सत्यमेव जयते

Report of the Comptroller and Auditor General of India on Public Health Infrastructure and Management of Health Services for the year ended 31 March 2022

SUPREME AUDIT INSTITUTION OF INDIA

लोकहितार्थ सत्यनिष्ठा

Dedicated to Truth in Public Interest

Government of National Capital Territory of Delhi

Report No. 3 of the year 2024

Performance Audit Report of the Comptroller and Auditor General of India

on

Public Health Infrastructure and Management of Health Services for the year ended 31 March 2022

Government of National Capital Territory of Delhi

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PREFACE

This Report of the Comptroller and Auditor General of India has been prepared for submission to the Lieutenant Governor of National Capital Territory of Delhi under Section 48 of the Government of National Capital Territory of Delhi Act, 1991 for being laid before the Legislative Assembly of the National Capital Territory of Delhi. The report has been prepared in accordance with the Performance Auditing Guidelines, 2014 and Regulations on Audit and Accounts, 2020 of the Comptroller and Auditor General of India.

The report of the Comptroller and Auditor General of India contains the results of Performance Audit of Public Health Infrastructure and Management of Health Services covering the period from 2016-17 to 2020-21. The data has been updated up to 2021-22, wherever feasible.

The audit has been conducted in conformity with the Auditing Standards issued by the Comptroller and Auditor General of India.

Audit acknowledges the cooperation received from the Department of Health and Family Welfare, Government of National Capital Territory of Delhi along with their field functionaries in conducting the Performance Audit.

Executive Summary

EXECUTIVE SUMMARY

Why did we take up this audit?

Health is a vital indicator of human development which is a basic ingredient of economic and social development. In India, the right to health care and protection has been recognized and is considered a priority.

Given the importance of functioning of health sector in Delhi, a performance audit to assess adequacy and effectiveness of Public Health Infrastructure and Management of Health Services of Government of National Capital Territory of Delhi (GNCTD) was conducted covering the period 2016-17 to 2021-22 to assess the adequacy of financial resources allocated, availability of health infrastructure, manpower, machinery and equipment in the health institutions as well as efficacy in the management of health services in the State. This report contains audit findings pertaining to secondary and tertiary hospitals only. The findings pertaining to primary healthcare centres and Mohalla clinics are included in the Compliance Audit Report of GNCTD. The performance audit also covers the efficacy of the regulatory framework being enforced by the Government to regulate private health sector, schemes being implemented by Government of India through GNCTD and overall linkage with the Sustainable Development Goal-3.

Against which benchmarks, performance has been assessed?

Ministry of Health and Family Welfare, Government of India, has issued a set of uniform standards called the Indian Public Health Standards (IPHS) to improve the quality of healthcare delivery in the country and serve as a benchmark for assessing performance of healthcare delivery system. The Indian Public Health Standards (IPHS) prescribe standards for the services, manpower, equipment, drug, building and other facilities. These include the standards to bring the health institutions to a minimum acceptable functional grade. However, it was observed that the Delhi Government does not follow Indian Public Health Standards, 2012 as it has not adopted the same.

In addition to IPHS, various standards and guidelines on healthcare services issued by Government of India such as Bio-Medical Waste Management Rules; Pharmacy Act 1948 and Pharmacy Practice Regulations, 2015; Indian Nursing Council Act, 1947; and Drugs and Cosmetic Rules were used to evaluate the healthcare facilities in Delhi.

What have we found and what do we recommend?

<u>Human Resource</u>

Adequate human resource is critical to achieve health policy goals. As of March 2022, there was a deficit of about 21 *per cent* staff in Health and Family Welfare Department of GNCTD. There was overall shortage of 30, 28 and 9 *per cent* in

the categories of teaching Specialists, non-teaching Specialists and Medical Officers respectively in respect of 28 Hospitals/Colleges, records of which were furnished to Audit. The deficit in the cadres of Nurses and Paramedic staff was about 21 *per cent* and 38 *per cent* respectively. There was 36 *per cent* shortage of staff for implementing the National Health Mission (NHM) schemes in the State. Absence of promotion and career progression opportunities and unchanged salary structure resulted in shortage of super specialist doctors in Janakpuri Super Specialty Hospital (JSSH) and Rajiv Gandhi Super Specialty Hospital (RGSSH).

Recommendations*:*

2.1 Vacancies against the sanctioned posts should be filled to improve the functioning of public health facilities of GNCTD.

2.2 In view of shortage of teaching doctors in its autonomous hospitals, Government may review the recruitment norms to make it more attractive for teaching doctors so that a satisfied and consistent workforce of teaching doctors is available in these hospitals.

Healthcare Services in the State

There was high workload in registration counters in test checked hospitals. The average consultation time per patient was less than five minutes in Medicine Department and Gynaecology Department of Lok Nayak Hospital (LNH). Patient load per Pharmacist/counter in LNH was high due to shortage of pharmacists. Medicines were not distributed on the same day. Shortage of essential medicines and equipment were observed in ICU/ emergency departments of two test checked hospitals (LNH and RGSSH). Shortage of toilets and scarcity of waiting area for attendants was noticed in LNH. Indoor Patient Departments (IPDs) were found crowded in many wards.

Average waiting time for major surgeries in the Surgery Department and Burn & Plastic Surgery Department of LNH was 2-3 months and 6-8 months respectively and at the same time, six out of 12 modular OTs in Rajiv Gandhi Super Specialty Hospital (RGSSH) and all the seven modular OTs in Janakpuri Super Specialty Hospital were lying idle due to shortage of manpower. Sushruta Trauma Centre of LNH did not have permanent arrangement of Specialist Doctors and Senior Residents for 24-hour emergency services. One Stop Centre (OSC) of LNH for providing multiple facilities and services under one roof to rape victims did not have dedicated staff. Records of review of child death cases and ANC were not maintained.

Major portion of fleet of Centralised Accident and Trauma Services (CATS) Ambulances were found running without essential equipment and devices.

Out of the four test checked hospitals, only Lok Nayak Hospital (LNH) had the facility to separate blood into its components while the other three, Janakpuri Super Specialty Hospital (JSSH), Rajiv Gandhi Super Specialty Hospital

(RGSSH) and Chacha Nehru Bal Chikitsalaya (CNBC), were holding licence for processing and storage of blood only. While huge waiting time was observed for radiological diagnostic services in LNH, the radiological equipment were found underutilised in the other three hospitals due to shortage of manpower. Atomic Energy Regulatory Board guidelines were not fully adhered to in these hospitals for ensuring the safety of staff and patients.

Dietary services were not available in JSSH and RGSSH. Periodic inspection was not conducted by the dieticians and quality of food was never checked.

There were shortfalls in conducting patient satisfaction survey, death reviews etc. by the test checked hospitals depriving themselves from getting the benefit of such assessments for further improvement of patient services.

Recommendations:

3.1 The Government should take immediate measures to reduce the waiting time for registration, consultation, diagnostics, surgery and pharmacy in its hospitals. Government should also ensure availability of basic amenities in its hospitals.

3.2 Hospitals should strengthen the Emergency services and ensure availability of essential medicines and equipment at all times and increase the number of beds in line with demand.

3.3 The fleet of CATS should be strengthened with enough call worthy ambulances equipped with required equipment and medicines.

Availability of drugs, medicines, equipment and other consumables

Essential Drug List (EDL) was not prepared annually and was prepared only thrice during the last ten years.

The Drug Policy, 1994 of GNCTD provides for setting up a Formulary Committee every year for preparation of Delhi State Formulary containing clinically oriented summaries of pharmacological information about selected drugs. Audit noted that Formulary was last prepared in 1994.

Central Procurement Agency (CPA) was entrusted with the duties of procurement of drugs and equipment for GNCTD hospitals. Audit noted that during 2016-17 to 2021-22, Hospitals had to procure 33 to 47 *per cent* of essential drugs contained in the EDL directly as CPA failed to deliver them. Out of 86 tenders floated for procurement of equipment by CPA, only 24 (28 *per cent*) were finally awarded. Audit noted that a lot of EDL medicines demanded by hospitals were not supplied by CPA in respect of four test checked hospitals. As CPA was not procuring the drugs timely for health institutions of GNCTD, hospitals were purchasing Essential Drugs from local chemists for meeting their day-to-day requirements.

Audit also noted short supply/shortage of injections for rare/fatal diseases like Haemophilia and Rabies. Hospitals also failed to monitor and evaluate timely and regularly the need for repair, maintenance, replacement and condemnation of equipment.

There were delays in empanelment of drug testing laboratories by CPA. It also failed to ensure that empanelled laboratories had valid National Accreditation Board for Testing and Calibration Laboratories (NABL) accreditation for testing drugs. CPA issued drugs to the user department before receipt of test reports from empanelled laboratories. Medicines procured by CPA are supplied directly to Hospitals by the suppliers. After the stipulated supply period, samples are picked up from hospitals by CPA for quality testing in the empanelled laboratories. Audit noted that there was a time gap of two to three months between the receipt of drugs from the CPA and receipt of test reports regarding quality of the drugs supplied. Audit noted that a few drugs supplied by the CPA were later reported as inferior quality by the laboratory. Moreover, in some cases inferior quality drugs were consumed in the hospitals. Audit also noticed procurement of medicines from blacklisted and debarred firms. There was shortage of equipment in labs/departments in test checked colleges/hospitals against norms of Medical College Regulations.

Recommendations:

4.1 The Government should prepare EDL on annual basis as envisaged in the Drug Policy.

4.2 The Government should take measures to prepare a Delhi State Formulary for facilitating the doctors/pharmacists in prescribing and dispensing drugs.

4.3 The drug samples for testing should be picked up in such a way that there should not be any time lag between the delivery of drugs and test reports to avoid the use of inferior quality medicines in hospitals.

4.4 The Government should emphasize on good quality control and assurance system for providing safe and effective drugs at public healthcare facilities.

4.5 The Government may develop a mechanism to test check the efficacy of test reports of empanelled laboratories from government or another laboratory.

4.6 The Government should evolve a mechanism to check that the firms supplying essential drugs are not debarred by other States for quality issues. The Government should also fix responsibility for the lapse of procurement of medicine from blacklisted firms.

4.7 Government should ensure availability of equipment in labs/departments in Medical colleges as per Medical College Regulations.

Availability and management of healthcare infrastructure in the State

The Government did not undertake any need based assessment to identify district-wise areas deficient in healthcare facilities.

Against the proposed addition of 10,000 beds (Budget speech 2016-17) only 1,357 beds were added during 2016-17 to 2020-21.

The Department was unable to utilize any of the 15 plots acquired (June 2007 and December 2015) at a cost of ₹ 648.05 lakh for establishing hospitals and dispensaries, despite having possession for periods ranging between six to 15 years. Out of the eight new hospitals under construction during the audit period, only three were completed. There were delays up to six years in completion of hospital projects.

Janakpuri Super Specialty Hospital (JSSH) and Rajiv Gandhi Super Specialty Hospital (RGSSH) could not provide Super Specialty tertiary care as envisaged in the Memorandum of Association due to weak monitoring and failure to develop a viable business model. There was delay in completion of various building and infrastructural projects in test checked Hospitals.

Several dialysis machines set up under PPP mode for free dialysis for BPL patients were not in use in one hospital due to in-appropriate water analysis report.

Recommendations:

5.1 The Government may undertake need based assessment of health care infrastructure to ensure its equitable distribution in Delhi.

5.2 The Government may strive to raise the bed availability in Delhi Government Hospitals to two beds per thousand populations in line with NHP 2017.

5.3 The Government may plan and execute its activities in a time bound manner to ensure maximum functional beds in its health care facilities.

5.4 Efforts should be made for timely setting up of machines in Dialysis Centres for free dialysis to BPL patients.

5.5 The Government may take steps to ensure that the built up facilities in its two super speciality hospitals viz. Rajiv Gandhi Super Speciality Hospital and Janakpuri Super Speciality Hospital are put to use.

5.6 The Government needs to co-ordinate with Health Department/PWD and land owning agencies so that the acquired plots are used for creating health care facilities in a time bound manner.

5.7 The Government needs to closely monitor all ongoing works to avoid delay in completion of health care infrastructure.

Financial Management

There were savings ranging from 8.64 *per cent* (2021-22) to 23.49 *per cent* (2016-17) against the budget allocated by GNCTD on Health sector during 2016-17 to 2021-22. There were savings ranging from 13.29 *per cent* (2021-22) to 78.41 *per cent* (2018-19) against the budget for healthcare infrastructure during 2016-17 to 2021-22.

GNCTD had spent 12.51 *per cent* of its total expenditure and 0.79 *per cent* of GSDP on health services during 2021-22 which was more than eight *per cent* of budget and way below 2.5 *per cent* of GSDP targeted under National Health Policy 2017.

Delhi State Health Mission (DSHM) could not utilize the funds released under National Health Mission as ₹ 510.71 crore was lying unspent in the bank accounts of Delhi State Health Society and its 11 Integrated District Health Societies (March 2022).

Recommendations:

6.1 State Government may increase the expenditure on health services to 2.5 *per cent* of GSDP in a time bound manner.

6.2 The Mission Director, DSHM may ensure optimum utilisation of funds received under various National Health Programmes through effective implementation and monitoring**.**

Outcome of selected Centrally Sponsored Schemes

National Health Mission (NHM) laid emphasis on reduction in Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR). Reproductive, Maternal, New-born Child and Adolescent Health (RMNCH+A) is the most important component/programme under NHM for improvement of Maternal and Child Health care.

During 2016-17 to 2021-22, out of total funds of ₹ 164.35 crore available for RMNCH with GNCTD, ₹ 94.98 crore (57.79 *per cent*) remained unutilised. Underutilisation of funds ranged from 58.90 *per cent* (2016-17) to 93.03 *per cent* (2019-20) indicating that the GNCTD was not implementing the programme adequately.

Audit noted significant shortfalls in the implementation of RMNCH+A as only 48.33 *per cent* registered pregnant women (PW) were provided all four Ante Natal Care, 35 *per cent* (TT- 1) and 28 *per cent* (TT-2) of PW had received Tetanus Toxoid (TT) shots, only 59.74 *per cent* PW had received the mandatory 100 Iron folic acid tablets and only 36.18 *per cent* and 18.91 *per cent* PW were tested for HIV and Sexually Transmitted Infection/ Reproductive Tract Infection (STI/RTI) respectively during April 2016 to September 2022.

Coverage for providing free diet and other facilities (free diagnostic) to pregnant women under Janani Shishu Suraksha Karyakram (JSSK) was also inadequate as only 30 *per cent* PW had availed the benefits. Mothers were discharged within 48 hours of delivery in 40.87 *per cent* cases during 2016-22 (up to September 2022).

Out of 2,822 maternal deaths occurred in Delhi during 2016-21, only 1,401 (50 *per cent*) cases were reviewed. Only 10 *per cent* (84 out of 806) Medical Officers and 16 *per cent* (281 out of 1,759) Auxiliary Nursing Midwives/health workers were given training for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke.

Audit noted shortfall in reporting on Health Management Information System (HMIS) by health centres such as Community Health Centre (50 *per cent)*, Sub-District Hospital (28 *per cent)* and District Hospital (14 *per cent*). Only one Tobacco Cessation Centre[1] was established against the target of 44 TCCs (July 2022).

Recommendations*:*

7.1 The Government should ensure that all registered pregnant women are followed-up for complete ante-natal care and post-natal check-up. Besides, TT vaccine and IFA tablets should be provided to all registered pregnant women.

7.2 All registered pregnant women should be screened for HIV and RTI/STI tests.

7.3 The Government should ensure arrangement for proper training of doctors, para medical staff etc. under each disease programme as prescribed in the operations guidelines of diseases programmes under NHM.

Adequacy and effectiveness of the regulatory mechanisms for ensuring quality healthcare services

Delhi Nursing Council was not reconstituted regularly by holding elections and notifying fresh members after three years. There were 37 Nursing Training Institutions functioning in Delhi out of which 20 Institutes were inspected with delays of seven to 41 months.

Out of 1229 Nursing Homes/Hospitals/Institutions employing nurses for providing health care services to public, 48 to 1044 institutions had sent the list of nurses to DNC for verification during the years 2016 to 2022.

Pharmacy Practice Regulations (PPR) notified by GoI in January 2015 has not yet been notified by GNCTD.

[1] TCC at RML Hospital under IDHS, New Delhi

There was overall shortage of 52 *per cent* staff in different cadres including 63 *per cent* shortage in key staff of Drug Inspector in Drugs Control Department.

There was delay in furnishing test reports by Drug Testing Laboratory (DTL). DTL was not accredited by National Accreditation Board of Laboratories (NABL). DTL did not have modern equipment and manpower. There was huge shortfall in the mandatory inspections of drug selling and manufacturing units and Blood Banks by the Drugs Control Department.

Two test checked hospitals were not accredited by NABH. None of the four labs of LNH/MAMC was accredited by NABL. Two out of three labs were not accredited by NABL in the case of RGSSH.

All deviations from the prescribed procedure for management of Bio-Medical Waste (BMW) by Common Bio Medical Waste Treatment Facilities were to be reported by every Chief District Medical Officer (CDMO) to the Delhi Pollution Control Committee (DPCC) and Directorate General of Health Services (DGHS) twice a month. DGHS did not maintain any records relating to receipt of any such reports nor did it develop any monitoring mechanism for compliance of the BMW rules. There was also shortfall in training to BMW workers.

Recommendations:

8.1 The Government may ensure that (i) DNC is constituted in time; (ii) registered Nurses are employed by health care institutions; and (iii) all institutes imparting training to Nurses are inspected regularly to ensure adherence to quality standards.

8.2 The Government may notify Pharmacy Practice Regulations without further delay and also ensure that an updated register of Pharmacists is maintained by Delhi Pharmacy Council.

8.3 The Government may take immediate action for ensuring lifting and testing of adequate number of samples from all units that are manufacturing/dispensing medicines including biological samples.

8.4 The Government may ensure that reports of tests or analysis of samples are furnished by Drug Testing Laboratory promptly so that immediate action can be taken to prevent consumption of sub-standard drugs by general public.

Achievement of Sustainable Development Goals related to Health sector

The Sustainable Development Goals (SDG) adopted in September 2015 set out a vision for a world free of poverty, hunger, disease and want.

Examination of individual indicators however revealed that Delhi lacked under two indicators, viz. case notification rate of Tuberculosis[2] and suicide rate.

Audit observed deficiencies in implementation of Revised National Tuberculosis Control Programme (RNTCP) such as lack of creating awareness about TB, non-formation/ delay in formation of District DR-TB Committees, inadequate monitoring of implementation of the scheme, etc.

Recommendation:

9.1 The Government should strive to reduce the case notification rates of TB in Delhi by conducting awareness activities amongst all stakeholders and general public about TB and Directly Observed Therapy. Besides, activities mandated under RNTCP should be implemented by the State Government.

Implementation of Programmes, schemes/projects/services of GNCTD

As per a judgement of High Court of Delhi (March 2007), all private hospitals which were allotted land on concessional rates by various Government land owning agencies were to provide 25 *per cent* of their OPD facilities and reserve 10 *per cent* IPD beds for free treatment of patients from Economically Weaker Sections (EWS).

As per orders, each Government Hospital (GH) was to set up a special referral centre to refer EWS patients to Identified Private Hospitals (IPH), within two weeks (i.e. 5 April 2007). Audit noted that 19 out of 47 GHs in Delhi had not established referral centres even after a delay of more than 15 years (as of June 2022). Audit noted that no separate complaint register for EWS patients was maintained. There was no system to watch for timely disposal of complaints. 43,951 EWS patients were referred by 28 Government hospitals whereas total 13.89 crore patients had taken treatment in Delhi Government Hospitals.

Delhi Arogya Kosh (DAK) was constituted (September 2011) as a society to provide financial assistance to poor patients suffering from life-threatening diseases. DAK has not maintained scheme-wise details of beneficiaries. It did not regularly seek UCs and details of unspent amount lying with government hospitals. Online Aadhar-based/biometric tracking of patients to ensure proper follow-up and to prevent any malpractices was not implemented by DAK. Audit noted that basic aims and objectives of DAK was not widely disseminated.

Free Surgery scheme of DAK provides for sending eligible patients from identified Delhi Government hospitals to empanelled private hospitals when the allotted date for a specified surgery is beyond one calendar month or when the specified surgery is not performed in the Government Hospital and under high-

[2] The number of TB cases (new and relapsed) notified to the national health authorities during a specified period of time per 100,000 population.

end diagnostic test scheme, patients from identified Delhi Government Hospitals, Polyclinics, etc., are referred to empanelled diagnostic centres. DAK did not carry out any assessment to verify the effectiveness of steps taken to reduce waiting period.

One of the conditions of reimbursement of bill of Medico-legal victims is that the victim is not covered in any insurance scheme. No mechanism was in place to check this before making payment.

Recommendations*:*

10.1 The Government should strengthen the referral system and ensure that Identified Private Hospitals comply with all the orders and instructions for optimum utilization of free OPD/IPD services for EWS.

10.2 The Government should set up oversight mechanism to watch redressal of complaints.

10.3 The Government should widely publicise the benefit of the scheme among all stake holders.

10.4 DAK should take concrete steps for developing a system of online Aadhar-based/biometric tracking of patients to ensure proper follow-up and to prevent any malpractices.

10.5 DAK should compulsorily check medical insurance status of the patient before making payment.

AYUSH

Number of IPD and OPD patients visiting AYUSH hospitals had declined during 2016-22.

Pathology lab, maternity ward and radiology departments in one of the test checked hospitals were not functional/partially functional. There was also shortage of essential medicines in the test checked hospitals. Moreover, savings were noticed under the heads 'Supply & Medicine' and 'Machinery & Equipment' despite shortage of medicines and equipment in both the test checked hospitals.

The overall shortage of staff in the AYUSH Department was 57.97 *per cent*. Besides, shortages in the cadres of doctors (51.89 *per cent*), paramedical staff (55.93 *per cent*) and nurses (32.21 *per cent*) were noticed in the four[3] Medical Colleges with attached Hospitals. Equipment costing ₹ 45.98 lakh procured (March 2018) for Pathology lab in one of the test checked hospitals were not put to use and were lying idle.

[3] A&U Tibbia College, BR Sur Homoeopathic Medical College & Research Centre, Nehru Homoeopathic Medical College and Hospital and Choudhary Brahm Prakash Ayurvedic Charak Sansthan

There was shortfall in conducting mandatory inspections of manufacturing and selling units of Ayurveda and Unani Drugs.

GNCTD did not set up a State Ayush Society nor did it submit State Annual Action plan to GoI for availing financial benefit under National Ayush Mission from 2016-17 onwards. ₹ 3.83 crore was still lying unutilized with GNCTD/Directorate of AYUSH from the grant received under National Ayush Mission during 2014-16.

Delhi Bhartiya Chikitsa Parishad (DBCP), intended to provide registration of medical practitioners of Indian Systems of Medicines, was not reconstituted since July 2015. Delhi Homoeopathy Anusandhan Parishad (DHAP), constituted to develop and coordinate research in Homoeopathy, was not functional since 2017-18.

Recommendations*:*

11.1 The Government should ensure timely procurement and availability of essential drugs in all AYUSH hospitals.

11.2 Hospitals should take immediate measures to install the idle equipment in Pathology, Radiology and Maternity departments to run these departments in a full-fledged manner.

11.3 The Government should take immediate measures to fill the vacant posts of medical officer, teaching staff, nurses and paramedical staff.

11.4 The Government should ensure proper functioning of regulatory bodies of Ayush.

Chapter I

Introduction

Chapter I

Introduction

Health is a vital indicator of human development which is a basic ingredient of economic and social development. In India, the right to health care and protection has been recognized and is considered a priority. The right to health is a fundamental part of human rights. Constitution of the World Health Organization (WHO) states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief or economic or social condition."

National Health Policy (NHP) 2017 consists of specific quantitative goals and objectives outlined under three broad components viz. (a) health status and programme impact, (b) health systems performance and (c) health system strengthening. These goals are aligned to achieve sustainable development in health sector in keeping with the policy thrust.

Given the importance of functioning of health sector in National Capital Territory of Delhi, a performance audit to assess adequacy and effectiveness of Public Health Infrastructure and Management of Health Services of GNCTD was conducted covering the period 2016-17 to 2021-22.

1.1 Health services

Health services provided by the hospitals can broadly be divided in the categories *viz.,* Line services, Support services, Auxiliary services and Managmement of hospital resources as shown in **Chart 1.1**.

Chart 1.1: Services provided by Hospitals

Line services

i. Outdoor patient department
ii. Indoor patient department
iii. Emergency Services
iv. Super specialty (OT, ICU)
v. Maternity
vi. Blood bank
vii. Diagnostic services

Support services

i. Oxygen Services
ii. Dietary service
iii. Laundry service
iv. Biomedical waste management
v. Ambulance service
vi. Mortuary service

Auxiliary services

i. Patient safety facilities
ii. Patient registration
iii. Grievance / complaint redressal
iv. Stores

Resource Management

i. Building Infrastructure
ii. Human Resource
iii. Drugs and Consumables
iv. Equipment

All public health services depend on the presence of basic infrastructure including availability of human resources. Every public health programme such as immunisation, infectious disease monitoring, cancer and asthma prevention, drinking water quality, injury prevention etc. requires health professionals who are competent in synergising their professional and technical skills in public health and provide organisations with the capacity to assess and respond to community health needs. Public health infrastructure has been referred to as "the nerve centre of the public health system". While creation of strong infrastructure is the responsibility of many organisations, public health agencies (health department) are considered the primary players.

The primary objective of National Health Policy, 2017 is to improve health status through concerted policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services provided through the public sector. The policy also recognises the pivotal importance of Sustainable Development Goals to ensure healthy lives and promote wellbeing for all at all ages. At the global level, the Sustainable Development Agenda aims to ensure healthy lives and promote well-being for all at all ages by 2030 as per Sustainable Development Goal (SDG) 3.

Indian Public Health Standards (IPHS) are a set of uniform standards envisaged to improve the quality of health care delivery in the country. IPHS norms were revised in 2012 and 2022 keeping in view the changing protocols of the existing programmes and introduction of new programmes especially for Non-Communicable Diseases.

1.2 Overview of healthcare facilities in the State

Healthcare system in Delhi was re-structured in July 2015 into a four tier system as follows:

a) Mohalla Clinic (Aap Ka Swasthya Kendra)

b) Multi Speciality Clinic (Polyclinic)

c) Multi Speciality Hospital

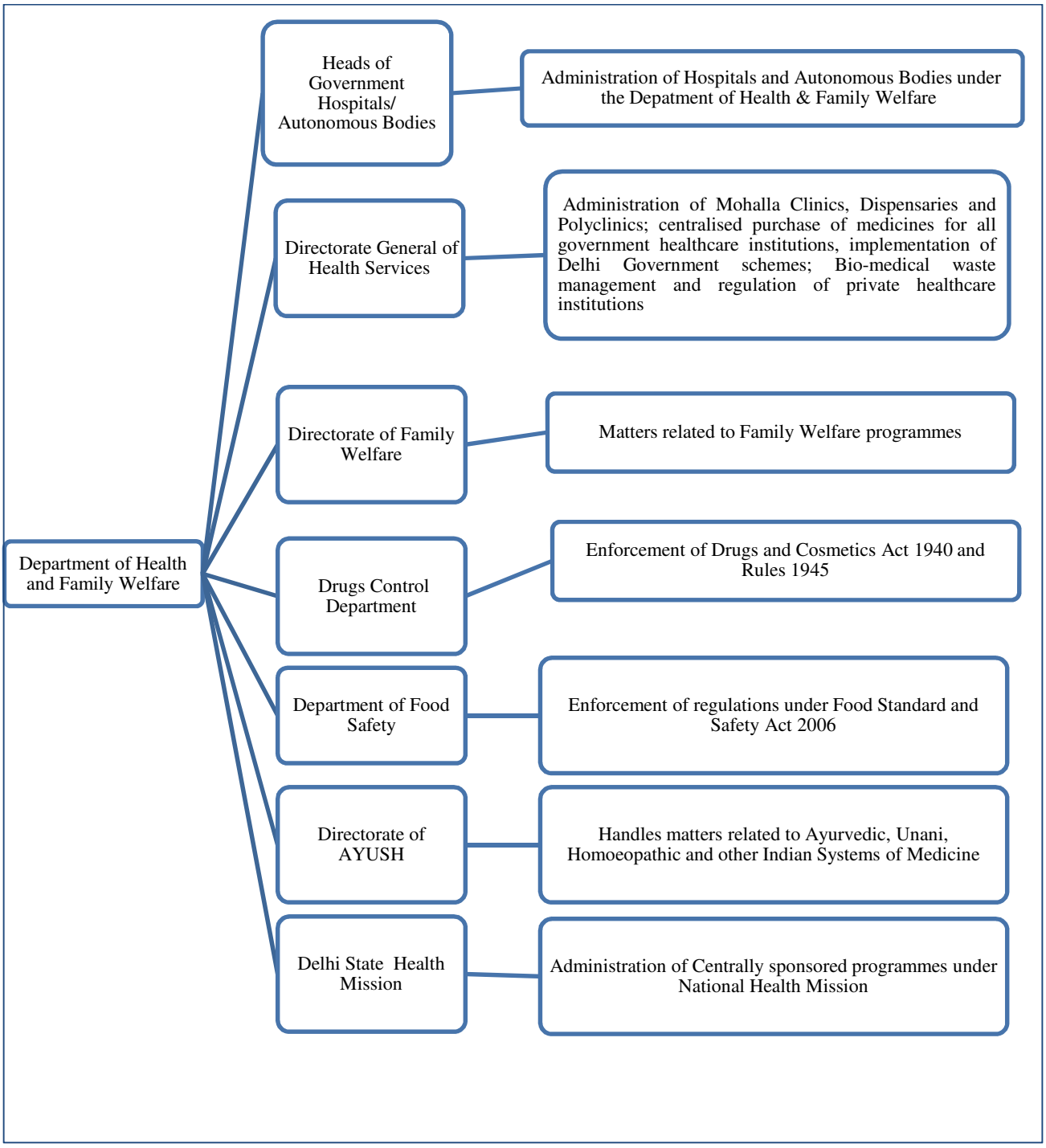
d) Super Speciality Hospital

There are referral and reverse referral mechanism for patients in all the four tiers of the Healthcare System.

1.3 Organisational Set-Up

Functions of various Directorates/Departments/branches under the Department of Health and Family Welfare, GNCTD are as indicated in **Chart 1.2**.

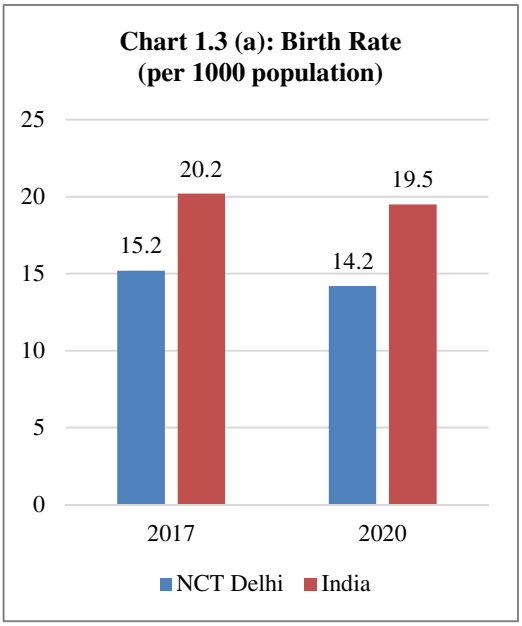
Chart 1.2: Functions of various Directorates/Departments under the Department of Health and Family Welfare

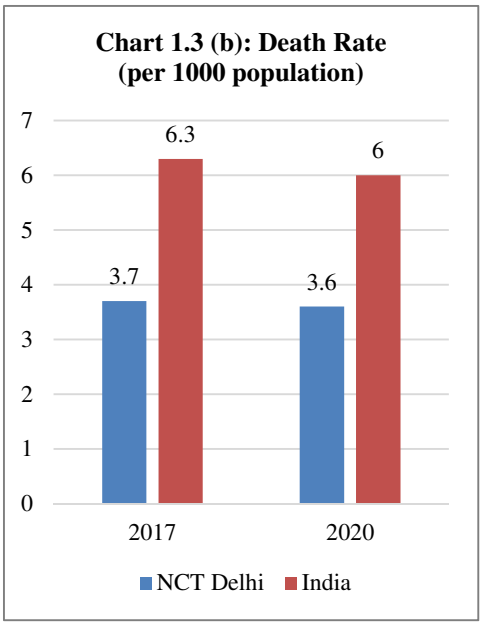


1.4 Status of Health Indicators in the State

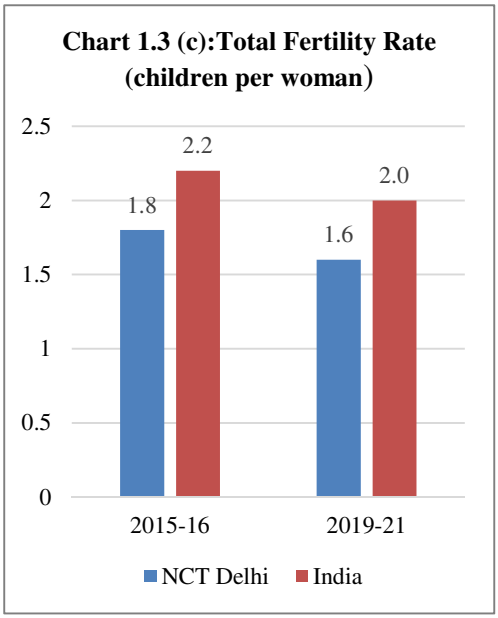
The healthcare services in a State can be evaluated on the basis of the achievement against benchmark of health indicators. The status of a few important health indicators of NCT Delhi vis-à-vis National average are given in **Charts 1.3**.

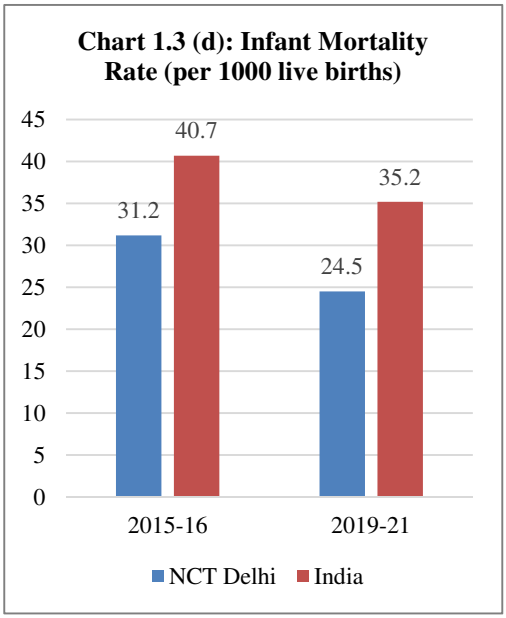
Charts 1.3: Health Indicators in the State





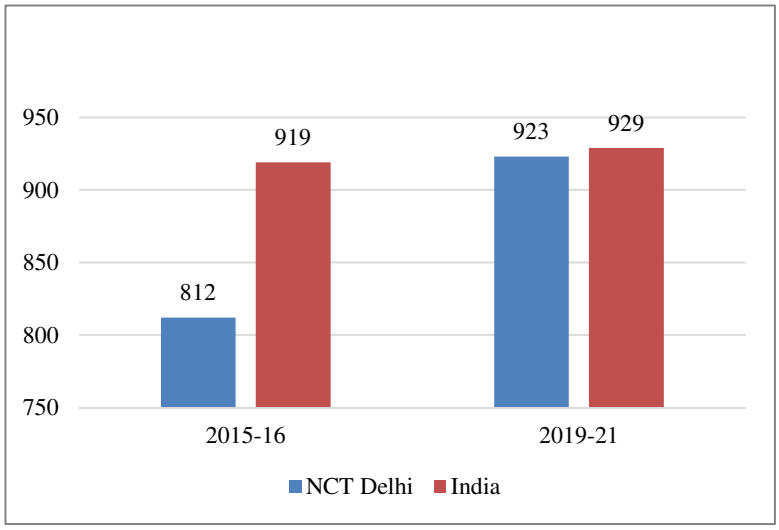
Source: Sample Registration Bulletin May 2019 (for 2017) and May 2022 (for 2020 figures)





Source: NFHS-4 (2015-16) and NFHS-5 (2019-21)

Chart 1.3 (e): Sex ratio at the birth for children born in the last five years (females per 1000 males)



Source: NFHS-4 (2015-16) & NFHS-5 (2019-21) Child Sex Ratio

It can be observed from **charts 1.3 (a)** to **1.3 (e)** that NCT of Delhi was placed better as compared to national averages in respect of all important indicators except sex ratio at the birth for children born in last five years (Females per 1000 Males) which increased from 812 (2015-16) to 923 (2019-20) but was still below the national average.

1.4.1 NCT Delhi Health Indicators compared with National Health Indicators as per National Family Health Survey-5 (NFHS-5)

The National Family Health Survey conducted in 2015-16 (NFHS-4) and NFHS-5 conducted in 2019-21, provide information on population, health and nutrition for India and each state/union territory (UT). Some of the important health indicators of NCT of Delhi are given in **Table 1.1**.

Table 1.1: Delhi Health Indicators as per NFHS-5

Indicator	NFHS -4 (2015-16)		NFHS-5 (2019-21)	
	Delhi	India	Delhi	India
Sex ratio of the total population (females per 1,000 males)	854	991	913	1020
Sex ratio at birth for children born in the last five years (females per 1,000 males)	812	919	923	929
Total fertility rate (children per woman)	1.8	2.2	1.6	2.0
Neonatal mortality rate (NNMR)	17.8	29.5	17.5	24.9
Infant mortality rate (IMR)	31.2	40.7	24.5	35.2
Under-five mortality rate (U5MR)	42.2	49.7	30.6	41.9
Mothers who had an antenatal check-up in the first trimester (%)	63.0	58.6	76.4	70.0
Mothers who had at least 4 antenatal care visits (%)	67.9	51.2	77.2	58.1
Mothers whose last birth was protected against neonatal tetanus[1] (%)	90.6	89.0	93.4	92.0
Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%)	53.8	30.3	69.1	44.1
Mothers who consumed iron folic acid for 180 days or more when they were pregnant (%)	29.9	14.4	49.0	26.0
Registered pregnancies for which the mother received a Mother and Child Protection (MCP) card (%)	86.6	89.3	94.0	95.9
Mothers who received postnatal care from a doctor/nurse/LHV/ANM/midwife/other health personnel within 2 days of delivery (%)	62.3	62.4	85.4	78.0
Average out-of-pocket expenditure per delivery in a public health facility (₹)	8518	3197	2548	2916
Children born at home who were taken to a health facility for a check-up within 24 hours of birth (%)	2.3	2.5	4.5	4.2
Children who received postnatal care from a doctor/nurse/LHV/ANM/midwife/other health personnel within 2 days of delivery (%)	NA	NA	86.7	79.1
Institutional births (%)	84.4	78.9	91.8	88.6
Institutional births in public facility (%)	55.5	52.1	62.4	61.9
Home births that were conducted by skilled health personnel[2] (%)	3.6	4.3	2.3	3.2
Births attended by skilled health personnel (%)	86.6	81.4	93.4	89.4
Births delivered by caesarean section (%)	26.7	17.2	23.6	21.5
Births in a private health facility that were delivered by caesarean section (%)	41.5	40.9	42.8	47.4
Births in a public health facility that were delivered by caesarean section (%)	26.5	11.9	17.7	14.3

State health indicators, which have been shaded green above have improved, those which have deteriorated are shaded red.

Health indicators (2019-21) of Delhi are better than national indicators except sex ratio. Sex ratio of total population has improved from 854 (2015-16) to

[1] Includes mothers with two injections during the pregnancy for their last birth, or two or more injections (the last within 3 years of the last live birth), or three or more injections (the last within 5 years of the last birth), or four or more injections (the last within 10 years of the last live birth), or five or more injections at any time prior to the last birth.

[2] Doctor/nurse/LHV/ANM/midwife/other health personnel.

913 (2019-21) but it remains below the national average of 1020. Sex ratio at birth for children born in the last five years at 923, however, is below the national average of 929.

There has been improvement in – Total fertility rate (children per woman), Neonatal mortality rate (NNMR), Under-five mortality Rate (U5MR), antenatal check-ups, use of iron and folic acid by pregnant women, registered pregnancies for which the mother received a Mother and Child Protection (MCP) Card, postnatal care and institutional births in public facilities in Delhi.

There has been decline in home births that were conducted by skilled health personnel. Births delivered by caesarean section have declined from 26.7 *per cent* to 23.6 *per cent* but it remains above national average of 21.5 *per cent* in NFHS-5 (2019-21).

1.5 Audit Objectives

Considering the goals laid down in NHP 2017 and the experience in COVID-19 Pandemic, it has become crucial to assess the adequacy of financial resources, availability of health infrastructure, manpower, machinery and equipment in the health institutions as well as efficacy in the management of health services in the State through existing policy interventions and scope for further improvement. Thus, to ensure timely and systematic corrections, performance audit on Public Health Infrastructure and Management of Health Services in the state of Delhi was taken up with the objective to provide a holistic view of the HealthCare Sector in the State i.e., a macro picture using State level information and data and a micro picture arising from detailed audit analysis/ findings on maintenance of infrastructure and delivery of health care services.

