birbhum & Rampurhat HD**	43.01	**Birbhum & Rampurhat HD**	24.00
Purulia	5.15	**Darjeeling & Kalimpong**	41.01	**Bankura & Bishnupur HD**	18.52
Jalpaiguri & Alipurduar	4.53	**Bankura & Bishnupur HD**	37.21	**Purba & Paschim Bardhman**	12.82
Hooghly	2.67	**Purulia**	36.64	**Purulia**	4.76
Darjeeling & Kalimpong	-4.02	**Purba & Paschim Bardhman**	31.45	**Howrah**	0.00
Howrah	-26.13	**Howrah**	27.36	**Darjeeling & Kalimpong**	-33.33

Source: HMIS data and IPHS norms and data furnished by H&FW Department
As figures of population are not available separately, all newly formed districts and/ or health districts[123] (HDs) have been included in the original district

It could be seen that individually, nine districts, in respect of SCs; 10 districts, in respect of PHCs; and 12 districts, in respect of CHCs; had shortages higher than the State average in that category, ranging up to 37 *per cent*, 80 *per cent* and 59 *per cent*, respectively. It is pertinent to mention that three districts *viz.* Uttar Dinajpur, Malda and Murshidabad, commonly featured among the top six deficient districts, in regard to all the three categories of facilities (SC/ PHC/ CHC).

[123] *A district which is not administratively created but created on the basis of health services only, with posting of a Chief Medical Officer, Health, in each such district, are known as Health District.*

No recorded reasons in this regard, nor any evidence of having carried out a gap analysis exercise, or formulation of a time-bound plan to address such shortages, was furnished to Audit, though asked for. Thus, the existing SCs/ PHCs/ CHCs of the State were serving populations beyond their prescribed capacities. Around 89 *per cent* of the Sub-Centres (8,533), whose data was available (9,587), were serving more than the prescribed 5,000 (3,000 in Hilly areas) population per SC, while the number was as high as 98 *per cent* (796) in the tribal areas of the State (812). The Department in its reply (February 2024) offered no response in this regard.

This apart, the existing health facilities lacked the essential infrastructure and resources necessary to render services as per IPHS, as discussed in the following paragraphs:

5.2 Absence of requisite physical infrastructure in the existing primary and secondary healthcare facilities

5.2.1 Physical Infrastructure of Sub-Centers

(i) Own building & location: As per IPHS, a Sub-Centre should have its own building. If that is not possible immediately, premises with adequate space should be rented, in a central location, with easy access. The norms specified that, as far as possible, no person must travel more than three kms. to reach a Sub-Centre.

Analysis of the Health Management Information System (HMIS) data revealed that 2,084 SCs of the State (20 *per cent*) were not operating from government buildings. Moreover, 5,893 SCs (56.84 *per cent*) were located more than three kms. from the furthest village, in coverage area of those SCs.

Of the 38 test-checked SCs, in the five selected districts, seven SCs (18 *per cent*) did not have their own buildings ***(Appendix 5.4)***.

In reply, Department stated (February 2024) that presently there are 1,208 rented SCs in the State. Further, GPS based exercise and notification of new SCs has been done to reduce distance gap.

(ii) Building & layout: The building and layout norms of IPHS prescribed that SCs should have a boundary wall/ fencing with gate, for safety and security; a waiting room; one room for store; one room for clinic/ office; and one toilet facility, each in the wardroom and in the waiting area. Further, the building should have provisions for easy access, like ramp with railing, for the disabled and elderly. It should also have one Labour Room (with one labour table and newborn care corner) for Type-B SCs[124], with toilet facility.

The buildings were supposed to have a prominent board, displaying the name of the Centre in the local language, at the gate and on the building. Display boards, providing information regarding the services available, and the timings of the SCs, were to be displayed at a prominent place. Suggestion/ complaint box, for the patients/ visitors and information regarding the person responsible for redressal of complaints, were also to be displayed.

[124] *Type B Sub-Centre-SCs provide facilities for conducting deliveries, apart from other basic primary healthcare facilities, to the community.*

Review of the infrastructure module of 10,368 SCs, in HMIS, showed significant deficiencies in the availability of physical infrastructure, in the SCs of the State, as shown below:

Table 5.3: Deficiencies in the availability of physical infrastructure in the SCs of the State

Sl. No.	Infrastructure	Number of deficient SCs	Percentage
1	Labour Room not available	9,625	92.83%
2	No boundary wall and/ or gate	7,535	72.67%
3	No provision for separate public utility (toilet)	5,814	56.08%
4	Complaint box not installed	3,494	33.70%
5	Examination Room not available	1,561	15.06%
6	Prominent display board/ patient charter not available	1,119	10.79%
7	Clinic Room not available	862	8.31%

Source: HMIS data

Non-availability of labour room in SCs is corroborative of the audit observation *(paragraph 3.1.1(ii) (A))* that all SCs were Type-A.

Thus, the availability of essential healthcare services, security, patient/ public utilities *etc.*, could not be ensured. The scenario in the 38 test-checked SCs, of the five selected districts, was similar to that of the State ***(Appendix 5.4)***.

Table 5.4: Deficiencies in the availability of physical infrastructure in the selected SCs

Sl. No.	Infrastructure	No. of deficient SCs	Percentage
1	Labour Room not available	38	100
2	No boundary wall and/ or gate	26	68.42
3	No provisions for separate public utility (Toilet)	38	100
4	Complaint box not installed	10	26.32
5	Examination room not available	38	100
6	Prominent display boards and Patient Charter not available	10	26.32
7	Clinic room not available	38	100

Source: Data provided by test-checked districts

Picture 5.1: No boundary wall at Aturia SC, Bashirhat (February 2022)

Non-availability of examination rooms and clinic rooms, in the test-checked SCs, was found to be higher than the position depicted in the HMIS.

In respect of non-availability of Labour Rooms, the Department stated in its reply (February 2024) that it is not promoting deliveries at SCs. The Department also claimed that except SCs under construction, display/ patient charters were available in all SCs. In respect of non-availability of separate toilets and examination rooms, the Department while accepting the facts, assured about gradual reduction in number. No comments in respect of non-availability of boundary walls and/ or complaint boxes were made.

Picture 5.2: No concrete building of Nimki Mohar SC of West Medinipur (April 2022)

Picture 5.3: Kachcha approach road of Nimki Mohar SC, which gets flooded with water from the side canals/ drains (April 2022)

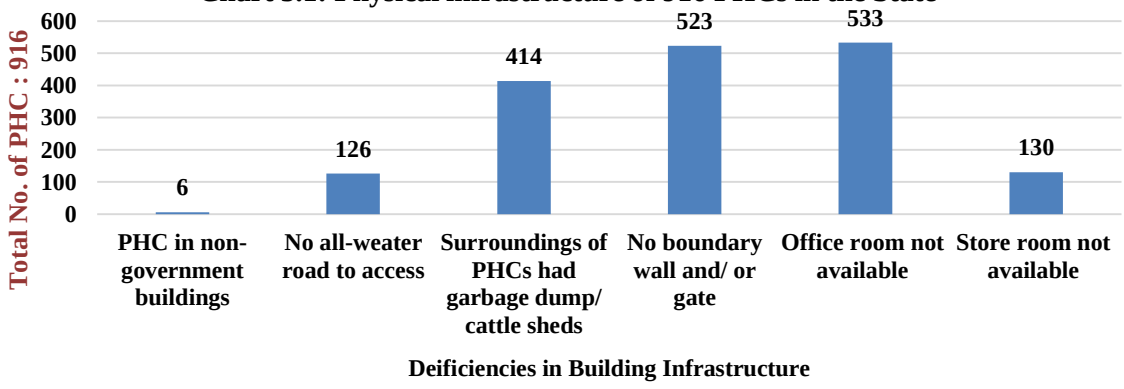
(iii) Water & Electricity: 43.39 *per cent* of the SCs in the State (4,499) did not have overhead tanks and/ or pumps, for ensuring water supply to the SCs. Moreover, out of the SCs where overhead tanks and/ or pumps were available (5,006)[125], in 568 SCs, either the tank was of insufficient capacity and/ or the pumps were non-functional. Uninterrupted power supply could not be ensured in 403 SCs.

In reply, the Department stated (February 2024) that overhead tanks and facility of uninterrupted power supply are mostly not available in rented/ rent free sub-centres the number of which is reducing gradually.

5.2.2 Physical Infrastructure of Primary Health Centres

(i) Building: As per IPHS, a PHC should have a building of its own. The surroundings should be clean with all-weather road communication and adequate water supply. Further, the PHC should be away from garbage collection, cattle shed, water logging area *etc.* A PHC should also have a proper boundary wall and gate.

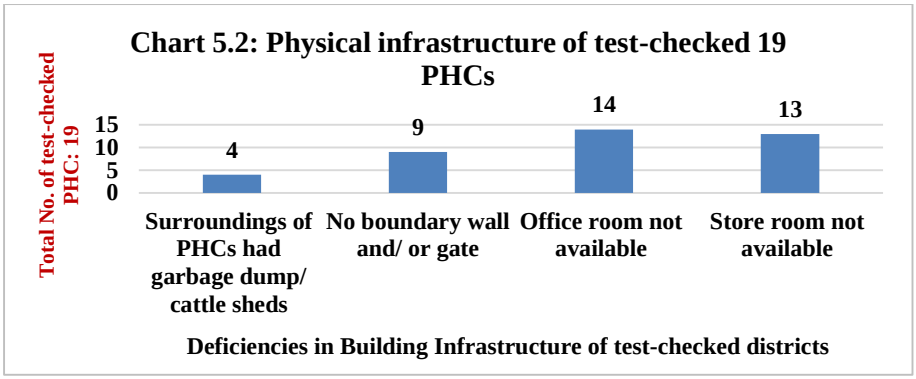
Chart 5.1: Physical infrastructure of 916 PHCs in the State



Source: HMIS data

Review of the HMIS data showed that, though only 6 of the 916 PHCs were not housed in government buildings, accessibility to 126 PHCs was not supported with all-weather roads. The surroundings of 414 PHCs had garbage dump and/ or cattle sheds. The premises of 523 PHCs were not secured by boundary wall and/ or gate. Office room and storeroom were not available in 533 and 130 PHCs, respectively.