The objectives of the Performance Audit (PA) were to:
• assess the adequacy of funding for Health care; • assess the availability and management of health care infrastructure; • assess the availability of drugs, medicines, equipment and other consumables; • assess the availability of necessary human resource at all levels e.g. doctors, nursing, para medics etc. • examine the adequacy and effectiveness of the Regulatory mechanisms for ensuring that quality health care services are provided by public/ private health care institutions/ practitioners; • assess whether State spending on health has improved the health and wellbeing of the people as per SDG3; • examine the funding and spending under various schemes of the Government of India.

1.6 Scope of Audit

Audit has been conducted in respect of secondary Hospitals and tertiary healthcare facilities/Hospitals under GNCTD covering the period from April 2016 to March 2021. Wherever feasible, the data have been updated up to 2021-22. Audit included test check of records of the following units during the period from December 2021 to August 2022.

Selected Units/Schemes

- Department of Health and Family Welfare (Department),
- Directorate General of Health Services (DGHS),
- Central Procurement Agency (CPA),
- Directorate of Family Welfare (DFW),
- Delhi State Health Mission (DSHM),
- Delhi Medical Council,
- Delhi Nursing Council,
- Delhi Pharmacy Council,
- Delhi Arogya Kosh,
- Scheme of free treatment to Economically Weaker Sections,
- Drugs Control Department of Delhi,
- Four hospitals of GNCTD (out of 39 hospitals#),
- Maulana Azad Medical College (linked to Lok Nayak Hospital),
- Centralised Accident and Trauma Services (CATS) and
- Three out of 11 Integrated District Health Societies (IDHSs).

includes 27 district level hospitals spread across ten districts, seven super specialty hospitals, one central jail hospital and four AYUSH hospitals

Sample selection of field units

In the selected four hospitals, Audit had selected specific departments viz. Medicine and Gynecology in Lok Nayak Hospital (LNH); Cardiology in Rajiv Gandhi Super Specialty Hospital (RGSSH) and Janakpuri Super Specialty Hospital (JSSH); and Pediatric Medicine in Chacha Nehru Bal Chikitsalaya (CNBC) for detailed examination. Radiology Branch was selected in all the four hospitals. One month's record in each year for the period 2016-17 to 2020-21 was also selected for in-depth examination in respect of all programmes under the schemes Ayushman Bharat Health Insurance and National Health Mission in the three selected IDHSs. Besides, certain information[3] in the Report is based on data collection. Information in respect

[3] District-wise availability of Doctors vis-à-vis sanctioned strength and Availability of line/support services and availability of OPD services in 27 GNCTD district level hospitals.

of Manpower and Line Services for all districts were collected from the DGHS, GNCTD and respective District Level Hospitals of GNCTD.

Similarly, Line Services (IPD, OPD and Emergency/ICU/CCU); Support Services (Oxygen services, Biomedical Waste Management and Ambulance services); and Auxiliary Services (Patient safety services and Grievance/complaint redressal) were also examined in the selected hospitals.

For the purpose of the audit of AYUSH, records for the period from 2016-17 to 2022-23 of four [4] Autonomous bodies of the Directorate, two Ayurveda/Unani/Homoeopathic Medical Colleges with attached hospitals[5], Directorate of AYUSH and Drug Control Cell (Ayurvedic & Unani Medicines) were examined.

An Entry Conference was held (3 February 2022) with the Department wherein Audit Objectives, Criteria, Scope and Methodology were discussed. After conclusion of audit, an Exit Conference was also held to discuss the audit findings with the stake holders on 13 December 2022. The final draft report was also issued to the Government in October 2023 and replies of the Department wherever received have been suitably incorporated in the report.

1.7 Doctor/patient Survey

The Audit Methodology involved scrutiny of records and documents of auditee units, response to audit queries, collection of information through questionnaires/proforma and Doctor and Patient Survey of selected service users/beneficiaries for end-user satisfaction. Apart from that, Joint Physical Inspection of hospital assets, substores and civil works was also conducted. A survey among 149 Out-patients and 109 In-patients was also conducted to understand the patient satisfaction. Likewise, 54 Doctors were selected by random sampling for survey. Analysis of database of a Web-application (Nirantar) was also conducted through iDEA.

1.8 Audit Criteria

Audit criteria adopted to achieve the audit objectives were:

- National Health Policy, 2017;
- Sustainable Development Goal -3;
- MCI Act 1956 replaced by National Medical Commission in 2019;
- Indian Public Health Standards, 2012;
- Indian Medical Degrees Act, 1916;
- Professional Conduct, Etiquette and Ethics Regulation 2002;

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[4] Board of Homoeopathic System of Medicine, Delhi Bhartiya Chikitsa Parishad (DBCP), Examining Body for Para Medical Training for Bhartiya Chikitsa Delhi, and Delhi Homoeopathic Anusandhan Parishad (DHAP)

[5] (i) Ayurvedic & Unani Tibbia College and Hospitals (Tibbia College and hospital), (ii) Dr. B.R. Sur Homoeopathic medical College Hospital and research centre (SHMC)

- Clinical Establishment Act, 2010;
- Drugs & Cosmetics Act, 1940;
- Pharmacy Act, 1948 and Pharmacy Practice Regulations, 2015;
- Indian Nursing Council Act, 1947;
- Bio Medical Waste Management Rules;
- National Accreditation Board for Testing and Calibration Laboratories Accreditation programmes for Testing Laboratories as per ISO/IEC 17025, Calibration Laboratories as per ISO/IEC 17025, Medical Laboratories as per ISO 15189 etc.;
- National Accreditation Board for Hospitals and Healthcare Providers accreditation programmes for various Health care providers such as Hospitals, Blood Banks and Allopathic Clinics etc.;
- Atomic Energy (Radiation Protection) Rules, 2004;
- Assessors' Guidebook for Quality Assurance in Government Healthcare Centres published by MoH&FW in 2013 and 2014;
- Manual, Orders, circulars and scheme guidelines issued by Government of India and GNCTD from time to time;
- Policies of the Department of Health and Family Welfare, GNCTD and Delhi Government Health Scheme as reflected in their Annual Plans and Master Plan-2021;
- National Disaster Management Guidelines, 2014 and National Disaster Management Guidelines for Hospital Safety, 2016;
- Framework for implementation of schemes issued by GoI ;
- State Programme Implementation Plans (PIP) and Approved Record of Proceedings (ROP) under National Health Mission;
- Operational Guidelines issued by GoI for disease control programmes under National Health Mission;
- Decisions/Orders issued by Health and Family Welfare Department of GNCTD and Directorate of AYUSH;
- Delhi Bhartiya Chikitsa Parishad Act,1998;
- Minimum Standard Requirements for Medical Colleges and Hospitals;
- National Ayush Mission guidelines.

However, it was observed that the Delhi Government does not follow Indian Public Health Standards, 2012 as it has not adopted the same.

1.9 Consideration of Ayushman Bharat in this report

The Government of India launched Ayushman Bharat Health Insurance Scheme for all States of India in September 2018. Ayushman Bharat Yojana subsumes the Senior Citizen Health Insurance Scheme (SCHIS) and

Rashtriya Swasthya BimaYojna (RSBY) and is also known as Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY). Ayushman Bharat Yojana caters to poor families of rural and urban areas. The PMJAY scheme aims to provide healthcare to 10 crore families (50 crore people), mostly belonging to poor and lower middle income groups. The purpose of the Scheme is to increase access to quality health and medication. Under the Ayushman Bharat - National Health Protection Mission, targeted family will have a benefit cover of ₹ 5 lakh per year. As per PMJAY Scheme, the expenditure incurred on premium payment is shared between Central and State Governments in specified ratio as per Ministry of Finance guidelines.

Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) for the benefit of common people has not been implemented by the State Government till date (December 2023). Thus, people of Delhi could not get the benefit of the scheme.

1.10 Acknowledgement

Audit acknowledges the cooperation of the Departments concerned as well as its field functionaries in providing assistance for smooth conduct of Audit.

1.11 Structure of the report

This report has been structured keeping in mind the major components of health care i.e., sufficiency of funding in health sector; availability of infrastructure, drugs & equipment, and human resources; functioning of regulatory bodies in respect of relevant Acts and Rules; performance of the GNCTD in management of Covid-19 pandemic; implementation of Centrally Sponsored Schemes; and achievements of targets identified under Sustainable Development Goals (SDG-3).

Audit findings relating to the identified components and the factors that contributed towards their achievement have been discussed in various chapters as given below:

Chapter II	Human Resource
Chapter III	Healthcare services
Chapter IV	Availability of Drugs, Medicines, Equipment and other Consumables
Chapter V	Healthcare infrastructure
Chapter VI	Financial Management
Chapter VII	Implementation of Centrally Sponsored Schemes
Chapter VIII	Adequacy and effectiveness of the regulatory mechanisms
Chapter IX	Sustainable Development Goal-3
Chapter X	Implementation of Programmes, schemes/projects/services of GNCTD
Chapter XI	AYUSH

Chapter II

Human Resource

Chapter II

Human Resource

Adequate human resource is critical to achieve health policy goals. As of March 2022, there was a deficit of about 21 *per cent* staff in Health & Family Welfare Department of GNCTD. There was overall shortage of 30, 28 and 9 *per cent* in the category of teaching specialists, non-teaching specialists and medical officers respectively in 28 Hospitals/Colleges records of which were furnished to Audit. Besides, the deficit in the cadres of nurse and paramedic staff was about 21 *per cent* and 38 *per cent* respectively.

There was 36 *per cent* vacant posts under NHM in Delhi (2020-21). There was skewed deployment of technicians in Radiology Department of Hospitals. Absence of promotion and career progression opportunity and unchanged salary structure resulted in shortage and inconsistency in the availability of super specialist doctors in two test checked hospitals. No person was posted against the posts of Health Educator, Chief Pharmacist, Psychological Social Worker and Fire safety officer in test checked Lok Nayak Hospital.

2.1 Introduction

For effective and efficient functioning of a health institution, adequate number of motivated, empowered, trained and skilled human resource is essential. Human resource planning is a must before investing in other components like infrastructure, equipment, drugs etc. The number and type of staff in terms of General Duty Medical Officers (GDMOs), Specialists, nurses, allied health professionals, administrative and support staff etc. has to be ascertained taking into consideration health facility requirements of the people to which the health institution caters to. Availability of manpower and related issues have been discussed in the succeeding paragraphs.

2.2 Human resource availability against sanctioned strength

None of the Health-related directorates maintained a complete list of permanent and contractual medical staff available in all health institutions under the Government of Delhi. Therefore, Audit analyzed the data of Human Resource Management system (HRMS), a module/application of Integrated Financial Management System (IFMS) obtained from Treasuries and Accounts Department, Delhi (31 March 2022). The HRMS data contains information of permanent staff deployed in various departments under GNCTD. Audit obtained and analyzed the data related to -

i. Department of Health and Family Welfare

ii. Directorate General of Health Services (DGHS)

iii. State Health Mission

iv. Drug Control Department

v. Maulana Azad Medical college

vi. Lok Nayak Hospital

vii. Rajiv Gandhi Super Speciality Hospital

viii. Janakpuri Super Speciality Hospital

ix. Chacha Nehru Bal Chikitsalaya

Sanctioned strength and person-in-position for all the offices of the above-mentioned departments were as given in **Table 2.1**.

Table 2.1: Manpower Position across the different Health Departments (as of March 2022)

Name of the Department/Institute	Sanctioned strength	Working Strength	Vacant Posts	Percentage of vacancy
Department of Health and Family Welfare	15508	12240	3268	21
Director General Health Services (DGHS)	4080	2548	1532	37.55
State Health Mission	3222	2186	1036	32.15
Drug Control Department	145	70	75	51.72
Selected Medical College and hospitals				
Maulana Azad Medical college	1111	608	503	45.27
Lok Nayak Hospital	4280	3699	581	13.57
Rajiv Gandhi Super Speciality Hospital	882	303	579	65.64
Janakpuri Super Speciality Hospital	457	159	298	65.20
Chacha Nehru Bal Chikitsalaya	787	465	322	40.91

Department of Health and Family Welfare and DGHS have major share in the total sanctioned strength. In terms of percentage of vacant posts, there was shortage of 21 *per cent* and 37.55 *per cent* in the above two Departments/Institutes. Audit also noticed that the percentage of vacancies in DGHS increased from 19.96 *per cent* in 2016-17 to 37.55 *per cent* in 2021-22. In selected hospitals and Drug Control Department, the vacancies persisted during the audit period.

Analysis of hospital data[1] revealed shortage of nurses, para-medical staff and doctors and their irrational distribution among these health units (**Annexure I**) as discussed below:

1. **Nursing staff**: There was overall shortage of nursing staff (21 *per cent*) and hospital-wise shortage ranged from one to 34 *per cent*. There were significant vacancies in major hospitals such as GB Pant Hospital (34 *per cent*), GTB Hospital (28 *per cent*), LNH (20 *per cent*) and Bhagwan Mahavir Hospital (33 *per cent*).

[1] Data of 28 hospitals/colleges furnished.

2. **Paramedical staff**: There were 79 categories of posts sanctioned under paramedical staff against which there was overall shortage of staff (38 *per cent*) and no staff was posted against 23 category of posts. There were more than 30 *per cent* vacancies in 19 different categories of posts such as Occupational Therapist/ Physiotherapist, Speech Therapist, Refractionist, Audiometric Assistant, Dietician, Post Mortem Assistant, Technical Assistant Ophthalmology, Orthoptist, Psychiatric Social worker, Lab Technician, OT Technician, Radiographer, Medical Record Technician etc. (**Annexure I B)**

3. **Teaching specialists, non-teaching specialists and medical officers**: The overall shortage in the categories of teaching specialists, non-teaching specialists and medical officers were 30, 28 and 9 *per cent* respectively. There were significant vacancies of non-teaching specialist in major hospitals such as Dr. Baba Saheb Ambedkar (38 *per cent*), LNH (40 *per cent*) and Babu Jagjiwan Ram Memorial (44 *per cent*).

   There was no sanctioned strength of specialists in three hospitals (Ambedkar Nagar Hospital, Burari Hospital and Indira Gandhi Hospital) but 11 non-teaching specialists were working in these hospitals on diverted capacity. Also, in these hospitals, 68 Medical Officers were working on diverted capacity against the sanctioned strength of 12.

   With regard to lack of sanctioned strength of specialists in three hospitals, Government stated (December 2023) that 36 specialists posts have been sanctioned in Indira Gandhi Hospital against which 17 posts have been filled on regular basis.

   Due to shortage of health staff, patient health care services are adversely affected. Department had not made any effort to fill up the vacant posts in different cadres.

4. **District and department-wise shortage of specialists in 27 district level hospitals**

   Data of sanctioned strength and availability of specialists/doctors in various departments of 27 district level hospitals[2] was collected by Audit. Hospitals located in a particular revenue district of GNCTD were grouped to ascertain the position district wise.

   Audit noted that in many of there 27 hospitals, ENT services (3), General Medicines (2), Pediatrics (2), General Surgery (3), Ophthalmology (2), Dental (7), Obstetrics & Gynecology (3), Psychiatry (19), orthopedics (3) and dermatology (5) were not available. Further audit noted that no GNCTD hospital was available in New Delhi district.

[2] Excluding seven super specialty hospitals, one central jail hospital and four AYUSH hospitals.

District wise distribution of doctors as of March 2023 under 10 specialty departments of 27 hospitals spread in 10 districts is given in **Table 2.2**.

Table 2.2: District wise distribution of specialists in hospitals

Name of the Dept[3]	Central		East		North		North-East		North-West		Shahdara		South		South East		South West		West		Total	
	SS	MIP	SS	MIP	SS	MIP	SS	MIP	SS	MIP	SS	MIP	SS	MIP	SS	MIP	SS	MIP	SS	MIP	SS	MIP
																					Shortage In *per cent*	
ENT	15	15	6	5	4	3	1	1	7	6	3	3	1	0	1	2	8	6	6	5	52	46
																					11	
GM	30	15	3	1	12	3	3	3	22	16	8	6	2	0	3	3	23	8	21	14	127	69
																					45	
Pead	40	34	90	63	10	3	2	3	17	11	17	12	1	1	2	2	21	13	19	18	219	160
																					27	
GS	33	22	24	14	10	3	2	2	12	7	7	3	1	0	3	1	23	7	17	14	132	73
																					44	
Optha	46	24	5	4	4	2	1	1	14	7	3	2	1	0	1	1	8	4	8	7	91	52
																					42	
Dental	1	0	5	2	6	1	2	1	8	5	2	2	1	0	2	1	6	3	8	5	41	20
																					51	
O&G	53	46	2	2	16	9	3	2	23	15	20	20	2	2	3	3	24	11	30	24	176	134
																					23	
Psy	0	0	1	1	2	0	0	0	3	3	0	1	0	0	0	1	3	1	1	1	10	8
																					20	
Ortho	31	29	8	8	8	3	2	2	12	6	5	5	1	0	2	1	16	8	13	8	98	70
																					28	
Derma	7	7	5	4	3	2	1	1	5	4	3	2	1	0	1	1	4	2	6	3	36	26
																					27	
Total	256	192	149	104	75	29	17	16	123	80	68	56	11	3	18	16	136	63	129	99	982	658
Shortage In *per cent*		25		30		61		5		35		17		72		11		53		23	33	

Shortage of manpower are shaded red

There was overall shortage of 33 *per cent* of doctors in the ten departments of 27 hospitals of GNCTD. District wise shortage was 72 *per cent* in South, 61 *per cent* in North and 53 *per cent* in South West Districts. Shortage of doctors in other districts ranged between 17 to 30 *per cent* except in South East (11 *per cent*) and North East (5 *per cent*).

Overall shortage of specialists in General Medicine, General Surgery, Ophthalmology and Dental were 45, 44, 42 and 51 *per cent* respectively. Shortage of doctors in other departments ranged between 20 to 33 *per cent* except in ENT (11 *per cent*).

There was shortage of doctors in all departments of hospitals in South West and North Districts. Further, in hospitals of North West and West Districts, shortage was noticed in all departments except Psychiatry.

2.3 Availability of staff in various posts under Directorate General of Health Services (DGHS)

In DGHS, 1,532 posts, i.e., 37.55 *per cent* of total sanctioned strength of 4,080 were vacant. Category wise vacancy position is shown in **Table 2.3**.

[3] **ENT**-Ear, Nose, Throat, **GM**- General Medicine, **Pead**- Peadiatrics, **GS**-General Surgery, **Optha**-Opthalmology, **O&G**- Obstetrics & Gynecology, **Psy**-Psychology, **Ortho**-Orthopedics, **Derma**- Dermatology

Table 2.3: Staff position in DGHS

Category	Sanctioned posts	Working strength	Vacant posts	Vacancy percentage
Doctor	677	539	138	20.38
Nurse	560	526	34	6.07
Paramedics	985	755	230	23.35
Other[4]	1858	728	1130	60.82
Total	**4080**	**2548**	**1532**	**37.55**

Source: DGHS, GNCTD Annual report 2021-22

It can be seen from above table that the vacant posts under above mentioned four categories ranged from 6.07 *per cent* to 60.82 *per cent*.

2.4 Human Resource under Drugs Control Department (DCD)

Total sanctioned strength of DCD, Delhi was 145. It has been observed that 51.72 *per cent* posts, i.e. 75 posts were lying vacant in DCD. Shortage of manpower in some of the posts in DCD were as given in **Table 2.4**.

Table 2.4: Manpower position under DCD (as of September 2022)

Sl. No.	Name of Post	Sanctioned posts	Working strength	Vacant posts	Percentage of vacant posts
1.	Drug Controller	1	0	1	100
2.	Deputy Drug Controller	2	1	1	50
3.	Senior Scientific Officer	1	0	1	100
4.	Drug Inspector	46	17	29	63
5.	Junior Scientific Officer	4	0	4	100
6.	Sr. Scientific Assistant	14	2	12	86
7.	Lab Assistant	2	1	1	50
8.	Sample Packer	1	0	1	100
	Total	**71**	**21**	**50**	**70.42**

Source: Information provided by the DCD

It can be seen from **Table 2.4**, that there was acute shortage of staff in the critical posts of Drug Inspector (63 *per cent*), Junior Scientific Officer (100 *per cent*) and Sr. Scientific Assistant (86 *per cent*).

2.5 Sanctioned strength and availability in test checked hospitals

During the FYs 2016-17 to 2021-22, there was shortfall in the availability of doctors, paramedical staff/technicians, and nursing staff against the sanctioned strength in the four selected hospitals as per the details given in **Table 2.5**.

[4] Dresser, Safai Karamchari, Attendant, etc.

Table 2.5: Staff position in selected hospitals

Hospital Name	Sanctioned strength	Number of staff posted						Vacancy (in *per cent*)
		2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	
Doctors								
LNH	669	542	542	553	551	573	587	12 to 19
RGSSH	238	61	64	82	73	115	119	50 to 74
CNBC	189	121	106	144	132	119	127	24 to 44
JSSH	158	74	70	78	79	57	76	50 to 64
Paramedical staff								
LNH	464 (16-17) 464 (17-18) 464 (18-19) 463 (19-20) 507 (20-21) 553(21-22)	363	345	327	316	348	454	18 to 32
RGSSH	136	106	96	78	67	67	60	22 to 56
CNBC	105	93	74	73	75	89	76	11 to 30
JSSH	88 (2016-17) 90 (2017-22)	36	42	34	36	34	31	53 to 66
Nursing staff								
LNH	1646 (1650 in 2020-22)	1449	1440	1416	1382	1458	1576	4 to 16
RGSSH	428	16	19	19	114	114	114	73 to 96
CNBC	408	238	237	236	221	220	213	42 to 48
JSSH	174	36	36	34	32	30	30	79 to 83

- In LNH, the shortage of doctors, paramedical staff/technicians and nursing staff ranged between 12 to 19 *per cent*, 18 to 32 *per cent* and 4 to 16 *per cent* respectively.
- In CNBC, the shortage of doctors, paramedical staff/technicians and nursing staff ranged between 24 to 44 *per cent*, 11 to 30 *per cent* and 42 to 48 *per cent* respectively.
- In RGSSH, the shortage of doctors, paramedical staff/technicians and nursing staff ranged between 50 to 74 *per cent*, 22 to 56 *per cent* and 73 to 96 *per cent* respectively.
- In JSSH, the shortage of doctors, paramedical staff/technicians and nursing staff ranged between 50 to 64 *per cent*, 53 to 66 *per cent* and 79 to 83 *per cent* respectively.

In addition to the above, specific and significant shortages in various cadres in all the test checked hospitals are highlighted below:

- In LNH, there was overall shortage of 21 *per cent* of specialist doctors in various departments of Anaesthesia, Neurosurgery, Burns and Plastic, General Surgery, Radio-diagnosis, General Medicine and Orthopaedics as of March 2022. There was acute shortage of senior residents in the Department of Neonatology against the nine new posts created in April 2016, the same were filled only in January 2023. Further, no person

was posted against some of the posts like CCU Assistant, Technical Supervisor (PCR), Technical Assistant (Dialysis), Technical Assistant (ENT), Technical Supervisor (ENT), Psychological Social Worker, Scientific Assistant, Health Educator, Chief Pharmacist, Mechanic OT, Neuro Technician, Neuro Assistant OT, Laundry Mechanic, Fire Safety Officer etc. as of September 2022.

- In JSSH, no Specialist doctors were posted in Microbiology and Pathology during 2016-17 to 2019-20 and in Cardiology Department during 2016-17 to 2018-19. Further, against 24 sanctioned posts (one post each of Professor, Associate Professor and Assistant Professor in eight Departments[5]), only two Professors, two Associate Professors and five Assistant Professors were posted (March 2022). No person was posted against some of the posts i.e. Technical Assistant (Radiology), Speech Therapist, Senior Radiographer (Radiology), Dark Room Attendant, Lab Attendant and Dresser as of March 2022. There were vacancies in the posts of Technical Assistants (five vacant out of seven), ECG Technicians (two vacant out of five) and Radiographers (23 vacant out of 24) as of March 2022.
- In RGSSH, against the sanctioned strength of 26 Professors/Associate Professors, no Professor/Associate Professor was available during the period 2016-17 to 2017-18 whereas only one to five Professors/Associate professors were available during the period 2018-19 to 2021-22.

Government replied (December 2022) that RGSSH conducts regular Walk-in-Interviews for SRs and tender has been floated for the post of paramedical staff and is under process.

Thus, shortage of doctors/para medical staff in departments/hospitals directly affect patient care services.

In respect of test checked hospitals, Audit noted instances where OTs were not being utilized due to shortage of manpower. Moreover, the average waiting time for surgeries in test checked hospitals ranged between one month to 10 months. This has been detailed in Chapter III of the Report.

2.6 Shortage of teaching doctors in selected autonomous Super specialty hospitals

Audit examined the availability of teaching doctors in selected autonomous[6] Rajiv Gandhi Super Specialty Hospital (RGSSH) and Janakpuri Super specialty Hospital (JSSH) of GNCTD.

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5 Cardiology, Nephrology, Neurology, Gastroenterology, Anesthesia, Radiology, Pathology and Microbiology

6 Both RGSSH and JSSH were to function as advanced centers for research and training in the field of medical sciences and were to be set up as a state of the art teaching facilities for Post-doctoral and post graduate levels.

As per MoA between GNCTD and hospitals concerned, teaching doctors are to be recruited for five years with performance review after three years and extension of one year each time on completion of five year tenure till superannuation on fixed remuneration. Remuneration for teaching faculties was fixed by GNCTD in July 2014 i.e., Assistant professors (₹ 1.25 lakh), Associate Professors (₹ 1.65 lakh) and Professors (₹ 2.00 lakh).

Audit noted that the aspects of promotions and career progression for a satisfied and consistent workforce had not been included in the MoA. In the absence of promotion and career progression opportunities, RGSSH and JSSH failed to attract teaching doctors. Audit observed that RGSSH had 14 (2017-18) to 29 (2020-21) teaching doctors (Regular/Contractual) against a sanctioned strength of 85 whereas JSSH had a maximum of eight teaching doctors against a sanctioned strength of 24 (31 March 2021). In the year 2016-17, there was no teaching faculty posted in JSSH. This resulted in shortage and inconsistency in the availability of Super Specialty Doctors to run super specialty departments like Cardiology, Pulmonology, Gastroenterology, GI surgery, Urology etc.

It was also observed that instead of revising the contractual terms and conditions and enhancing remuneration, RGSSH started recruiting teaching faculty for one year and thereafter, extension of one year was being given. Further, on not receiving sufficient responses even for one year, doctors (teaching faculty, SRs and JRs) had been recruited through walk-in interview for three months and then extension for another three months had been granted. The frequent change of doctors besides their shortage affected the functioning of the hospitals compromising the ability of these Hospitals in providing super specialty health care facilities to the patients.

2.7 Sanctioned strength and men-in-position in selected Medical College

There are three medical colleges of Government of NCT of Delhi. The details are given in **Table 2.6**.

Table 2.6: Details of medical colleges of GNCTD

Sl. No.	Name of the Medical College	Name of the University	Year of establishment	Number of seats
1	Dr. Baba Saheb Ambedkar Medical College, Rohini, Delhi	Guru Gobind Singh Indraprastha University	2016	125
2	Maulana Azad Medical College, New Delhi	Delhi University	1959	250
3	University College of Medical Sciences & GTB Hospital, New Delhi	Delhi University	1971	170

Maulana Azad Medical College (MAMC) was selected for detailed audit. Medical College Regulations, 1999 issued by MCI (now National Medical Commission) emphasizes that the number of teachers must be as per provisions

so as to effectively impart the education. The teaching staff of the college also provides patient care services in the Hospital. During the years 2016-17 to 2021-22, there was overall shortage of 20 to 32 *per cent* of faculty members in MAMC as shown in **Table 2.7**.

Table 2.7: Staff position in MAMC

Year	No. of posts sanctioned	Filled post	Vacancy	Vacancy (in *per cent*)
2016-17	288	195	93	32
2017-18	291	207	84	29
2018-19	292	211	81	28
2019-20	292	213	79	27
2020-21	292	234	58	20
2021-22	295	226	69	23.39

Further, out of total 295 teaching faculty posts, 73 posts were temporary in nature and had continued as such for the last 20 years in MAMC. Audit noted that 38 temporary posts in different categories[7] were lying vacant (March 2021).

Government replied (December 2022) that MAMC has initiated the process of filling up the vacant posts of teaching faculties on contractual basis.

2.8 Sanctioned strength and availability of staff in Nursing college, LNH

As per Indian Nursing Council guidelines, there should be one post of Principal and Vice Principal each and two posts of Associate Professors and three posts of Assistant Professors in each nursing college with intake of 40-60 students. There should be teachers in the ratio of 1:10 to the total intake of students. There were 172 (2016-17) to 224 (2021-22) students studying B.Sc Nursing Course in the Nursing College of LNH.

Audit noted that:

- No Principal was posted during 2016-17 to 2021-22.
- Five Associate Professors/ Assistant Professors were required as per norms. Against this only two posts were filled (2018-19 onwards) out of four sanctioned posts whereas post of Clinical Instructor filled ranged from one (2019-20) to five (2018-19) against the sanctioned strength of six.
- 17 to 22 teachers were required as per the norms. However, only 10 to 13 teachers were posted in the college during the period of audit against the sanctioned strength of 16. Thus, there was shortage up to 19 *per cent* (2018-19) to 37 *per cent* (2019-20) of teaching staff against the sanctioned strength.

[7] Neonatology (1), Pulmonary Medicine (2), Child Development Centre (7), Radiation Physics (1), Genetic Lab (1), Surgery (4), Medicine (4), Reproductive Biology Centre, (Dept of O & G) (9), and Nephrology (9).

2.9 Vacant posts under NHM

As per the MoU signed between GoI and GNCT of Delhi, contractual/outsourced human resource are to be engaged under NHM. DSHS sends the Programme Implementation Plan (PIP) to the MoH&FW, GoI (including requirement of human resource for programmes under NHM) every year for a period of 12 months. Thereafter, the MoH&FW, GOI approves human resources in the Records of Proceedings (RoP) against the proposed PIP.

As per RoP (approved PIP) of DSHS for the period 2020-21, the MoH&FW, GoI approved 2,581 posts of doctors, nurses, technicians and other para medical staff etc. against which only 1,643 posts were filled up and 938 posts (36 *per cent*) remained vacant as of March 2021.

The shortfall in various categories of posts are given in **Table 2.8**.

Table 2.8: Availability of staff under NHM

Sl. No.	Category of the post	Number of posts approved	Number of posts filled up	Vacancy	Vacancy in *per cent*
1.	Nurses	1163	845	318	27
2.	Technicians	439	347	92	21
3.	Pharmacists	134	98	36	27
4.	Physiotherapist / Occupation therapist	21	0	21	100
5.	Medical Officer (Doctors)	105	75	30	29
6.	Social workers	22	2	20	91
7.	Psychiatrists	5	0	5	100
8.	Dental staff for National oral health programme	106	0	106	100
9.	Counsellors	37	5	32	86
10.	Psychologists	19	1	18	95
11.	Microbiologists	6	2	4	67
12.	Audiometric assistants/Audiologists	18	1	17	94
13.	Lab Assistant / Attendant	23	13	10	43
14.	Consultant	29	1	28	97
15.	Miscellaneous medical staff	403	249	154	38
16.	Other administrative staff	51	4	47	92
Total		**2581**	**1643**	**938**	**36**

It can be seen from the above table that there were significant vacancies in important posts such as Medical Officers (29 *per cent)*, Nurses (27 *per cent*), Pharmacists (27 *per cent*), Lab Assistant (43 *per cent*) and Counsellors (86 *per cent*).

DSHM stated (July 2022) that it implements and runs the program by giving additional responsibilities to the existing contractual employees.

The reply is not acceptable as DSHS has not made any efforts for recruiting sufficient contractual/outsourced staff as approved in the PIP by GoI.

2.10 Deployment of Radiology staff

As per Atomic Energy (Radiation Protection) Rules 2004 and Medical Diagnostic Radiology Module (guidelines for e-Licensing of Radiation Applications- eLORA) issued by the Atomic Energy Regulatory Board

(AERB), radiologist/ X-ray operators/technicians are mandatory for obtaining License for all X-ray equipment.

Audit examined the records of availability of radiologists/doctors and technicians in health facilities vis-à-vis machinery and equipment available as of June 2022 **(Annexure II)**.

Audit found that in five hospitals viz. Rao Tula Ram Memorial hospital, Satyawati Raja Harish Chand hospital (SRHCH), Guru Gobind Singh hospital, Deep Chand Bandhu Hospital and A&U Tibbia College & Hospital, there was no Specialist/GDMOS/SR, thereby affecting reporting of the X-ray films in contravention of the eLORA diagnostic radiology guidelines. Moreover, in two hospitals viz. Rajiv Gandhi Super Speciality Hospital and Chaudhary Brahm Prakash Ayurved Charak Sansthan, no technicians were posted despite availability of X-ray machines.

The issue was also flagged in the meeting held (December 2018) under the chairmanship of Secretary (H&FW).

DGHS stated (February 2022), that the manpower distribution in the hospitals in respect of all cadres in diagnostic services is not in its purview.

The reply is not acceptable as overall responsibility for manpower distribution lies with the Department/DGHS.

Recommendation 2.1: Vacancies against the sanctioned posts should be filled to improve the functioning of public health facilities of GNCTD.

Recommendation 2.2: In view of shortage of teaching doctors in its autonomous hospitals, Government may review the recruitment norms to make it more attractive for teaching doctors so that a satisfied and consistent workforce of teaching doctors is available in these hospitals.

Chapter III

Healthcare Services

Chapter III

Healthcare Services

Line/support services such as Blood Bank, ICU, Oxygen, Mortuary and Ambulance were not available in all the district level hospitals of GNCTD. Heavy work load at Registration and Pharmacy counters as well as heavy patient load on doctors was noticed in two out of four test checked hospitals viz. Lok Nayak Hospital (LNH) and Chacha Nehru Bal Chikitsalaya (CNBC) which indicates more waiting time and less consultation time to patients. Shortage of toilets and scarcity of waiting area for attendants was noticed in LNH. Indoor Patient Departments (IPDs) were found crowded in many wards.

Major portion of fleet of Centralised Accident and Trauma Services (CATS) ambulances were found running without essential equipment and devices. Three out of four test checked hospitals did not provide ambulance services.

Only LNH has the facility to separate the blood components, the other three test checked hospitals were holding license for processing and storage of blood units only. While huge waiting time was observed for radiological diagnostic services in LNH, the radiological equipment were found underutilised in other three hospitals due to shortage of manpower. Atomic Energy Regulatory Board guidelines were not fully adhered in these hospitals for ensuring the safety of staff. Dietary services were not available in Janakpuri Super Specialty Hospital (JSSH) and RGSSH during the audit period. Periodic inspection was not conducted by the Dieticians and quality of food was never checked (except once in December 2021 in LNH) by the Government in test checked hospitals during the audit period.

JSSH had not established Emergency Services whereas shortage of essential medicines and equipment was noticed in the Emergencies/ICU of LNH and RGSSH. There was long waiting time for surgeries in two test checked hospitals. At the same time, six out of 12 modular OTs in Rajiv Gandhi Super Specialty Hospital (RGSSH) and all the seven modular OTs in JSSH were lying idle due to shortage of manpower. Sushruta Trauma Centre (STC) established for treating victims of road accidents had no separate administrative set up and was lacking permanent arrangement of Specialist Doctors and Senior Residents for 24-hour emergency services.

State Rapid Response team constituted in the wake of Covid to ensure emergency preparedness failed to carry out its assigned task. There was shortfall in conducting patient satisfaction survey, prescription audit, death reviews etc. by the test checked hospitals thereby depriving them from the benefit of such assessment for further improvement in patient services.

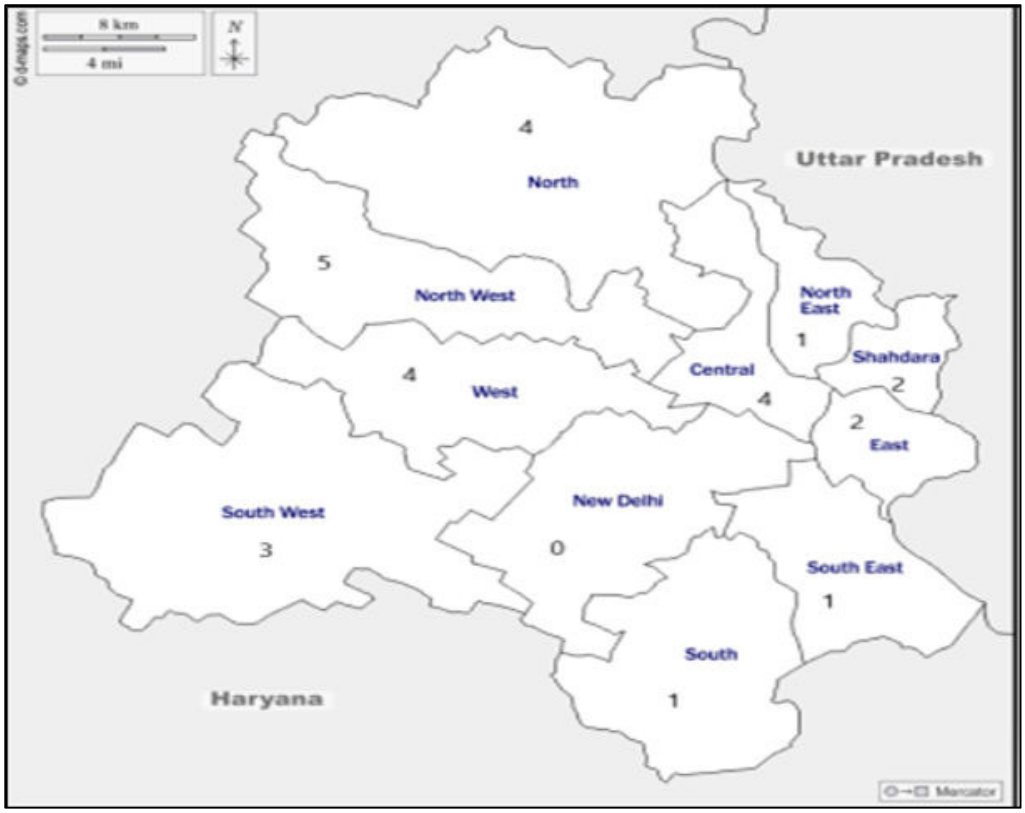
3.1 Delivery of line services

Point 3.3.2 of NHP aims to ensure that specialist skills are available within the district hospitals. IPHS envisage that each District Hospital should deliver essential services (minimum assured services) and aspire to deliver specialised services to address the needs of patients.

There are 27 hospitals, seven super speciality hospitals, four AYUSH hospitals and one Central jail hospital of GNCTD.

The distribution of 27 district hospitals in NCT of Delhi is given in **Chart 3.1**.

Chart 3.1: Distribution of district hospitals in NCT of Delhi



As per IPHS norms, OPD services such as ENT, General Medicine, Peadiatrics, General Surgery, Ophthalmology, Dental, Obstetrics & Gynecology, Psychology, Orthopedics are essential for District Hospitals whereas Dermatology is desirable.

As per information furnished in respect of OPD services provided by 27 hospitals, ENT in five, General Medicine in four, Peadiatrics in two, General Surgery in seven, Ophthalmology in five, Dental in nine, Obstetrics & Gynecology in three, Psychology in 20, Orthopedics in five and Dermatology in eight hospitals were not available. Psychology was not available in three out of 11 districts.

Availability of selected line services/support services in 27 GNCTD hospitals in 10 districts of NCTD is given in **Table 3.1**.

Table 3.1: Status of availability of Line services/Support services in 27 hospitals

Name of the hospital	Line services					Other services			
	Emergency	Imaging	Pathology	Blood Bank	Intensive Care Unit	Bio-medical Waste	Ambulance	Oxygen	Mortuary
South West									
Sri Dada Dev Matri Avum Shishu Chikitsalaya, Dabri	Yes	Yes	Yes	No	No	Yes	No	Yes	No
Rao Tula Ram Memorial Hospital, Jaffarpur	Yes	Yes	Yes	No	No	Yes	No	Yes	Yes
Indira Gandhi Hospital Dwarka	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes
North									
Maharishi Valmiki Hospital, Pooth Khurd	Yes	Yes	Yes	No	No	No	Yes	No	No
Babu Jagjivan Ram Memorial Hospital	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes
Burari Hospital Shankarpuri	Yes	Yes	Yes	Yes	No	No	No	No	No
Satyavadi Raja Harish Chandra Hospital, Narela	Yes	Yes	Yes	No	No	Yes	No	Yes	No
South									
Ambedkar Nagar Hospital Dkshinpuri	No	No	No	No	No	No	No	No	No
South East									
Pt. Madan Mohan Malviya Hospital, Malviya Nagar	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes
West									
Sardar Vallabh Bhai Patel Hospital, Patel Nagar	Yes	Yes	Yes	No	No	No	No	No	No
Guru Gobind Singh Government Hospital	Yes	Yes	Yes	No	No	Yes	Yes	Yes	No
Acharyashree Bhikshu Govt. Hospital, Moti Nagar	Yes	Yes	Yes	No	No	Yes	Yes	No	No
Deen Dayal Upadhyay Hospital, Hari Nagar	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Shahdara									
Dr. Hedgewar Arogya Sansthan, Karkardooma	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Guru Teg Bahadur Hospital, Shahdara	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Central									
Dr. N.C.Joshi Memorial Hospital, Karol Bagh	Yes	Yes	Yes	No	No	Yes	No	No	No
Aruna Asaf Ali Govt. Hospital, Rajpur Road	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes
Guru Nanak Eye Centre	Yes	No	Yes	No	No	Yes	Yes	No	No
Lok Nayak hospital	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Name of the hospital	Line services					Other services			
	Emergency	Imaging	Pathology	Blood Bank	Intensive Care Unit	Bio-medical Waste	Ambulance	Oxygen	Mortuary
North East									
Jag Pravesh Chandra Hospital, Shastri Park	Yes	Yes	Yes	No	No	Yes	No	Yes	No
North West									
Sanjay Gandhi Memorial Hospital, Mangol Puri	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Dr. Baba Saheb Ambedkar Hospital, Rohini	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Deep Chand Bandhu Hospital Ashok Vihar	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Aattar Sain Jain eye And General Hospital	No	No	Yes	No	No	Yes	No	No	No
Bhagwan Mahavir Hospital	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
East									
Chacha Nehru Bal Chiktisalaya, Geeta Colony	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Lal Bahadur Shastri Hospital, Khichripur	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Total	No (2)	No (3)	No (1)	No (16)	No (14)	No (4)	No (12)	No(8)	No (15)

Source: Information collected from respective hospitals.
Lack of services in the hospital are shaded red.

In Delhi there are 11 districts out of which 10 districts viz. South West (3), North (4), South (1), South-east (1), West (4), Shahdara (2), Central (4), North-east (1), North-west (5) and East (2) have GNCTD hospitals. New Delhi District does not have any GNCTD hospital.

Out of 27 hospitals, ICU services were not available in 14 hospitals, Blood Bank services were not available in 16 hospitals, Oxygen services were not available in eight hospitals, Mortuary services was not available in 15 hospitals and Ambulance services were not available in 12 hospitals.

District wise availability of essential lines services were as under (May 2023):

- There were no-line service/support service available in the only newly opened hospital in South District.
- Ambulance, Blood Bank, ICU and Mortuary services were not available in the only hospital of North-East District.
- Ambulance and Blood Bank services were not available in any hospital in two districts (South-West and South-East).
- ICU service were not available in any hospital in North District.

Government did not offer any comment in its reply dated 13 December 2023.

Deficiencies in delivery of line services/support services observed in selected hospitals are discussed in the succeeding paragraphs.

3.1.1 Availability of Out-Patient Department (OPD) Services in Hospitals

To avail outdoor services in hospitals, Out-patients first register at the OPD. After registration, the doctors concerned examine the patients for diagnosing ailments and prescribe either diagnostic tests for evidence based diagnosis or medicines on the basis of consultation.

The number of out-patients attended to in the four selected Hospitals are shown in **Table 3.2**.

Table 3.2: Out-patients in selected hospitals

Year	OPD patient			
	LNH	CNBC	RGSSH	JSSH
2016-17*	9,75,380	3,01,480	66,125	2,96,478
2017-18	18,54,141	3,61,665	1,40,309	3,59,854
2018-19	19,09,960	3,74,354	1,76,394	3,73,996
2019-20	18,42,976	3,38,458	2,42,239	3,77,588
2020-21**	80,373	1,85,635	84,277	2,85,808
2021-22	5,99,727	2,63,229	1,49,988	2,67,505
Total	**72,62,557**	**18,24,821**	**8,59,332**	**19,61,229**

Source: Annual Reports and information provided by the hospitals
* LNH figure does not include the OPD data for the period (July to Nov 2016) due to server failure
** LNH and RGSSH were declared as COVID only hospital.

As per IPHS, work load at OPD shall be studied and measures shall be taken to reduce the waiting time for registration, consultation, diagnostics and pharmacy. Audit noted that no study was conducted in the test checked hospitals to reduce the waiting time.

The OPD data for the period from 2016-17 to 2020-21 in respect of CNBC and for the period from 1 January 2018 to 21 March 2020 in respect of LNH which were provided to Audit was examined in detail and the observations are as under.

3.1.1.1 High workload in registration counters of OPD of LNH and CNBC

Registration counter is the first point of contact with the hospital and is an important part of hospital experience for patients and their attendants. OPD patient Registration Counters were managed by one person per counter who has to feed the patient's name and other details in the system and generate an OPD card. The Registration Counters were functioning from 7.30 AM to 11.30 AM, six days in a week with a holiday on Sunday.

Examination of OPD data of LNH revealed that average per day patient load/counter[1] in Main OPD, Orthopaedic OPD and Gynaecology ANC OPD

[1] No. of patient to be attended per day per counter

ranged between 305 to 340 patients, 506 to 628 patients and 102 to 126 patients respectively during the years 2018 to 2020[2].

Average patient load/counter in CNBC during the period 2016-17 to 2021-22, ranged between 103 (2020-21) and 213 (2018-19) patients.

Considering that OPD functions for 240 minutes a day and the work involves entering patient details in the system and issuing OPD cards, attending to such large number of patients ranging up to 628 in one counter results in long waiting time for patients at the hospital as is evident from the crowds at OPD counters shown in **Pictures 3.1** and **3.2**.

Government in its reply (December 2022) stated that both the hospitals are in the process of creating more OPD Registration Counters.

Picture 3.1: Crowded patient registration counters at LNH

Picture 3.2: Crowded patient registration counters at CNBC

3.1.1.2 Patient load in test checked departments of LNH

Patient load is defined as the average number of patients who are evaluated or treated per day per doctor. A very high patient load may lead to a long waiting time to meet doctors and subsequently a short consultation period. The consultation time per patient is a measure of quality of clinical care and patients' satisfaction[3].

[2] Data of 2021 was not included as LNH was declared dedicated COVID hospital in 2021.
[3] The consultation time in OPD of LNH was from 8 AM to 3 PM.

As per patient registration data of two test checked Departments (Medicine and Gynaecology) of LNH, the average registration of patients ranged from 673 to 718 (two Medicine OPD) and 205 to 253 (Gynaecology) respectively during the period from January 2018 to March 2020.

In respect of Medicine Department, information provided (January 2022) by the LNH showed that the two OPD units with a team of 7-9 doctors each attend OPD on daily basis and considering this, the workload per day per doctor[4] ranged from 84 to 89 OPD patients.

Considering the fact that a Doctor is available for seven hours a day (420 minutes) attending to an average patient load of 87 patients per doctor, resulted in average consultation time per patient per doctor of less than five minutes.

3.1.1.3 Workload in Pharmacy Counters

The GNCTD has not framed norms regarding number of patients per pharmacist. As per IPHS, there should be one dispensing counter for every 200 OPD patients.

Audit noted that Pharmacy Counters were not computerized and medicines were distributed manually. None of the selected Hospitals except CNBC provided data on actual number of patients to whom medicines were distributed. LNH informed (June 2022) that medicines are dispensed to all registered patients. Pharmacy Counters functioned from 8 AM to 5 PM in LNH and 9 AM to 8 PM in CNBC.

Based on the OPD data, patient load per pharmacist/counter in LNH ranged from 216 to 263 during the period January 2018 to March 2020[5]. It was noticed that many a time, due to shortage of pharmacists, medicines were not distributed on the same day. Heavy rush of patients was noticed at Pharmacy Counters. Pharmacists has to keep records of medicines distributed and also maintain stock in hand manually which effectively reduced the available time for dispensing medicines.

Similarly, patient load per pharmacist/counter in CNBC and JSSH was 110 to 192 and 238 to 315 respectively during the period 2016-17 to 2020-21 whereas in RGSSH, the average patient load per pharmacist/counter was 175 during the period 2018-19 to 2019-20.

In CNBC, the number of patients to whom medicines were distributed increased from 65,192 in 2016-17 to 1,13,761 (i.e. 74.50 *per cent*) in 2019-20 but the number of Pharmacy Counters remained only two.

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[4] Considering that on an average 8 Doctors are available daily.

[5] Upto 21 March 2020 only as LNH was declared dedicated COVID hospital.

CNBC in its reply stated (August 2022) that there were three dispensing counters in OPD Pharmacy but only two counters were operational because of scarcity of space in that area. CNBC also stated that they will relocate OPD pharmacy in bigger area.

Government replied (November/December 2022) that the process for filling up of vacant posts in LNH and RGSSH has been initiated. It was also stated that new Pharmacy Counters are being opened in LNH.

3.1.1.4 Basic amenities in OPD

IPHS provides that a hospital should have proper patient amenities like potable drinking water, functional and clean toilets with running water, etc. Further, proper signage should be present to guide the public. Citizen charter indicating patient rights and duties should also be displayed.

Joint Physical Inspection of LNH revealed that it had no toilets for patients and attendants in new OPD block and the visitors were forced to use toilets in the Emergency/Casualty building. Complaint boxes were provided on one floor only which caters to Anti-Retroviral Therapy (ART) Clinic whereas complaint boxes were not placed in other six floors which provide OPD services of other Departments. It was observed that the complaints placed by public in complaint boxes were not attended timely.

Joint Physical Inspection of CNBC revealed that one water cooler was available on ground floor while OPD is running on first floor also. Complaints placed in Complaint Box were not attended timely.

Picture 3.3: Water cooler not functioning in CNBC

Patient calling system was not operational in the OPD of any of the test checked hospitals, which would have helped in managing the crowds.

Government stated (November 2022) that toilet facilities are available in the OPD block of LNH. The reply is not tenable as the audit observation is based on facts observed during Joint Physical Inspection.

3.1.1.5 Availability of seating arrangement, toilet facility and patient calling system etc.

IPHS 2012 Guidelines for district hospitals prescribe various facilities. The status of these facilities in the test checked hospitals is given in **Table 3.3**.

Table 3.3: Status of availability of facilities in test checked hospitals

Name of service	LNH	CNBC	RGSSH	JSSH
Display of florescent fire exit sign	A	A	A	A
Enquiry/ May I Help Desk with staff fluent in local language	A	A	A	A
Directional signage for Emergency, Departments and Utilities	A	A	A	A
Display of safety, hazard and caution signs were displayed prominently at relevant places?	A	A	A	A
Important contacts like higher medical centres, blood banks, and fire department, police and ambulance services were displayed	A	A	A	A
Mandatory information (under RTI Act, PNDT Act, etc.) was displayed	A	A	A	A
Adequate seating facility	NA	NA	A	A
Patient Calling System (Digitalisation)	NA	NA	NA	NA
Separate toilets for male and female	A	A	A	A
Availability of toilets in OPD	A[6]	A	A	A
Complaint boxes in OPD	NA	NA	A	A
Water cooler	A	NA	A	A
Availability of adequate registration counters	NA	NA	A	A
Availability of Online Registration System	A	A	A	A
Patient Satisfaction Survey (OPD)	NA	A	NA	NA
Providing unique ID at the time of registration	A	A	A	A
Availability of Citizen charter at OPD	A	A	A	A

Note: Colour scheme has been used with red denoting lack of facility and green denoting availability of facility.

Source: Joint physical inspection reports, replies of the hospitals

3.1.1.6 Patient Satisfaction Survey in OPD conducted by Audit

NHM Assessor's Guidebook requires hospitals to conduct Patient Satisfaction Survey of outdoor patients on a monthly basis. The common reasons for patient's dissatisfaction are overcrowding, long waiting time to meet doctors and short consultation period. Patient satisfaction is a measure of success of the services being provided by the hospitals.

It was noticed that out of the four selected hospitals, only CNBC and JSSH had introduced Patient Satisfaction Survey during the audit period. LNH and RGSSH did not conduct any patient survey during the period 2016-17 to 2020-21. LNH introduced survey in 2021-22.

Patient Satisfaction Survey of 149 OPD patients was conducted in four selected Hospitals (JSSH-23, RGSSH-12, LNH-87 and CNBC-27) by Audit. Eleven *per cent* patients felt shortage of drinking water facilities at OPD

[6] There are three OPD blocks for patient registration in LNH with 19 registration counters out of which 16 counters were in New OPD block. It was observed that the new OPD block did not had Toilet facility.

premises and 30 *per cent* patients (most of them from LNH and CNBC) stated that clean toilets were not available. Twenty eight *per cent* patients stated that they had to wait more than one hour for OPD registration and 44 *per cent* for more than an hour for consultation. The waiting time in pharmacy for getting the medicines ranged between one to two hours in the case of 27 *per cent* of the respondents whereas in the case of nine *per cent,* the waiting time was more than two hours. The surveyed patients stated that the pathology tests (30 *per cent*) and radiology tests (33 *per cent*) recommended by the doctors were not done at the hospital.

Government replied (November 2022) that Patient Satisfaction Survey has been initiated in LNH under National Quality Assurance Standards.

Recommendation 3.1: The Government should take immediate measures to reduce the waiting time for registration, consultation, diagnostics, surgery and pharmacy in its hospitals. Government should also ensure availability of basic amenities in its hospitals.

3.2 Indoor Patient Department

Indoor Patients Department (IPD) refers to the areas of the hospital where patients are accommodated after being admitted, based on doctor's/specialist's assessment, from the Out-Patient Department, Emergency Services and Ambulatory Care. In-patients require a higher level of care through nursing services, availability of drugs/diagnostic facilities, observation by doctors, etc.

3.2.1 Lack of facilities in IPD of Hospitals

LNH provides IPD services in General and Super Speciality Departments of Medicine, Orthopaedics, Oncology, Neurosurgery, Paediatrics, Pulmonary, Gynaecology, Neonatology, Dermatology, Burns & Plastic, and ENT etc. Ophthalmology services, which is an essential general service as per IPHS, was not available in LNH as there is a full-fledged Eye Centre under MAMC to which LNH is attached.

Though a separate casualty was functioning in Gynaecology Department of LNH, no bed was available in the casualty and the patients were directly admitted to the labour rooms/wards. During Joint Inspection, it was observed that the maternity wards, labour rooms and connecting corridors were highly congested with stocks of medicines and general items stored in the corridors due to shortage of space.

On Joint Inspection of the IPD Department of LNH, it was observed that toilets in waiting area were not operational and where operational, these were found to be unhygienic and dirty. Security system existed but monitoring was weak as is evident from the fact that the IPDs were found crowded in many wards and stray dogs were roaming in corridors. There was scarcity of waiting space and chairs.

CNBC is a Paediatric Hospital and proper arrangement was not available for mothers whose neonates were admitted in NICU and they were usually allotted space in the basement area with no basic facilities like seating arrangement, drinking water and toilets.

Picture 3.4: Shortage of waiting area for attendants in CNBC and LNH

Shortage of chairs/ tables for attendants were noticed in LNH and CNBC and shortage of Bed side stools in wards were noticed in all the selected hospitals[7].

Government intimated (November 2022) that measures are being taken for improving the security in LNH. As regards to stray dogs, hospital stated that letter has been written to the PWD.

Further, LNH intimated that beds of adjacent Septic Labour Room are being used for Gynaecology Causality.

Recommendation 3.2: IPDs of hospitals should provide all basic amenities to patients and attendants and conduct periodic patient surveys to assess the quality of services being provided by the hospitals.

3.2.2 Bed Occupancy Rate

The Bed Occupancy Rate (BOR)[8] is an indicator of the productivity of the hospital services and is a measure of verifying whether the available infrastructure and processes are adequate for delivery of health service. As per IPHS, it is expected that the BOR of a hospital should be at least 80 *per cent*. High BOR is a sign of good productivity of the hospital. The BOR of test checked hospitals is given in **Table 3.4**.

[7] LNH, CNBC, RGSSH & JSSH

[8] BOR= (Total patient bed days in a month x 100) / (Total number of functional beds x Number of days in a month). BoR more than 100 *per cent* indicates that there were more patients than number of beds available.

Table 3.4: BOR of hospitals

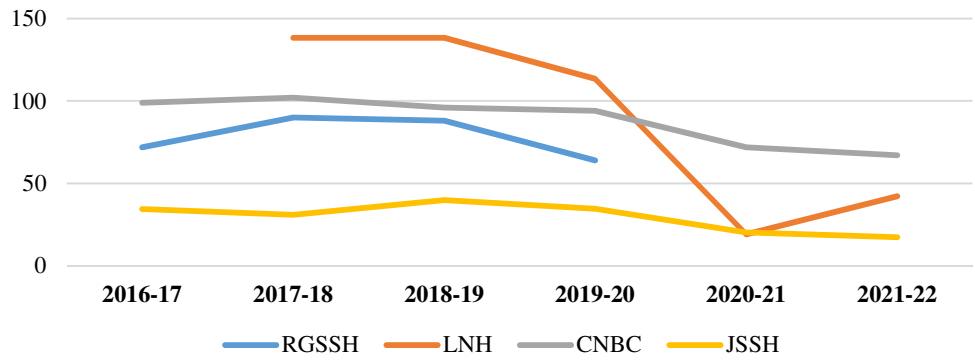
Year	RGSSH	LNH	CNBC	JSSH
2016-17	72	-	99	34.33
2017-18	90	138.27	102	30.99
2018-19	88	138.28	96	39.83
2019-20	64	113.44	94	34.56
2020-21	-	19.12	72	20.13
2021-22	-	42.1	67	17.36

Source: Information furnished by the department

Note: Data for the year 2016-17 not maintained by LNH. RGSSH and LNH were declared COVID only hospital during 2020-21 and 2021-22.

The trend of BOR in the selected hospitals is given in **Chart 3.2**.

Chart 3.2: Bed occupancy rate in selected hospitals.



It can be seen from the **Table 3.4** that bed occupancy rate was more than 100 *per cent* in respect of LNH (2017-18 to 2019-20) and CNBC (2017-18) signifying that number of patients admitted were more than the number of beds available. During Joint Inspection (July 2022) of CNBC general wards, beds were found allotted to more than one patient.

BOR at JSSH was very low showing low productivity of the hospital.

Government in its reply (December 2022) stated that the low occupancy in JSSH was due to shortage of staff.

The Department wise bed occupancy rate furnished by two[9] selected hospitals is given in **Table 3.5**.

[9] LNH and RGSSH did not maintain department wise BOR.

Table 3.5: Department wise BOR of two hospitals

Name of the Department	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
CNBC						
Emergency	130.64	142.26	128.81	135.11	91.8	83.86
Orthopedics	41.14	40.68	40.5	39.89	28.36	34.57
Paediatrics	127.56	114.35	127.61	110.79	79.73	73.54
Eyes	30.59	20.82	16.71	63.3	14.52	24.38
ENT	20.64	72.42	99.27	141.26	27.85	86.67
PICU	98.2	96.89	88.65	90.53	83.26	87.1
KMC	71.23	82.67	72.95	72.13	78.15	68.97
NICU	100	95.37	95.49	94.33	93.93	90.4
Medicines	107.79	122.42	106.26	105.28	79.40	75.50
JSSH						
Cardiology	*	26.42	35.42	33.58	28.67	26.36
Neurology	*	36.5	26.17	13.75	10.17	21.31
Gastroenterology	*	52.92	99.17	87	6.55	7.42
Nephrology	*	83.58	133.83	153.58	125.17	84.08

Source: Data furnished by the hospitals.
* Data not furnished

It can be seen from the above table that patient load was more than the capacity of available beds in Emergency (2016-20), Paediatrics (2016- 20) Medicines (2016-20) and ENT (2019-20) Departments in CNBC and Nephrology (2018-21) Department in JSSH.

Government did not offer any comment in its reply dated 13 December 2023.

3.2.3 Evaluating efficiency of hospitals

The Bed Turnover Rate (BTR)[10] is a measure of the utilization of the available bed capacity and serves as an indicator of the efficiency of the hospital. High BTR indicates high utilization of in-patient beds in a hospital while low BTR could be due to fewer patient admissions or longer duration of stay in the hospital.

Discharge Rate (DR)[11] measures the number of patients leaving a hospital after receiving due health care. High DR denotes that the hospital is providing health care facilities to the patients efficiently.

Average Length of Stay (ALoS) is an indicator of clinical care capability and to determine effectiveness of interventions. ALoS is the time between the admission and discharge/death of the patient.

The IPD indicators of selected departments of LNH during the period from January 2018 to March 2020 are given in **Table 3.6**.

[10] BTR=Total no. of discharges (including Referral, LAMA, Absconding and Death)/Total number of functional beds.

[11] DR=Total no. of discharges (excluding Referral, LAMA, Absconding and Death) x 100/Total number of Admissions.

Table 3.6: IPD indicators in LNH

Name of Hospital	Selected department	Average BTR	Discharge Rate	ALoS (No. of Days)
LNH	Gynaecology	4 to 31	95 to 98	9 to 14
	Medicine	1 to 38	81 to 97	7 to 12

Source: Data furnished by LNH.

Major portion of patients in Gynaecology Department of LNH were either referred or chronically sick patients. It can be seen from the above table that in Gynaecology Department of LNH, the average discharge rate was 96.63 *per cent* and the value ranged between 95 to 98 *per cent* which indicates that the number of patients leaving a hospital after receiving due health care was high. However, the average BTR was 20.87 *per cent* and the value ranged between 5 to 31 *per cent* whereas the ALoS was 12.49 *per cent* and the value ranged between 9 to 14 days which indicated LNH treated more number of acutely ill patients.

Similarly, in Medicine Department of LNH, the average discharge rate was 89.59 *per cent* and the value ranged between 81 to 97 *per cent* which indicates that the number of patients leaving a hospital after receiving due health care was high. However, the average BTR was 15.73 *per cent* and the value ranged between 1 to 38 *per cent* whereas the ALoS[12] was 9.55 and the value ranged between 7 to 12 days which indicates LNH treated more number of acutely ill patients.

Out of the four selected Hospitals, only LNH provided complete in-patient data for analysing these parameters and therefore, efficiency of other three Hospitals could not be evaluated.

3.2.4 Operation Theatres

Operation theatre (OT) is an essential service to be provided to the patients. As per NHM Assessor's guidebook, surgery performed per surgeon is an indicator to measure efficiency of the hospital.

All the surgical departments of essential/desirable services required for a District Hospital as per IPHS are available in LNH except Ophthalmology which is managed by the other hospital under MAMC to which LNH is attached.

The status of OT services against IPHS guidelines in test checked hospitals is given in **Table 3.7**.

[12] Average length of stay (ALOS) refers to the average time spent by a patient under treatment in the hospital.

Table 3.7: Availability of OT services in test checked DHs

Description	LNH	RGSSH	CNBC	JSSH
OT have convenient relationship[13] with surgical ward, intensive care unit, radiology, pathology, blood bank and CSSD.	Yes	Yes	Yes	OT Services not available.
Access to facility is provided without any physical barrier and friendly to people with disabilities.	Yes	Yes	Yes	
OT have piped suction and medical gases, electric supply, heating, air-conditioning, ventilation.	Yes	Yes	Yes	
Patient's records and clinical information is maintained.	Yes	Yes	Yes	
Has defined and established grievance redressal system in place.	Yes	Yes	Yes	
Whether all equipment are covered under AMC including preventive maintenance?	Covered under AMC subjects to shortfalls mentioned in audit findings.			

Note: JSSH has not started surgeries and hence not applicable.
Criteria: Indian Public Health Standards (IPHS) Guidelines for district hospitals

3.2.4.1 Waiting period for surgery in LNH and CNBC

There were 29 OTs (in all departments) in LNH and the total surgeries conducted in LNH during the period 2016-17 to 2021-22 are given in **Table 3.8**.

Table 3.8: Number of surgeries conducted in LNH

Year	No. of surgeries conducted	
	Major	Minor
2016-17	19,346	21,707
2017-18	23,842	21,558
2018-19	19,500	22,844
2019-20	19,017	19,766
2020-21 *	3,266	801
2021-22 *	10,998	8,198

Source: Reply of LNH
*Declared Covid hospital

As per information furnished by Surgery Department of LNH, the average number of major surgeries per month conducted ranged between 216 and 281 during the period from 2016-17 to 2019-20 and average waiting time was two to three months. One major OT of Surgery Department was not functional from 2016-17 till date (August 2022). Reason for not repairing or replacing the same and action taken to improve the waiting time for surgeries was not provided by the Hospital.

In respect of Burn & Plastic Surgery department of LNH, the average number of major surgeries conducted per month ranged between 86 and 95 during the same period whereas average number of minor surgeries conducted per month

[13] To indicate easy accessibility with other wards.

was between 85 and 375. Average waiting period was six to eight months in the case of major surgeries and 3-4 weeks in the case of minor surgeries.

Audit noted that there was shortage of doctors in LNH and the same has been discussed in Chapter V.

Similarly, CNBC, which is a Paediatric hospital, conducts Eye, ENT, Orthopaedics and Paediatric surgeries. Number of surgeries conducted in the Hospital during the audit period and average waiting time was as given in **Table 3.9**.

Table 3.9: Number of surgeries conducted in CNBC

Sl. No.	OT Name/Department		No. of Surgeries						Average waiting time
			2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	
1	Eye	OT	104	100	53	133	73	86	Less than one month
		Emergency	01	02	01	00	02	01	
2	ENT	OT	30	275	322	448	114	219	3 to 4 months
		Emergency	03	17	07	10	10	21	
3	Paediatric Surgery	OT	1824	1623	1118	1385	771	681	12 months
		Emergency	521	482	527	584	527	557	
4	Orthopaedics	OT	555	548	497	627	300	358	Less than one month
		Emergency	35	57	21	30	32	29	

Source: Reply of CNBC

In spite of such a long waiting period for patients to undergo surgery, the number of OTs remained five (three Major OTs, one minor OT and one emergency OT) during the period of audit. Further, one of the three major OTs was not functional due to shortage of manpower like Senior Resident doctor and Nursing, Technical and other support staff.

The Government stated (December 2022) that many pending cases in CNBC were due to Covid, disproportionate workload, lack of manpower and continuous inflow of emergency cases from Delhi and other States. Creation of more OTs and recruitment of staff is under process.

3.2.4.2 OTs lying idle in RGSSH

RGSSH is a Super specialty hospital and have the facilities of Gastro Intestinal, Urology and CVTS[14] surgeries. There were six functional OTs in RGSSH. Year wise number of surgeries conducted in GI Surgery, Urology, Cardiac and Thoracic OTs were as given in **Table 3.10**.

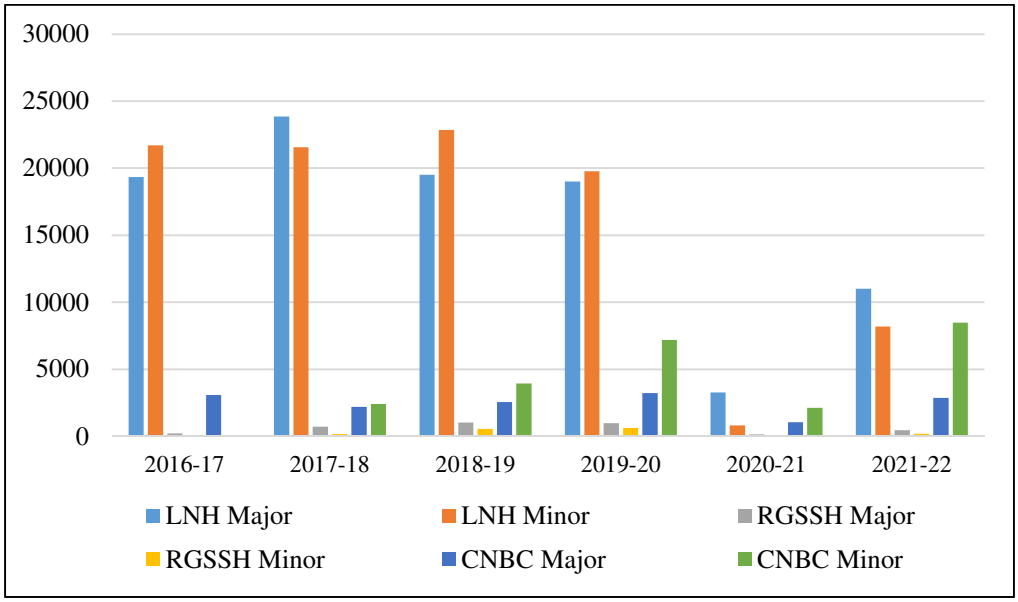
[14] Cardio vascular thoracic surgeries.

Table 3.10: Surgeries conducted in RGSSH

Sl. No.	OT Name/Department		No. of surgeries					
			2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
1	GI Surgery OT 1	Major	212	366	640	400	0	107
		Minor	0	0	0	0	0	15
2	Urology OT 2&3	Major	3	258	372	394	75	234
		Minor	0	160	526	419	35	107
3	Cardiac OT5	Major	0	0	0	28	39	46
4	Thoracic OT4	Major	0	0	3	154	29	62
5	Cardiac &Thoracic OT 4 and OT 5	Minor	83	0	26	210	54	68

Source: Reply of RGSSH

Chart 3.3: Major and Minor surgeries conducted in selected hospitals



It was observed from **Chart 3.3** that the number of surgeries conducted in the six functional OTs of RGSSH was much less as compared to that of other selected Hospitals. Apart from the six functional OTs, six more OTs were available in RGSSH which were lying unused due to shortage of man power. Underutilisation of infrastructure, created to provide quality service to patients, needs to be viewed seriously especially in view of the fact that patients are forced to wait for long periods for surgery in other hospitals.

There was no functional OT in JSSH as the work of commissioning of OTs was under process (July 2022). The same has been discussed in para 5.2.8.2 (d) of Chapter V.

3.2.4.3 Non-functional equipment in OT

In CNBC, many surgical equipment were not functional as per details given in **Table 3.11**.

Table 3.11: Equipment in OT not functioning

Sl. No.	Name of equipment	Date of installation	Date from which not functional
1	Cystoscope	December-2007	October-2019
2	Laparoscope	September-2008	December-2019
3	Hormone Cutting and Cogulation device	September-2016	October-2020
4	Three Surgical Cautery	November-2007 (one) & April-2008 (Two)	October-2020
5	Arthroscope	June-2008	August-2017
6	Ortho Electric Drill System-5	December-2010	April-2020
7	Battery Charger	December-2010	April-2020
8	Drill Machine	Augu-2007	July-2018
9	Virectomy	September-2008	January-2018
10	Ultrasonic cleaner	March-2013	March-2019

However, the Hospital could neither make the equipment functional nor purchase new equipment in lieu of non-functional equipment as of August 2022. Lack of functional equipment could hamper the working of OTs.

Similarly, the Anaesthetic Gas Scavenging System (AGSS) in MGPS was not working since February, 2016 and it was made functional only in June, 2020 after repeated reminders by the Hospital and even after that, it failed to function consistently. After this, a meeting was held in November 2020 in which the firm expressed inability to fix AGSS system. CNBC had finalized procurement of AGSS (July 2022). CNBC in its reply (February 2023) confirmed that the AGSS is still not functional.

Recommendation 3.3: Government/Hospitals should take immediate measures to lessen the waiting time for surgeries by providing more equipment and manpower and by distributing the patient load to all Health facilities and also by putting to use the infrastructure lying idle in some hospitals.

3.2.5 Lack of completeness of medical records

Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 requires the doctors to maintain medical records of patients in the prescribed format. These records are essential to measure effectiveness of care received by the patient for follow-up treatment as well as for legal purposes. Lack of properly maintained medical records would have an adverse impact on medical care provided to a patient, especially in cases of follow up or referral to higher facilities.

None of the test checked hospitals had computerised the medical records. The audit team checked medical records in respect of 100 patients who were discharged during January and February 2020 in selected Departments of selected Hospitals. It was noticed that patient occupation was not mentioned in the records of any hospital. In CNBC, it was not applicable, being a children hospital.

Name and signature of the doctor was not recorded in three *per cent* cases of LNH and 94 *per cent* cases in RGSSH. In CNBC, name of the doctor was not recorded in 99 *per cent* cases and patients left hospital without permission in four *per cent* cases.

3.2.6 Patient Satisfaction Survey not conducted

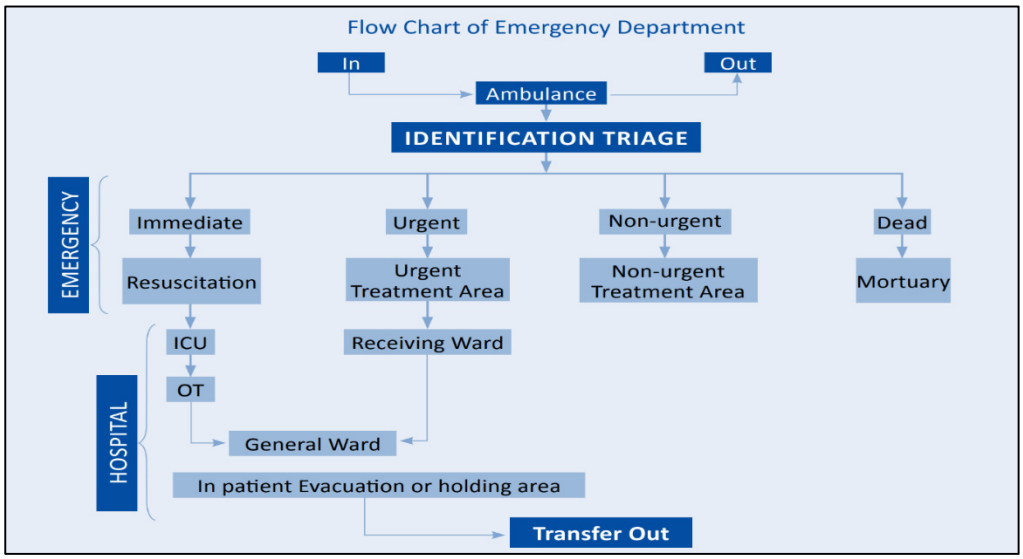
NHM Assessor's Guidebook requires hospitals to conduct Patient Satisfaction Survey of Indoor Patients on a monthly basis. Patient satisfaction is a measure of success of the services being provided by the hospitals. It was noticed that no patient survey was conducted during the period 2016-17 to 2020-21 in LNH and RGSSH. Thus, these hospitals were not in a position to understand the needs of their patients for improvement in its services. LNH later introduced patient satisfaction survey in the year 2022.

During the course of the audit, Patient Satisfaction Survey of 109 IPD patients of four selected hospitals (10 - JSSH, 10 - RGSSH, 66 - LNH and 23 - CNBC) was conducted. Out of the 23 patients surveyed in CNBC, 74 *per cent* patients stated that the doctor visited only one or two times in a day, 65 *per cent* of patients stated that they were not informed about their rights and responsibilities and 22 *per cent* stated that their complaints were not promptly attended to and the behaviour of hospital staff was not dignified and respectful. No significant shortcomings were reported in the other three hospitals.

3.3 Emergency Management

The goal of Emergency services is to provide treatment to those in need of urgent medical care, with the purpose of satisfactorily treating the malady, or referring the patient to a more suitably equipped medical facility. As per IPHS, 24x7 operational emergency with dedicated emergency room shall be available with adequate manpower in all the District Hospitals. Emergency should have mobile X-ray/laboratory, side labs/plaster room and minor OT facilities besides separate emergency beds.

Chart 3.4: Flow Chart of Emergency Department



3.3.1 Emergency facilities in hospitals

Out of the four hospitals selected for audit, in LNH, 25 beds were available in Causality and 142 beds in the Emergency wards. LNH is also managing a Disaster Ward of 50 beds to meet additional demands. Apart from these, LNH was also managing Sushruta Trauma Centre (STC) to treat victims of road accidents. CNBC and RGSSH had 12 and 10 emergency beds respectively.

Audit observed that in LNH, five[15] out of 20 essential drugs for managing Emergency services were not available during 2016-17 to 2020-21. Further, Mobile X-ray unit, as required under IPHS Guidelines was also not available during the above period. Besides, two minor OT tables and one ceiling light were not functioning in the Emergency OTs since August 2019 which were not found replaced/repaired. Three[16] out of 14 essential equipment as required under NHM Assessors Guidebook were not available in the Causality block. There was also no separate triage area in the Causality of LNH.

JSSH did not provide Emergency Services during the audit period. JSSH replied (December 2022) that it has started Emergency services at basic level for Cardiology, Nephrology and Neurology from 8 AM to 4 PM. RGSSH provided Emergency Services only to patients pertaining to their super speciality departments and refers other patients to nearby hospitals.

Seven[17] out of 20 essential medicines were not available in the Emergency of RGSSH during the audit period.

In CNBC, the annual emergency bed occupancy ranged from 129 *per cent* to 142 *per cent* during 2016-17 to 2019-20 while it was 92 *per cent* and 79 *per cent*

[15] Ampicillin, Inj. Carbopost, Inj Hydralazine, Methyldepa, Nifedipine
[16] Multiparatorch, HIV Kit, Laryngeal Mask Airway
[17] Ampicillin, Inj. Carboprost, Inj. Fortwin, Methyldopa, Pheniramine maleate, Poyvalent Snake Venom and Ringer Lactate

in 2020-21 and 2021-22 respectively. A bed occupancy of more than 100 *per cent* indicates that the number of beds available is inadequate which may hamper services to the needy in emergency.

Thus, complete complement of drugs and equipment were not available in the Casualty/Emergency of LNH, CNBC and RGSSH which may hamper the ability of these hospitals in providing critical care to those brought for emergency treatment.

Table 3.12: Availability of Emergency services as per IPHS[18] in test-checked hospitals

Particulars	LNH	CNBC	RGSSH	JSSH
Availability and functioning of Emergency OT	Yes	Yes	No	No
Availability of infrastructure hospital Emergency ward	Yes	Yes	Yes	No
Availability of infrastructure relating to trauma ward such as Bed capacity, machinery & equipment etc.	Yes	Yes	Yes	No
Availability of triage procedure to sort patients	Yes	Yes	Yes	No
Availability of emergency laboratory services	Yes	Yes	No	No
Availability of blood bank in close proximity to emergency department	Yes	Yes	Yes	No
Availability of mobile X-ray/ laboratory, side labs/plaster room in Accident and Emergency Service	Mobile X-ray unit not available	Yes	Yes	No
Availability of Emergency Operation Theatre for Maternity	Yes	Not applicable	Not applicable	Not applicable
Availability of Emergency Operation Theatre for Orthopaedic Emergency, Burns and plastic and Neurosurgery cases round the clock	Neurosurgery Not available	Burns and plastic and Neurosurgery Not available	No	No
Availability of facilities for Accidents and emergency services including poisoning and Trauma Care	Yes	No	No	No
Availability of separate provision emergency ward for examination of rape/sexual assault victim	Yes	No	No	No
Availability of sufficient separate waiting areas and public amenities in emergency ward for patients and relatives.	Yes	Yes	Yes	No
Availability of emergency protocols in emergency ward.	Yes	Yes	Yes	No
Availability of disaster management plan in emergency ward.	Yes	Yes	Yes	No

Note: Emergency services were not available in JSSH. Further, JSSH and RGSSH are super speciality hospitals and CNBC is a child hospital.

Source: Joint physical inspection reports, replies/records provided by hospitals

Government did not offer any comment in its reply dated 13 December 2023.

Recommendation 3.4: Hospitals should strengthen the Emergency services and ensure availability of essential medicines and equipment at all times and increase the number of beds in line with demand.

[18] IPHS 2012, Guidelines of District hospital (101-500 bedded) used.

3.3.2 Functioning of Sushruta Trauma Centre under LNH

Sushruta Trauma Centre (STC) generally treats victims of road accidents and the financial and administrative matters are dealt by LNH. Deployment of manpower in STC is under the purview of HOD of respective Departments such as Medicine, Surgery, ENT, Orthopaedics, Radiodiagnosis, Anaesthesia etc. of LNH.

Audit noted that Senior Residents (Medicines) were not posted in STC despite having a sanctioned strength of four (March 2022). Audit noted that senior residents were deployed on emergency duty from LNH during day time only.

Government replied (November 2022) that LNH has posted one SR (Medicine) to STC.

3.3.3 Intensive/Critical Care Unit (ICU)

The ICU provides intensive care to patients in critical conditions of various complications. All the test checked hospitals provide ICU services. However, the following issues were noticed in the functioning of ICUs:

Audit noted that in ICU of Medicine Department of LNH, out of 12 ECG machines, five ECG machines were not functioning (March 2020) and one ECG machine went missing (July 2020). Case for missing ECG was filed (February 2021). However no further information was available with the hospital. After outbreak of Covid 19 (March 2020), 13 new ECG machines were procured during April 2020 to October 2021.

Five Bipap[19] Machines available in ICU were not functional (March 2020), though 11 new machines were purchased and provided during July to November 2020. One Defibrillator was not functional (October 2020) and new defibrillator was purchased in February 2021.

Further, all the three Transport Monitors installed in March 2017 were not working since December 2021 and required maintenance and Treadmill Test Machine was not working since September/October 2019 and these were not replaced (as of July 2022).

Thus, it is evident from above that ICU department was short of functional equipment viz. ECG machines, Transport monitor, and Bipap at the outbreak of covid.

Government accepted (November 2022) the facts and intimated that the ICU is being upgraded with new advanced equipment.

3.3.4 Delay in maintenance of Medical Gas Pipeline System in CNBC

Maintenance of Medical Gas Pipeline System (MGPS) in CNBC was awarded to an agency for the period from February 2019 to April 2021. As per the

[19] Bipap machine is used for pushing air into lungs of those patients who have difficulty in breathing.

contract agreement, the agency was to ensure uptime of the equipment for at least 98 *per cent* calculated on quarterly basis. Penalty was leviable for failure to meet the targeted uptime at the rate of ₹ 5000 per one *per cent* increase in downtime in respect of each part of the equipment. Further, on any single occasion, the downtime of equipment should not exceed 72 hours except for Oxygen and Vacuum system for which the maximum downtime was three hours failing which a penalty of ₹ 2000 per day was leviable.