[125] *Information in respect of 863 SCs was not available in HMIS.*



Source: Data furnished by test-checked PHCs

In the test-checked 19 PHCs ***(Appendix 5.5)*** in the surroundings of four PHCs had garbage dumps and/ or cattle sheds. The premises of nine PHCs were not secured by boundary walls and/ or gates. Office room and storeroom were not available in 14 and 13 PHCs, respectively.

(ii) Signage: As per IPHS, a PHC building should have a prominent board, displaying the name of the Centre in the local language at the gate and on the building. Further, PHCs should have pictorial, bilingual directional and layout signage of all the departments and public utilities (toilets, drinking water). Prominent display boards, in the local language, providing information regarding the services available/ user charges/ fee[126] and the timings of the Centre, should be available. The Citizen's Charter, including patient rights and responsibilities, is to be displayed at the OPD and entrance, in local language.

Review of records revealed that 84 PHCs in the State did not have display boards of the names, services and charter of patient rights in the State. In the test-checked PHCs, eight PHCs did not have display boards of the names, services and charter of patient rights.

In reply, Department stated (February 2024) that all PHCs are now functioning with proper citizen charter. The Department, however, remained silent about non-availability of display boards of names and/ or services in the PHCs.

(iii) Barrier-free access and disaster management measures: IPHS envisaged that a barrier-free access environment (ramp, hand railing *etc.*) was to be ensured in the PHCs, for easy access to non-ambulant (wheelchair, stretcher), semi-ambulant, visually disabled, and elderly persons. All PHCs were to have a Disaster Management Plan, in line with the District Disaster management Plan. All health staff were to be trained and well conversant with disaster prevention and management aspects. Further, surprise mock drills were to be conducted at regular intervals.

A review of the 19 test-checked PHCs showed that 14 PHCs had no arrangements for a barrier-free access environment (ramp, hand railing *etc.*). None of the PHCs had a Disaster Management Plan[127], in line with the District Disaster management Plan and/ or had conducted surprise mock drills, at regular intervals**.**

[126] *Cost of services, like OPD registration charges, diagnostic charges of units set up for X-ray, CT, MRI, pathology etc., in PPP mode.*

[127] *Apart from the building and the internal structure being earthquake proof, flood proof and equipped with fire protection measures, all health staff was to be trained and well conversant with disaster prevention and management aspects. Surprise mock drills were to be conducted at regular intervals.*

In reply, Department stated (February 2024) that provisions for barrier free environment has now been incorporated in designs for new buildings of PHCs.

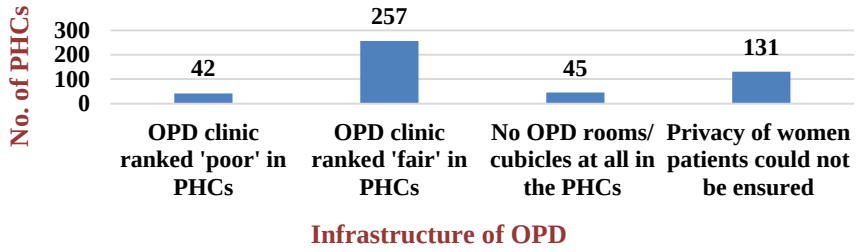
(iv) Waiting area: A waiting area, as per IPHS, was supposed to have adequate space and seating arrangements for waiting clients/ patients, as per the patient load. A locked complaint/ suggestion box was to be provided, and it was to be ensured that the complaints/ suggestions were looked into at regular intervals and addressed.

However, out of the 916 PHCs in the State, waiting areas for patients were not available in 258 PHCs (28 *per cent*), while complaint/ suggestion boxes had not been provided in 208 PHCs (23 *per cent*) in the State. In the test-checked PHCs, waiting areas for patients were not available in six PHCs, while complaint/ suggestion boxes had not been provided in 12 PHCs.

The Department replied (February 2024) that waiting area are now been constructed in all upgraded PHCs.

(v) Infrastructure for OPD and IPD: IPHS prescribes that outpatient rooms should have separate areas for consultation and examination, with provision for ample natural light and air. The area for examination should have sufficient privacy. There should be four to six beds in IPD of a Primary Health Centre. Separate wards/ areas should be earmarked for males and females, with the necessary furniture. Facilities for drinking water and separate clean toilets for men and women were also to be ensured. An Operation Theatre (optional) was to be in place, to facilitate conducting selected surgical procedures (*e.g.* vasectomy, tubectomy, hydrocelectomy *etc.*). It was to have a changing room, sterilization area, operating area and washing area. Each PHC was supposed to have a Labour Room, with provision for a Newborn Care Corner. There were to be separate areas, for septic and aseptic deliveries.

Chart 5.3: Physical Infrastructure of OPD clinics of 916 PHCs in the State



Source: HMIS data

HMIS data showed status of OPD clinics were poor[128] in 42 PHCs. However, the criteria standards for earmarking a PHC as poor was not on record. There were no OPD rooms/ cubicles in 45 PHCs. Privacy of women patients could not be ensured in 131 PHCs. Outpatient rooms, with separate areas for consultation, were not available in 8 of the 19 test-checked PHCs.

IPD: Analysis of HMIS data showed:

- There was no provision of beds in 34 *per cent* of the PHCs (316), while in 35 *per cent* of the PHCs (324), though bedded, IPDs were non-functional.

[128] *As ranked by the hospitals themselves in HMIS information*

- In PHCs with functional Beds (276), the status of IPDs was poor in 23 PHCs.
- There were no separate wards for males and females, in 86 PHCs.
- Separate public utilities, for males and females, were not available in 231 PHCs.
- The condition of toilets was poor in 101 PHCs.

Picture 5.4: IPD beds lying idle at Bajitpur PHC, Bashirhat (March 2022)

There was no Operation Theatre (OT) in 699 PHCs, while 18 of the existing OTs did not have power supply. Labour Rooms (LR) were not available in 473 PHCs, while 73 LRs suffered from problems of water seepage and 46 did not have power supply.

The status, as found in the test-checked 19 PHCs, showed that:

Table 5.5: Non-availability of IPD facilities in the test-checked PHCs

Sl. No.	Facilities not available	Deficient PHCs
1.	Provision of beds	13
2.	Separate wards for male and female patients	13
3.	Separate public utilities (toilets) for males and females	12
4.	Operation Theatre	17
5.	Operation Theatre (OT) for C-section deliveries	19
6.	Labour room with Labour table	10
7.	Labour room and OT of PHCs having Newborn Care Corner	13
8.	Labour room and Newborn Care Corner within LR, fitted with Radiant Warmer	12
9.	Arrangement for separate delivery areas, for septic and aseptic deliveries	19

Source: Data of the test-checked PHCs

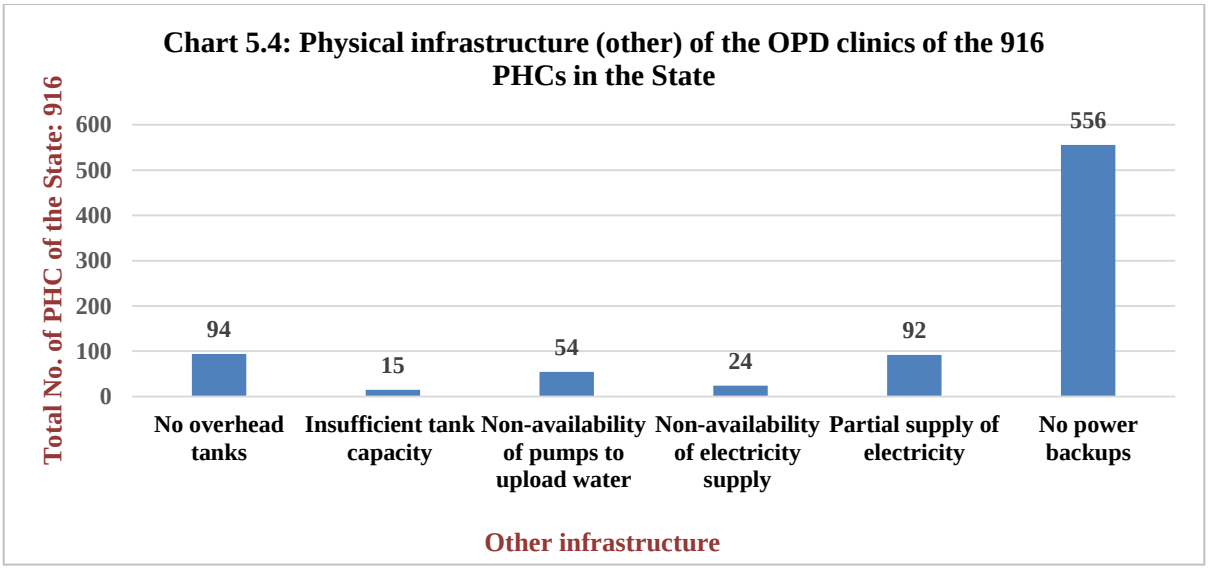
Thus, the test-checked PHCs were lacking in regard to providing privacy for women patients, conducting selected surgical procedures (*e.g.* vasectomy, tubectomy, hydrocelectomy *etc.*) and availability of resuscitation facilities for newborns.

(vi) Other infrastructure: Decent accommodation, with all amenities, such as 24-hrs water supply, electricity *etc.*, were to be ensured for Medical Officer, Nursing staff, Pharmacist, laboratory technician and other staff.

The PHCs were to be, as far as possible, environment friendly and energy efficient. Rainwater harvesting, solar energy use and use of energy-efficient bulbs/ equipment, were to be encouraged.

Adequate water supply and water storage facility (overhead tank), with piped water, was to be made available. Regular electricity supply, in all parts of the PHCs, with power backup facilities, was to be ensured.