Scrutiny of Performance report of the agency revealed that uptime of the equipment during nine quarters from February 2019 to April 2021 in respect of oxygen ranged from 80 *per cent* (5th quarter i.e. Feb 2020 to April 2020) to 96 *per cent* (2nd quarter i.e. May 2019 to July 2019). Similarly, the agency also failed to limit the downtime for the oxygen leakage and vacuum leakage (within three hours on each occasion) during the above period on 46 occasions when the downtime exceeded three hours. The downtime ranged up to seven days on one occasion (5th quarter - Feb 2020 to April 2020) for oxygen leakage. Both equipment/systems are very important for smooth functioning of hospitals, especially in OTs and for patients with respirational distress. Although penalty under the contract was levied for these failures, nothing can adequately compensate the distress faced by the Hospital and patients, especially during Covid-19.

Government did not offer any comment in its reply dated 13 December 2023.

3.3.5 State Rapid Response Teams instructions not followed

In the wake of the COVID pandemic, Delhi Government had constituted (March 2020) a State Rapid Response Team (RRT), to ensure that prompt adequate emergency preparedness and appropriate response structure are put in place to tackle the outbreak. The main functions and responsibilities of RRT were (i) to verify any report of disease outbreak in the State, (ii) notify and activate Cluster Containment Plan, (iii) to carry out outbreak investigation (iv) to propose and plan appropriate measures for containment of epidemics to the State Disease Surveillance Unit (SSU) and response Committees, (v) to participate actively in the implementation of epidemic prevention and control strategies, and (vi) to provide technical support to the District Surveillance Units (DSU) so that, the outbreaks can be quickly controlled and number of people affected can be reduced.

Audit observed shortcomings in the functioning of RRT as well as a total disregard for its instructions/suggestions by various agencies/institutions. After its constitution, the RRT met only five times, all in 2020 and no meeting was held in 2021 and 2022. In its meetings, RRT had given suggestions such as strengthening of active surveillance in containment zones for making decisions regarding mitigation required, analysis of testing reports of all districts at State Integrated Disease Surveillance Programme (IDSP), adoption of ICMR testing strategy, preparation of specific SOP for transfer and management of hypoxic

patients in community etc. However, Audit found no evidence that any of these suggestions were put into action.

Thus, activities suggested by RRT which could have helped in better management of COVID outbreak were not implemented which defeated the purpose of constituting RRT.

Government did not offer any comment in its reply dated 13 December 2023.

3.3.6 Death Audit Committee

In view of outbreak of COVID pandemic, Delhi Government had constituted a Death Audit Committee to audit each and every death in which the patient was COVID positive in government and private hospitals of NCT of Delhi. All government and private hospitals were directed to report all such deaths to the Committee along with a copy of case sheet for death audit. Death audit could have provided valuable inputs in refining treatment protocols for the pandemic so as to reduce mortality rate.

It was also noticed that Death Audit Committee did not analyse any case of COVID death during the period January to December 2021. From the records furnished to audit, (January 2022 to April 2022), it was observed that out of 938 deaths reported, only 684 deaths were analysed by the Committee. In respect of remaining 254 cases (27.07 *per cent*) Case sheets of Covid deaths were not furnished by the hospitals concerned. Further, the daily reports of Death Audit Committee were not being utilized by the Health Department to chalk out strategy/mechanism for better management of Covid cases, thus defeating the very purpose of constitution of the Committee.

Government did not offer any comment in its reply dated 13 December 2023.

3.3.7 Preparation for disasters

As per Disaster Management Act (DMA), 2005 the Department has to operationalize medical response plan and deployment of Quick Response Team (QRT) during any crisis (earthquake, fire, flood, building collapse etc.) to mitigate the suffering and provide quality emergency medical response and care to save lives and minimize the effect of injuries. In compliance of DMA, Disaster Management Cell, DGHS does the coordination among the nodal officers identified in hospitals/ CDMO offices. It has to conduct regular mock drills or exercise to keep the staff trained and well prepared for any untoward incident so that they can handle the situation efficiently and minimise the casualties.

3.3.7.1 Hospital Disaster Management Plan not prepared by the hospitals

As per Disaster Management Act 2005, each hospital (all government hospitals and private hospitals) had to prepare Hospital Disaster Management Plan (HDMP) for responding effectively to any disaster or disaster situation. DGHS issues SoP for Medical response in Emergency to 58 hospitals under the

Department of Health and Family Welfare, Delhi and other public hospitals managed by different administrative units. As per the SoP, hospitals were to keep the HDMP updated and maintain disaster cupboard keeping in perspective, the number of cases that can be managed in crisis situation as per surge capacity[20]. Audit noted that no mechanism was put in place by DGHS to ensure that requisite action circulated vide above SoP was initiated by the respective hospitals.

However, on scrutiny of the records of DGHS, Audit noted that no hospital had prepared HDMP during the period 2016-17, 2018-19, 2019-20 and 2020-21 though some hospitals had prepared HDMP in the years 2017-18 (35 hospitals) and 2021-22 (five hospitals).

3.3.7.2 Inadequate training to health staff

To enable staff attached with disaster management related work to perform their functions and duties efficiently and effectively, DGHS conducts trainings for medical/para medical staff each year. Though Disaster Management Cell of DGHS had prepared annual training calendar for the year 2018-19 and 2019-20, these were not approved but some trainings were conducted. DGHS office neither prepared any training plan for the years 2020-21 to 2021-22 nor conducted any training. Disaster Management Cell also did not have any database of trainees to check whether the same persons are being provided training multiple times or all employees are covered.

In response, the DGHS office stated (June 2022) that some trainings could not be imparted due to unavailability of trainees and other administrative issues. The training program for the period 2020-22 could not be prepared due to COVID-19 pandemic. The fact remains that adequate training was not provided to the staff.

3.3.7.3 Quick Response Teams in healthcare establishments

DGHS office had instructed all the healthcare establishments (government as well as private) to maintain Quick Response Team (QRT) on rotation basis every month for field deployment in times of acute need according to the number of beds (up to 100 beds – one QRT, up to 200 beds – two QRTs and more than 200 beds – three QRTs). As part of the preparedness relating to response in crisis situations, all Chief Medical Officers (CDMOs) were to maintain three QRTs on rotation basis every month from their pool of human resource and ensure maintenance of such teams in all healthcare establishments in the district. The respective institution should maintain emergency kit per team and should have tested SOP for responding to the direction of CDMO, reaching the site of crisis and provision of organized medical care.

[20] Surge capacity is the ability of a health service to expand beyond normal capacity to meet increased demand for clinical care.

As per SOP, all hospitals have to send the details of QRTs on regular basis to DGHS latest by 5th of every month electronically, but this information was neither provided by the hospitals/ institutions nor sought by the Disaster Management Cell. Information in respect of 45 out of 59 Government Hospitals provided by the Disaster Management Cell revealed that 34 out of these 45 hospitals did not maintain any QRT and four hospitals did not have the required number of QRTs. Further, only one hospital had deployed the required staff in the team.

The Department stated (June 2022) that details of QRTs were sought from hospitals regularly but due to COVID-19 pandemic and involvement of hospitals/CDMOs machinery for management of COVID, details of QRTs were not received and updated. Reply is not acceptable as hospitals have not shared details of QRTs during the Non-COVID period and same was also not updated by the cell.

3.3.7.4 Hospital safety during disasters

National Disaster Management Authority (NDMA), considering the safety of hospitals for human life, has formulated the National Disaster Management Guidelines on hospital safety in 2016 so that hospitals are not just better prepared but also fully functional immediately after a disaster and are able to respond without any delay. The guidelines were statutory in nature and were required to be adhered to by all stake holders. A quarterly report was to be sent to NDMA on implementation of these guidelines.

There were 59 Government Hospitals in Delhi which had to furnish the above details quarterly to DGHS. However, none of these hospitals submitted the details during the years 2016-17 to 2021-22. DGHS also did not take up this issue with the hospitals concerned for furnishing these details for onward submission to NDMA.

It was also noticed that as per the above guideline of NDMA, each state had to constitute a Hospital Safety Advisory Committee at State level for preparation and submission of State Action Plan for implementation of hospital safety guidelines but no Hospital Safety Advisory Committee was constituted by GNCTD.

The Department stated (June 2022) that all government hospitals in Delhi did not come under its administrative control. It received NDMA instructions in 2019 and the same were circulated to all the hospitals for compliance. Also, the health machinery was busy due to COVID-19 pandemic. The reply is not acceptable as being the nodal department, DGHS is responsible for monitoring and supervising disaster management related activities in all health establishments in Delhi, as envisaged in the above guidelines.

Government did not offer any comment in its reply dated 13 December 2023.

***Recommendation 3.5*: *Government should ensure that each hospital prepares a Disaster Management Plan and maintains Quick Response Teams*.**

Recommendation 3.6: Government should ensure regular training to health staff to deal with disaster related activities.

3.4 Maternity Services and Childcare

Out of the four selected hospitals, only LNH[21] provides Maternity and Childcare services. The Hospital also has 300-500 patient attendance per day in OPD and 24 hour emergency and One Stop Centre services[22]. Audit examined the records of Obstetrics and Gynaecology Department in LNH to assess the Maternity and Childcare services being provided.

3.4.1 Shortage of Staff

As per the Maternal and Newborn (M&N) Toolkit 2013, for providing best possible care during pregnancy, delivery and postpartum period with dignity and privacy to clients, an adequate number of competent Human Resource (HR) is required.

It was noticed that there was no Anaesthetist and Paediatrician posted in Maternity Wing of the hospital and they were on call basis as and when required. Further, only 51 doctors were available in the Department of Gynaecology against the sanctioned 67 posts. As per the Nursing staff norms of Indian Nursing Council, one nurse is required for every six beds for general ward and one nurse per bed in the case of ICU. It was noticed that there was acute shortage of 34 to 60 *per cent* nurses in the Wards and 52 to 70 *per cent* nurses in the High Dependency Unit of Gynaecology Department during 2016-17 to 2020-21.

3.4.2 Antenatal and Postnatal Care and Deliveries

Antenatal care (ANC), Intra-partum care or delivery care (IPC) and Postnatal care (PNC) are major components of facility based maternity services. ANC is the systemic supervision of women during pregnancy to monitor the progress of foetal growth and ascertain the well-being of the mother and the foetus. IPC includes safe delivery in Labour Room and Operation Theatre. PNC includes medical care of mother and new born especially during 48 hours post-delivery, which is considered critical.

Under ANC component of maternity care, pregnant women are provided at least four antenatal check-ups which include physical examination and laboratory investigation to monitor the pregnancy for signs of any complication for prompt management.

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[21] CNBC is a children hospital and RGSSH and JSSH provides selected services of super speciality treatment

[22] One Stop Centre (OSC) provides multiple facilities and services under one roof to rape victims

LNH could not provide the mechanism adopted to track the pregnant women for ensuring ANC and did not maintain the details of ANC provided to all registered pregnant women. However, the details of pregnant women monitored for ANC at State level under Central Scheme has been provided in Chapter 7. The Hospital also did not introduce Radio Frequency Identification Tag System for the new born.

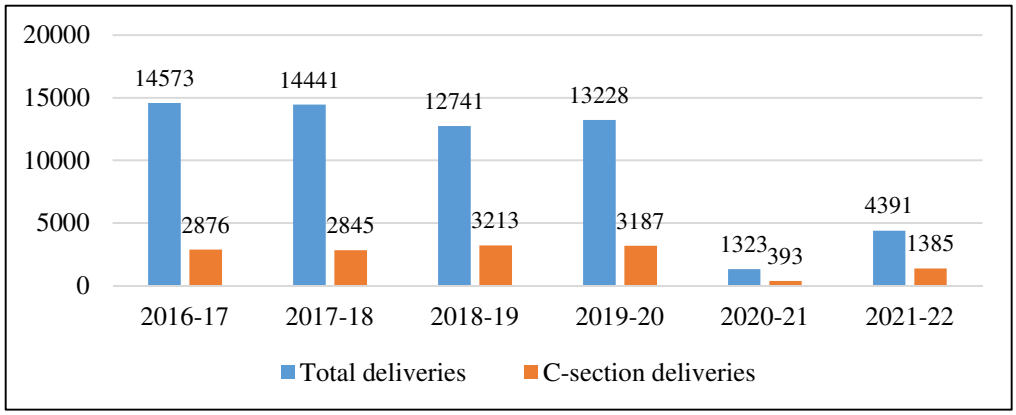
Details of total deliveries and C-section deliveries carried out during 2016-17 to 2021-22 is given in the **Table 3.14**.

Table 3.14: Deliveries carried out during 2016-17 to 2021-22

Year	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	Total
No. of deliveries	14573	14441	12741	13228	1323	4391	60697
C-section deliveries	2876 (19.73%)	2845 (19.70%)	3213 (25.22%)	3187 (24.09%)	393 (29.71%)	1385 (31.54%)	13899 (22.90%)
No. of ANC	8519	29607	21938	22378	1607	20521	104570 (43.07%)
No. of IPC	8821	8751	7250	6854	511	4391	36548 (60.21%)
No. of PNC	11697	11596	10463	10041	931	4391	49119 (80.92%)

Source: Reply of LNH

Chart 3.5: Total deliveries Vs C-Section deliveries in LNH



During the period 2016-17 to 2019-20 (except Covid years), C-Section deliveries ranged from 19.73 *per cent* (2016-17) to 25.22 *per cent* (2018-19). Further, the number of ANC, IPC and PNC was also less as compared to the actual number of deliveries carried out in LNH.

3.4.3 Stillbirths

The stillbirth rate is a key indicator of quality of care during pregnancy and child birth. Stillbirth and/or intrauterine foetal death is an unfavorable pregnancy outcome and is defined as complete expulsion or extraction of the baby from its mother with no sign of life. High stillbirth rate is the sign of badly managed antenatal care/delivery process in the hospital. As per NFHS-5 (2019-21), average stillbirth rate of Delhi was 0.8 per 100 pregnancy outcomes.

Audit observed that stillbirth was 1,238 against 60,697 deliveries during the period under report in the LNH as given in **Table 3.15**.

Table 3.15: Stillbirths

Year	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	Total
No. of deliveries	14573	14441	12741	13228	1323	4391	60,697
No. of stillbirth	302	297	228	238	31	142	1,238
Percentage	2.07	2.05	1.80	1.80	2.34	3.23	2.04

The average stillbirth rate in LNH was higher than the average stillbirth rate of Delhi.

Government stated (November 2022) that most of the stillbirth cases in LNH are referral cases from other centres.

3.4.4 Review of maternal and neonatal deaths

IPHS prescribes that all mortality that occurs in the hospital shall be reviewed on a fortnightly basis. Audit observed that 192 maternal deaths occurred during the period 2016-21. LNH stated that the review of maternal death was conducted monthly. However, it did not provide records of death review. Further, there should be a Committee for reviewing New-born death and it should meet at least once in a month or immediately after a child death is reported. It should prepare a report in such a manner that it should create knowledge and experience for use in future so as to avoid similar incidences. However, it was noticed that no such committee was functioning in the LNH during the period of audit. The hospital intimated that it has constituted the committee in April 2022.

Resultantly, Audit could not determine the reasons of maternal/neonatal deaths nor review the Committee's suggestions for preventing maternal/neonatal deaths.

3.4.5 Availability of essential and functional equipment

IPHS prescribes 31 types of essential equipment for Labour ward, Neonatal and Special New-Born care unit. Audit noted that three equipment namely, Cardiac Monitor (baby), CPAP machine and Nebulizer (baby) were not available in LNH.

Several equipment viz. one Mobile Examination Light unit (out of two purchased in December 2016), one CO_2 Insufflator (out of two installed in August 2016) and Weighing Machine for New-born (received in January 2017) of Gynaecology OT were not functioning as of date (July 2022). Further, five out of seven Vacuum extractors, six out of 10 CTG machines and all the five Infusion pumps in Clear Labour Room of Gynaecology Department were also not in working condition.

3.4.6 One Stop Centre (OSC)

The aim of One Stop Centre (OSC) was to provide multiple facilities and services under one roof to rape victims. As per the SoP of OSC prescribed by the GNCTD, it should have five Counsellors, five Senior Resident Doctors, five Staff Nurses and five Nursing Orderlies.

From April 2016 to January 2022, 1,169 cases were reported in the OSC in LNH which included 285 cases of sexual assault (24.37 *per cent*). Audit noted that LNH did not have any dedicated staff and it was being managed by the Senior Resident Doctors, Nursing Staff and Nursing Orderlies of Causality of the Department of Obstetrics and Gynaecology and Counsellor was called as and when required from the Rape Crisis Cell under Delhi Commission for Women (DCW).

Department stated (November 2022) that the average case load of one stop centre is very low and staff was deployed as and when required.

The fact remains that LNH could not set up OSC as per the norms.

Recommendation 3.7: LNH should review the child death cases on regular basis and should keep full records of ante-natal care. It should strengthen the One Stop Centre by providing staff.

3.5 Radiology Services

As per IPHS, there should be three X-ray Machines, one dental X-ray machine, and four colour Doppler ultrasound machines in a 500 bed district hospital. One Portable ultrasound, one CT scan machine and one MRI machine are desirable for a district hospital. One each of 500MA X-ray machine, mammography unit, C-Arm and Echocardiogram were to be provided as per need.

3.5.1 Availability of Radiology Equipment and Services

LNH provides all the above essential and desirable services except Dental X-ray. CNBC and RGSSH did not provide MRI services and JSSH and RGSSH did not provide dental services. The radiology equipment installed in Radiology Department of four selected hospitals are as shown in **Table 3.16**.

Table 3.16: Radiology equipment in test checked hospitals

Name of the equipment	Hospitals			
	LNH	CNBC	JSSH	RGSSH
MRI Machine	1	Nil	1(under PPP)	Nil
X-Ray	9	4	2	1
Colour Doppler Ultrasound Machine	9	3	2	1
CT Scan	3	1	1(under PPP)	1
Mammography	1	Nil	Nil	Nil
Dental X-Ray	Nil	1	Nil	Nil

Source: Replies of hospitals

Audit noted that the available X-Ray and Colour Doppler Machines were not in proportion to the bed strength since the requirement under IPHS was for a 500

bedded hospital whereas LNH had more than 2000 beds. Further, one X-Ray Machine and one Colour Doppler Machine in LNH were not functional. As a result, there was a waiting period of 2-3 months for Ultrasound, 15 days for MRI and seven days for CT Scan for outdoor patients of LNH.

In CNBC also, one X-Ray machine (since February 2022), one CT Scan Machine (since November 2021) and two Colour Doppler ultra sound machines (since July 2017/May 2018) were not functional and the waiting period for ultrasound was more than one and half months.

CNBC stated (December 2022) that they are in process of procurement of Ultra Sound machine and recruitment of Radiologist.

Government replied (November 2022) that Radiology services in LNH are being upgraded with new CT Machine. Further, Government is providing the facility through other diagnostic centres under Delhi Arogya Kosh for reducing the waiting period. However, waiting period in hospitals shows that benefits under the scheme of Delhi Arogya Kosh were not being availed by all the needy patients.

In spite of such long waiting periods for getting tests done, the available equipment were grossly underutilised in CNBC, RGSSH and JSSH as detailed in **Table 3.17**.

Table 3.17: Utilisation of diagnostic equipment

Name of service	Total Installed Capacity	Average No. of diagnosis conducted[23]					
		2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
CNBC							
X-Ray (4)	330 per day	123	112	105	109	83	NA
Ultrasound	35 per day	11	3	2	7	9	
CT -Scan	12 per day	4	3	4	3	4	
RGSSH							
X-Ray	70 per day	12	26	34	35	18	32
Ultrasound	50 per day	9	0	14	23	3	16
CT Scan (w.e.f November 2017)	26 per day	NA	1	7	14	5	11
JSSH							NA
X-Ray	70 per day	57	55	35	27	12	
Ultrasound	30 per day	16	17	8	1	5	

Source: Information provided by the hospitals.

Shortage of staff could be one of the main reasons for underutilisation of available diagnostic facilities as Audit observed that there was shortage of Radiologists and Radiographers in above three hospitals. There was no Radiologist available in CNBC and JSSH against sanctioned strength of three

[23] 300 working days taken for calculation

and eight respectively during the period of audit and one Radiologist/Consultant was deputed thrice a week to CNBC from GTB hospital since January 2018. In RGSSH, only two Radiologists were available against four sanctioned as of March 2021 which decreased to one as of September 2022.

In RGSSH, no Radiographer was posted and contractual staff were deployed for radiography duty. Three Radiographers were posted in JSSH against a sanctioned strength of 25 as of March 2022. However, CNBC had full complement of seven Radiographers. In LNH also, only 28 Radiographers were available against a sanctioned strength of 37 during the period from 2016-17 to 2020-21 which was later filled in 2021-22.

Government stated (December 2022) that procurement of an additional Digital Radiography Machine/high end USG Doppler Unit and deployment of associated manpower in CNBC will decrease the waiting period. It also stated that the process for recruiting Radiographers has been initiated in RGSSH.

Other shortcomings noticed in the functioning of Radiology Departments in the four selected hospitals are discussed in the succeeding paragraphs.

3.5.2 Training to staff not provided

Two[24] of the four selected hospitals had not organized any regular periodic training on radiation safety to the staff working in the Radiology Department during the period of audit and in JSSH, only six training programmes[25] were conducted during the audit period.

3.5.3 Compliance to AERB guidelines

Atomic Energy (Radiation Protection) Rules 2004 stipulates that all licensees should appoint a Radiological Safety Officer (RSO) who shall carry out routine measurements and analysis of radiation and radioactivity levels and prepare emergency plans for responding to accidents. However, there was no RSO appointed in LNH, RGSSH and JSSH.

Further, all the staff associated with operation of various diagnostic machines in Radiology department were to be registered for issue of Thermoluminescent Dosimeter (TLD) badges issued by BARC for measuring the radiation effect on the staff. It was noticed that TLD badges were not provided to the technicians of Radiology Department of RGSSH.

Health check-up including Blood cell count and General physical examination were also required to be conducted and recorded for all the radiation workers but no health check-up was conducted in LNH and RGSSH. In JSSH, health check-up of only one employee was conducted.

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[24] LNH and RGSSH

[25] Basic life support (BLS), BMW rules, Radiation safety, Infection control practices, PPE kit training, Needle stick injury.

Government did not offer any comment in its reply dated 13 December 2023.

Recommendation 3.8: Government should strengthen the radiology facility to reduce the waiting time for tests. Vacant post of radiology staff may be filled. Hospitals should adhere AERB guidelines to ensure safety of patient and staff.

3.6 Delivery of Auxiliary and Support Services

3.6.1 Ambulance Services

Centralised Accident and Trauma Services (CATS) was established as a Society in the Department of Health and Family Welfare, GNCTD in June 1989. It provides free ambulance service in Delhi for accident and trauma victims.

3.6.1.1 Response time for Ambulance services

With the aim of improving response time and availability of ambulances, CATS had outsourced (August 2019) the operation and maintenance of CATS Ambulance Services for a period of three years which was further extendable for two years on annual basis based on performance. A fleet of 200 CATS Ambulances[26] was handed over to an agency to provide free ambulance service in Delhi.

As per the agreement, the agency had to keep the response time within 15 minutes in 80 *per cent* of the calls and within 25 minutes in the remaining calls. The CATS could not calculate the average response time of ambulances up to December 2019 even though it envisioned to provide better response time to the victims. The average response time during the months from January 2020 to July 2020 ranged between 28 to 56 minutes and improved to 15 minutes as of September 2022. There were 49 instances in the selected month of February 2020 where calls were refused by the ambulances. Reasons mentioned in the records were absence of ambulance staff in the ambulance, unavailability of oxygen in the ambulance, unfit driving condition of ambulance etc.

3.6.1.2 Private Ambulances not empanelled for hiring in Emergencies

To meet the increasing calls for ambulance service during COVID19 in Delhi, GNCTD decided to hire 265 ambulances and 250 taxis/Cabs for vaccination purpose. The actual requirement of the hired ambulances/cabs was reviewed again (October 2021) and it was decided to hire 135 Ambulances and 320 Cabs. The tenure of hired 135 ambulances was further extended up to 31 March 2022.

Audit noted that GNCTD had not empanelled any agency for hiring of additional ambulances in emergencies. In the absence of any guidelines/ direction, ambulances were hired randomly by CATS.

[26] 93 Patient Transport Ambulances (PTA), nine Advanced Life Support Ambulances (ALS) and 98 Basic Life Support Ambulances (BLS)

3.6.1.3 Shortage of functional Ambulances

As per the agreement with the outsourced agency, the agency has to keep an active fleet of 90 *per cent* of the CATS Ambulances with 100 *per cent* uptime. Details of ambulances handed over to the outsourced agency and average number of call worthy ambulance during the period from January 2018 to December 2021 are given in **Table 3.18**.

Table 3.18: Availability of Ambulances

Year	Average no. of CATS Ambulances with agency	Average no. of call worthy Ambulances	Percentage of call worthy Ambulances (in *per cent*)
2018	265	227	86
2019	265	168	63
2020	229	169	74
2021	229	213	93
2022	229	217	95

Source: Data provided by CATS

As can be seen, the agency could not keep up to 90 *per cent* of the ambulances functional during 2018-20, as required in the agreement, due to which CATS was unable to attend all calls as discussed in para 3.6.1.1.

3.6.1.4 First response Vehicle.

GNCTD had approved (February 2018) introduction of First Response Vehicles (FRV) using Motor Cycles to provide medical assistance to needy persons especially in congested areas. As a Pilot Project, 16 FRVs were purchased in May 2018 at a cost of ₹ 12.84 lakh and deployed from February 2019 covering East, Shahdara and North East Districts. FRVs were operated by regular CATS employees.

Audit noted that these FRVs were later withdrawn in March 2020 due to shortage of staff and were lying idle (June 2022).

Picture 3.5: FRVs lying idle

No efforts were made to make these FRVs operational. Thus, the pilot project envisioned for improving the response time in congested areas and slums remained non-functional since March 2020. Besides, no assessment was done to ascertain the utility and impact of pilot project. Expenditure of ₹ 12.84 lakh was thus rendered infructuous.

3.6.1.5 Monitoring of Ambulances by CATS

As per the agreement of CATS with outsourced agency, CATS may inspect the ambulances to ensure compliance of service level agreements and other tender requirements. CATS management conducts monthly inspection of ambulances to assess availability of essential equipment in the ambulances managed by the private agency as per the ALS, BLS and PTA standards. Test check of Inspection Reports revealed that the ambulances were not fitted with functional essential equipment and devices[27]. CATS deducted penalty from the payment to the firm against the shortcomings but it was noticed that the irregularities continued in subsequent inspections also. Thus, CATS could not ensure availability of all essential equipment/devices in the Ambulances.

3.6.1.6 Failure to procure two Advanced Life Support Ambulances for infant transportation

Delhi State Health Mission had approved (February 2018) procurement of two ALS Ambulances for infant transportation. Director of Family Welfare was required to put up a detailed proposal for operation of these two Ambulances in Delhi through CATS. Besides, fund amounting to ₹ 56 lakh was approved (August 2018) by DSHM for purchase of these Ambulances.

Audit, however, noted that ALS Ambulances for infant transportation were not procured by CATS as of June 2022, thus depriving needy infants of specialised patient transport.

In its reply, CATS stated (January 2022) that approval letter was received from the DSHS, but the funds were not released for purchasing ambulances.

3.6.1.7 Location services of the caller to CATS control room not established

DSHM had approved (February 2018) ₹ 2.5 crore for integrating location services of the caller to CATS control room under 'Support to CATS under NUHM Innovations' so that the ambulances can reach the location swiftly and accurately. Audit noted that no action in this regard was taken by CATS.

In its reply, CATS stated (January 2021) that modern Control Room has been established in the year 2016, but did not provide any specific reply to the audit observation.

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[27] Cardiac monitor, Transport ventilator, Syringe pump, Glucometer, Ambubag, Wheel chair, Head immobilizer, Oxygen accessories, Portable oxygen delivery kit, Laryngoscope, B.P.Apparatus, Thermometer, Stethoscope, Forceps, Rescue tools, Blood transfusion sets, Pulse oximeters etc.

Government did not offer any comment in its reply dated 13 December 2023.

Recommendation 3.9: The fleets of CATS should be strengthened with enough call worthy ambulances equipped with required equipment and medicines.

3.6.2 Availability of Ambulance services/Mortuary vans in hospitals

As per the SOP for Ambulance services formulated by DGHS, the purpose of Ambulance services was to provide transport for the patients. As per SoP, every hospital should have a fleet of One Advance Life Support (ALS) Ambulance, one Basic Life Support (BLS) Ambulance, nine Patient Transport Ambulance (PTA) and five Hearse Vans.

The status of availability of ambulance service in test checked hospitals is given in **Table 3.19**.

Table 3.19: Availability of ambulances in hospitals

Health institutions	No. of ambulances	Availability of ambulance services 24X7
LNH	2 PTA	Available
CNBC	NA	NA
RGSSH	NA	NA
JSSH	NA	NA

It can be seen from **Table 3.19** that LNH had only two PTAs against the requirement of nine. LNH also had only two Hearse Vans against five. It did not have any ALS or BLS Ambulances. In spite of availability of Hearse Vans, LNH was using PTAs for carrying dead bodies to mortuary as also to transport store items, wheel chairs, etc. The Staff car drivers were assigned the duty to run these ambulances. Other three test checked hospitals did not have any Ambulance or Hearse Van. One ALS Ambulance procured by RGSSH in January 2019 for ₹ 36.58 lakh was not put to use as it was not registered and was lying idle.

JSSH stated (July 2022) that the requirement of ambulance service was limited as the hospital was a Tertiary care super speciality hospital and there was no functional emergency in the hospital.

CNBC stated (March 2022) that the hospital was providing ambulance services through CATS.

The fact remains that these hospitals did not have ambulances and hearse vans as per SoP issued by DGHS.

Government replied (December 2022) that LNH has hired ten hearse vans and the process for purchase of hearse vans is in process.

3.6.3 Dietary Services

Department of Dietetics is a paramedical department which forms an integral part of every in-patients therapeutic care during their hospital stay. The IPHS stipulates that apart from the normal diet, the food supplied should be patient

specific such as diabetic, semi-solid and liquid and distributed in covered container. The quality of diet should be checked by a competent person on a regular basis.

The quality of Dietary services provided in the selected hospitals as compared against those prescribed under National Assessor's Guidebook for Quality Assurance in District Hospitals, MoHFW, GoI is given in **Table 3.20**.

Table 3.20: Dietary services in test checked hospitals

Particulars	LNH	RGSSH	CNBC	JSSH
Availability of dietary service	Yes	No*	Yes	No*
If available, in-house/ outsourced	In-house	Outsourced from Oct 2021	Outsourced	Outsourced from Dec 2022
Availability of Kitchen	Yes	Yes	Yes	NA
Availability of standard procedures for preparation, handling, storage and distribution of clean, hygienic and nutritious diet to the indoor patients as per their caloric requirement	Yes	Yes	Yes	NA
Availability of policy and procedure for regular quality checking of raw material, kitchen sanitation, cooked food etc.	Yes	Yes	Yes	NA
Availability of Quality testing of diet supplied in health facilities	No	No	No	NA
Evaluation of dietary services in health facilities	Not feedback taken from patients	No	No	NA
Dietetic research on menu planning, preserving nutritional values, storage of food items, modern methods of cooking, etc. was not conducted to improve the dietary services in the hospitals	Yes	Yes	Yes	NA

*RGSSH started dietary service from October 2021 and JSSH from December 2022.

Source-Data collected from the hospitals.

3.6.3.1 Dietary Services not provided by RGSSH and JSSH

IPD services were started in February 2015 in JSSH and in April 2016 in RGSSH and 14940 and 36,708 patients respectively were provided indoor treatment during the period of audit. RGSSH started the Dietary service from October 2021 and JSSH stated (December 2022) that the kitchen services have been started (June 2022) under the guidance of dietician.

Audit noted that in RGSSH all the patients were given similar diet thereby ignoring the distinctive dietary requirement of different categories of patients.

3.6.3.2 Shortage of staff and Dietician

As per Nutritional Therapy Guidelines issued by DGHS, GoI, there should be one Chief Dietician, one Sr. Dietician, One Dietician and six Assistant Dieticians for 750 bedded hospitals. Against this, there were no sanctioned

posts of Chief Dietician/ Sr. Dietician in LNH and only two Dieticians and six Assistant Dieticians were posted. Further, against the sanctioned strength of seven Head Cooks and 50 Cooks, only one Head Cook and two to three Cooks were posted during the audit period up to March 2021 which further declined to only one cook in 2021-22. Due to shortage of Cooks, 27 Nursing Orderlies assisted the Cooks in various kitchen works.

Similarly, CNBC, which is a 221 bedded hospital, requires one Dietician and two Assistant Dieticians. In CNBC, there was no Dietician available and only one Assistant Dietician was available after October 2019.

CNBC stated (August 2022) recruitment for one post of Dietician and Assistant Dietician was under process.

3.6.3.3 Absence of monthly inspection

Monthly Inspection of each ward was required to be conducted by the Dietician. However, no records, though called for, were provided to Audit in LNH and CNBC. Audit noted that diet feedback was being taken from the Sister-Incharge of the Ward concerned instead of patients.

3.6.3.4 Quality of food not monitored by the Government

It was noticed that the Government Food Inspector never checked samples of food being served in LNH and CNBC during the entire audit period. In LNH, Department of Food Safety, GNCTD had inspected the quality of food only once in December 2021. GNCTD stated (December 2022) that an audit team from Food Safety and Standards Authority of India (FSSAI) inspected the dietary and kitchen services in July 2022. However, the result of the inspection was not provided to Audit.

Recommendation 3.10: Government should fill the vacancies of Dieticians, cooks etc. in the hospitals. Hospitals should ensure minimum prescribed inspection of wards by Dieticians. Government should actively monitor the functioning of RGSSH and JSSH to ensure full-fledged Dietary Services in these hospitals.

3.6.4 Blood Bank Centres in Hospitals

Ministry of Health and family welfare, GoI, stipulates that health facilities are required to obtain approval from the state/Union Territory Licensing Authority for setting up Blood Storage Centre. The approval shall be valid for a period of two years from the date of issue unless sooner suspended or cancelled. An application for renewal will have to be made three months prior to the date of expiry of the approval.

Audit observed that the license for operation of Blood Bank, processing of whole Blood and preparation of its components in LNH expired on 31 December 2021 and it applied for renewal of the same, albeit with a delay of

more than two months[28], on 17 December 2021. However, the license was yet to be renewed as of July 2022.

Audit observed that the Blood Bank at RGSSH and JSSH had licence for storage of blood and its components only.

Although RGSSH had licence for storage of blood and its components only, it had procured equipment for separation of blood components for ₹ 1.21 crore during 2014-2017. RGSSH received license for blood collection, storage, and processing of whole human blood IP and or its components only in November 2021. However, it has not received licence for separation of blood components and the equipment procured during 2014-2017 was lying idle as of November 2022. It was also observed that out of total 2671 blood units procured/collected during the period under audit, 309 blood units (12 *per cent)* were discarded by RGSSH. This indicates that RGSSH neither regulated blood collection according to requirement nor transferred excess units available to other needy hospitals.

Similarly, in JSSH Blood Bank building was developed in 2016 at a cost of ₹ 1.15 crore. Audit noted that only blood storage facilitiy was available and other planned facilities for Blood Bank were not operational. JSSH replied (July 2022) that existing Blood Storage area was sufficient to meet the requirement of the hospital which was less than 2000 units per year. It also stated that after surgical and other OTs in the hospital become operational and if the requirement of blood exceeds 2000 units per year, the Blood Bank would be made functional.

However, the fact remains that the Blood Bank infrastructure was not utilised and it did not have the facility to collect and process blood and its components even after six years of its development.

Government stated (November 2022) that LNH holds a valid Blood Bank licence which is renewed for next five years. Further, it intimated that the delay in acquiring licence for the process of blood separation in RGSSH was due to shortage of qualified man power to run the Blood Bank. However, it remained silent on other issues.

As regards LNH, the reply is not acceptable as LNH had applied for renewal in December 2021 and same was renewed only in September 2022.

3.6.5 Bio Medical Waste Management

The Bio-Medical Waste Management Rules, 2016 (BMW Rules) framed by GoI *inter alia* lays down the procedures for collection, handling, transportation, disposal and monitoring of the BMW with clear roles for waste generators i.e. health care facilities and Common Bio Medical Waste Treatment Facility (CBMWTF). The Delhi Pollution Control Committee (DPCC) has been

[28] As per rule, the due date for application of renewal was 1 October 2021.

designated as Prescribed Authority to implement these rules in the National Capital Territory of Delhi.

As per Section 4 (g) of BMW Rules, all health care workers and others, involved in handling of BMW were to be provided training at the time of induction and thereafter at least once every year by the respective organisations. Rule 3C of BMW Rules stipulates that the hospitals generating BMW should obtain authorization from the DPCC and also send an Annual Report of quantity of BMW generated and disposed to the DPCC. Rule 4H of BMW Rules states that all health care workers and others involved in handling of Bio Medical Waste should be immunized against diseases including Hepatitis B and Tetanus.

Audit noted:

- shortfall in training imparted to healthcare workers by the test checked hospitals. LNH did not impart training to its staff during the years 2016-17 and 2017-18 and imparted training to only 48 to 59 *per cent* of total staff of about 2300 during the period from 2018-19 to 2020-21. CNBC imparted annual training to 27 to 91 *per cent* of more than 400 employees during the period from 2016-17 to 2020-21. RGSSH and JSSH imparted annual training to all its staff during the audit period.
- Further, LNH could provide Hepatitis B vaccination records of only 11 out of 27 health care workers involved in handling biomedical waste during the audit period. In RGSSH and JSSH, outsourced housekeeping staff were engaged and they were deployed on reshuffling basis and all the staff (RGSSH[29] and JSSH[30]) were not vaccinated against Hepatitis B/Tetanus.
- DGHS and hospitals failed to obtain timely authorisation for disposal of BMW from DPCC. In respect of test checked hospitals, LNH did not provide letter of authorization for disposal of BMW prior to 16 July 2019 to Audit. In respect of RGSSH, it did not obtain authorization for disposal of BMW waste from June 2016 onwards.
- Within one year of notification of BMW Rules, all organisations dealing with BMW were to establish a Bar Code system for bags or containers containing bio medical waste to be sent out of the premises or place for any purpose. However, it was noticed that the Barcoding system was introduced in RGSSH and JSSH in 2019 only, i.e. after almost three years.

[29] 61 *per cent* house keeping staff did not take a single dose of hepatitis B vaccine in 2021 and approximately 20 *per cent* of the housekeeping staff could not get complete dose of vaccination during the period 2017 and 2019

[30] 60 *per cent,* 20 *per cent*, 46 *per cent,* 17 *per cent* and nil of housekeeping staff engaged in bio medical waste were vaccinated against Hepatitis B in 2017, 2018, 2019, 2020 and 2021 respectively took vaccination against Hepatitis B. Similarly, 25 to 48 *per cent housekeeping* staff were not vaccinated against Tetanus during 2018 to 2021.

Government it its reply (December 2023) intimated that it has no comment to offer.

3.6.6 Infection Control Management

Health care associated infections are a major burden on patients, society and healthcare management. Efficient infection control programmes in health care facilities reduce the chance of infections spreading among patients and staff in the facility.

Infection Control Committees were functional in all the test checked hospitals. However, the Committee was constituted in March 2022 in RGSSH. Audit observed presence of stray animals in LNH premises. Compliance on restriction of foot wear in critical areas and visitors to isolation areas was weak as per NQAS assessment done in February 2022.

Proper pest control also forms part of infection control in hospitals. LNH and CNBC had outsourced pest control services during the audit period. Audit observed that RGSSH had engaged a pest control agency for only two years during the audit period from September 2019 to September 2021.

3.6.7 Grievance redressal system and display of Citizen's Charter in hospitals

As per NHM Assessor's Guidebook, there should be an effective system for redressal of grievances of patients which *inter alia* include periodic monitoring of disposal of grievances and follow-up by superior authorities as necessary. Complaint boxes are to be available at suitable places with process for grievance redressal and name of contact person properly displayed.

Test check of records in respect of complaints and grievances of patients revealed that these were received through various methods of online and offline modes such as Public Grievance Monitoring System portal, Chief Minister's Office (CM Janta Samwad), CPGRAMS, 1031 Helpline etc.

All the test checked hospitals had constituted Grievance Cells for attending to complaints and grievances of stakeholders but Grievance Redressal Committee was not constituted in three out of the four test checked Hospitals. Officer-in-charge of the Grievance Cell was dealing with complaint cases by forwarding the complaints to the Units/departments concerned.

Table 3.21: Availability of services related to Grievance/Complaint Redressal

Particulars	LNH	CNBC	RGSSH	JSSH
Availability of Grievance Redressal Cell or Complaint cell to register patients' grievances regarding quality of supplied food to them	A	A	A	A
Availability of mechanism for receipt of complaints and whether suggestion boxes had been placed at appropriate places	NA	A	A	A
Formation of Grievance Redressal Committee	NA	A	NA	NA

Source: Information furnished by hospitals
A-Available, NA- Not available

It was also noticed that complaints were disposed off on the pretext that complainant was not responding to the call from the hospital. Besides there was no monitoring system to study the nature of grievances for initiating corrective measures to improve quality of services.

Recommendation 3.11: All hospitals should constitute Grievance Redressal Committees to dispose the complaints in an efficient manner and to assess the scope for improvement in its services.

3.6.8 Fire safety in Hospitals

National Building Code of India 2016 requires that fire extinguishers must be installed in every hospital, so that in case of any fire, the safety of the patients/attendants/visitors and the hospital staff may be ensured. As per IPHS, hospitals should have a Disaster Management Plan (DMP) in line with State Disaster Management Plan. DMP should clearly define the authority and responsibility of all cadres of staff and mechanism for mobilization of resources. All health staff should be trained and well conversant with disaster prevention and management aspects. Regular mock drills should be conducted and after each drill, the efficacy of disaster plan, preparedness of hospital and competence of staff shall be evaluated followed by appropriate changes to make plan more robust.

RGSSH did not conduct any mock drill during the audit period and could not submit the records of training imparted to staff on fire safety. It submitted a Fire Safety Certificate issued in September 2020 for the next three years, however, it could not provide Fire Safety Certificate for the previous years. Fire extinguishers were found expired during Physical Inspection. It was also noticed during Joint Physical Inspection that evacuation plans/routes for fire exit had not been displayed in the building.

LNH provided Fire Safety Certificates in respect of three out of eight blocks only i.e., (i) New Special Ward (ii) BL Taneja Block and (iii) New OT Block and informed that fire safety audit has been conducted by Delhi Fire Service on 29 April 2022. However, report in this regard was not provided to Audit. No

records in support of fire safety audit and mock drill conducted during the period of audit was provided. Further, the post of Fire Safety Officer was lying vacant in LNH, though it is one of the largest hospital having more than 2000 beds with an average footfall of more than 8000 patients per day.

Recommendation 3.12: All hospitals should timely take up the fire safety audit and conduct mock drills to ensure preparedness against any fire eventualities.

Chapter IV

Availability of Drugs, Medicines, Equipment and other Consumables

Chapter IV

Availability of Drugs, Medicines, Equipment and other Consumables

Drug Policy of NCT of Delhi (April 1994) provides for Central Drug Procurement, Storage and Distribution Centre with modern techniques of drug storage and inventory control. However, even after a lapse of 29 years this objective could not be achieved. CPA, which was entrusted with the duties of procurement of drugs and equipment, failed to deliver as the percentage of essential drugs to be procured by hospitals ranged between 33.74 and 47.29 *per cent* of the total EDL during 2016-17 to 2021-22. Similarly, during 2016-17 to 2022-23 (till September 2022), out of 86 contracts floated for procurement of equipment by CPA, only 24 (28 *per cent*) were finally awarded. CPA also failed to meet the demand of hospitals, forcing the latter to procure the drugs and equipment themselves thereby denying the benefits of economy of scale. Many of the essential drugs were not found available in the test checked hospitals. Even, there was short supply/shortage of injections for rare/fatal diseases like Haemophilia and Rabies. Hospitals failed to monitor and evaluate timely and regularly the need of repair, maintenance, replacement and condemnation of equipment.

CPA failed to update and prepare EDL on annual basis as envisaged in the Drug Policy of NCT of Delhi, to ensure availability of best drugs in health facilities and keeping pace with the ever changing field of drug industry. Formulary of Medicines was not prepared which would have facilitated doctors in prescribing drugs on rational basis, except in 1994 when the Drug Policy was formulated. On the quality control front, CPA did not engage laboratories to test biological quality control to rule out any chances of contamination. It also failed to ensure accreditation of empanelled laboratories and efficacy of test reports of empanelled labs. Procurement of medicines from blacklisted and debarred firms was observed along with administration of expired drugs due to mismanagement of stocks.

4.1 Introduction

The Drug Policy of NCT of Delhi, envisaged (April 1994) pooled procurement of drugs for all hospitals in Delhi along with establishment of a central drug procurement, storage and distribution centre. In Delhi, the Central Procurement Agency (CPA), under the administrative charge of the Directorate General of Health Services, is entrusted with the responsibility of procurement of all medicines required in health facilities under GNCTD. It is also entrusted with the responsibility of procuring equipment for various Delhi Government health institutions as per their demand. Besides, the Finance Department, GNCTD vide OM dated 7 August 2019 delegated full financial powers to the Head of Departments, Administrative Departments and Secretaries for purchase of

medical stores and equipment. As per the Government policy, health care institutions should ensure availability of all essential drugs at all times. As CPA did not ensure timely procurement and distribution of medicines and equipment to healthcare facilities, hospitals had to make their own agreements with local chemists to purchase medicines and float tenders to purchase various equipment.

4.2 Procurement and Availability of Drugs, Medicines and Consumables

4.2.1 Irregularities in preparation of Essential Drugs List (EDL)

(i) The Drug Policy of Delhi aimed at preparation of EDL[1], every year by a Special Committee consisting of eminent experts, to be used throughout the State at different levels of health care system. This Essential Drugs List was to be prepared annually by a Committee of Specialists, after consultations with concerned doctors. Suggestions were to be obtained from all health facilities, both hospitals and dispensaries, for inclusion and deletion of medicines. This list is then circulated amongst all the members of the Committee for Selection of essential medicines and finally after approval, to various Delhi Government health facilities. The procurement of medicines in EDL is done by CPA as well as by the hospitals concerned.

Audit noted that EDL was not prepared annually and was prepared only thrice[2] during the last ten years.

Essential Medicines List 2013 had two categories viz. Core-medicines[3] and Complementary-medicines[4]. The EDL was further segregated on the basis of the level of health care facility, i.e Primary, Secondary and Tertiary Health care facilities. EDL of 2016 and 2018, however, was not prepared on the basis of levels of health care facility/service.

(ii) The Essential Drug List 2018 was approved by Director General of Health Services (DGHS) in March 2018, on the basis of inputs received from a committee comprising of representatives from major hospitals. Audit noted that the Department received a letter (11 June 2018) from Minister of Health wherein, the issue of irregular inclusion of combination formulations and branded medicines in EDL 2018 was flagged. The Department was directed to

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1 Essential medicines are those that satisfy the priority health care needs of the population and are intended to be available at all times in adequate amounts, in appropriate dosage forms with assured quality and adequate information and at a price the individual and community can afford.

2 2013, 2016 and 2018.

3 Core which are defined as efficacious, safe, and cost effective medicines for priority conditions.

4 Complementary defined as medicines for priority diseases which are efficacious, safe and cost effective but not necessarily affordable or for which specialized health care facilities or services may be needed.

stop floating of tender of about 150 medicines with instructions to constitute a committee of experts from hospitals to examine the essentiality of combination, branded and proprietary drugs for inclusion in the EDL of Delhi Government hospitals.

Accordingly, a committee was constituted by DGHS (26 June 2018) to examine the issue, which submitted its report on 9 July 2018. Perusal of the report revealed that the Committee examined 182 drugs out of which 43 drugs were not approved for inclusion in the EDL.

Thus, exclusion of about 24 *per cent* of items from the list indicates that initially due diligence was not exercised while considering drugs to be included in EDL 2018.

It is clear from the above facts that the mechanism evolved by CPA to include medicines in the Essential Drug List as per actual requirement, was not functioning properly.

Recommendation 4.1: The Government should prepare EDL on annual basis as envisaged in the Drug Policy.

4.2.2 Delay in preparation of Formulary

The Drug Policy, 1994 of GNCTD provides for setting up a Formulary Committee every year for preparation of Delhi State Formulary[5] which would be made available to doctors and pharmacists free of cost. Audit noted that Formulary was last prepared in 1994.

Department replied (February 2022) that proposal would be started afresh for preparation/updating formulary**.**

***Recommendation 4.2: The Government should take measures to prepare a Delhi State Formulary for facilitating the doctors in prescribing and dispensing drugs*.**

4.2.3 Centralized procurement of drugs

As per decision taken in the meeting held on 16 August 2017 chaired by Chief Minister of Delhi, CPA was to ensure 100 *per cent* availability of medicines. It was directed to issue tenders in time, much before any medicine got exhausted. Thus, it was imperative on the part of CPA to invite tenders, process and finalize the rate contracts with the suppliers of drugs. Audit observed that despite establishment of a Centralized Procurement Unit, many drugs were left to be procured by the hospitals as shown in the **Table 4.1**.

[5] Formulary is a manual containing clinically oriented summaries of pharmacological information about selected drugs. The manual may also include administrative and regulatory information pertaining to the prescribing and dispensing of drugs.

Table 4.1: Status of drugs procured under EDL during 2016-17 to 2021-22

Period	Total number of drugs in EDL	Total number of drugs to be procured by Hospitals	Percentage of drugs to be procured by Hospitals
2016-17	1390	469	33.74
2017-18	1390	469	33.74
2018-19	1180	558	47.29
2019-20	1180	480	40.68
2020-21	1180	480	40.68
2021-22	1180	480	40.68

Source: Information furnished by CPA

It can be seen from the above table that the percentage of essential drugs to be procured by hospitals ranged between 33.74 and 47.29 *per cent* of the total EDL during 2016-17 to 2021-22.

CPA replied (January 2022) that it had no information as to how various medical institutions met the requirement of medicines in EDL. In the absence of finalization of contracts/non-procurement by it, the burden of purchasing essential drugs is passed on to the patients by public health care facilities.

The Government accepted (February 2023) the facts and stated that as of December 2022, rate contracts were available for more than 55 *per cent* of medicines and would reach between 80-90 *per cent* by March 2023 (including Anti Rabies vaccines).

The EDL medicines demanded by four test checked hospitals[6] and supplied by CPA for the period 2016-17 to 2021-22 is shown in **Table 4.2**.

Table 4.2: Demand and Supply of drugs in selected hospitals

Period	Total number of items demanded by hospital	Total number of items for which supply order not issued by CPA	Total number of items not received against the Supply order	Gross total of items not received against demand	Shortfall (in *per cent*)
Lok Nayak Hospital					
2016-17	1295	135	255	390	30.12
2017-18	1246	315	303	618	49.60
2018-19	1968	502	453	955	48.53
2019-20	1307	415	266	681	52.10
2020-21	1120	443	86	529	47.23
2021-22	1540	676	42	718	46.62
Chacha Nehru Bal Chikitasalaya					
2016-17	1021	324	76	400	39.18
2017-18	621	62	0	62	9.98
2018-19	832	144	0	144	17.31
2019-20	889	326	0	326	36.67

[6] Nirantar Portal Database

Period	Total number of items demanded by hospital	Total number of items for which supply order not issued by CPA	Total number of items not received against the Supply order	Gross total of items not received against demand	Shortfall (in *per cent*)
2020-21	977	349	0	349	35.72
2021-22	661	191	52	243	36.76
Janakpuri Super Speciality Hospital					
2016-17	944	203	84	287	30.40
2017-18	748	158	47	205	27.41
2018-19	1026	321	35	356	34.70
2019-20	644	156	0	156	24.22
2020-21	475	176	0	176	37.05
2021-22	692	236	30	266	38.44
Rajiv Gandhi Super Specialty Hospital					
2018-19	182	63	0	63	34.62
2019-20	471	120	0	120	25.48
2020-21	374	91	0	91	24.33
2021-22	806	295	0	295	36.60

Source: CPA portal

It can be seen from above that against the items demanded by the hospital, the total number of items not received by hospital ranged between 30 and 52 *per cent* in LNH, 9 and 39 *per cent* in CNBC, 24 and 38 *per cent* in JSSH and 24 and 36 *per cent* in RGSSH.

Thus, CPA was not able to fulfil the supply of items requested by the hospitals which shows lack of seriousness of the Department in implementing the Drug Policy. It also indicates poor inventory control of drugs, as in the absence of central procurement, CPA was unable to undertake need based re-allocation of drugs in the health care facilities. Audit analysis revealed that tenders were floated with delays ranging between seven months and two years.

The reasons attributed by CPA for not finalising the rate contracts were deficit in logistics and trained manpower.

Recommendation 4.3: The Government should take necessary action to revamp CPA so as to enable it to carry out its duties in an efficient and effective manner.

4.2.4 Risk purchase/penalty clause for non-supply of orders

As per tender document, in order to ensure 100 *per cent* availability of medicines, in case of alternate purchase effected by CPA due to late execution/not executing of orders by the suppliers, the differential cost/risk purchase amount incurred was to be recovered from the suppliers along with 20 *per cent* of value of such supply orders. If such default occurs for three or more supply orders placed during the tender period, penal action like blacklisting from participating in present and future tenders may be enforced.

Department did not respond about the total amount recoverable from the suppliers on account of failure to supply and risk purchase made during 2016-17 to 2021-22, along with letters issued to the suppliers concerned. However, analysis of CPA data revealed that against 67 supply orders issued to 329 suppliers during the period 2016-17 to 2022-23 (as on 30 September 2022), risk purchase and failure to supply penalty amounting to ₹ 27.98 crore was recovered from the suppliers. Test check also revealed that CPA had issued repeated supply orders[7] in September 2019 to three suppliers who defaulted on previous occasions as shown in **Table 4.3**.

Table 4.3: List of repeat defaulting suppliers

(Amount in ₹)

Sl. No.	Name of the firm (M/s)	Risk purchase amount recoverable in tenders 16_08 and 17_03	Amount recoverable in tenders 18_01 and 18_04
1.	Biogenetic Drugs Pvt. Ltd.	42,590	2,84,738
2.	Daffodills Pharmaceuticals Ltd.	324,111	6,87,947
3.	Eurolife Healthcare Pvt. Ltd.	3,29,594	22,35,644

Government stated (February 2023) that last order for risk purchase by CPA was placed on 4 February 2020 and that no risk purchase/penalty was imposed for not supplying because of Order issued (May 2020) by GoI which stipulated that penalty clause will not be invoked if the default was on account of disruption of supply chains due to spread of Corona Virus. Reply is not tenable as the GoI order was not applicable since the cases mentioned in Table 4.3 pertained to September 2019, i.e., prior to Covid period.

4.2.5 Local purchase of drugs/surgical/consumable items in test checked hospitals

(a) LNH: For the purpose of selection of empanelment of agency for supplying medicines/surgical/consumable items/general items, LNH had estimated (August 2016) a total annual requirement of drugs and other items costing ₹ 2.37 crore. One of the conditions stipulated that address of the firm should be within five kilometre radius of the hospital. Two agencies[8] were selected for two years from December 2016 on the basis of maximum discount offered on MRP. Further the contract was extended from time to time for 28 months up to April 2021.

As per contract, the agency was to supply emergency/casualty items immediately or within three hours after receipt of order. Delivery of the other supplies was to be made immediately/next working day by 9 AM or at the earliest opening hours of the units/store of the hospital.

[7] Supply orders dated 14.9.2019, 16.9.2019, 17.9.2019 and 21.9.2019
[8] M/s Super Medicos and M/s Popular Generics

Audit however, noted that:

- Selection of agencies was based on annual requirement of ₹ 2.37 crore whereas the actual procurement[9] was much higher and ranged between 225 *per cent* and 1,364 *per cent* of the annual requirement. Besides, fresh contract could not be initiated and finalized timely, as a result, the contract period was extended regularly up to 28 months till April 2021.
- Procurement from local chemist was to meet emergency requirement only. However, Audit noted that ₹ 94.09 crore was incurred on local purchases, which included procurement of medicines and other consumable items in bulk from these agencies to meet the day to day requirements.
- The distance criteria adopted by the hospital limited the competition as two out of nine agencies applied for the tender were rejected on this ground.

For new contract period starting from April 2021, only a single firm finally qualified for supplying medicines, injection, IV fluids, surgical consumables and Implant and devices. Audit noted that the above contract also was restrictive as it allowed bidding by firms within seven kilometre radius of the hospital only.

LNH replied (May 2022) that CPA failed to supply medicines as per the demand raised by the hospital and suggested either CPA should function properly or it should be dissolved. In order to ensure availability of all medicines as per the Government policy, hospital had to procure locally. Government further stated (November 2022) that the selection of local chemist in LNH in April 2021 was not based on single tender as there were 10 bids and the firm was selected as it offered more discount than the previous contract. The fact remains that the only eligible firm was awarded the contract.

(b) CNBC: The hospital was also procuring medicines/surgical consumable items/general items which were not available in the store from local chemists on the basis of approved discount rate on MRP. As per terms and conditions of the rate contract, vendor was to supply the drugs within 24 hours of the placement of order. Test check of records relating to local procurement of items which were not available in store revealed that in some cases, it took more than two days for supply of drugs.

CNBC stated (August 2022) that it takes time as supply orders were placed after approval of competent authority and enquiry of rate from firms approved for local purchase.

[9] ₹ 5.34 crore, ₹ 10.36 crore, ₹ 15.03 crore, ₹ 31.03 crore and ₹ 32.33 crore during year 2016-17, 2017-18, 2018-19, 2019-20 and 2020-21 respectively

4.2.6 Quality Control

Quality of public procurement and logistics is a major challenge to ensure access to free drugs and diagnostics through public facilities.

4.2.6.1 Warehouse facilities for drugs storage not developed

The Drug Policy of NCT of Delhi (April 1994), envisaged establishment of Central Drug Procurement, Storage and Distribution Centre to ensure modern techniques of drug storage and inventory control. The aim was to ensure that drugs did not pass their expiry dates and that any imbalances, such as shortage of a particular drug at one hospital and unused stocks at another, are identified and corrective measures taken well in time. A meeting was also convened in the chamber of Minister of Health (May 2015) to discuss issues related to drug procurement. After due deliberations, it was decided that CPA shall procure all medicines, consumables, non-consumables lab items, major equipment and their maintenance and other miscellaneous items required in health facilities/hospitals under GNCTD. It was also decided to establish initially four drug warehouses in different geographical locations of Delhi for issuing of medicines and other items to health facilities/hospitals on monthly basis.

For this purpose, Director Health Services was to prepare a proposal for site selection, infrastructure and staff requirement, etc. In this regard, DGHS was requested to furnish the Action Taken Report. However, no report was furnished.

Audit also noted that DGHS failed to provide adequate space to CPA for warehouse. It was further observed that though temporary arrangements were made for warehouse facilities at three locations, nevertheless, the programme was not successful due to absence of adequate space for receiving goods. Thus, the Department missed an opportunity to reap the benefits of modern techniques of drug storage and inventory control as envisaged in the Drug Policy, due to failure of DGHS to arrange for adequate space for warehouse.

Government stated (February 2023) that all consignees of CPA have their own drugs store which has adequate storage space for the items procured by CPA so there is no requirement of separate warehouse at present. Reply of the Government shows laxity in implementing its own Drug Policy to ensure modern techniques of drug storage and inventory control which could have avoided expiry of drugs as pointed out by Audit.

4.2.6.2 Distribution of drugs to patients before testing of samples

Drug Policy of NCT of Delhi envisages making available safe, effective and good quality drugs at health facilities but does not elaborate on specific steps to be taken to ensure quality of drugs.

Audit noted that medicines procured by CPA are supplied directly to Hospitals by the suppliers. After the stipulated supply period, samples[10] are picked up from hospitals by CPA for quality testing in the empanelled laboratories. In case any sample shows undesired results (not of standard quality), the testing report is conveyed to all user departments for taking necessary action as per the tender conditions.

During test check of records of LNH and CNBC, Audit noted that there was a time gap of two to three months between the receipt of drugs from the CPA and receipt of Government Analyst's report regarding quality of the drugs supplied. Audit noted that a few drugs supplied by the CPA were later reported as inferior quality **(Annexure III)**. Audit observed that some of these inferior quality drugs were consumed in the hospital before the receipt of quality testing reports.

LNH reiterated (May 2022) the procedure for testing of medicines supplied by CPA, however, it did not comment on the use of inferior drugs in the hospital.

Further, the Department was requested to elaborate on the mechanism put in place by it to ensure that all the firms attach certificates from lab that the drugs are of standard quality. Similarly, end-user wise stock position of drugs showing quantity consumed, unused quantity of drugs available and total unused quantity disposed off as per tender conditions in respect of samples which were declared as 'Not of Standard Quality' were also sought. The Department, however, failed to furnish the requisite information. In view of the time lag between consumption of drugs, their analysis and eventual intimation to the stakeholders concerned, efficacy and safety of drugs distributed to patients could not be vouched for.

Government stated (February 2023) that CPA mandates requirement of valid drugs licence and in-house quality analysis report of the supplied batch of medicines and the same is approved by the state Drugs Controller Authority. CPA considers these reports to be sufficient for quality assurance. The reply furnished by the Government is not tenable as procedure in place was inadequate to ensure that only quality drugs are provided to patients.

Recommendation 4.4: The drug samples for testing should be picked up in such a way that there should not be any time lag between the delivery of drugs and test reports to avoid the use of inferior quality medicines in hospitals.

4.2.6.3 Delay in empanelment of drug testing laboratories

The Drug Policy of NCT of Delhi, emphasizes on good quality control and assurance system for providing safe and effective drugs. Records relating to empanelment of laboratories for testing of drug samples revealed delay in empanelment of drug testing laboratories. It was observed that agreement for

[10] The particular batches of medicines for testing are picked up by the CPA through its procurement software, NIRANTAR based on where the maximum quantity is received.

fresh empanelment of laboratories was signed by DGHS in May 2018 though extension of empanelment was only upto April 2017. It was further noted that the renewal of empanelment again became due in May 2021, however, the same was approved in July 2021 and that only six out of 11 labs gave consent for renewal of empanelment.

The Department was requested to furnish (a) specific reasons for delay in empanelment of labs, (b) capacity of each of the empanelled laboratory in terms of the number of samples that could be tested and stored per day, and (c) details of drug samples that were sent for testing to the labs during the period when validity of empanelment of labs ceased to exist. The Department, however, did not respond to the audit query which indicates lackadaisical approach of the department to ensure a sound system for quality control of drugs being made available at public health care facilities.

Government attributed (February 2023) delay in empanelment of drug testing labs to cancellation of tenders due to problems in BOQ and glitches in the tender. It was further submitted that new tender has been uploaded on e-tendering site.

Recommendation 4.5: The Government should emphasize on good quality control and assurance system for providing safe and effective drugs at public health care facilities.

4.2.6.4 Empanelment of Labs without ensuring NABL Accreditation and license from Drug Control Department

Drug Policy of NCT of Delhi, envisages making available safe, effective and good quality drugs at all times at all health facilities. This requires strengthening of quality control mechanism. The empanelled lab should have a valid Accreditation from NABL[11] and license[12] from any State Drug Control Department/Central Drug Standard Control Organisation. This was one of the tender conditions pre-requisite for empanelment of labs for testing samples of drugs.

Audit noted the following issues in the empanelment of laboratories:

- NABL Certifications were available for part periods for 11 labs empanelled in May 2018 and for six labs empanelled from July 2021 as per records produced to audit. Government stated (February 2023) that

[11] National Board for Testing and Calibration Laboratories (NABL) has been established with the objective of providing Government, Industry Associations and Industry in general with a scheme of Conformity Assessment Body's accreditation which involves third-party assessment of the technical competence of testing including medical and calibration laboratories.

[12] The Drugs and Cosmetics Rules 1945 provides that approval for carrying out such tests of identity, purity, quality and strength of drugs or cosmetics, on behalf of licensee for manufacture of drugs or cosmetics shall be granted in Form 37 and its renewal in Form 38 by the Licensing Authority appointed by the State Government.

the Tender Evaluation Committee had checked on e-tendering portal and mentioned in file that the NABL Accreditation Certificates in respect of all empanelled labs were available on the portal at that time. Moreover, letters have been written to all empanelled labs to provide their NABL Accreditation Certificates.

- Names of two labs[13] also featured in the list of labs suspended by NABL, effective date of suspension being 16 August 2019 and 11 October 2019 respectively which shows that there was no mechanism in the Department to ensure NABL Accreditation status of labs.
- In five out of 11 NABL accredited labs, approval (Form 37)/renewal of approval (Form 38) for carrying out tests of identity, purity, quality and strength of drugs or cosmetics from the Licensing Authority was not available on record, whereas, in case of two labs, the approval was available for only part periods pertaining to the years 2016-17 to 2021-22. Likewise, in six labs, empanelled from July 2021, requisite approval was available for part periods in only two cases. The Department, however, failed to provide copies of approvals/renewals in respect of remaining laboratories/period, in the absence of which testing of drug samples by unauthorized laboratories could not be ruled out.

Department did not reply on the details of samples sent to different labs during the period of audit.

Recommendation 4.6: CPA should ensure that laboratories who have tendered for testing of sample drugs fulfil the eligibility criteria of valid NABL Accreditation and License from Drugs Control Department.

4.2.6.5 Verification of efficacy of empanelled laboratories not done

To assess the correctness of test results being given by the empanelled laboratories and to ward off collusion with the suppliers, CPA was required to send random samples to the government analyst or another empanelled laboratory for testing. In case of gross variation in the analytical reports, empanelled laboratory may be blacklisted for a period of two years.

Audit noted that CPA had no mechanism for sending samples to either government lab or to any another lab, on random basis. The two labs empanelled by the DGHS on 24 May 2018 were blacklisted in other States, for a period of five[14] years, due to variation in test reports. Audit also noted that samples were sent for testing to a lab which was not in the approved list of empanelled labs.

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[13] M/s Standard Analytical Laboratory (ND) Pvt. Ltd. and M/s Shree Sai Test House Pvt. Ltd.

[14] M/s Ozone Pharmaceuticals Ltd. (Analytical Lab), Bahadurgarh, Haryana and M/s Devansh Testing and Research Laboratory Pvt. Ltd. black listed for five years each w.e.f. 7.4.2017 and 1.8.2018 by Odisha and Haryana respectively.

Government stated (February 2023) that CPA empanels only NABL accredited laboratories licenced by the State Drugs Controller Authority and also asks for Form 37 and 38 from the laboratories to ensure their efficacy. Moreover, the government analyst is involved only in case of dispute. Reply of the Government reaffirms Audit apprehension that verification of lab reports of the empanelled lab to ensure correctness of reports was not being done.

Recommendation 4.7: The Government may develop a mechanism to test check the efficacy of test reports of empanelled laboratories from government or another laboratory.

4.2.6.6 Analysis of biological products not conducted

Biological products include vaccines, blood and blood components, etc. which tend to be heat sensitive and susceptible to microbial contamination. Audit noted that biological products were ordinarily not tested post-delivery to stores.

Department stated (April 2022) that biological products were not sent for testing as they required specialized facilities for testing. Thus, the Department compromised with biological quality control testing to rule out any chances of contamination.

Government stated (February 2023) that biological analysis facility is available only in government laboratories and CPA accepts supply only after submission of biological analysis report by government laboratories. Reply given by the Government contradicts the reply furnished by the Department in April 2022. Moreover, Government failed to show any documentary evidence in support of its reply.

4.2.6.7 Procurement of medicines from blacklisted and debarred firms

As per one of the eligibility conditions for supplying medicines to CPA, the bidder should not be currently blacklisted, debarred or de-registered for forgery, mis-representation or supplying "Not of Standard Quality" (NSQ) product(s) by any government/autonomous body/ institution, hospital in India. It was, however, observed that the Department procured medicines from firms without ensuring that they were not blacklisted/debarred by other institutions in India. Some cases are illustrated in **Table 4.4**.

Table 4.4: List of blacklisted and debarred firms

Sl. No.	Name of the firm (M/s)	Institution by whom blacklisted/debarred	Period of debarment	Period of default in GNCTD
1.	Jackson Laboratories Pvt. Ltd.	Blacklisted by Tamil Nadu Medical Services Corporation Limited	5.12.2017 to 4.12.2022	The firm also defaulted in supplying medicines in tender 16_08 & 17_03, as well as in paying risk purchase/penalty amount.
2.	Aculife Healthcare Pvt. Ltd.	Blacklisted by Odisha State Medical Corporation Ltd.	10.8.2018 to 9.8.2021	The firm defaulted in supplying medicines in tender 18_01 to 18_04, as well as in paying risk purchase/penalty amount. The firm was also declared non-eligible for bidding (Order dated 15.3.2018) by O/o Deputy Director Health Services, West Bengal, being a loss making company.
3.	Centurion Laboratories Pvt. Ltd.	Blacklisted by Gujarat Medical Services Corporation Ltd. and Haryana Medical Services Corporation Ltd.	GMSCL: 02.09.2016 to 01.09.2019; & HMSCL: 28.12.2016 to 27.12.2019	The firm also defaulted in supplying medicines in tender 16_08 & 17_03, as well as in paying risk purchase/penalty amount.
4.	Maan Pharmaceuticals Ltd.	Debarred by Gujarat Medical Services Corporation Ltd.	9.12.2021 to 8.12.2024 (for supplying NSQ items during 2019).	The firm also defaulted in supplying medicines in tender 18_01 to 18_04, as well as in paying risk purchase/penalty amount.

Source: Departmental records

The Department could not provide the list of blacklisted/debarred firms during 2016-17 to 2020-21, by drug controllers/institutions of other states. The above facts show that the Department had not evolved a mechanism to ensure eligibility of firms in this regard.

Government stated (February 2023) that adequate care is taken during technical evaluation of the participating firms with respect to their debarring and black listing in other states to ensure no such firms qualify in the tendering stage. The reply is not tenable as it does not clarify on the blacklisted firms from whom procurement of drugs was made.

Recommendation 4.8: The Government should evolve a mechanism to check that the firms supplying essential drugs are not debarred by other States for quality issues. The Government should also fix responsibility for the lapse of procurement of medicine from blacklisted firms.

4.2.6.8 Drug Therapeutic Committees and Prescription audit

As per the Standard Operating Procedure for pharmacists issued by the DGHS, GNCT of Delhi, in 2016, all hospitals need to establish Drug Therapeutic Committees as a first step to improve quality of management of drugs in all stages of use. Further, it has to conduct the prescription audit. It stipulates that doctors should write prescriptions in clear, legible hand writing and affix their name and stamp with date. They should recommend only generic medicines which are in the EDL.

An audit record of prescribing habits of all doctors should be maintained and in case of any default, remedial action may be taken against the clinician. For this

purpose audit record of at least two *per cent* of the prescriptions should be scanned and kept.

Audit noted that:

- Drug Therapeutic Committee was formed in July 2021 (RGSSH) and December 2021 (LNH) only. Drug Therapeutic Committees were in existence in CNBC and JSSH during the period of audit.
- Prescription audit in LNH was conducted in March 2022. Report revealed that in 43 *per cent* cases, dosage of drugs/right strength was not mentioned, known allergy was not documented in all the test-checked prescriptions, medicines were not mentioned in capital letters in 97 *per cent* cases. Branded medicines were prescribed in 57 *per cent* cases and irrational use/over prescription noticed in 26 *per cent* cases.
- JSSH had conducted only one prescription audit in September 2020 covering June to August 2020. Report revealed that known allergy was not documented in 72 *per cent*, abbreviations were used in 70 *per cent*, vital charting not mentioned in 36 *per cent* and drug frequency in hours was not mentioned in 25 *per cent* of test checked cases.
- CNBC had conducted six prescription audits. Major issues pointed out in the reports were lack of documentation of known allergy, use of un-approved abbreviations and medicines not mentioned in capital letters.

CNBC stated (August 2022) that cases of non-compliance mentioned above were due to high workload and shortage of doctors as compared to daily OPD patient load. It further stated that the hospital was making continuous efforts to improve prescription compliance through induction training programmes and special lectures.

Thus, essential function of Drug Therapeutic Committee through prescription audit for ensuring accuracy and completeness in prescriptions was not ensured in the test checked hospitals.

Recommendation 4.9: Hospitals should ensure proper functioning of Drug Therapeutic Committee and conduct regular prescription audit to ensure management of drugs in all stages of use.

4.2.6.9 Delay in receipt of Line Probe Assay (LPA) Test Reports

Programmatic Management of Drug Resistant Tuberculosis (PMDT) Guidelines 2017 prescribe two tests for detection of specific/multiple drug resistance TB cases viz. (i) Cartridge Based-Nucleic Acid Amplification Test (CBNAAT) and (ii) Line Probe Assay (LPA). The regimen of the medicines would be changed on the basis of the reports, if the patients are diagnosed as Drug Resistant (DR-TB) or Multi Drug Resistant (MDR)-TB as per PMDT guidelines. The Guidelines prescribe that the District Drug Resistance -TB Centre should be in close proximity of the CBNAAT site/ LPA lab in the district.

Audit noted that the facility for Line Probe Assay (LPA) Test was not available in Chest Clinic, Nehru Nagar and patients were referred to AIIMS, New Delhi. As this arrangement led to considerable delay of more than one month against the prescribed time of 72 hours in receiving the reports, patients were given first line anti-TB medicines even though such patients were found diagnosed with Drug Resistant (DR-TB) or Multi Drug Resistant (MDR) TB on receipt of report. Thus, due to lack of availability of LPA test facilities, MDR patients were deprived from prompt and targeted treatment.

Recommendation 4.10: The Government may develop testing facilities for prompt and targeted treatment as per Programmatic Management of Drug Resistant Tuberculosis (PMDT) Guidelines 2017.

4.3 Effective System for Inventory Control

4.3.1 Annual Physical verification

Rule 213 (2) of General Financial Rules 2017 stipulates that physical verification of all consumable goods and materials should be undertaken at least once in a year and discrepancies, if any, should be recorded in the stock register for appropriate action by the competent authority.

The Central Store under DGHS issues surgical items to Delhi Government Dispensaries. The records were maintained manually and no computerised system of inventory management was being used. Audit noted that the Store (as nodal store) issued various items viz. Sanitizer, Gloves, N-95 mask, surgical mask and PPE kits to all Delhi Government Hospitals during the pandemic. Audit was unable to verify the veracity of the physical verification of Central Store as complete information was not available as detailed below:

- In three (2016-18 and 2020-21) out of five years' audit period, no date was mentioned on the Physical Verification Certificate to ascertain actual date of verification of stores.
- 3,520 items expired during 2017-18, however, the facts were mentioned only after five years in the Physical Verification Report of 2021-22. Moreover, these expired items were neither found to be stored separately, to avoid inadvertent distribution for human consumption, nor disposed off as of May 2022.
- In two years (2018-20), a common date, i.e. 23 September 2020 was mentioned on the certificates, implying that verification for two years was irregularly done at the same time rendering the whole exercise futile.

Government stated (December 2022) that inadvertently dates were not mentioned in the report but were mentioned on the noting side of the file. Regarding expiry of 3,520 items, it was stated that only 35 items expired during 2017-18 and that these items were stored in a separate room for which process

of disposal was in progress. On conducting physical verification for two years on same date, it was attributed to unavoidable reasons and assured to conduct next physical verification on time.

Reply is not acceptable as the Government failed to furnish Physical Verification Reports on the basis of which certificates were issued. In the absence of supporting reports, discrepancies, if any, detected during verification and action taken by competent authority on them could not be verified in audit. As far as expiry of items is concerned, the reply is not tenable as the Physical Verification Certificate for the year concerned contradicts the contention of the Government.

4.3.2 Physical verification of stocks in selected hospitals

Audit noted in LNH and RGSSH, physical verification of drugs, equipment, linen, general stores, and wards of selected departments[15] was not conducted except for the year 2018-19 in the case of LNH. Further, Cardiology Department of RGSSH has not maintained stock registers of drugs. Other two hospitals (CNBC and JSSH) had conducted physical verification of stocks during the period of audit.

4.3.3 Idle stock in the equipment store of LNH

Examination of equipment stock register of LNH revealed that large quantities of equipment[16] purchased prior to April 2016 were not issued as of December 2021. This shows deficient stock management system of equipment in the hospital.

Government stated (November 2022) that it has initiated action to distribute the idle stock of equipment lying in Store.

4.3.4 Discrepancies in Stock Registers

Audit noted discrepancy in figures of closing balance and opening balance of medicines in Stock Register of LNH during the period 2016-17 to 2020-21 resulting in not accounting of loss of medicines from the stock. Similar discrepancies in figures of closing balance and opening balance of medicines[17] were also noticed in the stock registers of test checked Medicine Wards.

Stock of tablets expiring in the next financial year, were not brought forward in the opening balance for next year. As a result, 47 medicines with shelf life remaining were not taken in Stock Register and thus not accounted for in

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15 Medicine & Gynaecology department of LNH and Cardiology department of RGSSH

16 Adson forceps tooth (979), Adson forceps non-tooth (1054), BP Handle (257), chitle forceps (661), Metsenbaurn scissors (1086), sponge holder (93), stitch cutting scissors (47), towel clips (108), Mayo scissors (2819)

17 Less shown Inj Zylistine (210) in the opening balance of 2017-18 and less shown Inj Octride (236), Inj Tazact (511), Inj Heparin (284), Inj Pantocid (746) and Inj Solumedrol (200) in the opening balance of 2020-21.

RGSSH from April 2018 to March 2021. Moreover, there was overwriting and cutting at several places in the stock register.

RGSSH stated (August 2022) that medicines were going to expire in the next year and hence entered in the expiry register. The reply is not acceptable as stock has to be debited on their expiry and not before. Closing balance of many drugs with shelf life of six to 32 months remaining were not taken into opening balance of next year which shows insensitivity towards wastage of usable medicines.

Audit further noted that drugs are issued from the main stores to various users/patient care departments as per the Indent Sheets submitted by the user departments. The day-to-day issue of drugs to various departments are noted in the consumption sheets for each month and after the end of month the total consumption of quantities are accounted for in the main Stock Register. Audit noticed mismatch of figures in the main Stock Register, Consumption Sheet and Indent Sheets in the selected months.

4.3.5 Expiry of drugs due to mismanagement of stocks

Online Nirantar portal of CPA/DSHM facilitates tracking of stock balance of drugs in all health institutions of GNCTD so that the excess stock available in one health institution can be utilized by others on need basis. This would ensure optimum utilization and minimize loss due to expiry of medicines.

Audit observed from records that LNH and RGSSH were not using Nirantar portal for stock management of drugs and instead, physical registers were maintained. Due to this, excess stock in these hospitals could not be used by other hospitals on need basis and life of a large quantity of drugs had expired[18].

[18] **LNH** - Acyclovir 200mg (31970, Date of Expiry 09/20), Acyclovir 400mg (22400, 06/20), Cephalexin 250mg (23984, 10/20), Ciprofloxacin 250 mg (38770, 09/20), Conjugated Estrogen 0.625mg(10304, 01/21), Dilitiazen 60mg (25000,01/21), Fexofenadine 120mg (30000,03/21), Isotretinoin 10mg (23300, 03/21), L-Thyroxine 100mg (67700, 02/21), L-Thyroxine25mg (18600, 12/20), L-Thyroxine 50mg (32200, 01/21), Nitrofurartoin 100mg (62300,01/21), Pheneramine Maleate (113805, 12/20), Propanlol 40mg (15500, 01/21), Rifaximin 550mg (14690,02/21), Sodium Valporate 200mg (131880,12/20),Spirolactone 25mg (19000,12/20), Tamsulosin 0.4mg (32703, 12/20),Udiliv 300 (65400, 03/21), Udiliv 150 (34050, 09/20), Allopurinol 100mg (13610,03/18), Brufen 200mg(54870, 02/18), Finasteride 1mg(189890, 11/17) and Serropeptidose 10mg(151040, 11/17).

RGSSH - Acebrophylline,100 mg (16700,03/21), Alphacalcidol, 0.25 mcg Vitamin D (25675,05/20), Cilastazol, 50mg(12800,02/21), Ethamsylate, 500mg(13200,01/21), Enalapril (Envas), 5mg(17800,03/21), Glucosamine Sulphate, 750 mg(29860,01/21), Fexofenadine, 180 mg(19600,03/20), Hydroxy Chloroquine Phosphate, 200 mg(42000,11/19) and Pregabalim, 75mg(62380,03/20).
Note : In the order of Name of the medicine, quantity and month of expiry.

Moreover, it was also observed that expired medicines[19] were issued to indenting departments. In the case of RGSSH, gross irregularities were noticed in issuing medicines to patient care departments, OPD and Wards where the store department had issued expired medicines after changing the expiry date to a future date in the records.

CNBC was also not using Nirantar portal and instead was monitoring stock on some other online portal for drug management. It was observed that drugs worth ₹ 1.32 lakh expired as per the condemnation reports.

CNBC stated (June 2022) that due to decrease in consumption of said items and despite the best efforts taken by the departments and hospital authorities, the medicines could not be used before the expiry date.

Government replied (December 2022) that RGSSH has implemented e-hospital for maintaining stocks and for indenting process.

4.3.6 Storage of drugs in LNH

It was observed that the injection, tablet and syrup/ointment stores of LNH were not air conditioned though most of the medicines were to be kept at around 25 degrees Celsius. Shelves/Racks were not found labelled. During inspection, drugs were found stored wherein they were touching the walls.

Government accepted the facts and replied (November 2022) that the shortcomings in LNH are being addressed.

4.4 Availability of Drugs and Medicines

The requirement of drugs by hospitals were sent to CPA on quarterly basis. Findings with regard to availability of drugs are discussed below:

4.4.1 Unavailability of Essential Drugs in test checked hospitals

As discussed in para 4.2.3, CPA was not procuring drugs timely for health institutions of GNCTD. Thus, hospitals were purchasing essential drugs from local chemists for meeting their day-to-day requirements.