Records of HMIS, however, showed that provisions for overhead tanks had not been made in 94 PHCs in the State and, of the PHCs where tanks were available, 15 were not of sufficient capacity and 54 PHCs did not have pumps to upload water into the tank. Electricity supply was not available in 24 PHCs and was only partially available in 92 PHCs. There were no provisions for power backup in 556 PHCs.



Source: HMIS data

Picture 5.5: Non-functional generator at Hingalganj PHC, Bashirhat (April 2022)

In the 19 test-checked PHCs, it was found that, in eight PHCs, accommodation with amenities like 24-hrs water supply, electricity *etc.*, were not available, for Medical Officers, nursing staff pharmacists, laboratory technicians and other staff. In 17 PHCs, there was no arrangement for rainwater harvesting and use of solar energy. Further, no provisions for power backup, were found in the Operation Theatres in 15 PHCs ***(Appendix 5.5)***.

The Department, in respect of non-availability of power supply in PHCs, stated (February 2024) that initiative to resolve this issue has been taken up utilising 15th FC funds.

5.2.3 Physical Infrastructure of Community Health Centres

(i) Location: The area chosen for a CHC, as per IPHS, should have facility for all-weather road communication. Further, CHC should be away from garbage dumps, cattle sheds, water logging areas *etc.*

Records revealed that seven of the 348 CHCs in the State did not have all-weather roads, to make them accessible in all-weather conditions. There were garbage dumps in the vicinity of 172 CHCs, while 47 CHCs had cattle sheds in their vicinity.

(ii) Building: As per IPHS, CHCs should not be in a low-lying area, to prevent flooding. CHCs should have a dedicated, intact boundary wall, with a gate. The name of the CHC, in the local language, should be prominently displayed at the entrance. Further, all CHCs should have a Disaster Management Plan[129], in line with the District Disaster Management Plan. All health staff should be trained and well conversant with disaster prevention and management aspects. Surprise mock drills should be conducted at regular intervals.

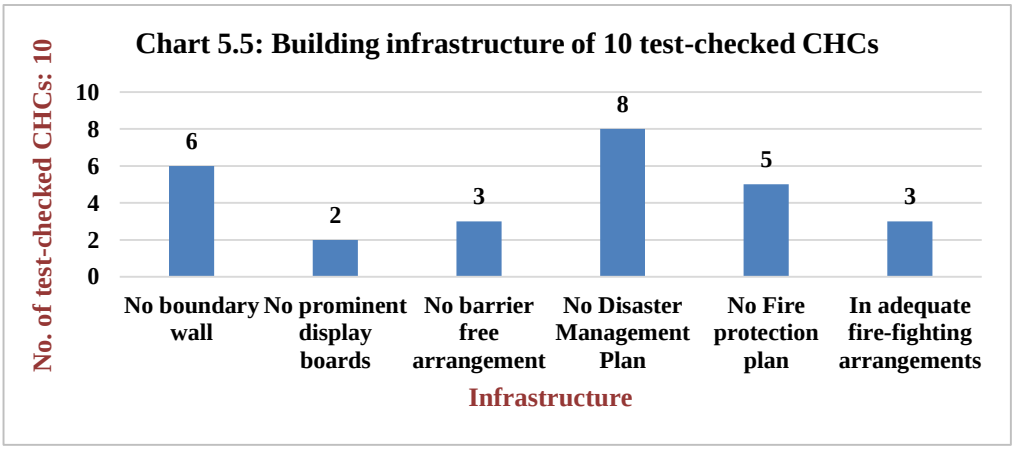
[129] *Apart from the building and the internal structure being earthquake proof, flood proof and equipped with fire protection measures, all health staff was to be trained and well conversant with disaster prevention and management aspects. Surprise mock drills were to be conducted at regular intervals.*

The CHC should be, as far as possible, environment friendly and energy efficient. Rainwater harvesting, solar energy use and use of energy efficient CFL bulbs/ equipment, were to be adopted.

Records showed that 66 CHCs in the State did not have boundary walls, while boundary walls were partially available[130] in 102 CHCs. Prominent display boards, in the local language, as also the charter of patients, had not been provided in 24 CHCs.

Picture 5.6: No boundary wall of Sandelerbill RH, Bashirhat (April 2022)

In the 10 test-checked CHCs ***(Appendix 5.6)***, there were no boundary walls in six CHCs. Prominent display boards, in the local language, were not available in two CHCs. Three CHCs had no arrangements of a barrier-free environment (ramp, hand railing *etc.*) for easy access. Eight CHCs had no Disaster Management Plans, while there were no Fire prevention Plans in five CHCs. Moreover, fire-fighting arrangements were not adequate, in three CHCs.



Source: data provided by test-checked CHCs

(iii) Entrance Zone: IPHS stipulated that prominent display boards, in the local language, providing information regarding the services available and the timings of the hospital, were to be installed. Directional and layout signages for all the departments and utilities (toilets, drinking water *etc.*) were to be appropriately displayed for easy access. All the signages were to be bilingual and pictorial. Citizen charter's were to be displayed at the OPD and Entrance, in the local language, including patient's rights and responsibility. Clean Public utilities, separate for males and females, Suggestion/ complaint boxes for the patients/ visitors and information regarding the person responsible for redressal of complaints, were to be provisioned for, in the CHCs.

Review of HMIS records showed that, out of 348 CHCs in the State, 24 CHCs had not displayed the charter of patient rights. Separate public utilities, for males

[130] *Boundary walls were not available all round the campus.*

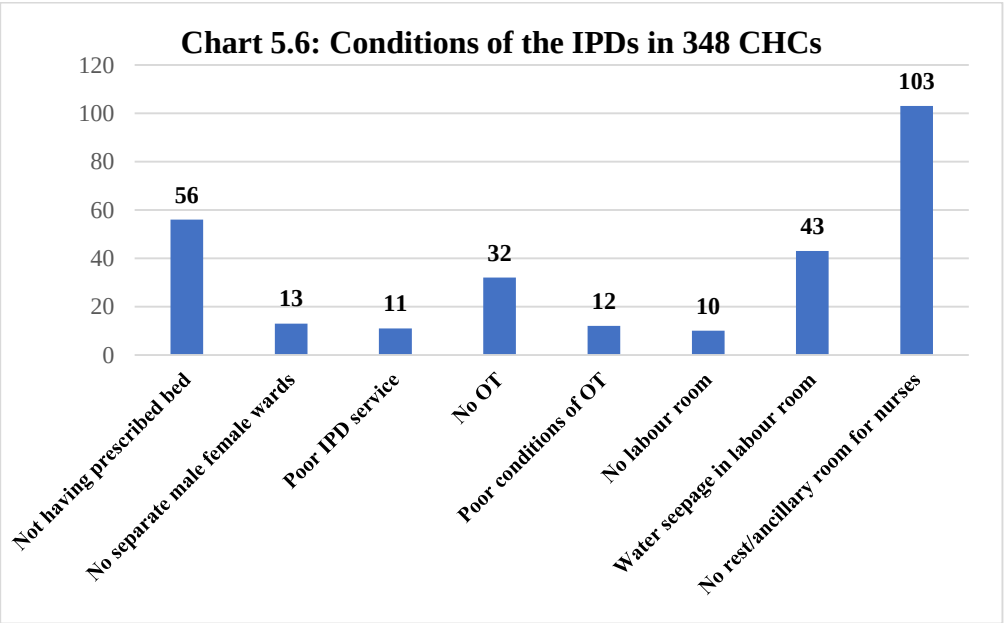
and females were not available in 16 CHCs. Where toilets were available, HMIS showed conditions as 'poor' in 25 CHCs. Complaint and/ or suggestion boxes had not been installed in 11 CHCs, for the purpose of grievance redressal.

(iv) OPD & Emergency: Provisions for clinics, as per IPHS, for general medicine, general surgery, dental, Obstetrics and Gynaecology, Paediatrics and family welfare, were essential in CHCs. Separate cubicles for general medicine and surgery, with separate areas for internal examination (privacy), were to be provided, if there were no separate rooms for each. A separate earmarked emergency area was to be located near the entrance of hospital, preferably having four rooms, one each for doctor, minor OT, plaster/ dressing and patient observation (at least four beds). In a CHC, there was to be a waiting room for patients and a pharmacy for drug dispensing.

Review of records showed that there were no rooms or cubicles for OPD clinics, in 15 CHCs. The condition of OPD clinics, in 10 CHCs, was 'poor' as shown in HMIS. Provisions for ensuring the privacy and dignity of women patients had not been ensured in 23 CHCs. Family welfare clinics were non-existent in 60 CHCs. Further, there were no provisions for emergency and/ or casualty areas in 48 CHCs. Waiting rooms for patients had not been provided in 51 CHCs.

(v) IPD: IPHS prescribed that a CHC should be a 30-bedded hospital. Separate toilets for males and females in IPD and separate space/ room, for patients needing isolation, were to be provisioned. CHCs were to have a nurse's rest room/ ancillary room. Operation theatre/ Labour rooms were required to have a Patient waiting Area, Pre-operative and Post-operative (recovery) rooms and Newborn care Corner. Review of records showed the following:

Chart 5.6: Conditions of the IPDs in 348 CHCs



Source: HMIS data

Out of the 348 CHCs in the State, 56 CHCs had less than the prescribed number of 30 beds. While 13 CHCs did not have separate male or female wards, the condition of IPDs, in 11 CHCs, was 'poor'. Similarly, while 32 CHCs did not have any OT, conditions of the OTs in 12 other CHCs were 'poor'. Labour Room (LR) was not available in 10 CHCs, while 43 LRs suffered from water seepage. There were no provisions for nurse's rest room or ancillary rooms, in 103 CHCs.

In 10 test-checked CHCs, it was observed that, in two CHCs, there was no patient waiting area. While pre-operative and post-operative (recovery) rooms were not available in six CHCs, Newborn Care Corner was also not available in one CHC ***(Appendix 5.6)***. At the Kunor BPHC, in the Uttar Dinajpur district, only one third of its sanctioned beds (30) were functional.