Scrutiny of indents for medicines received from user departments in the main stores for selected months[20] in test checked hospitals revealed that at the time

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[19] **LNH** - Levamisole 150 mg (500, 02/21, 03/21), Allendronate 35/70mg(400, 02/21, 03/21), Amino salicylic Acid (360,06/20, 09/20 to 01/21), Methergine, 0.125 mg (170, 10/19, 11/19), Asthalin 2mg(420, 05/18, 06/18), Alprazolam 0.5 mg (3130,01/18, 02 & 03/18), Asthalin 2mg(2240, 12/17, 01/18)

RGSSH - Framycetin 1% Cream, 30gm tube (500,06/20, 07/20), Budesonide Inhalation IP 100 mcg/dose(200,01/20, 02/20), Povidone Iodine 5% Ointment(50, 09/19, 10/19), Hydrogen eroxide(20, 05/10 &10/19, 08/19 &03/20) Clotrimazole Paint 1% Oral Paint 50ml(75, 10/18,12/18), Labetalol, 100 mg(2200,05/21, 06/21), Atenolol, 50mg(100, 07/20, 09/20), Azathioprine, 50 mg(2800, 04/21, 06/21), Ethamsylate, 500mg(500, 01/21,03/21), Methotrexate, 2.5 mg(1500, 03/21, 06/21), Fexofenadine, 180 mg(3800, 08/19, 12/19), Voglibose, 0.3 mg(990, 11/19, 12/19), Voriconazole, 200 mg(100, 09/19,12/19)

[20] October 2016, May 2017, December 2018, February 2020 and January 2021

of demand received from the patient care departments, many essential drugs were not available in the store for issue.

Further, there was delay (ranging between one month and more than one year) in procurement of drugs (Details in **Annexure IV**).

Unavailability of essential drugs indicates short-comings in the system of procurement of drugs which needs to be addressed by the Hospital/Department.

CNBC stated (July 2022) that stock in the Central Store was nil or likely to be nil as the supply was still awaited. However, sufficient stock was available at sub-station /user department.

Reply is not satisfactory as the Central Store of CNBC had failed to provide essential drugs to the user department on demand in the above cases.

4.4.2 Availability of Haemophilia injections in LNH not ensured

Haemophilia is a rare disease and availability of medicines are important to reduce morbidity and mortality associated with this rare disease.

Audit noted that the monthly number of Haemophilia patients treated with inj. Factor IX ranged between 70 and 141 and number of Injections of Factor IX consumed ranged between 207 vials and 403 vials during the period from April 2016 to March 2021. Further, test check of records of Haemophilia Centre revealed that Factor IX Injection was out of stock on four occasion[21] during October 2018 to June 2019.

Thus, the hospital was not in a position to treat Haemophilia patients due to unavailability of injections.

The Government accepted (November 2022) the failure of CPA in ensuring supply of injections.

4.4.3 Laxity in procurement of drugs prescribed for Maternal Health

The Directorate of Family Welfare, GNCTD had instructed (November 2017) CPA to procure maternal health drugs prescribed for pregnant women by GoI. The CPA was instructed to include the items in Essential Drug List and till that time procure the items as per specifications and quantity mentioned. As per Nirantar portal, the quantity of maternal health drugs procured vis-à-vis requirement by CPA is shown in **Table 4.5**.

[21] 31.10.2018 to 29.11.2018, 04.12.2018 to 12.12.2018, 27.12.2018 to 12.01.2019 and 04.5.2019 to 26.06.2019

Table 4.5: Details of maternal health drugs procured by CPA

Name of drug	Quantity to be procured	Quantity procured
Tab. Calcium 500 mg + vitamin D3 (250 IU)	30,00,000	Nil procurement during 2017-18 & 2018-19 4,58,155 purchased during 2019-20 4,43,925 purchased during 2020-21 27,400 purchased during 2021-22 Nil purchased during 2022-23 (upto 30.9.2022)
Tab. Folic acid 400 mg	10,00,000	Nil
Glucose sachet (75 gms) Oral swallow-able	1,00,000	Nil procurement during 2017-18 to 2019-20 2,70,500 during 2020-21 Nil purchased during 2021-22 44,500 purchased during 2022-23 (upto 30.9.2022)

In respect of test checked hospitals, LNH provides maternity services but had not procured the above said drugs during the audit period. Moreover, only 600 Glucose sachet were received from CPA during 2020-21.

This shows that CPA did not comply with GNCTD instructions indicating insensitivity towards maternal health.

4.4.4 Unavailability of Anti-Rabies vaccine in Delhi Government health facilities

Rabies is a fatal but preventable viral disease, which can spread to people and pets, if they are bitten or scratched by a rabid animal. Minister of Health, GNCTD flagged (June 2018) the issue of unavailability of anti-rabies vaccines at Delhi Government hospitals.

Audit noted that CPA had issued supply order (June 2018) for 80,900 vaccines for 22 hospitals, however, only seven hospitals received vaccines (31,100) from the suppliers. Similarly, against supply order issued by CPA for 1,15,981 vaccines (November 2019) for 20 hospitals, 18,200 were short supplied. Resultantly, vaccines were not supplied in four hospitals.

During 2020-21 and 2021-22, 2.69 lakh and 3.36 lakh anti-rabies vaccines were demanded against which only 1.13 lakh and 2.72 lakh respectively vaccines supplied.

Government attributed (February 2023) shortage of rabies vaccine to withdrawal of rate contract by the bidder, unavailability in open market and nil participation from bidders in open tenders.

4.4.5 Unavailability of reserve stocks of essential medicines for TB patients

As per Technical and operational Guidelines for Tuberculosis Control in India 2016, reserve stock of three months has to be maintained in State Drug Store.

All the drugs of TB including Cap Rifabutin and Delamanid etc were being supplied by the Central TB Division to the State TB Cell. Audit observed that the Central TB Division was sending 150 Cap Rifabutin against the average consumption of 1,642 per month and no supply of Delamanid was made. Central TB division directed State TB Cell in June 2019 that Cap Rifabutin may be purchased on their own, but medicines were purchased only on 5 September 2019, due to which Cap Rifabutin and Delamanid remained out of stock as per details shown in **Table 4.6**.

Table 4.6: Out of Stock TB drugs

Sl. No.	Name of the Drug	Used for	Stock-out period	Total days
1	Cap Rifabutin 150	HIV Infected TB Patients	1 April 2019 to 5 September 2019	161
2	Delamanid	Drug Resistance-TB patient	1 January 2020 to 12 May 2020	222
			25 May 2020 to 25 August 2020	

The unavailability of such an essential drug meant for HIV TB Patients and failure to take timely action to maintain buffer stock indicate lackadaisical approach of the department.

Department stated (June 2022) that they do not purchase tablet Delamanid as the drug is provided by Central TB Division, GoI.

The reply is not acceptable as the State TB Cell is required to keep a buffer stock or purchase the essential medicine from the market in case of delay/non delivery from the Central TB division.

Recommendation 4.11*: *Department should strive to achieve availability of all essential drugs at all health facilities as envisaged by the Government.

4.5 Procurement and Availability of Equipment

4.5.1 Irregularities related to procurement of Equipment by Central Procurement Agency

CPA is responsible for obtaining administrative approval from DGHS for procuring equipment[22] in health facilities of GNCTD (including hospitals).

Test check of records of CPA revealed the following:

- Contracts were awarded only in 24 cases (28 *per cent)* out of 86 tenders floated during the FYs 2016-17 to 2022-23 (till September 2022)[23].
- In 12 cases[24] NIT was cancelled in 2017, as administrative approval of DGHS for inviting tender and uploading it on website was not obtained

[22] CT Simulator, Advanced Vessel Sealing Energy Device, Linear Accelerator, Surgical Examination light etc.

[23] 2020-2021 information not provided

[24] Dual Energy Linear Accelerator, C-ARM Machine, Intra Aortic Balloon Pump (IABP), Advanced Continuous Haemodynamic Monitor, 1000 mAH Radiography System, CT

by CPA. Outcome of disciplinary action recommended against erring officials by DGHS was not furnished by CPA.

- 37 tenders issued (between February 2016 and January 2017), were put on hold (January 2017) by DGHS, based on the complaint filed by Delhi Surgical and Medical Association. These tenders were finally cancelled.
- In ten cases (2016-17), bids were cancelled due to receipt of single bid. However, retendering was done in respect of only six cases wherein one tender was successful. As per information furnished, no further efforts were made by the Department in this regard.

Instead of fulfilling the obligation for timely procurement of equipment, CPA replied (June 2022) that concerned hospitals were equally competent to procure equipment/instruments as per their requirement through GeM/open tender. It also stated that no assessment was made by DGHS, GNCTD to verify as to whether the items requested by hospitals were finally purchased by hospitals for their intended use.

Government attributed (February 2023) cancellation of tenders to the requirement to procure through GeM portal and the necessity of obtaining approval from Minister of Health and Family Welfare for medical equipment worth more than rupee one crore. Regarding disciplinary cases, it was stated that the related files were with Vigilance Department.

Reply is not acceptable as the reasons furnished by the Government for not procuring equipment merely states the codal formalities to be met by CPA. Moreover, the above facts create a doubt about the actual requirement of equipment in the health facilities and also exhibit lackadaisical approach of the Department.

Office of Minister of Health directed (6 October 2015) CPA to procure 100 ventilators along with support accessories on urgent basis. Expert Committee of Maulana Azad Medical College had recommended compressor based ventilator as the other turbine based ventilators, were not considered safe for patients in case of turbine/air failure.

Audit noted that CPA/DGHS had floated a tender for procurement of 125 ventilators. Revised approval for purchasing extra 25 ventilators was not obtained from the Office of Minister of Health. Besides, the recommendation of Expert Committee for procurement of compressor-based ventilator was not brought to the notice of the special purchase committee and finally ₹ 9.38 crore was incurred (March 2016) for procurement of 125 turbine-based compressors. Thus, the input for patient safety was not taken into account.

Simulators, Adult Flexible Intubation Fibroscope, Dual Energy Device for open and Laproscopic Abdominal Surgery, Ultrasonic Surgical Aspirator, Neurosurgery OT Table, Neurosurgery Spine drill electrical, Water Dissector for liver surgery.

4.5.2 Delay in procurement of equipment by hospitals

There were many instances of inordinate delay in procurement of equipment or the demand of user departments was not fulfilled in selected hospitals. This resulted in the patient care departments functioning with no stock or limited stock, thus affecting patient care. Some of the significant cases noticed in audit are detailed in **Table 4.7**.

Table 4.7: Instances of delay in procurement of equipment by hospitals

Sl. No.	Name of item(Quantity)	Name of the hospital	Name of the user department	Date when requested by user department	Taken up by purchase committee	Status of procurement	Remarks
1	Ventilators (3)	LNH	Anesthesia	May 2018	Oct 2018	Not procured	In July 2019, Purchase Committee decided to call for fresh demand from the department due to slow progress in the process.
2	Ventilators (6)	LNH	Anesthesia	Aug 2019	Sept 2019	Not procured [25]	the Technical Evaluation Committee in May 2020 found that both the firms which had applied for tender did not have the technical qualification and accordingly, the tender was cancelled.
3	Stabilizer for Cryofuge6000i(1)	LNH	Blood Bank	26 Apr 2018	May 2018	Procured in Nov. 2018	The machine which is used for component preparation of blood was not functional for six months for want of stabilizer affecting the functioning of blood bank
4	High-Definition Camera with Monitor(1)	CNBC	ENT	Sept. 2018	Jan. 2020	Procured in Mar. 2021	In June 2020, the tender was cancelled as there was only one qualified bid. Re-tending started in July 2020.
5	Direct Digital Flat Panel Fluoroscopy and Radiography System	CNBC	Radiology	Sept. 2015	Not available	Procured in July 2019	The CNBC in its reply stated (August 2022) that main reason for delay was return of the proposal to procure the equipment by CPA after 16 months.
6	Linear Accelerator (LINAC) machine	LNH	Radiotherapy	May 2017	Sept. 2017	Procured and installed as of Dec 2022	CPA initiated tender in Sept. 2017 and awarded the order after a lapse of two years in December 2019. LNH initiated process for Letter of Credit in February 2021, but due to shortage of fund, the letter of credit was opened only in September 2021.
7	2D Echo and colour Doppler System	LNH	Medicine	Oct. 2018	Oct. 2018	Procured in January 2022	Delay due to slow progress in bid process.
8	Advanced Respiratory Endoscopy Unit consists of 14 equipment[26]	RGSSH	Pulmonary	Jul 2016	Jul 2016	Procured only two items in January 2018 and March 2020	Advanced Respiratory Endoscopy unit is still not procured. Reasons not provided.
9	Seven Equipment for Pathology [27]	RGSSH	Pathology	Mar 2014	Mar 2014	One equipment procured in 2015, three equipment in 2020-21[28]	Status of procurement of remaining equipment not available.

[25] Anasthesia department of LNH later received eight new ventilators from PM Care Fund during Covid period (3 in September 20 and five in March 2021)

[26] Jet Ventilator, bronchoscopy simulator, rigid bronchoscopy system, therapeutic video bronchoscope, Cryo system for bronchoscopy, pediatric video bronchoscope, ultrasonic endowasher, electrocautery unit with argon Plasma coagulation, portable bronchoscope etc.

[27] Tissue Embedding Station, Fully automated Tissue Processor, Semi-automated Rotary microtome, cryo microtome, trinocular microscope with high resolution camera, fully automated Slide Stainer and imported grossing station

[28] Trinocular microscope (2015) and Tissue Embedding Station, Tissue Processor and Semi Automated rotary microtome (2020-21)

LNH accepted (May 2022) the facts regarding delay in purchase of ventilators. Regarding High Definition Camera with monitor for ENT Department, CNBC stated (August 2022) that as the equipment was a high budgetary equipment, the process was completed with scrutiny at all levels, evaluation committee also took time for taking demonstration of the quoted equipment, sought clarification from the firm, evaluation of bids, rate justification and making reports. It further stated that there was lack of manpower and doctors involved in procurement process were also involved in clinical duties besides administrative duties.

The fact remained that shortage of staff delayed the completion of procedure in procuring the equipment which finally delayed the installation of equipment.

4.5.3 Non-maintenance of Assets Register and weak monitoring of equipment

As per the SoP issued by the H&FW department, the in-charge of Repair & Maintenance Section should evaluate all medical equipment at least quarterly/half yearly for the specific purpose of recommending replacements/condemnation based upon the repair history, life expectancy and condition of the equipment. The user departments have to watch the periodic repair and maintenance of the equipment and to intimate the proposal to Repair & Maintenance Section.

Audit noted that all the test checked hospitals were not maintaining Assets Register of equipment installed in the hospital. Resultantly, they were not in a position to monitor and evaluate the need of repair, maintenance, replacement, condemnation of equipment regularly and timely. Thus, centralized monitoring of the equipment was absent in the hospitals.

LNH intimated (May 2022) that action has been initiated to centralize the repair and maintenance work

4.5.4 Delay in initiating tendering process to replace old machines in LNH

LNH is maintaining some major equipment beyond the life cycle of the machine after paying enhanced AMC charges. As per the purchase agreement, major equipment are under free of cost Comprehensive Annual Maintenance Contract (CAMC) for the first five years and under paid CAMC for the next five years.

However, it was noticed that the some of the equipment[29] were beyond ten years and were maintained at enhanced rate of AMC without covering the replacement cost of major parts and also on best effort basis. 15 OT tables

[29] Digital X Ray 2063 Digital X Ray 2068 Colour Doppler USG XRay 1000MA digital Genious 60 Xray machine60MA Mobile XRay Sonatam Definition AS CT Scan CT Scan machine Emotion 16 Anderson Gas Sterilisation system Securex Sterilisers (two nos.) Cryofuge 6000i(two machines) Stifenhofer Sterilizers (two) OT tables(15) Automated Bacterial Identification and Susceptibility System

(1990-95), two Stifhnhofer Sterilizers (87-88) and two Securex Sterilizers (1992-93) were found to be more than 25 to 30 years old.

The hospital/department has not yet initiated/finalized the tender for purchase of new equipment in place of these outdated equipment. In the case of Genius 60 Portable X ray Machine, the department had spent ₹ 2.60 lakh on its repair and maintenance whereas the cost of the machine was ₹ 1.45 lakh. Further, in the case of some of these equipment, more than 50 *per cent* of the cost of machine has already been incurred on its maintenance[30].

LNH intimated (May 2022) that action has been initiated to procure new equipment and to condemn the old ones.

4.5.5 Delay in issue/installation of Equipment

Equipment are purchased to enhance the efficiency of patient care on the basis of demand of the User Department. Equipment are required to be installed immediately after their receipt, for optimum utilization as well as to claim the comprehensive maintenance warranty provided by the seller. Failure to install equipment immediately after the receipt leads to blockage of Government money and denial of patient care. Further, Rule 144 (iv) of General Financial Rules 2017, envisages that care should be taken to avoid purchasing quantities in excess of requirement to avoid inventory carrying cost.

Scrutiny of Stock Registers of equipment of CNBC and LNH revealed that 156 equipment were issued with a delay ranging from four months to 8 years. 17 types (114 quantity) of equipment in LNH were issued with a delay ranging from 5 to 36 months and 10 types (42 quantity) of equipment in CNBC were issued with a delay ranging from six to 96 months.

Moreover, Stock Registers of CNBC and LNH showed that four [31]items in LNH and one[32] item in CNBC were procured in excess of their requirement and were lying unused in stock for long periods ranging from 18 months to 95 months as on 31st March 2021.

It highlights the absence of centralized monitoring mechanism to assess the requirement and manage the usage and distribution of equipment in the hospitals.

Government replied (December 2023) that the indents from departments concerned are received and recorded in the Stock Register after satisfactory installation of equipment by CNBC.

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30 In the case of Securex Sterilisers, Stifnhofer Sterilizers and CT Scan machine Emotion 16 an amount of ₹ 59.16 lakh, 52.58 lakh and ₹ 1.47 crore have been spent topwards their repair and maintenance whereas the actual cost of equipment were ₹ 65.21 lakh, ₹ 86 lakh and ₹ 2.66 crore respectively.

31 Two Pharmaceutical refrigerators (18 months), two infant ventilators (60 months), 17 Otoscopes (58 months) and four ICU Ventilators (51 months)

32 Three Examination Table (95 months)

The reply is not acceptable as the entry in the Stock Register is made immediately on receipt of the equipment and there was huge delay in installation as per the Stock Register.

4.5.6 Shortage of equipment in labs/departments of MAMC and LNH

Each department of a Medical College with 250 admissions is required to have a minimum number of equipment as per the Medical College Regulations, 1999.

(i) It was observed that 10[33] essential equipment were not available in the Pathology and Biochemistry laboratories of MAMC. Further, shortage of seven[34] equipment was noted in these labs. Grossing Station used for cutting, sampling and for microscopic examination of tissues, purchased (January 2020) was not installed in the Pathology department.

Moreover, three equipment[35] in clinical laboratories of LNH were not in working condition. As per the information provided by the LNH, there was also a need of 15 different equipment in Genetic lab and six equipment in Clinical Lab which have not been made available to them yet.

(ii) There was shortage of various equipment in Pharmacology, Community Medicine, Forensic Medicine and Anatomy Departments of MAMC as per the details given below:

- Pharmacology department had shortage of important items such as Special Drug Delivery system (10 against 25) and samples of dosage formulations (10 against 25). Pharmacology department should have a computer assisted learning laboratory with enough computers with CAL programme for teaching Experimental Pharmacology. Audit noted that computer assisted learning laboratory of Pharmacology department did not have enough computers with CAL programmes /software.
- In Community medicine department, ten[36] different equipment were not available. It had huge shortage of Dissecting microscope (three against 60) and Microscope oil immersion (one against five).

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[33] Weighing machines for cadavers, Heated paraffin embedded module, Cold plate for modular Tissue embedded system, Fully automated Flexible Cover/slipping workstation, Automated high speed Slide Scanner, Automatic Urine Analyser in Pathology and Urinometers, Chromatography unit and Glucometer in Biochemistry department.

[34] Autoclave (2 against 4), Centrifuge machine (2 against 8), Microscope for students (81 against 150), X ray viewing box (1 against 5) in Pathology and Student Microscope (4 against 10), Thermometer (1 against 5) and PH meter (1 against 5) in Biochemistry department.

[35] Fully automatic blood cell counters (2) and Lab Centrifuge Machine (1)

[36] Comparator(1), Extraction apparatus(1), Filter Pasteur Chamberland, Berke fed(2), Hydrometers(7), Incubator(1), Balance analytical(1), Centrifuge clinical(1), Sterilizer(2) and Autoclave(1)

- In Forensic medicine department, four[37] different equipment were not available. There was shortage of Microscope student type (20 against 40), X Ray view box (one against seven) and Brain knife (two against eight).
- In Anatomy Department, Drill Machine, Dissection Microscope and Incubators were not available. Further, there was shortage of tables (23 against 37), Xray viewing lobby (three against eight), articulated skeleton set (five against 10) and Bone sets (10 against 45).

Government replied (December 2023) that procurement process for purchasing the deficient equipment has been initiated.

Recommendation 4.12: Government should ensure availability of equipment in labs/departments in Medical colleges as per Medical College Regulations.

4.5.7 Repair and Maintenance

Many of the patient care services are essentially dependent on the equipment. Without the appropriate equipment, hospitals cannot provide desired or committed service to the patients or the community. Thus a reliable, dependable and sustainable repair and maintenance program is essential for every hospital and health care institution. The objective of the hospitals repair and maintenance programme is to keep all the medical equipment in working order through timely maintenance, repair and condemnation and replacement of the equipment in a cost effective manner.

4.5.7.1 Improper Maintenance of Log Book in hospitals

As per the terms and conditions of Comprehensive Annual Maintenance Contract (CAMC), if the downtime of the machine exceeds more than five *per cent* in a year, penalty in the form of extended CAMC period of double the number of days for which the equipment was not of service (in excess of the five *per cent* permissible limit) was applicable. However, it was noticed that neither the log books were maintained clearly indicating the number of non-functioning days of various equipment nor the calculation was ever done and taken into account while approving the renewal of contract. Further, Performance Guarantee from the firms was not taken before awarding the Annual Maintenance Contract.

4.5.7.2 Delays in renewing CAMC

In the absence of any mechanism for timely renewal of maintenance contract, it was noticed that in some instances, the CAMC was not extended after the first five years' free CAMC period resulting in delay in replacement of parts thereby effectively causing denial of service to patients.

Illustrative instances noticed during audit are mentioned in **Table 4.8**.

[37] Hacksaw (4), Digital Spectrometer(1), Electric auto slide projector (1), Spectroscope lens with adjustable slit (2)

Table 4.8: Cases of delay in finalization of AMC

Sl. No.	Hospital	Equipment name	Date from out of CAMC	Instances of delay in repair
1	LNH (Radiology)	Ultrasound machine Acuson S2000	February 2017	Machine had malfunctioned (1 July 2017) due to problems in Transducer and was replaced on 10 October 2017.
2	LNH (Radiology)	Philips Ultrasound Machine(IU 22)	June 2017	Delay in replacement of parts (July 2021 to Nov. 2021) and April 2018 to January 2019).
3	LNH (Blood Bank)	Two pharmaceutical refrigerators	Feb 2018	Equipment became non-functional from 30 October 2018 to 31 December 2018 and 31 January 2019 to 29 March 2019.
4	Sushruta Trauma Centre (STC), LNH	Digital X ray machine	September 2015	The machine was not operating for more than four months due to delay in getting the machine functional after its breakdown at various occasions from 2017 to 2020.
5	CNBC (Microbiology)	Medical Waste Disinfection System	September 2019	Though the CAMC expired on 9 September 2019, the department accepted the proposal of CAMC w.e.f. 30.03.2020. Audit observed that during the non CAMC period the equipment was non-functional from 25th October 2019 to 5th December 2019 (41 days). A payment of ₹ 6490 was made for the repair of the equipment.

4.5.7.3 Delay in Repairing of Equipment in LNH

During test check of Comprehensive Annual Maintenance Contract of sterilization equipment used in OTs, Audit noted that two high speed sterilizers located at OT-III and Gynaecology OT were not functioning since June 2016 and December 2017 respectively due to steam leakage though the Jacket and Chamber. These parts were not covered in the CAMC. There was procedural delay in decision making which resulted in unavailability of service of sterilizers in Gynaecology OT for six months and OT III for one year. The equipment was finally repaired in July 2018 and was functioning since then.

4.5.7.4 Award of CAMC with Retrospective Effect

There were numerous instances where Comprehensive Annual Maintenance Contract had been awarded with retrospective effect in hospitals.

(i) LNH

- The CAMC award letter for the period from 4 June 2016 to 3 June 2017 in respect of Stifhnohofer Sterilizers was issued in August 2017 with ex-post facto approval from the competent authority.
- In the case of Anderson ETO Gas sterilization system (purchased in August 2008) which is used for sterilization of the entire hospital including OT, ICU etc., there was delay in awarding CAMC for the period from September 2018 to August 2019. However, it was observed

that CAMC was awarded in May 2020 with retrospective effect from September 2018 and payment was made for the same.

- In the case of two high speed sterilizers used in Gynaecology OT and OT II of CSSD, CAMC was awarded in the month of August 2017 with retrospective effect for the contract period September 2016 to August 2017. Again the contract was awarded with retrospective effect in January 2019 for the period from September 2018 to August 2019.

In all these cases, it was noticed that the contracting firms were providing the services of the machines even in the absence of extension of contract, however, any sudden breakdown of the machines would have created delay in repairing the machine in the absence of a legal contract.

(ii) RGSSH

There were numerous instances where CAMC was awarded with retrospective effect as shown in **Table 4.9**.

Table 4.9: List of equipment for which CAMC issued with retrospective effect

Sl. No.	Name of equipment	CAMC start date	Date of issue of award
1	Fully Automated Integrated Urine Chemistry and Sediment Analyser	08.05.20	15.09.20
2	CO_2 Incubator	03.06.20	07.01.21
3	Fully automated Coagulation Analyser	01.04.20	21.10.20
4	FCR + Dry Laser Printer	14.01.20	23.03.21
5	LH 750 Analytical Station	25.06.20	07.01.21
6	Automated Immunoassay Analyser	10.07.20	16.12.20
7	Video Bronchoscope System	01.04.21	14.07.21
8	Schiller TMT Machine	10.09.20	07.07.21
9	Endobronchial Ultrasound system	01.04.21	14.07.21
10	High end Anasthesia Machine	01.05.17	20.11.17

The above instances shows that the monitoring mechanism to ensure timely maintenance of equipment is weak in these hospitals.

4.5.7.5 Short levy of penalty due to downtime of equipment

As per the terms of agreement for supply of equipment, during the warranty/ guarantee, the supplier has to guarantee an uptime of 95 *per cent* of equipment failing which a penalty would be imposed equivalent to double the amount of daily cost of the unit for each day's delay in proper functioning of the unit beyond five *per cent* down time per annum.

In CNBC, G.I. Video endoscope was non-functional for a period of 135 days during the AMC period from January 2020. The hospital levied a penalty of ₹ 32,232 based on double the cost of CMC per day instead of double the daily running cost resulting in short levy of penalty amounting to ₹ 4,42,374.

Similarly, Anaesthesia work station used in OTs revealed that the equipment was non-functional for a period of 330 days during the warranty of five years

from 20 November 2015. Thus, the equipment suffered down time period in excess of stipulated norms during warranty, for which a penalty of ₹ 8.36 lakhs should have been imposed. However, no penalty was imposed on the supplier.

Government in its reply stated (December 2023) that CNBC has since recovered ₹ 6.42 lakh out of ₹ 12.78 lakh and the remaining amount was still pending for recovery.

Chapter V

Healthcare Infrastructure

Chapter V

Healthcare Infrastructure

The Government did not undertake a need based assessment to identify district-wise areas deficient in health care facilities. There was laxity in creation of healthcare facilities on allotted land due to lack of pursuance from land owning agencies. The aims and objectives of RGSSH and JSSH to provide medical treatment in all the envisaged super specialty branches and to provide medical infrastructure in the form of equipment and highly specialized diagnostic machines was not achieved, primarily due to defective policy of the Government which resulted in unavailability of requisite staff. Neither any assessment for remodeling work of existing Casualty Block nor any study to assess the requirement of more hospital beds/new building was conducted at LNH. There was delay in completion of various building and medical infrastructural projects in LNH. Bed population ratio was less than the ratio recommended by National Health policy, 2017. Dialysis Centre under PPP Mode in Delhi Government Hospitals and State Health System Resource Centre could not be set-up. 25 dialysis machines installed in Bhagwan Mahavir Hospital were not in use, out of this ten dialysis machines were shifted to another hospital and 15 machines were lying idle in the Hospital. ASHA workers could not get the facility of Mobile App for screening of non-communicable diseases as DSHM did not procure smartphones which were approved by the Governing Body in November 2019.

Government could not utilize the installed facilities for patient care in RGSSH. This resulted in blockade of Government money. At the same time, six modular OTs in RGSSH and all the seven modular OTs in JSSH were lying idle due to shortage of manpower to start various specialty services. There was lack of monitoring on the progress of the sanctioned work resulting in delay in completion of works.

5.1 Introduction

Health infrastructure is an important indicator for understanding the health care policy and welfare mechanism in a State. It signifies the investment priority with regards to the creation of health care facilities. Infrastructure has been described as the basic support for delivery of public health activities. To deliver quality health services in public health facilities, adequate and properly maintained building infrastructure and equipment are of critical importance.

Examination of records disclosed inadequacies in infrastructure, as discussed in the succeeding paragraphs.

5.2 Planning and Assessment of Infrastructure

Point 3.3.4 of National Health Policy (NHP) emphasized filling up of wide gaps in infrastructure development. Further, second report of Voluntary National Review (VNR) presented by NITI Aayog advocates Government efforts to revamp public health infrastructure through Ayushman Bharat Scheme. However, Ayushman Bharat Scheme was not implemented in Delhi.

GNCTD provides health care facilities relating to Primary, Secondary and Tertiary levels at its Diagnostic Centres, Dispensaries, Mohalla clinics, Mobile Health Centres, Hospitals and Polyclinics. Details of available health care institutions in Delhi as of March 2022 are given in **Table 5.1**.

Table 5.1: Details of health care institutions in Delhi

Sl. No.	Type of health care facility	Number of units	Level of health service provided
1	Dispensaries (Allopathic)	253	Primary and Secondary care
2	Dispensaries (Ayurvedic)	49	
3	Aam Aadmi Mohalla Clinics	517	
4	Dispensaries (Unani)	22	
5	Dispensaries (Homoeopathic)	108	
6	Polyclinics	28	
7	Mobile Health Clinic	8	
8	School Health Clinic	50	
9	Hospitals (27 district hospital + 7 super speciality + 4 AYUSH hospital + 1 jail hospital)	39	Secondary and Tertiary care

Source: Annual Report of Department of Health and Family Welfare – 2021-22

5.2.1 Distribution of GNCTD hospitals

There are 38 district/super speciality/AYUSH hospitals and one central jail hospital in Delhi under GNCTD. The district wise distribution of these 38 district/super speciality/AYUSH hospitals is given in **Table 5.2**.

Table 5.2: Distribution of Delhi Government Hospitals

Sl. No.	District	District hospitals	Super specialty hospitals	AYUSH hospitals.	Total
1	Central	4	2	0	6
2	East	2	0	0	2
3	New Delhi	0	1	1	2
4	North	4	0	0	4
5	North East	1	0	0	1
6	North West	5	0	0	5
7	Shahdara	2	3	0	5
8	South East	1	0	0	1
9	South West	3	0	2	5
10	West	4	1	0	5
11	South	1	0	1	2
Total		**27**	**7**	**4**	**38**

It can be observed that Hospitals were not evenly distributed in various Districts of Delhi. There was only one hospital each in North East and South East district.

In response (June 2022), DGHS stated that in near future, total 77,277 number of beds will be available in Delhi. The reply is out of context as the observation is regarding unequal distribution of Hospitals amongst districts.

It is clear from the above facts that no need based assessment was done by the Government to ensure equitable distribution of Health Care Infrastructure in Districts of Delhi.

Recommendation 5.1: The Government may undertake need based assessment of health care infrastructure to ensure its equitable distribution in Delhi.

5.2.2 Availability of beds against norms

The National Health Policy, 2017 recommends two beds per 1000 population. As per IPHS norms, one bed per 1000 population is an 'Essential' norm for every district while two beds per 1000 is a 'Desirable' target they should aspire towards. Further, the final number is influenced by its population, local epidemiology, burden of disease, community requirements, health-seeking behaviour of the population and contribution of private sector for each district. The 'Essential' number of beds in a district should be provided through the public health system of Tertiary care, Secondary care and Primary care.

The sanctioned beds capacity in Public/Private health institutions in Delhi (March 2022) is given in **Table 5.3**.

Table 5.3: Beds capacity sanctioned in Public/Private health institutions in Delhi

Sl. No.	Agencies	Institutions	Beds Sanctioned	Bed ratio[1]
1	Delhi Government	39	14,244	0.68
2	Municipal Corporation of Delhi	45	3,337	2.18
	New Delhi Municipal Council	2	221	
	Government of India (DGHS, CGHS, Railway, ESI, Army Hospitals, LRS Inst.)	19	9,544	
	Other Autonomous Bodies (Patel Chest Inst., IIT Hospital, AIIMS, NITRD (earlier LRS))	5	3,163	
	Private Nursing Homes/ Hospitals/ Voluntary Organizations	1,119	29,348	
Total		**1,229**	**59,957**	**2.86**

Source: Economic Survey of Delhi, 2021-22

In Delhi, bed population ratio as per beds available in Delhi Government hospitals was 0.68 (2021-22). Thus, Delhi Government did not achieve the desirable target of two beds per 1000 population as recommended under NHP.

Out of the total available beds of 59,957 in 1,230 hospitals, 29,348 beds constituting about 50 *per cent* were in 1,119 private institutions indicating that,

[1] Calculated by dividing sanctioned bed by total population in thousands.

in a large number of cases, people of Delhi have to depend on private healthcare institutions for medical care.

Recommendation 5.2: The Government may strive to raise the bed availability in Delhi Government Hospitals to two beds per thousand population in line with NHP 2017.

5.2.3 Availability and enhancement of beds in Government hospitals

The status of sanctioned beds vis-à-vis functional beds in GNCTD hospitals during 2016-17 to 2021-22 was as given in **Table 5.4**.

Table 5.4: Number of beds sanctioned and available in hospitals

Sl. No	Year	Number of hospitals	Beds sanctioned	Beds functional	Shortage of beds (in *per cent*)
1.	2016-17	38	11,308	10,184	9.94
2.	2017-18	38	11,353	10,520	7.33
3.	2018-19	38	11,770	10,646	9.54
4.	2019-20	38	11,814	11,052	6.45
5.	2020-21	39	12,603	11,541	8.43
6.	2021-22	39	14,244	13,214	7.23

Source: Annual reports of DGHS

District-wise sanctioned and availability of beds in 27 GNCTD hospitals (excluding four AYUSH, one Jail and seven Super specialty hospitals) is given in **Table 5.5.**

Table 5.5: District-wise sanctioned number of beds vis-à-vis availability of beds in 27 GNCTD hospitals (March 2022)

District	SS	Availability	Excess/shortage
South West	1,447	1,467	20
North	1,268	1,308	40
South	600	200	-400
South East	100	103	3
West	1,240	1,040	-200
Shahdara	1,771	1,809	38
Central	2,466	2,482	16
North East	210	210	0
North West	1,368	1,368	0
East	334	381	47
Total	**10,804**	**10,368**	**-436**

Examination of records revealed that in 10 out of 39 hospitals, number of functional beds was less than sanctioned as given in **Table 5.6**.

Table 5.6: Availability of beds against sanctioned beds

Sl. No.	Name of the hospital	Period	No. of beds sanctioned	Functional beds	Deficit in the number of beds
1.	Central Jail Hospital	2016-17	270	240	30
		2020-21	318	270	48
2.	Dr. N.C. Joshi Memorial Hospital	2016-17	100	100	--
		2020-21	100	60	40
3.	Guru Teg Bahadur Hospital	2016-17	1512	1456	56
		2020-21	1512	1448	64
4.	Institute of Human Behaviour and Allied Science	2016-17	500	336	164
		2020-21	356	236	120
5.	Institute of Liver and Billary Science (ILBS)	2016-17	180	151	29
		2020-21	549	284	265
6.	Janak Puri Super Speciality Hospital	2016-17	300	100	200
		2020-21	300	100	200
7.	Rajiv Gandhi Super Speciality Hospital	2016-17	650	60	590
		2020-21	650	500	150
8.	Burari Hospital	2020-21	768	320	448
9.	A&U Tibbia College and Hospital	2016-17	300	240	60
		2020-21	300	240	60
10.	Nehru Homoeopathic Medical College And Hospital	2016-17	100	89	11
		2020-21	100	60	40

Source: Annual Reports of DGHS

It can be seen that in Dr. N.C. Joshi Memorial Hospital and Nehru Homoeopathic Medical College and Hospital, the number of functional beds declined during the audit period whereas in Institute of Liver and Biliary Science (ILBS), the number of sanctioned beds increased without corresponding increase in functional beds. Thus, the Government could not make available adequate number of beds it considered necessary to provide medical facilities to general public.

Apart from the above, Government announced proposed addition of 10,000 beds and 15,000 beds in Budget speeches of 2016-17 and 2017-18 respectively by re-modelling its existing hospitals and establishing new institutions. Similarly, assurance was also given for addition of 7000 new beds in Budget speeches of 2019-20 and 2020-21. Audit noted that as against this budget announcement, there was addition of only 1,357 beds in GNCTD hospitals (including Autonomous Bodies) during 2016-17 to 2020-21.

Audit noted that due to not augmenting the number of beds in-line with the Budget announcement, in nine hospitals[2] (2018-19), the percentage of bed occupancy ranged between 101 and 189 *per cent.* Similarly, in seven hospitals[3] (2019-20), the bed occupancy ranged between 109 and 169 *per cent*.

[2] Baba Saheb Ambedkar, Babu Jagjivan Ram, Dada Dev, Deen Dayal Upadhyay, Guru Gobind Singh, Lal Bahadur Shastri, Lok Nayak, Madan Mohan Maliviya, Sanjay Gandhi Memorial hospitals

[3] Baba Saheb Ambedkar, Dada Dev, Guru Gobind Singh, Lal Bahadur Shastri, Lok Nayak, Madan Mohan Maliviya, Sanjay Gandhi Memorial hospitals

DGHS while accepting (June 2022) the facts, confirmed that only 1235 number of beds were added in Delhi Government Hospitals during 2016-17 to 2020-21.

Thus, it is evident that GNCTD failed in its planning and vision for providing optimum functional beds as assured in the budget speeches.

Recommendation 5.3: The Government may plan and execute its activities in a time bound manner to ensure maximum functional beds in its health care facilities.

5.2.4 Hospital beds for management of Covid

For management of Covid, GNCTD nominated Government/private hospitals and started Designated Covid Health Centres (DCHC) for meeting the demand for Covid treatment. The number of designated Government hospitals/centres and Covid beds were increased from time to time as per the details given in **Table 5.7**.

Table 5.7: Availability of hospital beds during Covid

Month	No. of GNCTD hospitals	No. of MCD hospitals	No. of DCHC	Total no. of Covid beds	Total no. of Covid beds with ICU
March 2020	9	0	0	1000	0
April 2020	6	0	0	2050	0
May 2021	13	0	0	7450	2070
July 2021	16	5	8	19225	5150
January 2022	14	0	8	8450	2075

In addition to the above, 14000 beds (including 4253 ICU beds) of private hospitals and 3775 beds (including 1191 ICU beds) of GoI hospitals were also earmarked for Covid treatment in July 2021 to meet the emergency situation.

5.2.5 Infrastructure development in respect of Delhi State Health Mission and Delhi State Health Society

(i) State Health System Resource Centre not set-up

Delhi State Health Mission (DSHM) was to set-up a State Health System Resource Centre (Centre) consisting of eight senior consultants and two fellows/interns for providing technical assistance to the Directorate of Family Welfare and DSHM in planning and implementing different policies and strategies. In a meeting of the Governing Body of Delhi State Health Society on 15 November 2016, it was decided to set up State Health System Resource Centre and the same was proposed in the Programme Implementation plan (PIP) 2016-17. The budget requirement was to be submitted to GoI as a part of PIP. However, the proposal was not approved by GoI as stated by the DSHM. Due to this, the same was not set up by the DSHM.

State Programme Manager, DSHM replied (March 2022) that the Centre could not be set up in the absence of approval of GoI.

Department did not furnish the reasons given by the GoI for not approving the proposal for setting up the centre. Thus, absence of the Centre deprived the Government of necessary assistance in planning and implementing different policies and strategies of National Health Mission.

(ii) Dialysis Centre under PPP Mode not set up

Governing body of DSHS approved (May 2017) setting up of Dialysis Centres under PPP Mode in Delhi Government Hospitals with creation of a dedicated PPP Dialysis Cell in the Department. Fund of ₹ 25.12 crore was approved by DSHS (September 2017/February 2018) for free dialysis of BPL patients with the direction to adhere to NHM guidelines for setting up new centres.

Setting up of Dialysis Units in six hospitals on PPP mode was awarded to an agency in January 2018 at ₹ 1,274 per session of dialysis. These centres were to be set up by 25 April 2018.