(vi) Water Supply & Power backup: Arrangements were to be made for supply of 10,000 litres of potable water per day, to meet all requirements (including laundry) except firefighting. Storage capacity, for two day's requirements, was to be based on the above consumption. Round-the-clock water supply was to be made available to all wards and departments of the hospital. Separate reserve emergency overhead tank was to be provided for the OT. Necessary water storage overhead tanks, with pumping/ boosting arrangements, were to be made available. Further, generator back-up was to be ensured in all healthcare facilities (hospitals). Generator of 5 KVA with POL[131], was necessary for Immunisation Cold Chain maintenance.

Review, however, showed that, out of 348 CHCs in the State, 10 CHCs did not have any overhead tank and/ or pump. Of the CHCs where overhead tanks were present, those were not of sufficient capacity in 26 CHCs. Scrutiny of HMIS data showed that 59 CHCs suffered regular to frequent power cuts. Standby generator facility was not available in 61 CHCs (apart from the 21 CHCs in respect of which no data was available); while, separate power-backup, in 63 CHCs had not been provisioned.

In the 10 test-checked CHCs, it was observed that Generator back-up was not available in the Labour Rooms and OTs of four CHCs. Moreover, 5 KVA generator sets, for maintenance of Immunisation Cold Chain, were not available in three CHCs. Adequate water supply was not available in Sandelerbil BPHC, in Bashirhat HD ***(Appendix 5.6)***.

The Department in reply stated (February 2024) about availability of 7.5 KVA generators at district level. However, the Department did not respond in regard to non-availability of 5 KVA generator at defaulting CHCs.

(vii) Administrative Zone: As per IPHS, separate rooms were essential for Office and Stores; CHCs needed to have a minimum of eight quarters for doctors and eight for staff nurses/ paramedical staff, two quarters for ward-boys and one quarter for driver, so that they remained available round the clock, in case of need.

HMIS records, however, showed that 13 CHCs (3.73 *per cent*) did not have provision for an office room, while nine CHCs (2.58 *per cent*) did not have storerooms. Kitchen rooms were not available in 40 CHCs (11.49 *per cent*).

Out of the 10 test-checked CHCs, three CHCs (30 *per cent*) did not have the requisite quarters for doctors, staff nurses/ paramedical staff ***(Appendix 5.6)***. Quarters for ward-boys and drivers were not available in eight CHCs (80 *per cent*).

The Department in its reply (February 2024) offered no response in this regard.

[131] *Petrol Oil Lubricant*

5.2.4 Physical Infrastructure of District/ Sub-District Hospitals

(i) Building Infrastructure and location of Hospitals

As per the IPHS, the Hospital Management Policy was to emphasize on quake proof, fireproof, protected, flood proof buildings and be away from high tension wires. The infrastructure was to be eco-friendly and disabled friendly. Provision was to be made for water harvesting, solar energy/ power back-up, and horticulture services, including herbal garden. The hospital was to have a high boundary wall, with at least two exit gates.

Further, the following factors were to be considered in locating a Sub-district Hospital and District Hospital:

- The location was to be near the residential areas. If the buildings were too old, they could be demolished and new construction was to be done in its place.
- It was to be free from the danger of flooding; it was, therefore, not to be sited at the lowest point of the district.
- Necessary environment clearance was to be taken by the hospital authorities.

Analysis of information, against 18 District Hospitals and 36 SDHs of the State, in the HMIS data, revealed the following ***(Appendices 5.7 & 5.8)***:

- Hospital buildings were not free from danger of flooding, in case of five SDHs and one DH.
- Disabled friendly provisions, in terms of the Disabilities Act, were not available in 11 SDHs.
- Two SDHs were operating without having obtained the necessary environment clearances.
- Compound walls/ fencings were partial for protecting the premises of 11 SDHs and eight DHs.

Of the three test-checked SDHs, the buildings of two[132] test-check SDHs were not earthquake proof and located in flood prone areas. Environment-friendly measures, like Rainwater harvesting, had not been adopted by any of the three test-checked SDHs.

(ii) Waiting spaces and other facilities at hospitals

Registration, assistance and enquiry counter facilities were to be made available in all the clinics, along with proper sitting arrangement, drinking water, ceiling fans and toilet facilities (separate for males and females). The main entrance, general waiting and subsidiary waiting spaces, were required to be adjacent to each consultation and treatment room, in all the clinics.

Analysis of the State data of HMIS showed that:

- Registration counters were not available in two SDHs.
- Waiting spaces, adjacent to the consultation and treatment rooms, were not available in one SDH.
- Assistance and enquiry counter was not available in one SDH.
- Non-availability of separate toilet facility, for males and females, was noticed in eight SDHs and five DHs.

[132] *Ghatal and Raghunathpur SDH*

(iii) Residential Quarters

All the essential medical and para-medical staff were supposed to be provided with residential accommodation, to ensure availability of essential staff 24 x 7, in cases of need.

Analysis of HMIS data revealed that residential quarters, for all medical and para medical staff, were not available, in nine SDHs and seven DHs ***(Appendices 5.9 & 5.10)***.

(iv) Clinics

The clinics, in a secondary level hospital, were supposed to include general, medical, surgical, ophthalmic, ENT, dental, obstetrics and gynaecology, Post Partum Unit, paediatrics, dermatology and venereology (Desirable in SDH), psychiatry (Desirable in SDH), neonatology, orthopaedic and social service departments. Clinics for infectious and communicable diseases were to be located in isolation, preferably, in a remote corner, provided with independent access.

Analysis of State data, as available in HMIS, however, showed that the following clinical services were not available in different SDHs in the State ***(Appendices 5.7 & 5.8)***.

Table 5.6: Non-availability of services in different SDHs in the State

Sl. No.	Name of the Clinic	No. of SDHs not having services	No. of DHs not having services
1	Neonatology	16	3
2	Orthopaedics	3	-
3	ENT	1	-
4	Dental	1	-
5	Dermatology	8	1
6	Psychiatry	15	-

Source: HMIS data

Further analysis showed that infectious and communicable disease clinics were not located in remote corners with independent access, in 10 SDHs and 2 DHs, although this was prescribed in the IPHS.

(v) Operation Theatres

An Operation Theatre was supposed to have a Preparation Room, Pre-operative room and Post-Operative Resting Room. Operating rooms were to be made dust-proof and moisture-proof. There was also to be a scrub-up room, where the operating team could wash and scrub their hands and arms, put on their sterile gowns, gloves and other covers, before entering the operation theatre. The theatre was to have sinks/ photo sensors, for water facility. Laminar flow of air was to be maintained in the operation theatres.

Analysis of HMIS data, however, revealed that pre-operative rooms were not available in nine SDHs & two DHs and Post-operative rooms were not available in 10 SDHs and 2 DHs.

Further, scrub-up rooms were not available for washing and scrubbing, in two SDHs ***(Appendices 5.9 & 5.10)***.

Delivery Suite Units: The delivery suit units were to be located near operation theatre. The delivery Suit Unit was to include facilities of accommodation for various facilities, such as:

(i) Reception and admission
(ii) Examination and Preparation Room
(iii) Labour Room (clean and a septic room)
(iv) Neo-natal Room
(v) Sterilizing Room
(vi) Sterile storeroom
(vii) Scrubbing Room

Review of records showed the following ***(Appendices 5.9 & 5.10)***:

- Fully equipped delivery units, located near OTs, were not available in seven SDHs and two DHs
- Examination and preparation rooms were not available in two SDHs.
- Neo-natal rooms were not available in seven SDHs and one DH.
- Sterilization rooms were not available in three SDHs[133] and one DH[134].

The Department in its reply (February 2024) offered no response in this regard.

5.2.5 Findings of the beneficiary survey

Survey of patients, randomly selected in the test-checked PHCs and CHCs, showed the following scenario, in respect of the quality of infrastructure of the healthcare facilities:

A. OPD infrastructure

Table 5.7: Beneficiary survey report in regard to the OPD infrastructure of the test-checked PHCs and CHCs

Sl. No.	Issues raised through surveys	No. of patients surveyed	No. of patient confirming the issue	Percentage
1	Non-availability of Enquiry/ 'May I Help' desk, with competent staff	179	128	71.51
2	Inadequate/ not good seating arrangement at the registration/ OPD counter of the facility	366	138	37.70
3	Non-availability/ not good condition of drinking water facility for the patients at the healthcare facilities	366	149	40.71
4	Non-Availability/ not good status of neat and clean toilet facility	366	161	43.99
5	Inadequate number of registration counters	179	94	52.51
6	Time taken for registration more than 10 minutes	179	43	24.02
7	Time taken for registration more than 30 minutes	179	20	11.17
8	OPD area not clean	179	37	20.67
9	Non-satisfactory patient calling system at the facility	179	116	64.80
10	Non-availability of complaint box in OPD	179	131	73.18
11	Sufficient information (regarding direction & location signages, Registration counter, Laboratory, Radiology dept., dispensary *etc.*) not available in Hospital	187	21	11.23
12	Promptness at Medicine distribution counter ranked below "good"	187	40	21.39

Source: beneficiary survey of test-checked PHCs/ CHCs

[133] *Mathabanga SDH, Coochbehar; Gangarampur SDH & SSH, D. Dinajpur & Ghatal SDH & SSH, Paschim Medinipur*
[134] *Alipurduar DH, Alipurduar*

An analysis of the average patient load on registration counters of the test-checked CHCs showed 6 of the 10 CHCs had patient load of more than 100 ranging up to 177 (Itahar RH) during 2016-22 ***(Appendix 5.11)***.

B. IPD infrastructure

Table 5.8: Beneficiary survey report in regard to the IPD infrastructure of the test-checked PHCs and CHCs

Sl. No.	Issues raised through surveys	No. of patients surveyed	No. of patient confirming the issue	Percentage
1	Clean and adequate toilet facility not available for male and female patients	96	35	36.46
2	Cleanliness of the wards was ranked below 'good'	86	15	17.44
3	Cleanliness of surroundings and campus drain was ranked below 'good'	86	19	22.09

Source: beneficiary survey of test-checked PHCs/ CHCs

It could be seen that patients were largely dissatisfied with the facilities and amenities which should have been provided in the OPDs of the test-checked hospitals. Moreover, almost 73 *per cent* of the patients said that there were no provisions (complaint boxes) to register a complaint in the OPD areas. Though complaints for inadequate and unclean IPD toilets had emerged from the survey, the overall opinion about IPD infrastructure was better than it was in regard to the OPD infrastructure.