In this regard, Audit noted that -

- Centres were set up in five hospitals[4] between 14 May and 11 August 2018 after delays ranging from nine to 109 days.
- 25 machines installed at Bhagwan Mahavir Hospital could not be used due to in-appropriate water analysis report and machines were lying idle. SPO- Dialysis (PPP) stated (March 2022) that 10 of these machines have been shifted to Indira Gandhi Hospital, Dwarka.

(iii) Tablet computers for Auxiliary Nurse and Midwives (ANM) not procured

Governing Body of Delhi State Health Society decided (May 2017) to provide Mobile Tablets alongwith internet connectivity to ANMs to reduce their paperwork, easy tracking of beneficiaries and obtaining real time data. Accordingly, a proposal for procurement of Tablets and internet for 800 ANMs for eight months (remaining period of financial year 2017-18 from June 2017 to March 2018) with a total financial implication of ₹ 181.45 Lakh was approved and validated by GoI in Program Implementation Plan (PIP), 2017-18. It was observed that the Governing Body of DSHS revalidated the approval in January 2020, but the Tablets were not purchased as of August 2022. In the absence of procurement of Tablets even after five years of the approval (May 2017) by the Governing Body of the DSHS, the very purpose to provide facilities to ANMs for reducing the paperwork, easy tracking of beneficiaries etc. was defeated.

[4] Deendayal Hospital, Maharishi Balmiki Hospital, Deep Chand Bandhu Hospital, Pt. Madan Mohan Malviya Hospital and Bhagwan Mahavir Hospital

(iv) Smartphones for ASHAs not procured

Similarly, Governing body of DSHS approved (November 2019) procurement of smart phones and internet connectivity to 2,779 Accredited Social Health Activists (ASHAs). These Smart phones were to be used by ASHAs in Non-communicable Diseases App for screening and other Apps. The other purpose Smart phones was to eliminate the burden of converting manual records into digital records. The Governing Body also approved an amount of ₹ 289.02 lakh in 2019-20 for this purpose. Audit noted that Smart phones were not purchased by DSHS as of February 2022 even though more than 26 months had elapsed since it was approved by the Governing Body due to failure to finalise the bidder.

Due to non-procurement of Smartphones, ASHA workers could not avail the facility of Non-communicable Diseases App for screening and facility for converting of manual records into digital records.

In its reply, the Department stated (February 2022) that the number of smartphones have been revised to 2861 and the procurement of Smart Phones is under process.

To summarise, DSHM did not set up State Health System Resource Centre even though the Governing body of DSHS approved the same in November 2016. Absence of the Centre deprived the Government of necessary assistance in planning and implementing different policies and strategies of National Health Mission. Six Dialysis centres were to be installed by April 2018, but five centres were set up after delays and 25 dialysis machines could not be installed in Bhagwan Mahavir Hospital. DSHM did not procure tablets for ANMs even after the approval of Governing body in May 2017. DSHM did not procure smartphones for ASHA workers which were approved by the Governing Body in November 2019.

Recommendation 5.4: Efforts should be made for timely setting up of machines in Dialysis Centres for free dialysis to BPL patients and also for timely procurement of necessary equipment like Tablet computers for ANM and Smartphones for ASHAs for discharging their duties more efficiently.

5.2.6 Infrastructure development in respect of the selected hospitals

5.2.6.1 Rajiv Gandhi Super Speciality Hospital (RGSSH) and Janakpuri Super Speciality Hospital (JSSH)

Both RGSSH and JSSH were registered as Societies in September 2013. The primary mission of these Societies was to develop the Hospitals as Centres of Excellence in the field of curative, rehabilitative, palliative and preventive healthcare. Besides, the Hospitals were also to function as advanced centres for research and training in the field of medical sciences and were to be set up as state of the art teaching facilities for post-doctoral and post graduate levels. The

Hospitals were to establish referral centres in different areas of Delhi with the approval of Government.

The main source of funds for the Hospitals was Grant-in-Aid from the Government on the basis of Pattern of Assistance (PoA). Also, a viable business model for running these Hospitals was to be developed and reviewed from time to time by the Hospitals/Government.

In respect of RGSSH, Audit noted that:

- RGSSH was constructed with a built up area of approximately 61,198 Sq. metres at a cost of ₹ 153.68 crore in 2003 but completion certificate of the building was yet to be received from the competent authority due to pending work of fire check doors, Detailed Project Report of water pipeline, rain water harvesting etc.
- Approximately half of the total built up area of the hospital building was lying unutilized as patient care departments/specialities like Rheumatology, Nephrology, Clinical Haematology, Bone Marrow Transplant and Nuclear Medicine were yet to start.
- Six modular/semi-modular Operation Theatres (OT), Stone Centre, Transplant ICU and Wards, Kitchen, 77 private/special rooms, 16 ICU beds, 154 general beds and Resident's Hostel Rooms were not functional (July 2022) as can be seen in **Picture 5.1**. Mortuary and Rapid Response Centres were made functional only in 2020-21.

Picture 5.1: Infrastructure lying idle in RGSSH

- Against the proposed bed strength of 650 beds, 250 beds were approved for functioning in the first phase starting from November 2015. It was observed that only 64 beds were operational till September 2017. Thereafter, the bed strength was increased from time to time to 250 beds as of July 2022.

- Academic and Research activities as envisaged in the Memorandum of Association (MoA) of the Society were not undertaken. It has neither started Post graduate and Post-doctoral teaching facilities nor opened any referral centres at different part of Delhi as envisaged in the MoA.

- Governing Council (GC) had met only five times and Finance Committee had met three times during the period from November 2013 to June 2022 against the requirement of quarterly meetings indicating that the apex bodies responsible for administering and controlling the affairs of the Hospital were not functioning as required. There were delays in finalising policies for user charges, recruitment and pay and allowances of doctors and other staff although these were under discussion by the Governing Body since 2013. However, it was noticed that the recruitment policy of doctors was finally adopted at par with AIIMS in the meeting held in January 2020. Although, GC decided to implement user charges at CGHS rates in January 2016, the same was not implemented.

As regards JSSH, Audit noted that -

- JSSH had not undertaken Academic and Research activities, as envisaged in the MoA.

  The Government stated (December 2023) that Post Graduate Course in Cardiology (2 seats) has been started in the year 2022 and two research activities in Cardiology and Neurology are being processed.

- Governing Committee had met only nine times and Finance Committee had met six times from September 2013 to March 2023 against the requirement of quarterly meetings indicating that affairs of the hospital were not being given adequate direction and guidance.

- Against a proposed bed strength of 300 beds, only 100 beds were operational from February 2015 to 2020-21 and the bed occupancy ranged from 20 *per cent* to 40 *per cent* during the same period.

- Seven Modular OTs, kitchen, blood bank, emergency, Medical Gas Pipeline System, 10 CCU beds and 200 general beds were not operational/available during the audit period.

Audit is of the view that underutilisation of built up facilities in RGSSH and JSSH were mostly due to shortage of manpower as these Hospitals had not

implemented the policy to recruit permanent staff against the sanctioned posts. There were 50 to 74 *per cent* shortage of doctors, 73 to 96 *per cent* shortage of Nursing staff and 17 to 62 *per cent* shortage of paramedical staff during the audit period.

As per MoA between the Government and the Hospitals, Doctors who were also Teaching Faculty were to be recruited for five years. GNCTD fixed remuneration for the teaching faculty in July 2014 as ₹ 1.25 lakh, ₹ 1.65 lakh and ₹ 2.00 lakh for Assistant professors, Associate Professors, and Professors respectively and continued it without a change for six years till August 2020. There was no provision for promotion and career progression to attract teaching faculty for super tertiary level treatment. This lacuna in policy of GNCTD resulted in shortage and inconsistency in the availability of doctors to run super speciality departments like Cardiology, Pulmonology, Gastroenterology, GI surgery, Urology, CTVS etc. It was observed that instead of revising the contractual terms and conditions and enhancing remuneration, hospitals started recruiting teaching faculty for one year and thereafter extension for one year and so on. When it did not get sufficient responses even for one year, doctors (teaching faculty, SRs and JRs) were recruited through walk-in interview for three months and then extension for three-three months.

Government, in its reply, intimated (December 2022) that Diplomate of National Board (DNB) courses have since been started in three seats in RGSSH. Further, the infrastructure in RGSSH is lying idle due to unavailability of man power even after repeated advertisements. In case of JSSH, it was stated that academic and training activities have now been started. It was further stated that Kitchen Services and Emergency Services have been started at a basic level from 8 AM to 4 PM. The fact remains that RGSSH and JSSH could not provide Super Specialty tertiary care as envisaged in the MoA due to weak monitoring and failure to develop a viable business model.

Thus, weak monitoring of the Government, as evident from the fact that very few meetings of Governing Council and Finance Committee, coupled with failure to develop a viable business model to generate user charges and to ensure consistent work force resulted in under-utilisation of facilities in RGSSH and JSSH depriving the needy patients of Super Specialty health care facilities.

5.2.6.2 Non-availing of Hostel facility by Senior Residents/Junior Residents

Residency scheme for Senior Residents/Junior Residents (SR/JR) vide No.S.11014/3/91-ME (1), Ministry of Health & Family Welfare, Government of India envisaged that Resident Doctors will be provided with free furnished accommodation and they will be required to be on-call duty not exceeding 12 hours at a time. Further, Para 14 of the offer of appointment to the post of SR/JR stated that they have to work under the residency scheme, applicable from time to time.

Audit however, observed that Resident Medical Officer (RMO) hostel was constructed for accommodating SRs/JRs at the premises of RGSSH in October 2015. There were 54 Senior Residents and 48 Junior Residents working (April 2022) at the hospital, but none of them were staying as out of 130 rooms available 92 rooms were used as office/store and the remaining 38 rooms were lying vacant. Hence, the purpose of constructing the hostel for accommodating the SRs/JRs in the interest of Patient Care has been defeated as per the Residency Scheme.

In JSSH, Residence hostel has not been constructed for accommodating SRs/JRs at the premises of the hospital. However, a proposal has been approved by the Governing Council as informed by the hospital (August 2022).

Recommendation 5.5: The Government may take steps to ensure that the built up facilities in its two super specialty hospitals viz. Rajiv Gandhi Super Specialty Hospital and Janakpuri Super Speciaity Hospital are put to use.

5.2.6.3 Lok Nayak Hospital (LNH)

(i) Planned assessment for remodelling work of existing Casualty Block in LNH not done

A proposal for remodelling of existing Casualty block of LNH consisting of seven floors was approved by the Expenditure Finance Committee (EFC) on 8 March 2019 with increase in number of beds from 384 to 574. The work was awarded at a cost of ₹ 39.23 crore and started on 15 December 2019 with stipulated date of completion as 14 March 2021. The date of completion was later changed to July 2023 due to delay in handing over of site and slow progress of work. As per Financial progress Report, 35 *per cent* of funds were expended (January 2023). Audit observed the following deficiencies in planning and execution of the project:

- Detailed reports for the actual assessment of the number of beds required in the under-construction Emergency/Casualty block were not furnished to Audit.
- Plans to utilise existing medical equipment/facilities after remodelling was not prepared.
- Proposal for requirement of additional medical equipment and manpower including specialists was not prepared.
- Against the requirement of 80 sqm of gross floor area per bed (as per clause 13.1 of Unified Building Bye Law, 2016), the re-modelling has been planned with area per bed of 36.18 sqm.

Department did not offer any comment.

(ii) Study to assess the requirement of more hospital beds in new building at LNH not conducted

The work of Construction of New Block for Medicine, Maternity and Advanced Paediatric Centre at LNH with 1,570 beds was approved by the EFC in March 2019 at a cost of ₹ 465.52 crore. The work was started on 4 November 2020 and was under progress (June 2022). As per the information provided, 60 *per cent* civil work has been completed.

Audit noted that -

- The Department/Hospital had not assessed the requirement of beds/new building in the hospital complex with respect to the population of the area. Other activities which need to be synchronized with the completion of new block viz. approval of man power, purchase of equipment etc. was not done.
- Against 80 sqm of gross floor area per bed required (as per clause 13.1 of Unified Building Bye Law, 2016), the new building has been planned with an area per bed of 54 sqm which was against the norms and would be inadequate.

Government replied (December 2022) that the process for purchase of equipment and assessment of manpower will be initiated shortly.

Thus, the Government neither ensured undertaking of assessment for remodelling work of existing Casualty Block nor conducted any study at LNH to assess the requirement of more hospital beds/new building.

5.2.7 Acquisition of land for creation of Health Care Facilities

DGHS, GNCTD is also responsible for acquiring land for creation of health care facilities, viz. Dispensaries, Public hospitals, etc. On receipt of allotment letter from the land owning agency, the status of land with respect to its being encumbrance/litigation free is obtained by DGHS from the land owning agency. The DGHS also issues Administrative Approval and Expenditure Sanction to Public Works Department (PWD)/DUSIB etc. for payment of land cost to land owning agency. Thereafter, the process of taking possession and building health care facility on the acquired land is initiated by the executing agency.

Audit noted the following deficiencies on the part of DGHS/PWD:

Possession not obtained after allotment of land

a) In one case, despite allotment of land at village Harewali for construction of a dispensary in May 2012, DGHS did not issue sanction for land costing ₹ 37.47 lakh for want of confirmation of status of land from land owning agency. Although correspondence was made with the land owning agency in this regard, it was at lower level and the matter was not escalated to higher level and no correspondence was made after February 2015.

b) In six other cases[5], DGHS had issued AA&ES of ₹ 485.70 lakh to PWD (May 2012 and March 2015) but it had not obtained status of payment to the land owning agency by PWD. Further, there were delays in subsequent follow-up with PWD in ascertaining payment status due to which possession of allotted land could not be taken over. The Government informed (December 2022) that in one case[6], status of payment was received from PWD on 25 March 2022. For remaining cases, it assured regular follow-up with PWD.

c) Further, in nine cases[7], despite allotment of land (between January 2012 and March 2015) and payment of ₹ 5153.43 lakh to land owning agencies, DGHS failed to take possession of allotted pieces of land due to delayed correspondence (one to three years) with land owning agencies for handing over them. The Government submitted (December 2022) that in one case[8], possession of the plot was taken over from DDA in March 2022 and assured to ensure regular follow-up with concerned land owning agencies for remaining cases.

d) In three cases[9], despite allotment of seven Bigha of land by land owning agency on 'No Cost Basis' (between August 2012 and August 2015), DGHS was unable to take possession of land from land owning agencies. Correspondence with the land owning agency for possession of the allotted land was not made available to Audit due to which Audit could not ascertain reasons for delay.

Thus due to lack of coordination between DGHS and the executing agency (PWD), DGHS did not have details such as confirmation of land free from encroachment, payment to land owning agencies, possession of land, etc.

Utilisation of acquired plots not done by the Department

The Department was unable to utilize any of the 15 plots[10] acquired (June 2007 and December 2015) at a cost of ₹ 648.05 lakh for establishing hospitals and dispensaries, despite having them in its possession for periods ranging between six to 15 years.

Audit noted that development of health care facilities on acquired land could not be achieved due to delays in taking decisions in construction of Dispensary/Polyclinic, inadequate pursuance with the land owning agency for

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5 (i) Mangolpuri Industrial Area (ii) Trilokpuri (2 Plots) (iii) Sawda Ghevra (iv) Madanpur Dabas (v) Salahpur Majra

6 Payment of ₹ 106.67 lakh for plot measuring 1403.15 sqm at Sawda Ghera Phase-II

7 (i) Rohini (2 plots) (ii) Model Town (iii) Shahbad Daulatpur (iv) Narela (v) Nasirpur (vi) Sawda Ghevra (vii) Trilok Puri (viii) Bakhtawarpur

8 Possession of land (1000 sqm) costing ₹ 76.02 lakh at Shahbad Daulatpur

9 (i) Vill. Chandpur (ii) Vill. Salahpur Majra (iii) Vill. Madanpur Dabas

10 (i)Kutubgarh (ii) Nijampur (iii) Mundka (iv) Bakkarwala (v) Shafipur Ranholla (vi) Shastri Park (vii) Gandhi Vihar (viii) Kapashera (ix) Rohini Ext. (x) Dariyapur Kalan (xi) CS/OCF-2, Sector 23 (xii) Neb Sarai (xiii) Jhatikara (xiv) Bamnoli (xv) Molarband

alternate land in case of land falling under green belt, not obtaining demarcation and approval of layout plans from the authorities concerned **(Annexure V)**. The Government informed (December 2022) that there was no change in the status of above mentioned plots.

Thus, lackadaisical approach of the Department led to idling of plots meant for augmentation of health care facilities at various locations of Delhi, thereby depriving people of Delhi with the much needed medical facilities.

Recommendation 5.6: The Government needs to co-ordinate with Health Department/PWD and land owning agencies so that the acquired plots are used for creating health care facilities in a time bound manner.

5.2.8 Delay in execution of projects

Status of construction of new hospitals as well as major works executed in test checked hospitals is provided in the succeeding paragraphs.

5.2.8.1 Construction of new hospitals

Construction of hospitals is undertaken by the Directorate General of Health Services of Department of Health and Family Welfare (DHFW) and the works are executed by Public Work Department of GNCTD. Out of the eight new hospitals which were under construction/taken up during the audit period, three were completed and four were under progress (August 2023). Status of one of the hospital (Ambedkar Nagar Hospital with 600 beds) was not provided to Audit. The details of status of construction of seven new hospitals is provided in **Table 5.9**.

Table 5.9: Construction of New Hospitals of GNCTD

Sl. No.	Name of Delhi Government Hospital	No. of Beds	Tendered Cost (₹ in crore)	Date of Start	Stipulated date of completion	Actual date of Completion	Total Exp. Till date (₹ in crore)	Physical progress of work (in %)
1.	Construction of Hospital at Madipur	691	269.71	11.11.20	10.11.22	WIP	178.43	86
2.	Construction of Hospital at Jwalapuri	691	269.50	14.08.20	13.08.22	WIP	191.73	87
3.	Construction of Indira Gandhi Hospital (700 beds) at Dwarka Sec-9	1241	522.49	27.08.14	26.02.17	31.08.22	837.39	100
4.	Construction of Hospital at Hastsal	691	211.12	17.06.21	16.06.23	WIP	64.48	39
5.	Construction of Hospital at Siraspur	1505	384.40	10.08.20	09.05.23	WIP	284.83	74
6.	Construction of 200 (now 800) bedded hospital at Burari	800	95.15	07.02.13	06.08.15	20.07.21	136.41	100

Sl. No.	Name of Delhi Government Hospital	No. of Beds	Tendered Cost (₹ in crore)	Date of Start	Stipulated date of completion	Actual date of Completion	Total Exp. Till date (₹ in crore)	Physical progress of work (in %)
7.	Extension of Maulana Azad Dental Institute Phase II	0	51.21	29.09.14	28.05.16	30.09.19	77.57	100
	Total	**5619**	**1803.58**				**1770.84**	

Source: Information provided by the Department

Audit observed the following:

(i) Two hospital projects (Indira Gandhi Hospital at Dwarka and Burari Hospital) started in August 2014 and February 2013 have been completed with delays of five to six years. Delay is attributed to increase in the scope of work due to enhancement of number of beds.

(ii) Construction of Maulana Azad Dental Institute Phase II, started in September 2014, was completed with a delay of more than three years and with a cost escalation of 51.47 *per cent*.

(iii) Construction of Jwalapuri hospital (691 beds), Madipur Hospital (691 beds), Siraspur Hospital (1505 beds) and Hastsal Hospital (691 beds) were going on with delays of more than two months to one year from the stipulated date of completion with physical progress of 87 *per cent*, 86 *per cent*, 74 *per cent* and 39 *per cent* respectively. Delay is attributed to stoppage of work during Covid, site constraints etc.

(iv) It was noticed that no new hospital construction was taken up during the period from 2015-16 to 2019-20.

In addition to the above, GNCTD took up two new projects for construction of Semi-permanent/temporary ICU hospitals. Two projects, (i) setting up of Semi-permanent / Temporary ICU Hospitals at Shalimar Bagh (1430 beds), Kirari (458 beds) and Sultanpuri (527 beds) and (ii) Setting up of Semi-permanent/ Temporary ICU Hospitals at Sarita Vihar (336 beds) and Raghubir Nagar (1577 beds) started in September 2021 with date of stipulated completion as 22 February 2022 were still under progress with physical progress of 76 *per cent* (Shalimar Bagh and Sultanpuri sites), 83 *per cent* (Sarita Vihar) and 49 *per cent* (Raghubir Nagar). The work of ICU hospital at Kirari with 458 beds had not yet started (August 2023).

5.2.8.2 Status of execution of works at selected Hospitals

As per clause 2.8 CPWD Works Manual, the Administrative Department/ Ministry shall be kept informed at regular intervals about the stages of progress of work so that the client's observations, if any, could be responded to before the work is completed. On completion of the work, the Administrative Department should be intimated of the same and formal handing over arranged in writing.

Financial and Administrative Sanction for carrying out 153 works costing ₹ 59.23 crore in LNH, 46 works costing ₹ 40.67 crore in RGSSH, 60 works costing ₹ 16.9 crore in JSSH, 78 works costing ₹ 18.46 crore in CNBC and 74 works costing ₹ 23.96 crore in Maulana Azad Medical College (MAMC) were issued during the audit period.

Audit noted that there was delay in completion of works in 110 (48 *per cent*) out of 227 sanctioned works in LNH and MAMC during the audit period. Maximum delay was two years. It was also noticed that the work of renovation of Department of Pulmonary Medicine of LNH was not undertaken after sanction of work due to unavailability of site. As the hospitals did not provide complete information, the reasons for delay could not be ascertained.

Government replied (November 2022) that the client departments regularly monitor the works executed by PWD. The fact remains that there were delays in execution of works in 48 *per cent* cases in LNH and MAMC.

A few test checked cases in respect of selected hospitals are discussed below:

(a) Delay in establishing Tertiary Care Cancer Centre (TCCC) in LNH

The broad objective of the Centrally Sponsored Scheme, National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS), was to develop capacity for Tertiary care for cancer in all States so as to provide universal access to comprehensive cancer care. GoI approved a total Grant-in-Aid (GiA) of ₹ 39.82 crore (June 2016) and released ₹ 29.87 crore till December 2017 for purchase of equipment as detailed in **Table 5.10**.

Table 5.10: Equipment for which GIA was approved

(₹ in crore)

Sl. No.	Name of Equipment	Recommended as per ceiling price
1	High End Dual Energy Linear Accelerator with IMRT/ IGRT/ SRS/ SRT/ SBRT on turnkey basis with treatment planning system	24.00
2	CT Simulator	6.00
3	C Arm	1.00
4	Additional Accessories	2.00
5	QA Tools + Physics Equipment	2.50
6	TPS	1.50
7	Navigation based endoscopic system for ENT	1.00
8	High definition laparoscopic sets	1.00
9	Harmonic scalpels	0.50
10	Fully automated Coagulation Analyser	0.17
11	Fully automated Dry Chemistry Analyser	0.15
Total		**39.82**

Source: MoHFW, GoI, approval of Grant in Aid

Out of these equipment, LNH could procure and install only one equipment till August 2022 (CT Simulator in October 2019) at a total cost of ₹ 6.59 crore. Thus, LNH could not establish the TCCC in spite of being provided with funds for the same by GoI and as a result, cancer patients of Delhi were deprived of better treatment facility.

The Government replied (November 2022) that work of procurement of Linear Accelerator was delayed due to delay in finalisation of specifications, tender process and starting of turnkey work for installing the machines. Further, the Department intimated (December 2022) that Linear Accelerator has been installed in LNH and the funds allocated has been fully utilized and the facility of TCCC will be operational shortly.

The fact remains that there was delay in procurement though the process was started in November 2016 and complete funds were received from GoI in December 2017.

(b) Delay in installation of Modular Operation Theatre in LNH

Administrative Approval and Expenditure Sanction of ₹ 35.30 crore for supplying, installation, testing and commissioning of modular operation theatre and medical gas pipeline system in Orthopaedic Department of LNH including Emergency Trauma Services and Intensive Care beds was accorded in November 2019. Thereafter, it took almost 23 months to complete the process of Technical sanction and appointment of Consultant (October 2021) by PWD. Tender for the work has been invited in November 2022.

(c) Delay in installation of Medical Gas Pipeline JSSH

The work of installation of Medical Gas Pipeline System (MGPS) in JSSH was awarded to an agency in November 2016 with date of completion as 21 June 2017 and ₹ 5.72 crore was given to the agency in advance in November 2016.

Audit noted that the MGPS work was completed in only May 2022, after a delay of more than five years and the same was not handed over to JSSH till July 2022.

JSSH stated (August 2022) that the project has been completed by the vendor and same would be vetted by the consultancy firm and a Technical Committee of experts would be constituted for Physical Inspection and Technical Evaluation for commissioning the project.

(d) Delay in installation of Modular Operation Theatre in JSSH

A proposal for installation of seven Modular Operation Theaters (MOT) was approved (two in July 2014 and five in March 2016) by the Governing Council of JSSH. The work was awarded (May 2017) on turnkey basis for ₹ 11.86 crore to be completed within 270 days. Audit noted that MOT had not been installed till date, i.e. even after five years.

JSSH stated (July 2022) that there was delay in completion of the project and that the project has now been completed and a Technical Committee of experts has also been constituted for Physical Inspection and Technical Evaluation for commissioning of Operation Theatre complex.

(e) Kitchen facilities in RGSSH and JSSH not utilised

Picture 5.2: Kitchen in RGSSH lying idle

Audit observed that PWD had installed a modular kitchen in RGSSH since 2017 with all the equipment such as vegetable cutters, peelers, pulverisers, grinders, burners, chillers, digital thermostat, chapatti makers, refrigerated display, air washers etc. However, it had not been taken over by RGSSH and was lying idle due to a conflict between hospital and PWD for pending payment of ₹ 1.50 crore, causing wastage and blockage of Government money.

Area of the JSSH hospital earmarked for hospital kitchen had been taken over by the Delhi State Cancer Institute in the year 2012 under the orders of H&FW Department, GNCTD and was taken back by JSSH in June 2021 and thus hospital area was not available with them to provide dietary services.

Government replied (December 2022) that the kitchen in RGSSH has been taken over from PWD and tendering is in process for running the kitchen. Further, in case of JSSH, kitchen facilities had been started in June 2022.

f) Encroachment of Hospital and Medical College premises

As per IPHS Guidelines, there shall be no encroachment in and around hospitals. Audit observed that LNH premises and surrounding areas were encroached by unauthorised shops and vendors leading to congestion on approach roads.

In addition to the above, approximately 5.65 acres out of 122 acres of MAMC area was under encroachment by 1047 houses. MAMC has informed (28 July 2022) that a proposal for relocation of JJ Clusters on encroached land is under process.

Government replied (November 2022) that the hospital has taken up the matter with MCD and Delhi Police for removing the encroachments. Further, it has taken up the matter with DUSIB for expediting relocation of slum.

g) Upgradation of infrastructure in the Nursing College of LNH not done

The Nursing College at LNH had an annual intake of 43 to 56 students during 2016-17 to 2021-22. Procurement of ACs, Smart Board, Computers, LCD Projectors, etc were pending for the last two years. Resultantly, classrooms were running without audio visual facilities as the existing systems were too old to repair and were not functioning for the last three years. Besides, CCTVs were not installed in the college. There was no ACs in Lecture halls/Classrooms.

Recommendation 5.7: The Government needs to closely monitor all ongoing works to avoid delay in completion of healthcare infrastructure. Besides, it should also ensure that healthcare infrastructure created are fully utilized.

Chapter VI

Financial Management

Chapter VI

Financial Management

Financing is increasingly being recognized as an area of major policy relevance to achieve Universal Health Coverage (UHC). Appropriate Health Financing is a means to ensure adequate funds for health care, provide equitable access to all population groups and reduce barriers to utilize health services. National Health Policy, 2017 envisages increasing health expenditure by Government as a percentage of GDP to 2.5 *per cent* by 2025. Against this, the expenditure of GNCTD on public health as a percentage of GSDP ranged from 0.65 *per cent* to 0.79 *per cent* during 2016-17 to 2021-22. There were huge savings against budget allocation during the audit period (2016-2022), especially in infrastructure projects, which indicates unrealistic budget estimates, shortcomings in planning and delay in execution of works.

There were many instances of delay in releasing funds from State treasury to the implementing agency which is Delhi State Health Mission (DSHM). It was also noticed that DSHM could not even utilize the released fund as evident from the fact that ₹ 510.71 crore was lying unspent in the bank accounts of Delhi State Health Society (DSHS) and its 11 IDHSs. There were delays in submitting Utilization Certificates against Central fund.

There was under-utilization of budget (₹ 245.11 crore out of ₹ 787.91 crore) provided under India Covid-19 Emergency Response and Health preparedness package.

In respect of four selected hospitals, under-utilization of funds during 2016-17 to 2021-22 ranged between 13.14 to 34.95 *per cent* in Lok Nayak Hospital, 9.4 to 49.88 *per cent* in Rajiv Gandhi Super Specialty Hospital, 6.1 to 10.42 *per cent* in Janakpuri Super Specialty Hospital and 6.31 to 27.31 *per cent* in Chacha Nehru Bal Chikitsalaya.

6.1 Introduction

Finances for health infrastructure and management of health services in the State are sourced through the State budget. Government of India provides funds under Centrally Sponsored Schemes (CSS). Details of budget allocation, expenditure and savings against the funds provided by Government of India and GNCTD during 2016-17 to 2021-22 is given in **Table 6.1**.

Table 6.1: Budget allocation and expenditure on Health Sector (GoI and Government of Delhi)

(₹ in crore)

Budget allocation to the State for Centrally sponsored schemes				Government of Delhi			
Year	**Funds released**	**Expenditure**	**Savings**	**Total budget provision**	**Expenditure**	**Savings**	**Savings (in *per cent*)**
2016-17	231.72	Details of expenditure out of Central funds are not being maintained by DSHM	NA	5,238.71	4,008.24	1,230.47	23.49
2017-18	208.72		NA	5,710.45	4,735.91	974.54	17.07
2018-19	135.51		NA	6,699.96	5,482.03	1,217.93	18.18
2019-20	108.38		NA	7,498.22	5,756.96	1,741.26	23.22
2020-21	846.71		NA	7,652.78	6,314.31	1,338.47	17.49
2021-22	70.45		NA	9,870.25	9,016.97	853.64	8.64

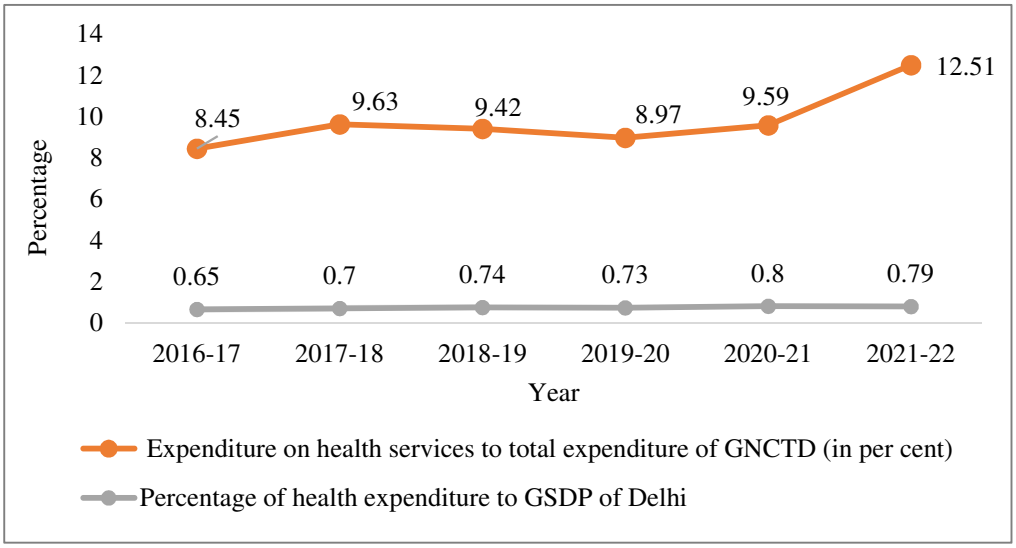
Source: Delhi Budget Speech and information furnished by Department

6.2 Expenditure on Health Sector by the State vis-a-vis National Health Policy norms

Paragraph 2.4.3.1 of NHP 2017 envisages increase in the health expenditure by Government as a percentage of GDP from the existing 1.15 *per cent* to 2.5 *per cent* by 2025 and increase State sector health spending to more than eight *per cent* of their budget by 2020.

The graph below indicates the percentage of the State expenditure on Health sector to GSDP of GNCT of Delhi and its total expenditure.

Chart 6.1: Expenditure on Health by Delhi Government to the Total Expenditure of State/GSDP



Source: Annual Reports and Information furnished by the Department.

From **Table 6.1**, it is seen that Government spending on health sector has increased from ₹ 4,008.24 crore (8.45 *per cent* of total expenditure of State) in 2016-17 to ₹ 9016.97 crore (12.51 *per cent* of total expenditure of State) in 2021-22. Against the target of raising public health expenditure to 2.5 *per cent* of the GDP (by 2025), the expenditure on health by the State Government increased from 0.65 *per cent* (2016-17) of the GSDP to 0.79 *per cent* (2021-22)

of GSDP. As such, there is still scope for the Government to increase public expenditure on Health Sector. It was also noticed that Government has not prepared any roadmap to increase the expenditure on Health Sector.

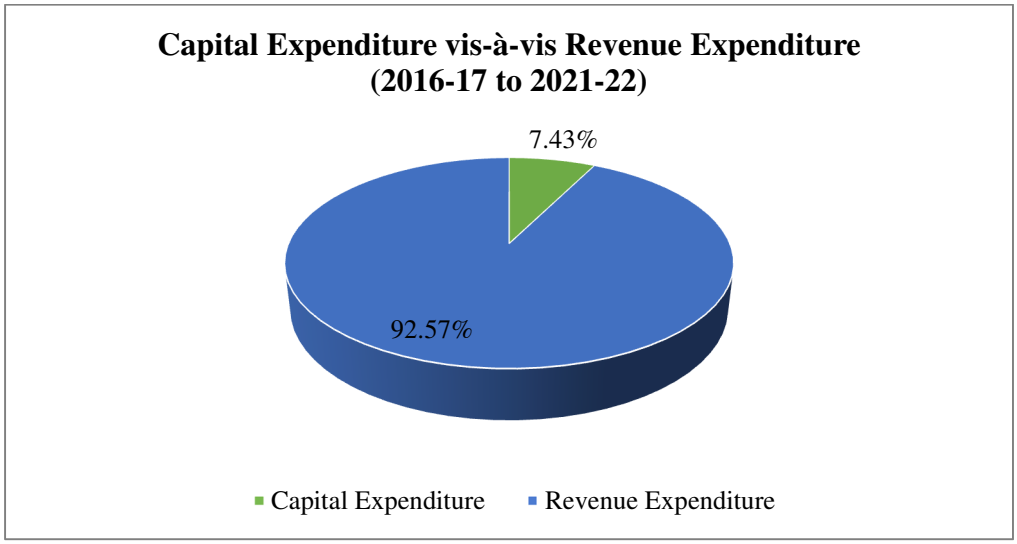
Government did not offer any comment in its reply dated 13 December 2023.

6.3 Revenue and Capital Expenditure

Revenue expenditure includes establishment expenses, Grants-in-aid to various Institutions (NHM, AYUSH, etc.), expenditure on training programmes, immunisation Programme, family planning programmes, Employees State Insurance Scheme, various schemes/ programmes of State/ Central Government, assistance to other Non-Governmental Institutions, purchase of medicines, etc. Capital Expenditure includes construction/ major repairs of buildings of Health institutions, acquisition of land, etc.

Out of the total expenditure of ₹ 35,314.42 crore incurred on health during 2016-22, Revenue Expenditure was ₹ 32,691.07 crore (92.57 *per cent*) while Capital Expenditure was ₹ 2623.35 crore (7.43 *per cent*) as indicated in **Chart 6.2**.

Chart 6.2: Capital Expenditure vis-à-vis Revenue Expenditure



6.4 Expenditure on Health infrastructure

The Department had allocated budget ranging from ₹ 518.26 crore to ₹ 1440.50 crore for different projects relating to healthcare infrastructure during the period 2016-17 to 2021-22 as detailed in **Table 6.2**.

Table 6.2: Budget allocation and actual expenditure for infrastructure projects

(₹ in crore)

Year	Budget Allocation	Actual expenditure	Saving	Percentage of saving
2016-17	625.49	337.04	288.45	46.12
2017-18	518.26	235.78	282.48	54.51
2018-19	706.24	152.48	553.76	78.41
2019-20	746.7	249.45	497.25	66.59
2020-21	866.5	399.58	466.92	53.89
2021-22	1440.50	1249.02	191.48	13.29

Source: Consolidated budget and expenditure of Health Department

It can be seen from the **Table 6.2** that during 2016-17 to 2021-22, 13.29 *per cent* (2021-22) to 78.41 *per cent* (2018-19) of allocation on health infrastructure remained unutilised.

6.5 Financial provision and management of Centrally Sponsored Schemes (CSS)

Audit examined provision of funds for health care services and its management with respect to CSS and deficiencies noticed are as follows:

6.5.1 Flow of funds

Delhi State Health Society (DSHS) prepares a Programme Implementation Plan (PIP) in line with the broad guidelines provided by MoH&FW, GoI. NHM was 100 *per cent* sponsored by the Central Government, but with effect from 2018-19, Central and State Governments provides 60:40 shares respectively to DSHS.

The status of funds received and expenditure incurred by DSHM during 2016-17 to 2021-22 is given in **Table 6.3**.

Table 6.3: Status of fund received and expenditure by DSHM

(₹ in crore)

Financial Year	Unspent balance	Received from GoI	Released by GNCTD	Other income (interest etc.)	Total Grant available	Actual Expenditure	Adjust-ment etc.	Unspent balance at the end of the year
i	ii	iii	iv	V	vi (ii+iii+iv+v)	viii	vii	ix (vi – vii-viii)
2016-17	109.44	231.72	47.87	32.82	421.85	140.88	22.74	258.23
2017-18	258.23	208.72	0.00	8.95	475.90	182.13	2.00	291.77
2018-19	291.77	135.51	70.00	6.78	504.06	134.08	0	369.25
2019-20	369.25	108.38	104.17	7.82	590.35	154.57	0	435.05
2020-21	435.05	83.47	100.80	12.26	631.58	213.02	0	418.56
2021-22	418.57	70.45	125.91	9.10	624.04	177.52	5.24	510.71[1]
Total		**838.25**	**448.75**	**77.73**		**1002.2**	**29.98**	

Source: Annual accounts of DSHM and figures furnished by DSHM

The total expenditure during 2016-22 was ₹ 1002.2 crore and ₹ 510.71 crore was lying unspent in the bank accounts of DSHS and its 11 IDHSs (31 March 2022).

[1] Include unspent Central Share of ₹ 398.72 crore and State Share of ₹ 111.99 crore

Reasons for under-utilisation of funds were vacancies in various posts of contractual/outsourced staff approved under NHM, shortfall in conducting trainings, workshops, outreach activities etc., delay in approval of activities and shortage of staff in NLEP programme, shortfall in 'Monitoring, Evaluation & Supervision' activities under National Vector Borne Disease Control Programme (NVBDCP) etc.

Audit findings relating to implementation of selected Centrally Sponsored Schemes are covered under Chapter VII of this Report.

6.5.2 Delay in remittances of funds to Delhi State Health Society

MoH&FW, GoI issues sanction orders for NHM programmes to the Pr. PAO, GNCTD under National Health Mission for further remittance to the Delhi State Health Society. The Department of Economic Affairs, Ministry of Finance, has fixed (October 2017) the rate of interest that should be claimed by the State Health Society in cases of delay in transfer of funds from the State treasury for more than 15 days.

Scrutiny of Annual Accounts of DSHS for the year 2020-21 revealed that ₹ 29.93 crore was kept by the Pr. PAO and remitted to DSHS with delays ranging from 81 to 104 days as detailed in **Table 6.4**.

Table 6.4: Delay in remittance of funds to DSHS

(₹ in crore)

Year	Programme /head in which fund released by the Government of India	Date of credit from RBI to State Treasury	Date of Credit in Delhi State Health Society	Amount	Number of days delay released funds by the State Government to DSHS
2020-21	RCH	20.10.2020	1.2.2021	0.75	104 days
		20.7.2020	9.10.2020	3.02	81 days
		1.3.2021	23.6.2021	0.30	114 days
	HSS NRHM	20.7.2020	9.10.2020	17.38	81 days
		20.10.2020	1.2.2021	4.35	104 days
		2 .3.2021	23.6.2021	0.82	113 days
		15.3.2021	23.6.2021	0.45	100 days
	Other Health System Strengthening-NUHM	6.11.2020	12.2.2021	2.86	98 days
Total				**29.93**	

Delay in releasing funds to DSHS resulted in funds remaining unspent in 2020-21. Further, DSHS did not claim any interest from the Pr. PAO, GNCTD for delayed remittance of funds.

6.5.3 Delay in submission of Utilization Certificate to MoW&CD, GoI

As per the MoU signed between the Ministry of Health and Family Welfare, GoI and Department of Health and Family Welfare, the Utilization Certificates for the funds released for National Health Mission are to be submitted within the period stipulated in GF Rules, 2017.