Results of a survey of 38 doctors, of these test-checked health facilities, showed that more than one third (37 *per cent*) of the doctors believed that requisite infrastructure for proper examination of patients, was lacking in the hospitals.

- Survey of patients randomly selected in the test-checked DH/ SDHs, showed the following scenario in regard to the quality of infrastructure of the healthcare facilities:

Table 5.9: Survey of randomly selected patient in test-checked DH/ SDH

Sl. No.	Issues raised through surveys	No. of patients surveyed	No. of patient confirming the issue in PSS[135]	Percentage
OPD				
1	Enquiry/ 'May I Help' desk not available with competent staff	81	42	51.85
2	Seating arrangement not adequate at registration/ OPD counters	81	34	41.98
3	Drinking water facility not available for patients	81	28	34.57
4	Rate list not displayed in the reception area	81	20	24.69
5	Facilities for differently abled persons not available	81	20	24.69
IPD				
1	Clean and adequate toilet facility not available for male and female patients	79	42	53.16

Source: patient satisfaction survey of test-checked DHs/ SDHs

[135] *Patient Satisfaction Survey*

It could be seen that 25 *per cent* to 53 *per cent* of the patients were not happy with the OPD and IPD facilities like 'May I help' Desk, drinking water, rate chart, clean toilets *etc.* The Department in its reply (February 2024) offered no response in this regard.

5.2.6 Lack of action to plug gaps

The State Health & Family Welfare Department had failed to provide any document, which could suggest that an action plan had been prepared to identify and plug gaps, against a specific time frame, in the infrastructure position relating to the primary health sector of the State. No plan and/ or effort, to bridge the shortage in number of available primary health facilities, was evident from records. The number of available health facilities, at present, in the State, when compared to the position prevailing in 2016, showed the following:

Table 5.10: Comparison of availability of Primary healthcare facilities

Type of Facility	Number of health facilities		Creation of new facility
	As on 31.12.16	As on 31.03.22	
Sub-Centre	10,357	10,368	11
Primary Health Centre	913	916	3
Community Health Centre	348	348	0

Source: HMIS data State level

It may be seen from **Table 5.10** that only 11 new sub-centres and three new Primary Health Centres had been set up in the State, in the last six years.

In the test-checked Jalpaiguri District, it was observed that the Chief Medical Officer of Health (CMOH), Jalpaiguri, had sent a proposal (April 2015) to the Health Department, GoWB, for setting up a new PHC at the Samsing Tea Garden in Matiali Block (hilly area) of Jalpaiguri, as there was no nearby health facility. Due to the unavailability of nearby health services, home deliveries (20 *per cent*) and transit deliveries (average five per year) were also very high in the area. Review revealed that Administrative Approval from the Health Department had been accorded in March 2017, with financial sanction of ₹ 388.07 lakh. In the same order, a meagre amount of ₹ 5,000 only had been allotted to the Chief Engineer, Headquarters, PWD, as the first instalment.

Subsequently, when the CMOH asked (April 2017) the Executive Engineer, PWD, Jalpaiguri, to prepare the detailed estimate of the proposed construction work, the estimated value was derived at ₹ 656.40 lakh (Civil: ₹ 581.05 lakh; Electrical: ₹ 75.35 lakh). The revised estimate was sent (September 2017) to the Department for administrative approval and fresh Financial Sanction. It was sent back to the CMOH (December 2018), with queries and observations regarding the huge cost escalation, as well as non-commencement of work after passing of one and a half years of Administrative Approval. The CMOH, in his clarification, mentioned revision in the schedule of rates of PWD, as well as some modifications/ changes in the plan, among the reasons for the escalation. The Department finally approved (November 2021) the escalated cost of the project.

Up to June 2022 the Health Department had only released the first instalment of ₹ 5,000 (March 2017). Thus, delay in approvals and release of a meagre amount for the work, were the main reasons for delay in the progress of the work.

Resultantly, after a lapse of seven years, the work was still lying (June 2022) incomplete, with only 12 *per cent* of the work having been executed so far (June 2022), thereby depriving the people of the Matiali Block of primary healthcare services.

The case was corroborative of the absence of a comprehensive plan and action on part of the State department, in a case where deficiencies in coverage, due to inadequate primary health facilities, had been noticed.

The Department in its reply (February 2024) offered no response in this regard.

5.3 Lack of physical Infrastructure at Medical College and Hospitals (MCHs)

The following observations emerged from a review of available infrastructure in the four test-checked MCHs, out of the 18 MCHs of the State:

- As per provision contained in clause A.1.5 for the National Medical Commission (NMC) standard for 200 admissions, lecture halls should have a provision for 'E-class'. There were five lecture halls at the IPGME&R, Kolkata, having a capacity of 730 students. However, these halls had no provision for conversion to e-class/ virtual class, for teaching.
- In the Raiganj Medical College & Hospital (RMC&H), an auditorium-*cum*-examination hall, having an area of 800 sq.m, had been constructed without seating facilities, as of March 2022.
- As per provision contained in A.1.7 of the NMC standard for 200 admissions, facilities for microphotography[136] and mounting should be provided at the central photographic section of the medical college. However, no such facility was available, either at the IPGME&R or at the RMC&H.
- As per provision contained in A.1.8 of the NMC standard for 200 admissions, there should be a central workshop, having facilities for repair of mechanical, electrical, air conditioners and refrigeration equipment of the college and the hospital, manned by qualified personnel. However, no such facility was available, either at the IPGME&R or at the RMC&H.
- As per provision contained in A.1.19 (b) of the NMC standard for 100 admissions, there should be one well-equipped Central Research Laboratory in the Medical College, which could be under the control of the Dean of the college. However, no such laboratory was available at the RMC&H.
- As per provision contained in A.1.21 of the NMC standard for 100 admissions, every Medical College was to have one Rural Health Training Centre, under the administrative control of the Dean of the College, for training of students in community-oriented primary healthcare and rural-based health education for the rural community,

[136] *Microphotography: This is a process where photography can be undertaken while viewing the sample under a microscope.*

attached to it. Separate residential arrangements for boys, girls and interns, with mess facilities, was also to be provided. The Raiganj Medical College & Hospital did not have any such rural health training centre, affiliated to any Govt. owned health centre for training of students and interns, while residential arrangements were under construction, at the rural health training centre owned by the IPGME&R, as of March 2022.

- As per provision contained in A.1.19 (b) of the NMC standard for 200 admissions, every Medical College was to have Close-Circuit Television (CCTV) system in the Medical College and shall provide live streaming of both classroom teaching and patient care in the teaching hospital, to maintain a constant vigil on the standard of medical education/ training being imparted. Both were to be integrated as a part of the "Digital Mission Mode Project" of the College Council. However, RMC&H and IPGME&R did not provide such live streaming of classroom teaching and patient care, in the teaching hospital.

The Department in its reply (February 2024) offered no response in this regard.

5.4 Infrastructure of newly created Multi/ Super Specialty Hospitals (SSHs)

5.4.1 Idle infrastructure of the SSHs

With the aim of decongesting teaching hospitals in and around Kolkata and discouraging patients being referred from far away districts, and for providing Speciality and Super-specialty healthcare services at the district/ sub-district level, the H&FW Department, decided (September 2011) to set up 34 Multi/ Super Speciality Hospitals (SSHs), by utilizing Special Central Assistance, under the BRGF[137] (State Component) fund, in 11 BRGF districts[138]. Setting up of eight more SSHs were also decided (January 2014) from State funds in non-BRGF districts, as Tertiary Healthcare Facilities. In the meeting (23 December 2011) of the Empowered Committee, under the Planning Commission, GoI, it was decided that the WBMSCL would implement the project and funds for the purpose would be routed through the "Deposit Account" of the WBMSCL.

Based on presumptive demand, two types of SSHs were planned, *viz.* 10 storied 500-bedded SSHs and five storied 300-bedded SSHs, for construction at different places across the State ***(Appendix 5.12)***. The works of 29 SSHs (BRGF: 21 & non-BRGF: eight), at a total estimated cost of ₹ 1,858.30 crore, and other 13 SSHs (BRGF), at an estimated cost of ₹ 683.97 crore, were awarded to different executing agencies, selected through the tender process, on Turnkey and non-Turnkey basis, respectively. In the Turnkey basis contract, apart from construction of the buildings, the agencies were to supply the agreed quantity/ number of equipment and furniture to the SSHs, as a package.

[137] *Backward Regions Grant Fund (BRGF), launched in February 2007, funded by GoI, for solving the problems of poverty, low-growth and poor governance in the backward districts.*

[138] *Bankura, Birbhum, Dakshin Dinajpur, Jalpaiguri (Jalpaiguri & Alipurduar), Malda, Murshidabad, , Paschim Medinipur (Paschim Medinipur & Jhargram), Purba Medinipur, Purulia, South 24 Parganas and Uttar Dinajpur,*

In case of the 28 SSHs (except for the SSH at Uluberia, Howrah), taken up on turnkey basis, details of planning, design and construction, along with supply of specified medical equipment and furniture, was part of, NITs. However, no Detailed Project Reports (DPRs), detailing the specifications, quantities and costs (as per the PWD Schedule) of the material to be used for construction, were annexed, as part of the tender documents.

The works of 41 SSHs (except SSH at Belda, Paschim Medinipur[139]) were completed and these SSHs were made functional between January 2016 and March 2019. The Corporation, however, could not provide SSH-wise expenditure, though sought for.

Review of records, however, showed that, out of 41 newly constructed SSHs, 30 SSHs had to be merged (January 2018) with the attached District Hospital/ Sub-Divisional Hospital/ State General Hospital and could not render the intended services due to acute shortage of manpower as shown in subsequent paragraphs.

(i) Non-posting of Manpower in SSHs against posts sanctioned

The H&FW Department created and sanctioned (27 November 2014) 13,701 posts, of different categories, for 40 SSHs[140].

While analyzing records relating to that manpower in 40 SSHs, Audit observed that the manpower position of 30 SSHs had been shown by merging the Men-in-Position of attached DHs/ SDHs/ SGHs. Hence, the status of postings against the Sanctioned Strength of these SSHs, could not be determined. MIP, in respect of the remaining 10 SSHs[141], as of March 2022, was as below:

Table 5.11: Shortage of Manpower in SSHs

Sl. No.	Manpower Category	Manpower in 10 SSHs			
		Sanctioned Strength	Men in position	Shortage	Shortage (Percentage)
1	Medical Officer	360	122	238	66
2	Nursing Staff	1,090	675	415	38
3	Technical Staff	170	119	51	30
4	Others*	1,430	344	1,086	76

*Source: WBMSCL data; * Medical Technologists, sweeper, GDA, official staff, etc.*

Posting of Medical Officer, Nurses, Technical staff and others, was highly inadequate in the SSHs, leading to shortage, of 66, 38, 30 and 76 *per cent*, against the sanctioned strength. Consequently, the SSHs could not use the created infrastructure and render desired services as discussed in succeeding paragraphs.

(ii) Beds of SSHs not made functional, as sanctioned

Out of 40 SSHs, six SSHs were planned as 500-bedded and 34 SSHs as 300-bedded. However, review of 15 SSHs showed that 13 *per cent* to 52 *per cent* of the sanctioned beds had not been made operational, till the date of audit (June 2022) ***(Appendix 5.13)***, despite the passage of almost four years of their becoming operational. IPD beds, had, however, been supplied, as planned in respect of the Turnkey projects, by the executing agencies.

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[139] *The works could not be completed due to failure of contractors, execution of re-tenders etc.*

[140] *SSH Hatuara, Purulia, was converted as an attached hospital to the Deben Mahato Government Medical College and Hospital.*

[141] *Bolpur, Domkal, Diamond Harbour, Kalna, Rampurhat, Nayagram, Gopiballavpur, Sreerampore, Bongaon and Islampur.*

(iii) Absence of Super Specialty Services

SSHs were set up at district/ sub-district levels, to provide specialty/ super-specialty (tertiary) healthcare services. Accordingly, the H&FW Department had specified SSH-wise super-specialty services (ranging between one and four) for each SSH, like ENT, Eye, Orthopaedics, Trauma Care, Skin, Dialysis *etc.*

Review, however, showed that 26 of the 40 SSHs ***(Appendix 5.14)*** had failed to deliver any kind of super-specialty services. Super-specialty services, only for Eye and/ or ENT, were available in 10 SSHs. As such, the intended objective of providing super speciality healthcare services at the district/ sub-district levels, had not been fulfilled.

In reply (February 2024), the Department remained silent about non-availability of super-speciality services in the SSHs as pointed out in audit. The Department has, however, claimed that SSHs of Jangipur, Domkal and Raghunathpur are having functional SNCU super speciality services.

(iv) Non-Functioning of Intensive Care Units (ICUs) and Cardiac Care Units (CCUs)

The Intensive Care Units (ICUs), which had been established in 12 of the 41 SSHs, had not been made functional in six[142] SSHs, as of March 2022.

Similarly, the Cardiac Care Units (CCUs), in seven[143] SSHs, had not been made functional (out of the 19 SSHs where those they had been setup, with sophisticated equipment).

Non-delivery of super-specialty services, even after creation of physical infrastructure with significant expenditure, not only frustrated the project objectives, but, the built-up infrastructure, along with the costly equipment installed therein, remained idle, suffering wear and tear.

(v) Equipment lying Idle and equipment not found in place

For providing super specialty services through SSHs, 5,230 items of bio-medical equipment[144] (4,764, for 28 SSHs, on turnkey basis and 466, for 12SSHs, on non-turnkey basis), costing ₹ 363.15 crore (Turnkey: ₹ 356.17 crore and Non-turnkey: ₹ 6.98 crore), had been procured and installed in 40 SSHs.

Scrutiny of records relating to tagging of assets[145] for maintenance and the replies furnished to Audit, revealed that 290 items of equipment, valuing ₹ 1.50 crore, were lying in the stores of 16 SSHs (as of June 2022), even after a lapse of six to seven years, from initiation of their operations.

Moreover, 1,633 items of equipment, valuing ₹ 72.80 crore (Turnkey: ₹ 71.12 crore and Non-turnkey: ₹ 1.68 crore), in 39 SSHs, could not be traced in the SSHs, as of June 2022, during the tagging exercise, for repair and maintenance of the equipment.

The Department in its reply (February 2024) offered no response in this regard.

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[142] *Panskura SSH, Sagardighi SSH, Basirhat SSH, Metiabruz SSH, Bangaon SSH and Uluberia SSH.*
[143] *Falakata SSH, Domkal SSH, Suri SSH, Uluberia SSH, Basirhat SSH, Metiabruz SSH and Bangaon SSH.*
[144] *Biomedical/medical devices are instruments, machines, implants, in vitro reagents, software, materials, or other related articles, that are purposed for the safe and effective prevention, diagnosis, treatment, and rehabilitation of illness and disease for human beings.*
[145] *Assets tagged with bar-codes for tracking and maintenance*

5.4.2 Absence of General Compliance in SSHs

Apart from the above, the following general facilities, which should have been available in a hospital, were absent in the SSHs:

(i) Accessibility for Persons with Disabilities

Rights of Persons with Disabilities Act, 2016, under Section 45, mandates that all public buildings shall be made accessible to Persons with Disabilities (PwD), with physical infrastructure, like ramps with handrail, toilets suitable for PwDs *etc*.

It was, however, observed that there were no ramps in 12 SSHs, to provide accessibility to the PwDs. No barrier-free toilets, for persons with disabilities, were available in five SSHs.

(ii) Handling and Management of BMWs without valid Authorization from WBPCB

Every Healthcare Facility handling bio-medical waste (BMW) is required to obtain authorization from the West Bengal Pollution Control Board (WBPCB) under Rule 10 of the Bio-Medical Waste Management Rules, 2016. Four SSHs, were, however, handling bio-medical waste, without obtaining BMW authorization from WBPCB, in violation of the provisions of the BMWM Rules. Thus, compliances required for BMW management had not been assessed and/ or monitored by the Department.

(iii) SSHs functioning without Fire Safety Certificate

Fire Safety Certificates, given under the WB Fire Service Act, 1950, indicate conformity with the requirements of fire safety. They are given to building structures such as hospitals, educational institutions, government offices, and private offices. Audit, however, observed that 13 of the 40 SSHs were running without obtaining fire safety certificates, keeping their patients and staff exposed to the risk of fire hazards. It was also noted that, though there had not been any casualties, there had been fire incidences in five[146] SSHs, during the period covered under audit.

The Department in its reply (February 2024) offered no response in this regard.

5.5 Non-availability of facilities for Trauma Care & Burn Injuries

With the objective of bringing down preventable deaths due to road accidents, to 10 *per cent*, by developing a Pan-India trauma care network, in which no trauma victim is to be transported for more than 50 kilometers and a designated trauma centre is available at every 100 km, GoI initiated a pilot project during the 9th Five Year Plan (FYP), which, during the 11th FYP period, was re-modified as a 100 *per cent* Centrally Assisted scheme[147]. The scheme was further extended to the 12th FYP, to set up new Trauma Care Facilities (TCFs), with 60:40 Central and State fund sharing. The unit costs, as fixed for Levels I, II and III TCFs[148], under the 11th FYP and 12th FYP, are detailed in ***Appendix 5.15***.

[146] *Asansol SSH, Basirhat SSH, Diamondharour SSH, Egra SSH and Sreerampore SSH.*

[147] *Assistance for Capacity Building for Developing Trauma Care Facilities (TFCs) in Government Hospitals on National Highways*

[148] *Level III TCF was to provide initial evaluation and stabilization (surgically, if appropriate) to the trauma patient; Level II TCF was to provide definitive care for severe trauma victims with in-house Emergency physicians, surgeons, Orthopaedic and Anesthetists; Level I TCF was to provide the highest level of definitive and comprehensive care, for patient with complex injuries.*

In view of increasing burnt cases every year coupled with absence of organized burn care at primary and secondary healthcare level, Ministry of Health & Family Welfare introduced the programme named 'National Programme for Prevention and Management of Burn Injuries' (NPPMBI) during the 12th FYP. Under the scheme GoI grants were to be provided (60: 40 ratio) to identified Medical Colleges of the State Government for developing a 12-bedded Burn Unit including four ICU beds, one OT and procurement of some essential equipment at total project cost of ₹ 6.58 crore per unit.

In West Bengal, five hospitals ***(Appendix 5.16)*** during 11th FYP and another five hospitals[149] in 12th FYP ***(Appendix 5.21)*** were identified for setting up the Trauma Care Facilities. Six hospitals[150] of the State were selected for setting up Burn Injury Units (BIUs) during 12th FYP. A review of implementation of the scheme revealed the following:

5.5.1 TCFs of the 11th Five Year Plan

Though the TCFs approved under 11 FYP were shown to have been completed and become functional, scrutiny of the utilisation of funds received for procurement of equipment ***(Appendix 5.16)*** for the TCFs, revealed gross irregularities, as discussed below:

(i) Doubtful Expenditure and submission of false utilisation certificates- funds remaining un-utilised:

Out of ₹ 17.76 crore of the grants received for procurement of equipment, a total amount of ₹ 15.92 crore was shown to have been utilised by the State, as detailed in **Table 5.12**.

Table 5.12: Receipt and utilization of funds for procurement of equipment in TCFs

Sl. No.	Name of hospital	Funds received for procurement of Equipment *(₹ in crore)*		Utilisation *(₹ in crore)*		
				By the Hospital	By WBMSCL[151]	Total
1	Burdwan MCH	2011-12	3.83	2.50	11.50	
2	North Bengal MCH	2015-16	4.99	0.00		
3	Asansol DH	2015-16	5.00	0.00		
4	Islampur SDH	2015-16	1.98	0.00		
5	Kharagpur SDH	2006-07 & 12-13	1.96	1.90		
	Total		**17.76**	**4.40**	**11.50**	**15.90**

Source: data received from H&FW Department, Govt. of West Bengal

Review, however, revealed that:

- Though utilisation of an amount of ₹ 11.50 crore (November 2019) had been shown by WBMSCL, a list of procured equipment, valuing only ₹ 8.64 crore, could be produced to Audit, when called for. A further scrutiny of the list revealed that procurement of equipment, valuing ₹ 0.85 crore, was not admissible under the scheme for TCFs and the equipment was not even in possession of the TCFs for which it was shown to have been procured ***(Appendix 5.17)***. The list also contained lumpsum entries of procurement,

[149] *Murshidabad MCH, Diamond Harbour MCH, Ranaghat SDH, Alipurduar SDH, Raiganj DH*
[150] *SSKM, Burwan MCH, NBMCH, Murshidabad MCH, Malda MCH and Bankura MCH*
[151] *Responsible for efficient execution of construction works of TCFs and procurement of trauma care equipment.*

valuing ₹ 1.62 crore, without any description of equipment and against which no bills could be produced before Audit ***(Appendix 5.18)***. This indicated submission of doubtful utilisation certificates of ₹ 2.86 crore[152], coupled with incurring of doubtful expenditure of ₹ 2.47 crore[153].

- Utilisation Statements against spending of ₹ 2.51 crore, by the Burdwan Medical College & Hospital (BMC&H), revealed that ₹ 2.42 crore had been spent by BMC&H, for procurement of equipment for different departments of BMC&H and/ or for its super specialty block, other than the TCF. Thus, not only was there a diversion of GoI funds of ₹ 2.42 crore, but also the requirements of the TCF had remained unfulfilled.

The actual position of the unspent grants could not be furnished to Audit, though called for.

(ii) Non-availability of trauma equipment

In the above backdrop, the actual status of availability of trauma equipment, in five TCFs, when checked by Audit, revealed that a considerable number of items of equipment were not available in the TCFs, as shown below:

Table 5.13: Non-availability of TCF equipment

Name of the TCF	Level	Types of Equipment required as per norms	Types of Equipment not available	Total No. of equipment comprising all types required for the facility	Total no. of equipment actually available
North Bengal MCH	II	33	11 (33.33%)	73	46
Burdwan MCH			11 (33.33%)		61
Asansol DH			29 (87.87%)		06
Islampur SDH	III	20	09 (45%)	41	19
Kharagpur SDH			04 (20%)		47

Source: data received from H&FW Department, Govt. of West Bengal

From the Statement of non-availability, as detailed in ***Appendix 5.19*** & ***Appendix 5.20***, it may be seen that the shortages in equipment relating to Radiology, Anaesthesia, OT, Orthopaedic *etc.*, ranged between 20 *per cent* and 45 *per cent*, in four TCFs, whereas Asansol DH did not have 88 *per cent* of the different types of equipment. Further, Asansol DH had only six types of equipment, against the normative requirement of 73. On the other hand, it was observed that excess numbers of equipment had been supplied to Kharagpur SDH.

(iii) Non-availability of Human Resources

The operational guidelines for Capacity Building for Trauma Care Facilities prescribed the Human Resource requirements in a TCF, for its operation. A scrutiny of the availability of manpower, in the TCFs constructed under 11th FYP, showed that there was almost no manpower posted in the facilities to run the TCFs. The table below depicts the status of manpower in the TCFs:

[152] *₹ 11.50 crore minus ₹ 8.64 crore*
[153] *₹ 0.85 crore plus ₹ 1.62 crore*

Table 5.14: Availability of manpower in TCFs

Sl. No.	Human Resource		Requirement as per scheme guideline	Men in position as on (1st April of every year)		
				NBMCH*	BMC**	Asansol
Availability in Level II TCFs:						
1	Specialist	General Surgeon	2	0	0	0
2		Radiologist	2	0	0	0
3		Orthopaedic Surgeon	3	0	0	01
4		Anaesthetist	3	0	0	0
5		Neurosurgeon	1	0	0	0
6		Casualty Medical Officer	8	0	8	0
7	Nursing Staff	Staff Nurse	40	0	16	28
8		Nursing attendant	16	0	0	0
9	Para Medics	OT Technician	5	0	4	0
10		Radiographer	4	0	4	0
11		Lab Technician	2	0	2	01
12	MTS	Multitask worker	15	0	0	0
	Total:		**101**	**0**	**34**	**30**
Level III TCFs						
Sl. No.	**Human Resource**		**Requirement as per scheme guideline**	**Islampur**		**Kharagpur**
1	Specialist	General Surgeon	2	0		01
2		Orthopaedic Surgeon	2	0		0
3		Anaesthetists	2	0		0
4		Casualty Medical Officer	6	0		0
5	Nursing Staff	Staff Nurse	25	06		01
6		Nursing attendant	13	07		0
7	Para Medics	OT Technician	5	0		0
8		Radiographer	4	0		0
9		Lab Technician	2	02		0
10	MTS	Multitask worker	12	05		0
	Total		**73**	**20**		**02**

Source: Data received from H&FW Department, Govt. of West Bengal;
** No MIP from FY 2016-17; ** From FY 2021-22*

It may be seen that no manpower had been posted in the TCF in North Bengal Medical College. Specialist doctors, like General Surgeons, Radiologists, Anaesthetist and Neurosurgeons, were not available in any of the Level II TCFs. In Level III, Islampur also had no Specialist doctors posted. Asansol (Level II) and Kharagpur (Level III) had one Orthopaedic surgeon and one General Surgeon, respectively. Moreover, posting of nurses, with no doctors and/ or paramedics in the centres, raised questions about the utilisation of the services of these nurses.

Evidently, with absolutely no or miniscule posting of doctors, paramedics and nurse in the Level II and Level III TCFs, none of the Trauma Care Facilities could be made optimally functional, even after the passage of almost 15 years of their approval, rendering the expenditure incurred towards the construction and equipment unfruitful. The Department in its reply (February 2024) offered no response in this regard.

5.5.2 Trauma Care Facilities and Burn Care Facilities under the 12th FYP

GoI had released ₹ 21.09 crores for construction of five TCFs (₹ 8.41 crore) and six Burn units (₹ 12.68 crore) in the State, between 2014 and 2017, under the 12th FYP ***(Appendix 5.21)***. Scrutiny of records, however, showed that the State had not been able to initiate any of the projects, as on the date of audit (June 2022), for reasons not found available on records and the entire funds had remained unutilised, for periods ranging from five to eight years.

The grants in aid, received from GoI under the 12th FYP, were to be deposited in an interest-bearing account and the interest accrued on the grant was to be deposited in the Government account, as revenue of GoI. The sanction of ₹ 11.98 crore, released (2015-16) by GoI, in favour of WBMSCL, for procurement of equipment under the 11th FYP projects, was also governed by the same criteria.

Review, however, showed that, instead of keeping the GoI grants in interest--bearing accounts, the grants had either been kept with the State exchequer or in Deposit Accounts maintained with the treasuries. This action had resulted in loss of GoI revenue of at-least ₹ 3.95 crore arrived by a conservative calculation as shown in table below (detailed in ***Appendix 5.22***).

Table 5.15: Calculation of bank interest *(₹ in crore)*

GoI Grants	Grants received	Total amount of interest	Kept in State Exchequer/ Deposit A/ c
12th FYP TCF grants kept in state exchequer	**14.95**	**2.01**	Out of total 21.09 core released (2014-17) by GoI under 12th FYP, ₹ 14.95 crore were not drawn and kept in state exchequer ***(Appendix 5.22)***.
12th FYP Burn Unit grants kept in state exchequer	**6.14**	**1.22**	The remaining 6.14 crore of grants under 12 FYP was drawn and kept in bank account. However, the earned interests were not deposited to GoI ***(Appendix 5.22)***.
11th FYP TCF grants kept in non-interest-bearing Deposit Account of WBMSCL	**11.98**	**0.72**	₹ 11.98 crore of GoI grants released (2015-16) to WBMSCL for procurement of equipment under 11th FYP, was kept in non-interest bearing Deposit Account of WBMSCL ***(Appendix 5.22)***.
Total:	**33.07**	**3.95**	

Source: Data received from H&FW Department, Govt. of West Bengal

As such, failure of the State government, in operationalising the TCFs approved by GoI in the 11th FYP and non-utilisation of grants given to the State for setting up another five TCFs and six Burn Care Units in the State, during the 12th FYP, resulted in non-availability of the intended facilities for patients encountering Trauma and Burn injuries, in the last 15 years.

Evidently, the objective of bringing down preventable deaths due to road accidents, by setting up Trauma Care Facilities, remained unfulfilled. It was noted that, although SDG Goal 3.6 set the target of reducing deaths and injuries from road traffic accidents by half by 2020, in West Bengal, deaths due to road traffic accidents had increased by 58.69 *per cent* (from 627 in 2016-17 to 995 in 2018-2019), up to 2019. However, deaths reduced to 569 in 2020.

The Department in its reply (February 2024) offered no response in this regard.

5.6 Non-utilisation of newly set up Integrated AYUSH Hospital, Paschim Medinipur involving a cost of ₹ 8.78 crore

A 50-bedded integrated AYUSH Hospital was proposed (June 2016) to be set up in the Paschim Medinipur district. WBMSCL acted as the executing agency for the project. Administrative and financial sanction of ₹ 8.79 crore was accorded (November 2017) in favour of WBMSCL.

Though the said construction was completed by November 2019, CMOH, Paschim Medinipur, took over this building only in April 2021. In between, the hospital was used as a Covid hospital.

Records, however, revealed that the proposals for creation of 26 regular posts[154] under different categories and 45 posts on contractual/ outsourcing basis, as well as engagement of Specialist Doctors on call, for six disciplines, was deferred (December 2019) in the Cabinet meeting and no further action was found in this respect till June 2022.

The IPD services of the hospital could not start functioning, due to lack of manpower and only OPD services were rendered, from March 2022 onwards, with one Senior Ayurvedic Medical Officer (SMAO) and One Homoeopathy Medical Officer (HMO) attending each day.

As such, even after completion of almost three years of the construction of the Integrated AYUSH hospital, having financial involvement of ₹ 8.79 crore, it had not been operationalised, due to delay in deployment of manpower.

The Department in its reply (February 2024) offered no response in this regard.

5.7 Release of Central grants to non-entitled Nursing Schools

Ministry of Health & Family Welfare, GoI, released (May and July 2017) ₹ 20.06 crore, under a centrally sponsored scheme for Upgradation/ Strengthening of Nursing Services, as the second and final instalment, towards the cost of civil works, transport, laboratory equipment/ furniture, AV aids and books, for the ongoing project of setting up of eight General Nursing and Midwifery (GNM) schools[155], at different districts of the State.

Review of records revealed that, instead of spending the fund towards the specified GNM schools, ₹ 2.40 crore had been spent (during FYs 2020-21 and 2021-22) for procurement of projectors and other accessories *etc.*, for making smart classrooms in 31 other GNM Nursing Training Schools, under the head of AV aids, by diverting the funds of the centrally sponsored scheme. Similarly, release and expenditure of ₹ 1.17 crore was noticed (FY 2021-22) for procurement of furniture for eight GNM Nursing Training Schools[156] (NTS), other than the specified for procurement of furniture.

Thus, there was diversion of GoI grants, amounting to ₹ 3.57 crore, for procurement of AV aids and furniture for non-entitled Nursing Training Schools. The Department in its reply (February 2024) offered no response in this regard.

5.8 Facilitating health service availability through Health Insurance Schemes

With a view to providing health insurance cover to Below Poverty Line (BPL) families, Government of India (GoI) had introduced a health insurance scheme titled 'Rashtriya Swasthya Bima Yojana (RSBY)[157]' from 2008-09. In West Bengal, the Health & Family Welfare Department (H&FW Department) was responsible for implementing the scheme since September 2013.

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[154] *Medical superintendent, Special Medical Officer (AYUSH), General Duty Medical Officer (AYUSH), RMO (AYUSH), Accounts Officer, Staff Nurse etc.*

[155] *NTS Ghatal, NTS Barasat, NTS Tamluk, NTS Jangipur, NTS Jhargram, NTS Uluberia, NTS Kolkata Uttar (Sagar Dutta), NTS Bashirhat*

[156] *NTS Bolpur, NTS Rampurhat, NTS Kalimpong, NTS Shrirampur, NTS Howrah DH, NTS Kharagpur, NTS Berhampur MCH, NTS Purulia MCH*

[157] *.Beneficiaries under RSBY were entitled to a hospitalisation coverage of up to ₹30,000 and the premium was to be shared between the GoI and the State in the ratio 60:40.*

However, in December 2016, the Government of West Bengal introduced "Swasthya Sathi", a Group Health Insurance Scheme with an aim to cover initially the lowly paid contractual workers/ volunteers associated with various schemes/ projects/ programmes administered by different Departments of the State Government who were not covered under any health scheme. In October 2018, the Swasthya Sathi Samity decided to subsume RSBY beneficiaries into Swasthya Sathi Scheme. At present, the scheme covers all permanent resident of the State except those covered by any health insurance/ assurance scheme/ coverage by any Government/ Government organisations/ Parastatals/ Public Sector Undertakings, *etc*. The Government did not implement Centrally Sponsored Scheme of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PMJAY)[158] launched by the GoI in September 2018.

Initially the Swasthya Sathi scheme was implimented by engaging Insurance Companies, where secondary and tertiary care upto ₹ 1.5 lakh per annum was covered by Insurance Companies and coverage above ₹ 1.5 lakh and upto ₹ 5.00 lakh was provided by the Department itself. Entire premium paid to the Insurance Companies was borne by the State Government (Hybrid mode). It was later decided that services (*i.e.* enrolment and claim management) to those beneficiaries would be provided without engaging insurance companies (Assurance mode). Hybrid mode and Assurance mode were operated simultaneously upto July 2022 and from July 2022 entire scheme was shifted to Assurance mode.

As of March 2023, 2.43 crore families were enrolled under the Scheme and 2,605 Hospitals were empaneled under the Scheme. Detailed implementation statistics in respect of Swasthya Sathi is depicted in ***Appendix 5.23***.

Implementation of Swasthya Sathi was subjected to compliance audit and mention was made in the Report of the Comptroller & Auditor General of India on Government of West Bengal for the year ended March 2020 (Report No. 5 of 2021) in respect of

- Avoidable payment of health insurance premium of ₹ 10.20 crore towards premium of Rashtriya Swasthya Bima Yojana (RSBY) due to overlapping with that of Swasthya Sathi (***vide para 3.9 of that Report***).
- Non-recovery of` ₹ 6.11 crore as penal amount from Swasthya Sathi Insurance Companies by the State Nodal Agency, from Insurance Companies for their under-performance, in spite of having enabling provisions in the agreement (***vide para 3.10 of that Report)***.

The report was tabled in the Legislative in March 2022; however, the same has not yet been discussed in the Public Accounts Committee. The Department in its reply (February 2024) offered no response in this regard.

5.9 Infrastructure for Emergency Response & Health System Preparedness (ER&HSP)

Government of India sanctioned (2021-22) India COVID 19 Emergency Response and Health Systems Preparedness Package (ER&HSP) - Phase II as a

[158] *The scheme aimed to cover poor and vulnerable families providing coverage upto five lakh rupees per family per year for secondary and tertiary care hospitalization. The scheme subsumed the then existing health insurance schemes like 'Rashtriya Swasthya Bima Yojana and Senior Citizen Health Insurance Scheme.*

Central Sector Scheme (60:40) to support preparedness and prevention related functions, that would address not only the COVID-19 outbreak, but also such outbreaks, in future. States were to prepare Emergency COVID Response Plans (ECRPs) for obtaining and utilising funds under these packages.

Slow progress in works relating to upgradation of health facilities (COVID units):

Out of the funds under ER&HSP Package- Phase II against Emergency COVID Response Plan (ECRP-II), the Department of Health and Family Welfare (Department) decided (FY 2021-22) to construct Covid units, at various existing health care facilities of the State. It was also decided to set up 435 new Paediatric Intensive Care Units (PICUs), in addition to the already sanctioned 244 such PICU beds. The expenditure was to be met from ECRP-II funds. The present status of construction was as follows:

- **Construction of PICUs**: The Department issued (September 2021) Administrative Approval & Financial Sanction (AA&FS) for setting up of 435 PICU beds and released ₹ 1.35 crore to different hospitals for minor electrical, civil and Medical Gas Pipeline System works to prepare and ready the sites. Its further sanctioned (December 2021 and March 2022) ₹ 15.18 crore, for procurement of 41 Catalogue items [159] for setting up these PICU beds, at different hospitals. However, as per the reports made available to Audit, 356 beds (82 *per cent*) were functional while the rest remained non-functional (as of February 2023).
- **Construction of permanent Covid units in existing health facilities:** The Department decided (April 2022) to construct permanent Covid units, at different health facilities of the State, and issued (April 2022) AA&FS, amounting to ₹ 307.77 crore, against an estimate of the same amount, prepared by the PWD. The status of construction, as furnished (as of February 2023) by the Department, was as follows:

Table 5.16: Position of construction of permanent Covid units in the existing health facilities

Sl. No.	Type of construction	Number of projects sanctioned	Status of Completion	Percentage of incomplete works
1.	Covid units with 100 beds	25	Not completed	10% to 30% - 20 units 31% to 50% - 05 units
2.	Covid units with 50 beds	5		30% to 90%
3.	Covid units with 20 beds	119	Completed : 52 units Incomplete : 67 units	10% to 30% - 09 units 31% to 50% - 20 units 51% to 70% - 38 units

Source: Covid Funds under NHM (State level)

As may be seen from **Table 5.16** in regard to construction of 119 permanent Covid units with 20 beds, only 52 (44 *per cent*) had been completed and the rest were incomplete, with the progress of work ranging between 10 *per cent* and 70 *per cent*. However, none of the Covid units with 50 and 100 beds, were complete, and the percentage of incomplete work ranged between 10 *per cent* and 90 *per cent*.

[159] *Infusion Pump, Multichannel monitor, Crash Cart Trolley, Suction Machine, Laryngoscope with curved and straight blade etc.*

Non-completion of the Covid units and non-functioning of a number of PICU Beds, pointed towards deficiencies in providing quality healthcare services, as per the targets fixed by the Department.

- **Setting up of Hybrid Critical Care Units:** The Department decided (September 2021) to establish 24-bedded Hybrid Critical Care Units[160] (8 CCU beds and 16 HDU beds), at 79 MCHs/ DHs/ SDHs/ SSHs across the State, under the ECRP-II package. Accordingly, AA&FSs were issued, on different occasions, for 73 units, having 1,682 beds. The Department released funds, from time to time, to different CMOsH/ Medical Superintendent-*cum*-Vice-Principals (MSVPs) and PWD, for civil and electrical works relating to repair and renovation, at earmarked hospitals. Funds were also released to the West Bengal Medical Service Corporation Limited, either for purchase of different equipment for use in the CCUs, or in the hospital, to make the Medical Gas Pipeline System (MGPS) operational. As per records made available to Audit, during 2021-23, ₹ 29.76 crore (₹ 27.52 crore in FY 2021-22 and ₹ 2.24 crore in FY 2022-23) was released to different hospitals, for the said purpose.

As per the completion report furnished by the department (February 2023), out of 73 Hybrid CCU units being established, 26 units (36 *per cent*) were not ready for use (as of March 2023), resulting in 614 beds remaining non-functional.

Recommendation:

12. The H&FW Department may ensure setting up of the required new health facilities, throughout the State to reduce the shortages of health facilities in the State. Infrastructure deficiencies, in the existing healthcare facilities, may also be plugged.

[160] *Hybrid Critical Care Unit is a care unit where all beds are not CCU beds. It has High Dependence Unit (HDU) bed (which is essentially a step lower than CCU bed) along-with some CCU beds.*