DSHS was required to submit UC in respect of funds received in the preceding financial year in the month of July.

Audit revealed that there were delays in submission of UCs by DSHS from 23 to 187 days during the years 2016-21. Reasons for delay were stated to be delay in consolidation of accounting data and Covid-19 pandemic. In the absence of UCs, Audit could not verify whether the funds were utilized for the purpose they were sanctioned for.

Government did not offer any comment in its reply dated 13 December 2023.

6.6 Utilisation of fund received from Central Government for Covid-19

Under Emergency Covid Response Plan, GNCTD received total funds of ₹ 787.91 crore (Lump sum amount of ₹ 24.67 crore, ₹ 292.22 crore in first phase and ₹ 471.02 crore in the second phase) from GoI. Out of this, GNCTD utilised only ₹ 542.84 crore (November 2021) as per details given in **Table 6.5**.

Table 6.5: Budget allocation and expenditure for Covid

(₹ in crore)

Sl. No.	Purpose	Total amount released	Expendi-ture	Balance (+) Unspent (-) Excess	Significant savings (in *per cent)*
1	Lump-sum amount released during 2019-20	24.67	0	24.67	100
2	Diagnostics including Sample Transport	371.06	302.15	68.91	18.57
3	Drugs and supplies including PPE and masks	119.85	36.71	83.14	69.37
4	Equipment/facilities for patient care including support for ventilators etc.	108.69	134.05	- 25.36	-
5	Human Resources (including incentives for Community Health Volunteers)	52.00	21.48	30.52	58.69
6	Mobilities Support	33.70	39.20	-5.50	-
7	IT Systems including Hardware and software etc.	11.30	4.26	7.04	66.37
8	IEC/BCC	6.93	0.73	6.20	-
9	Training	0.42	0.25	0.17	-
10	Miscellaneous	61.11	4.00	57.11	93.45
Total		**787.91**	**542.84**	**245.07**	

It can be seen from the above table that percentage savings under several heads were significant. The reasons for under-utilization of funds for implementation of the programme Covid-19 Emergency Response and Health System Preparedness Package are awaited.

As regards expenditure related to COVID-19 by selected Hospitals, Audit observed that NHM had released a sum of ₹ 55.47 crore and ₹ 31.18 crore during the year 2020-21 to LNH and RGSSH respectively for dealing with Covid Pandemic. RGSSH received additional grant of ₹ 8.25 crore during 2021-22. These funds were mainly utilized for procuring equipment, consumables, accommodation of doctors and other staff, kitchen items, transportation, manpower outsourcing etc. during the COVID period. LNH and RGSSH utilized ₹ 54.18 crore and ₹ 31.05 crore respectively from the grant received during 2020-21.

RGSSH has not shown GIA received from Delhi State Health Mission and expenditure against the same separately from details of regular GIA received/expenditure of the hospital in its accounts. Further, separate Stock Registers or Inventory Records were not maintained in either of the hospitals against procurement and distribution of various items (Drugs, PPE kits, masks, gloves, medical equipment etc.) out of NHM funds. As such, Audit could not verify the expenditure incurred against the NHM fund.

6.7 Delay in release of funds for Covid-19 Vaccination

The Ministry of Health and Family Welfare (MoH&FW), GoI conveyed sanctions for Grants-in-Aid under the head "COVID-19 Vaccination" to the Department of Health and family Welfare, GNCTD for further remitting it to the Delhi State Health Society (DSHS). The Income and Expenditure Account (2020-21) of the DSHS and relevant sanction orders revealed that MoH&FW released Grant in-Aid of ₹ 9.60 crore in two instalments, ₹ 3.46 crore in January 2021 and ₹ 6.14 crore in March 2021 to the DoH&FW, GNCTD under the head "COVID-19 Vaccination" but these funds were released to DSHS in April and May 2021 only.

DSHS had remitted the funds to the Integrated District Health Societies for further distribution. As per utilisation certificate, ₹ 7.93 crore out of ₹ 9.60 crore remained unspent as of March 2022.

6.8 Under-utilisation of funds by the test checked Hospitals

Year-wise release and expenditure of funds during 2016-17 to 2021-22 pertaining to test checked hospitals were as shown in the **Table 6.6**.

Table 6.6: Utilisation of funds by selected hospitals

(₹ in crore)

	2016-17	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**2021-22**
LNH						
Budget Allocation	362.64	437.19	508.48	531.79	606.97	730.69
Expenditure	345.64	416.46	473.53	496.59	563.21	717.55
Savings	17	20.73	34.95	35.2	43.76	13.14
RGSSH						
Grant received + Unspent GIA of previous year	51.40	56.74	71.06	70.47	114.28	110.39
Expenditure incurred	36.66	40.68	61.66	20.18	78.89	77.70
Savings	14.74	16.06	9.4	49.88	35.39	32.69
JSSH						
Grant received + Unspent GIA of previous year	56.53	45.24	52.1	54.3	40.81	45.28
Expenditure incurred	28.79	39.14	37.3	32.49	30.09	34.86
Savings	27.74	6.1	14.8	21.81	10.72	10.42
CNBC						
Grant received + Unspent GIA of previous year	76.23	85.13	104.08	99.81	89.94	99.93
Expenditure incurred	64.1	65.05	76.77	79.12	83.63	91.08
Savings	12.13	20.08	27.31	20.69	6.31	8.85

Source: Information provided by the Hospitals

It can be seen from **Table 6.6** that the test checked Hospitals were unable to utilize total available funds during 2016-17 to 2021-22. There was underutilization of allotted funds to the tune of 13 to 71 *per cent* in RGSSH, 13 to 49 *per cent* in JSSH, seven to 26 *per cent* in CNBC and two to seven *per cent* in LNH.

6.9 Absence of separate budget head for drugs

Standard Operating Procedure on Pharmacy of the Department envisages that "The health facility must specify the budget for drugs under a separate head, "Budget for Drugs". Audit noted that in respect of Lok Nayak Hosptial, budget for drugs was subsumed under the head Supplies & Materials which also covered equipment, surgical consumables, stationery, kitchen items and ration etc. The remaining three selected hospitals receive Grant-in-Aid from the Department under Salaries, General and Capital Asset Heads only. It was therefore, not possible for Audit to segregate expenditure made against purchase of drugs and other items.

CNBC in its reply (August 2022) admitted that its accounts branch was maintaining the records only under three specific heads under which budget has been allotted in the form of Grants-in-Aid.

Government did not offer any comment in its reply dated 13 December 2023.

***Recommendation 6.1: State Government may increase the expenditure on health services to 2.5 per cent* of GSDP in a time bound manner.**

Recommendation 6.2: The Mission Director, DSHM may ensure optimum utilisation of funds received under various National Health Programmes through effective implementation and monitoring.

Chapter VII

Implementation of Centrally Sponsored Schemes

Chapter VII

Implementation of Centrally Sponsored Schemes

The GNCT of Delhi was one of the States selected for implementation of the programme of National Health Mission. The key strategy of NHM was to bridge gaps in health care facilities, facilitate decentralized planning in the health sector and provide an overarching umbrella for the existing programmes of the Health and Family Welfare Department.

It was observed that enough efforts have not been made by the Delhi State Health Mission (DSHS) to achieve the goals and objectives of the Projects/programmes of National Health Mission Scheme as funds approved for programmes of NHM were not fully utilised.

Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCH+A) is the most important component/programme under National Health Mission (NHM) for improvement of Maternal and Child Health care.

It was observed that coverage for providing free diet and other facilities (free diagnostic) to pregnant women under Janani Shishu Suraksha Karyakram (JSSK) was inadequate. Maternal Death Review (MDR) which is an important strategy to reduce maternal mortality was inadequately conducted.

It was noticed that post-natal check after 14 days of delivery was not done in most cases during 2016-21. Audit observed that target of 100 *per cent* child immunization was not achieved. The Health Management Information System (HMIS), which serves as a tool for monitoring the performance of health systems, was found containing inconsistent and erroneous data and thus, did not represent actual status of implementation for proper monitoring of the programme. DSHS had not established 44 Tobacco Cessation Centres approved for the purpose of counselling common people to help them quit tobacco consumption. During 2016-17 to 2020-21, DSHS did not implement National Mental Health Programme as no expenditure was incurred despite availability of funds.

7.1 Introduction

Health being a State subject, the Central Government supplements the efforts of the State Governments in delivering health services through various schemes of Primary, Secondary and Tertiary care. Central Sector and Centrally Sponsored Schemes (CSS) are extended to the States by the Union Government under Article 282 of the Constitution.

Government of India (GoI) launched the National Rural Health Mission (NRHM) in April 2005. The National Urban Health Mission (NUHM) launched in May 2013 was subsumed as a sub-mission along with NRHM

under Nation Health Mission (NHM). The main objective of NHM was to provide equitable, affordable, reliable and effective health care facilities to poor and vulnerable sections of the population. NHM laid emphasis on reductions in Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR), while carrying forward the Government's efforts in the field of prevention and control of communicable, non-communicable as well as endemic diseases with the involvement of community in planning and monitoring of the Schemes. The key strategy of NHM was to bridge gaps in health care facilities, facilitate decentralized planning in health sector and provide an overarching umbrella for the existing programmes of Health and Family Welfare Department of the State including Reproductive and Child Health-II and various disease control programmes.

7.2 Organizational Set-up

At the State level, Delhi State Health Mission (DSHM) launched in 2006 and headed by the Chief Minister of Delhi, follows the guidelines of the NHM, GoI and implements various health programs of NHM in Delhi. The activities under the NHM are carried out through the Delhi State Health Society (DSHS), an autonomous body of DSHM, which serves as an additional managerial and technology capacity for implementation of health programs under overall aegis of NHM.

DSHS has a Governing Body and an Executive Committee chaired by Principal Secretary of the Department and the Mission Director, NHM as its Member Secretary. The State Programme Management Unit (SPMU) acts as secretariat to DSHS and is headed by the Mission Director. There are 11 Integrated District Health Societies (IDHSs) in Delhi. District Collector is the chairperson and Chief District Medical Officer (CDMO) is the Member Secretary of each IDHS.

7.3 Funding Pattern

The Ministry of Health & Family Welfare (MoHFW), GoI provides a resource envelope to support the implementation of an agreed Delhi State Programme Implementation Plan (PIP) submitted by the GNCTD to the Centre. Delhi State PIP is the aggregation of eleven District Health Action Plans including activities to be carried out at State level. The Central and State share of Centrally Sponsored Schemes/programmes under NHM was 60:40 from 2018-19 but prior to 2018-19, NHM was fully funded by GoI. Grant-in-aid from GoI is transferred by the GNCTD to the account of DSHS for smooth implementation of programmes under NHM as per government approved operational guidelines.

7.4 Pattern of Assistance

Pattern of Assistance governs the Grants-in-Aid from Government and other assistance in any form to DSHS, which has to be utilized for various functions

as enumerated in the Memorandum of the Association (MoA) and Rules DSHS. MoHFW and Department of Health and Family Welfare (Department), GNCTD signed (May 2019) a Memorandum of Understanding (MoU), revised from time to time, valid upto May 2022. As per the MoU, Delhi State Health Mission (DSHM) is responsible for implementation of the programs/activities envisaged under the Mission. DSHM was also to ensure that funds made available to support the agreed State PIP under this MoU are used for financing the State Program Implementation Plan and for routine expenditure that are the responsibility of the State Government.

7.5 Reproductive, Maternal, New-born Child and Adolescent Health (RMNCH+A)

Reproductive, Maternal, New-born Child and Adolescent Health (RMNCH+A) is the most important component/programme under NHM for improvement of Maternal and Child Health care. The Programme includes maternal health, child health and family planning services. The aim of the programme is that every pregnant woman (PW) receives care at delivery, deliveries are institutional and other family planning services are provided.

7.5.1 Funds received and expenditure under RCH Flexipool

RMNCH is funded through RCH Flexible Pool which is one of the components of NHM funding. During 2016-17 to 2021-22, out of total funds of ₹ 164.35 crore available for RMNCH to GNCTD, ₹ 94.98 crore (57.79 *per cent)* remained unutilized. Underutilization of funds ranged from 58.90 *per cent* (2016-17) to 93.03 *per cent* (2019-20) indicating that GNCTD was not implementing the programme adequately. It was also noticed that Closing balance (2018-19) did not match with Opening balance of next financial year (2019-20) in the accounts of DSHS.

During 2016-17 to 2017-18, against the available funds of ₹ 403.92 lakh, only ₹ 40.67 lakh (10.07 *per cent*) was utilised under training component.

The Department replied (March 2022) that due to COVID 19, many hospitals were converted to COVID hospitals, hence regular and preventive child health services were affected. It also stated that human resource is critical and their recruitment was an issue in running the programme.

Reply was not acceptable, as the situation was the same during the period prior to pandemic also.

7.5.2 Maternal Healthcare

Maternal health care package with its focus on health of women during pregnancy, childbirth and post-partum was a vital component of NHM due to its profound effect on the health of women, immediate survival of the new-born and long-term well-being of children. Key strategies to improve maternal health included improved access to skilled obstetric care through

facility development, increased coverage and quality of antenatal and postnatal care, increased access to skilled birth attendance, institutional delivery, etc. The Delhi Government is implementing various programmes i.e. Janani Suraksha Yojana (JSY), Janani Sishu Suraksha Karyakram (JSSK), Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) and LaQshya[1] etc. for achieving maternal health.

7.5.3 Strategic interventions under maternal healthcare

Strategic interventions for maternal healthcare are discussed in the following paragraphs.

a. Ante Natal Care (ANC)

Guidelines for Antenatal Care and Skilled Attendance at Birth, 2010 issued by MoH&FW, GoI aimed to provide four ANCs to all registered pregnant women for ensuring proper investigations like haemoglobin, blood grouping, urine examination, administration of two doses of Tetanus Toxoid (TT) and providing 100 Iron Folic Acid (IFA) tablets. The first ANC was to be provided within 12 weeks, second within 14-26 weeks, third within 28-34 weeks and fourth check-up within 36 weeks up to term of pregnancy to monitor the progress.

The position of ANC registration and services provided in Delhi during April 2016 to September 2022 as per Health Management Information System (HMIS) portal are as shown in **Table 7.1**.

Table 7.1: Antenatal Services provided to PW

Year	Total Pregnant Women (PW) registered for ANC	Number of PW Registered within first trimester (12 weeks)	Number of PW received four ANC checkups	Number of PW not received four ANC checkups	Pregnant women who received TT1	Pregnant women who received TT2	Pregnant women who received 100 IFA tablets
2016-17	9,93,842	3,25,393	5,63,171	4,30,671	2,87,858	2,52,056	5,24,760
2017-18	9,82,022	3,25,818	3,61,594	6,20,428	2,86,564	2,28,339	4,41,010
2018-19	9,31,041	3,35,500	4,07,668	5,23,373	2,97,500	2,35,993	4,77,566
2019-20	7,21,322	3,27,469	4,07,582	3,13,740	2,32,814	1,85,663	4,68,981
2020-21	5,35,699	2,36,122	2,86,493	2,49,206	2,08,543	1,58,210	4,30,465
2021-22	462620	211345	319256	143364	248712	193422	378351
2022-23 (upto Sept. 2022)	270703	119879	184685	86018	146783	122289	204707
Total	**48,97,249**	**18,81,526**	**25,30,449**	**23,66,800**	**17,08,774**	**13,75,972**	**29,25,840**
Percentage		**38.42**	**51.67**	**48.33**	**34.89**	**28.10**	**59.74**

Source: Health Management Information System (HMIS)

It can be seen from **Table 7.1** that out of 48.97 lakh registered pregnant women, 23.67 lakh (48.33 *per cent*) were not provided all four ANC during April 2016 to September 2022. Further, 18.82 Lakh (38.42 *per cent*) women

[1] Labour room quality improvement initiative

had registered within the first trimester of pregnancy. There was shortfall in percentage of women who received Tetanus Toxoid (TT) shots as only 34.89 *per cent* and 28.10 *per cent* women had received TT-1 and TT-2 respectively. Similarly, 59.74 *per cent* pregnant women had received 100 Iron folic acid tablets during April 2016 to September 2022.

Audit observed that Department was not able to keep track of pregnant women who were registered for ANC and ensure whether all of them received stipulated quantum of ANC check-ups, TT and IFA tablets at timely interval.

The Department stated (July 2022) that the reason for shortfall was due to multiple registration of pregnant women for ANC at two or more facilities. It further stated that all the facilities have been instructed to report registered ANC pregnant women on HMIS portal.

Reply is not acceptable as the Department should have ensured entry of unique record of pregnant women registered for ANC in the system.

Recommendation 7.1: The Government should ensure that all registered pregnant women are followed-up for complete ante-natal care and post-natal check-up. Besides, TT vaccine and IFA tablets should be provided to all registered pregnant women.

b. Testing of pregnant women for HIV and STIs/RTIs infections

The RMNCH+A Guidelines issued by GoI (January 2013) identified parent-to child transmission of Human Immunodeficiency Virus (HIV) as a major route for new and emerging HIV infections in children and suggested universal confidential HIV screening of PW to be included as an integral component of routine ANC check-up. Sexually Transmitted Infections (STIs) and Reproductive Tract Infections (RTIs) are associated with a number of adverse pregnancy outcomes including abortion, stillbirth, preterm delivery, low birth weight, postpartum sepsis and congenital infection. Therefore, STI/RTI management must be linked to pregnancy care. Audit observed that out of 48.97 lakh PW registered for ANC check-ups during April 2016 to September 2022, 17.72 lakh (36.18 *per cent*) and 9.26 lakh (18.91 *per cent*) were tested for HIV and STIs/RTIs respectively during April 2016 to September 2022. Audit noted that 7,720 instances of pregnant mothers afflicted with HIV were detected during the period. The possibility of more such cases escaping detection due to non-testing of PW could not be ruled out.

The Department stated (July 2022) that the reason for shortfall in HIV & RTI testing is due to duplication/triplication of same PW getting registered at two to three facilities.

Reply is not acceptable as the Department should have ensured entry of unique record of pregnant women registered for ANC in the system.

Recommendation 7.2: All registered pregnant women should be screened for HIV and RTI/STI tests.

c. Caesarean Section Deliveries

As per WHO, C-sections are effective in saving maternal and infant lives, but only when they are required for medically indicated reasons. The ideal rate for C-Sections should be between 10 and 15 *per cent*. As per NFHS – 5 (2019-21), national average of C-sections deliveries was 21.25 *per cent*. Further, C-section deliveries at private institutions were on higher side (42.8 *per cent*) as compared to those at public health facility centres (17.7 *per cent*).

As per HMIS portal, during April 2016 to September 2022, against 15.94 lakh institutional deliveries, the percentage of C-Section deliveries was 31.67 *per cent*. The variation in percentage ranged between 29.19 *per cent* (2017-18) and 34.66 *per cent* (2021-22).

The Department stated (July 2022) that health facilities were instructed to avoid unnecessary caesarean section. It further stated that caesarean section audit guidelines have been disseminated to all public and private facilities for them to conduct audit and share the report every month. However, Department had not attached the copy of the said guidelines and the date on which the guidelines were issued.

d. Discharging of mothers within 48 hours of delivery and Post Natal Care

As part of Post Natal Care (PNC), a PW has to stay for minimum 48 hours after delivery. NRHM guidelines also provide that the first 48 hours of the post-partum[2] period followed by first one week are the most crucial period for the health and survival of both the mother and the new-born. In all cases, at least three postnatal visits to the mother and six postnatal visits to the new-born are to be made within six weeks of delivery/birth. In case of home based delivery, the first visit should take place within twenty-four hours of birth. In case of institutional deliveries, second and third visit should occur on third and seventh day after delivery.

The status of post-partum check-up of mothers during April 2016 to September 2022 is shown in **Table 7.2**.

[2] A Postpartum (or postnatal) period begins immediately after the birth of a child and extends for about six weeks, as the mother's body, including hormone levels and uterus size, returns to a non-pregnant state by that time.

Table 7.2: Status of Post-partum check-up of mother

Period	Total deliveries (Home + Institutio-nal)	Number of Institutional Deliveries conducted (Including C-Sections)	Out of total institutional deliveries number of women discharged within 48 hours of delivery	Women receiving 1st post-partum check-up between 48 hours and 14 days	Women receiving 1st post-partum check-up between 48 hours and 14 days (in *per cent)*
2016-17	271514	255017	99065	168874	62.20
2017-18	271991	260117	110520	171179	62.94
2018-19	283717	271485	110124	149479	52.69
2019-20	286281	275161	107041	142984	49.95
2020-21	206603	195481	82631	78265	37.88
2021-22	227936	217255	90350	78165	34.29
Up to Sept 2022	123602	119643	46609	37634	30.45
	1671644	**1594159**	**646340**	**826580**	

Source: HMIS portal

From **Table 7.2**, it can be seen that

- out of 15.94 lakh cases of reported institutional deliveries during April 2017 to September 2022, mothers were discharged within 48 hours of delivery in 6.46 lakh cases (40.54 *per cent).*
- out of 16.71 lakh deliveries, only 8.27 lakh (49.45 *per cent*) mothers received post-partum check-up between 48 hours and 14 days after delivery.

According to National Rural Health Mission guidelines, the first 48 hours after delivery are the most critical in the entire post-partum period. Most of the major complications of the post-partum period, such as postpartum hemorrhage and eclampsia, which can lead to maternal death, occur during this period. Thus, due to inadequate hospital facilities, medical care of mother and the new born especially during the 48 hour post-delivery in all cases could not be ensured.

The Department stated (July 2022) that due to high bed occupancy rate in hospitals, there was doubling of women with their new-born on one bed and to avoid an increased risk of infection for mothers and new-born, the health facilities were discharging mothers within 48 hours of delivery for non-high risk deliveries. It also stated that hospitals have been instructed to discharge women after 48 hours of delivery.

As per RCH portal, during 2016-17 to 2021-22, only 55,015 PW (2.92 *per cent*) received all the prescribed PNC check-ups out of 18.88 lakh women registered for PNC whereas 6.29 lakh (33.35 *per cent*) women registered for PNC did not receive any PNC. Thus, Department was not able to keep track of women registered for PNC and did not ensure that all of them received stipulated quantum of PNC check-ups at timely interval.

e. Home based deliveries not attended by trained health professional

Government of India (GoI) considers a Skilled Birth Attendant (SBA) to be a person who can handle common obstetric and neonatal emergencies and is able to timely detect and recognise when a situation reaches a point beyond his/her capability, and refers the woman/new born to an appropriate facility without delay. SBA is defined as a trained health professional for conducting deliveries e.g. Doctor/Nurse/Auxiliary Nurse and Midwife (ANM) whereas Non-SBA includes Trained Birth Attendants, relatives, etc.

NFHS-5 report also noted that home births conducted by skilled health personnel[3] reduced to 2.3 *per cent* during 2019-21 from 3.6 *per cent* in 2015-16. Further, Home Based New-born Care (HBNC) stipulates home visit by ASHA for early detection of disease and promoting hygienic practises.

As per HMIS portal, during April 2016 to September 2022, out of 77,485 home based deliveries, only 2,076 (2.68 *per cent)* were attended by SBA.

Thus, home based deliveries under hygienic conditions and under the supervision of Skilled Birth Attendant (SBA) were not being ensured.

The Department stated (July 2022) that SBAs are available in the community at the time of delivery, but in most cases, Dais were conducting delivery for such clients, therefore, is recorded as non-SBA.

Reply confirms the fact that in most cases, deliveries were attended by Dais who may not have adequate training to deal with various complications that may arise during childbirth.

f. Low birth weight (LBW) babies

WHO defined Low Birth Weight (LBW) babies as infants with a birth weight of 2,499 grams or less. At the National Level, average LBW is 12.4 *per cent*. As per programme guidelines, low birth weight (LBW) are more likely to have impaired growth, higher mortality and risk of chronic adult diseases.

RCH programme under NHM provides *inter alia* screening of pregnant women for anaemia and Iron Folic Acid (IFA) supplementation, Calcium supplementation etc. during pregnancy.

The status of ANCs to all registered pregnant women has been discussed in para 7.5.3 (a) wherein only 59.74 *per cent* pregnant women had received 100 Iron folic acid tablets during April 2016 to September 2022.

As per HMIS portal, during April 2016 to September 2022, 3.55 lakh (22.10 *per cent)* out of 16.06 lakh weighed at birth were born with LBW. Percentage of LWB during the said period ranged between 19.60 *per cent* (2017-18) to 26.04 *per cent* (2021-22).

[3] Doctor/nurse/LHV/ANM/midwife/other health personnel.

It can be seen that LBW hovered around 22 *per cent* which was more than the national average of 12.4 *per* cent which indicates that the efforts of GNCTD in ensuring proper care to PW was inadequate.

The Department stated (July 2022) that instructions have been issued to all facilities to conduct nutritional counselling, testing haemoglobin levels of all PWs and linking undernourished PW to nearest Anganwadis for nutritional support/dietary supplement.

g. Maternal Death Review (MDR)

Maternal Death Review (MDR) is an important strategy to improve the quality of obstetric care and reduce maternal mortality. Every health facility is required to conduct death audit of all deaths happening in the facility and send the reports to CMO of the district concerned. The MDR Committee of CMO is required to review all the reports and take adequate steps to prevent such deaths wherever possible in future. The status of maternal death review during 2016-21 is shown in **Table 7.3**.

Table 7.3: Status of maternal death review

Period	Number of maternal deaths reported during the period	Maternal Deaths reviewed by District MDR Committee of CMO	Percentage of Maternal Death Reviewed
2016-17	508	262	51.57
2017-18	584	354	60.62
2018-19	610	230	37.70
2019-20	603	339	56.22
2020-21	517	216	41.78
2021-22	638	332	52.04
2022-23 (upto Sep 22)	317	250	78.86
Total	**3777**	**1983**	**52.50**

Source: Information furnished by Department

As can be seen only 1983 (52.50 *per cent*) of the maternal deaths occurred in Delhi during April 2016 to September 2022 were reviewed. In the absence of comprehensive review of maternal deaths, Government was not in a position to institute measures to prevent maternal deaths due to similar reasons in future.

The Department stated (August 2022) that all districts conduct MDR regularly under the chairmanship of CDMO within their permissible limits. Further, the staff working in the districts and at facilities were involved in Covid related activities in Financial Year 2020-21.

The reply is not acceptable as percentage to MDR review prior to COVID-19 ranged between 37.70 *per cent* (2018-19) to 60.62 *per cent* (2017-18) only.

7.5.4 Implementation of schemes

Audit of various programme/schemes under NHM are discussed below:

7.5.4.1 Janani Suraksha Yojana

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under NHM being implemented since 2005 with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among PW below poverty line, SC PW, ST PW etc. This scheme integrated cash assistance with delivery and post-delivery care. As per Guidelines, the cash assistance of ₹ 700/- under JSY was admissible only to mothers belonging to BPL families who hailed from rural areas and ₹ 600/- to those from urban areas in Delhi, being a high performing State.

During the period 2016-21, only 50,975 PW (54 *per cent)* were registered under JSY for benefits against target of 94,000. Percentage of PWs registered against the target during the said period ranged between 27 *per cent* (2020-21) to 72 *per cent* (2016-17).

Overall, only 51 *per cent* of the budget was utilized during 2016-17 to 2020-21. Percentage utilization of funds during the said period ranged between 23 *per cent* (2020-21) to 70 *per cent* (2017-18).

Department stated (March 2022) that deserving people belonged to migratory population and they did not have complete documents such as Bank account, Aadhaar card etc. It also stated that due to change in payment to DBT mode, the district and facility staff including account personnel's were not conversant in making payment via PFMS Portal and the JSY registration could not be boosted much in view of the very low amount of incentive.

Audit also analysed the data in selected three districts, which revealed that -

- Only 254 (5.32 *per cent*), 5,372 (5.72 *per cent*) and 1821 (3.23 *per cent*) PW were identified as beneficiaries to be paid incentives against 4,772, 93,897 and 56,405 deliveries reported in South-East, North-West and New Delhi districts respectively during 2018-19 to 2020-21.
- Out of 254, 5,372 and 1,821, only 18 PW, 773 and 72 PW belonging to South-East, North-West and New Delhi Districts respectively got incentives during the period 2018-19 to 2020-21. The reason for not paying the incentive under the scheme was not found in the reports.

Thus, the reply is not acceptable as the Department failed to provide financial support even to the identified beneficiaries. Moreover, the staff deployed at the facilities were not made conversant for streamlining the payment through PFMS. This showed lackadaisical attitude of the Department towards disadvantaged people.

7.5.4.2 Janani Shishu Suraksha Karyakram (JSSK)

JSSK, launched in June 2011, is an initiative to assure cashless services including normal deliveries, C-sections, and treatment of sick new-born (upto 30 days after birth) to all PW in all public health institutions. The entitlement

for PW under JSSK included zero expense delivery including C-section, free drugs and consumables, free diagnostics, free diet during stay in health institutions, free provision of blood, free transport facilities from home to health institutions and drop back from health institutions.

a. Out of pocket expenditure per delivery under JSSK

The objective of the JSSK scheme was to provide free and cashless service to all PW and sick neonates accessing public health institutions. As per National Family Health Survey-5 (NFHS-5) report for the period 2019-21, the out of pocket expenditure per delivery in Public health Centres (urban areas) in Delhi was ₹ 2,577.

The Department stated that out of pocket expenditure per delivery was ₹ 8,518 during 2015-16 which declined to ₹ 2,548 in 2019-21.

Fact remains that the objective of providing PW free delivery in public health institutions including cases of Caesarean section could not be achieved.

b. Free diet and other facilities to PW

The success of the scheme depends on the knowledge of entitlements of the service seekers and the capacity of the state to deliver service commitments. Total number of PW registered as per HMIS portal for ANC for the period 2016-17 to 2020-21 was 41.64 lakh, out of which only 12.50 lakh beneficiaries[4] (30 *per* cent) benefited by availing free services such as diet, transportation, drug and consumable etc.

Overall, only 22 *per cent* and 70 *per cent* beneficiaries availed free transport and free diet facilities respectively. Percentage of beneficiaries who availed free transport during the said period ranged between 14 *per cent* (2019-20) to 28 *per cent* (2018-19) and who got free diet ranged between 63 *per cent* (2018-19) to 80 *per cent* (2016-17).

The Department stated (March 2022) that PW are provided a number of services during their antenatal services and during delivery services i.e diet, drugs and consumables, blood transfusion, diagnostics and transport. Therefore, so much record keeping for each individual PW and sick infant is practically not feasible by health facilities for each service. Thus, they provide an approximate figure in proportion to PW registered for ANC and deliveries conducted by health facilities.

c. Inconsistency of data in JSSK Scheme

As per Annual Reports for the years 2017-18 to 2020-21, 9.83 lakh beneficiaries got free drugs and consumables and 6.62 lakh got free diet. However, as per HMIS portal, only 7.59 lakhs and 5.37 lakhs beneficiaries

[4] As per annual report of JSSK.

availed free drugs and consumables and free diet respectively. The same data inconsistency was found in diagnostic services as well.

The Department stated (March 2022) that it is making efforts for uniformity in submission of report.

d. Complaints/grievance cases under JSSK

Grievance redressal guidelines issued by Ministry of Health and Family Welfare, GoI *inter alia* stipulates setting up a health helpline system through help desks, call centre and web portal. As per Annual Reports, no complaints/ grievance related to free entitlements was received during 2016-21. It shows that either State and District level JSSK/RCH Nodal officers were not reporting grievances cases or the Department did not create and disseminate information about the redressal mechanism, if any, amongst general public.

The Department stated (March 2022) that Delhi Government is making all efforts to provide free services under JSSK scheme. If any complaints received from PW or her relative at any facility, they are addressed there and then.

Audit is of the view that even if the complaints are addressed, they need to be analysed for systemic deficiencies and corrective action and therefore, proper records need to be maintained in this regard.

7.5.4.3 Pradhan Mantri Surakshit Matritva Abhiyan programme

The Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) was launched by MoH&FW in June, 2016. PMSMA provides for fixed day assured, comprehensive and quality antenatal care universally to all pregnant women (in 2nd and 3rd trimester) on the 9th of every month. While antenatal care is routinely provided to pregnant women, special ANC services are provided by OBGY specialists/ Radiologist/ Physicians at government health facilities under PMSMA. One of the critical components of the Abhiyan is identification and follow-up of high risk pregnancies and red stickers are added on to the Mother and Child Protection cards of women with high risk pregnancies.

a. State and District Level meetings not conducted under PMSMA Programme

As per operational framework for PMSMA, preparatory activities included establishment of State and District Level Coordination Committees and regular meetings were required to be conducted to spearhead the programme in the right direction. Audit observed that although the State Level Committee was constituted in May 2016, only one meeting was conducted (May 2016) during the years 2017-18 to 2020-21 and no meeting was held at District level. Thus, there was no state and district level coordination and monitoring of the scheme.

The Department stated (July 2022) that all districts were instructed (June 2016) to identify District PMSMA Nodals for constitution of a District Level Committee and names were to be shared with the Government. It further stated that details of District Level Committee were not shared by districts.

This shows lack of monitoring for ensuring compliance on the instructions issued by Department.

b. Coverage of PW under the scheme

As per information furnished by the Department, total 3.82 lakh PW were registered under PMSMA. As per guidelines, one ultrasound is recommended for all PW during 2nd/3rd trimesters of pregnancy. The percentage of PW who underwent USG test on the fixed day during the period 2016-17 to 2020-21 ranged between 8.84 *per cent* (2019-20) to 16.56 *per cent* (2018-19).

During 2016-17 to 2020-21, Audit noted that 16,557 (4.33 *per cent*) out of 3.82 lakh PW registered under PMSMA were identified as high-risk PW. The percentage variation of high risk PW identified during 2016-17 to 2020-21 ranged between 1.61 *per cent* (2018-19) to 10.74 *per cent* (2020-21). Out of 16,557 identified high risk PW, details of only 7164 cases (44.75 *per cent*) were shared with respective ANMs and ASHAs of different blocks of urban areas for follow up.

As regards to the shortfall in the percentage of women who received USG on the fixed day, Department stated (July 2022) that if USG is conducted in routine antenatal clinics by facilities, the number of USGs will automatically decrease.

The reply is not convincing as no information regarding actual number of PWs who underwent USG at routine antenatal clinics was furnished in support of reply.

c. Counselling services to PW

PMSMA guidelines provide that before leaving the hospital/facility, every PW needs to be counselled, individually or in groups, for acquiring knowledge relating to nutrition, post-partum family planning, etc.

Department did not maintain any data of counselling services provided to PW in the absence of which Audit could not verify whether these were actually provided.

d. Monthly report not submitted to MoHFW, GoI

PMSMA guidelines stipulate that ANMs are to compile the information of the services provided during PMSMA and submit the same to facility In-charge who in turn would submit it to the District authorities. States must compile the reports submitted by the districts and submit it to MoHFW within 15 days of conducting the camps as required under PMSMA. Audit noted that

District-wise reports to be submitted to MoHFW were not compiled by the Department. There were 506 facilities registered on the portal which were required to upload monthly reports on the portal. During 2018-19 to 2021-22, facilities uploading monthly reports on the portal ranged between 60 *per cent* (2019-20) and 25 *per cent* (2018-19) depicting incomplete reporting of the scheme.

The Department stated (July 2022) that PMSMA portal was launched much later after the launch of PMSMA program and in the last two years, many facilities have enrolled on PMSMA portal but some organizations such as CGHS, Private facilities etc. were not participating actively in PMSMA programme and therefore, not consistently submitting the reports on PMSMA portal.

Reply is misleading as it did not comment on lack of reporting in respect of facilities directly under its supervision.

e. Specific services not provided to pregnant women under the programme

As per guidelines, ANM and Staff Nurses are required to ensure that all basic laboratory investigations are done before the beneficiary is examined by the OBGY/Medical Officer.

The status of specific services provided to PW under the programme are shown in **Table 7.4**.

Table 7.4: Status of services provided to PW under PMSMA

Period	Total number of pregnant women Received Antenatal care under PMSMA	Total number of pregnant women Received Antenatal care by an OBGYN specialist	Total number of pregnant women Received Antenatal care by MBBS doctor	PW Tested for Haemoglobin	PW Tested for Blood Group	PW Tested for Urine albumin	PW Tested GDM by OGTT	PW Tested for HIV under PMSMA
2016-17	40116	0	0	21208	0	0	8785	11661
2017-18	99063	0	36	54075	0	35	37637	24021
2018-19	95002	366	1275	46470	798	830	31496	24727
2019-20	86550	36683	57608	41245	25193	36711	22238	69516
2020-21	31077	14817	18158	10625	8188	11549	6532	19261
2021-22	44516	17807	26647	15760	11165	17201	8878	28194
2022-23 (upto Sept 2022)	24571	10818	14279	7444	5626	8578	4521	16230
Total	**420895**	**80491**	**118003**	**196827**	**50970**	**74904**	**120087**	**193610**
In percentage		19.12	28.04	46.76	12.11	17.80	28.53	46.00

Source: PMSMA portal

The overall percentage of PW who underwent basic laboratory investigations for haemoglobin, blood group, urine albumin and HIV was 46 *per cent,* 12 *per cent,* 18 *per cent* and 46 *per cent* respectively.

It can be seen from the above table that only 47.16 *per cent* (1,98,494 out of 4,20895) PW registered had received antenatal by OBGYN specialist and MBBS doctors during the period from April 2016 to September 2022.

The Department stated (July 2022) that reason could be some error in understanding the data by health facilities, therefore appropriate data was not submitted.

The reply is not acceptable as audit comment is based on beneficiaries registered under PMSMA programme only and data integrity was also Department's responsibility.

7.5.4.4 LaQshya programme under NHM

LaQshya Programme launched in 2017 aims to improve quality of care in Labour Room and Maternity Operation Theatres (OTs) in public health facilities which will be assessed through NQAS (National Quality Assurance Standards). Every facility achieving 70 *per cent* score on NQAS was to be certified as LaQshya certified facility.

As per guidelines, all LaQshya related data was required to be uploaded on the portal for prompt report generation as well as visualization of dashboard to monitor progress. Department stated (December 2021) that LaQshya portal was made live from 19 July 2019 and it was using DSHM State Portal for submission of internal assessment of hospitals under NQAS and LaQshya.

The implementation of the programme could not be examined in Audit as the Department neither provided data from LaQshya/ DSHM portal nor did it provide access to above portals.

However, Audit noted that against a target of 18 facilities in 2020-21, only three public health facilities were certified as LaQshaya certified facilities under the programme.

The Department stated (July 2022) that three more hospitals are in process for certification.

7.5.4.5 Health care of children through MAA (Mothers' Absolute Affection) Programme

Ministry of Health and Family Welfare, GoI launched (August 2016) Mother's Absolute Affection (MAA) in an attempt to bring undiluted focus on the promotion of breastfeeding and provision of counselling services for supporting breastfeeding through health systems.

As per indicators on child feeding practices of NFHS-5 (2019-21), 51.2 *per cent* children under age of 3 years were breastfed within one hour of birth[5] while,

[5] Based on the last child born in the 3 years before the survey

64.3 *per cent* children under the age of 6 months were exclusively breastfed[6] in Delhi.

a. Shortage of staff for MAA

Staff nurse, RMNCH+A counsellors and medical officers were responsible for communication and counselling of mothers/caregivers on Infant and Young Child Feeding (IYCF). As per the Annual report MAA programme (2020-21), Audit noted significant shortage of staff in respect of Medical officer (32 *per cent)* and Staff nurse (58 *per cent*). Shortage of staff indicates low priority assigned to infant/child health services by the Department.

Department stated (May 2022) that there was shortage of staff, but recruitment of staff was not under the Directorate of Family Welfare.

Reply is not acceptable as GoI had approved human resources every year in the Record of Proceeding and Directorate of Family Welfare/DSHM should have ensured that vacant posts were filled timely.

Recommendation 7.3: The Government should ensure proper recruitment of Human Resource as approved in the ROP under NHM so that the programmes of NHM can be implemented properly and smoothly.

b. Shortage of dedicated space/room for breastfeeding mothers

As per Guideline of MAA, all health facilities should have a dedicated space/room for breastfeeding mothers who come for consultation and desired a private space for breastfeeding. It was noticed that space/room for breastfeeding was available at only 205 out of 338 health facilities/Centres under MAA Programme in Delhi.

The Department stated (May 2022) that most of the health facilities/Centres were providing all health care services inclusive of Immunisation/ANC only in two rooms.

c. MAA coordination committee not constituted

As per Guideline of MAA, a Coordination Committee formed at State level may oversee the implementation of suggested activities mentioned in the guidelines.

Audit found that no MAA coordination committee was constituted by the Department.

The Department stated (May 2022) that activities under MAA programme are being monitored and reviewed at the facility, District and State levels.

Reply is not acceptable as, in the absence of coordination committee, activities cannot be monitored adequately.

[6] Based on the youngest child living with the mother

7.5.4.6 Home Based New-born Care Programme (HBNC)

As per operational guidelines of HBNC, the key activities under HBNC constitute "Care for every new-born through a series of home visits by a ASHA in the first six weeks of life, extra home visits for preterm and low birth weight babies by ASHA or ANM, and follow up for sick new-born after they are discharged from the facilities".

During 2016-17 to 2020-21, 47.89 *per cent* (6.26 lakh out of 13.08 lakh) infants registered, got home based new born care and extra home visits by ASHAs after they were discharged from healthcare facilities. Further, against a target of 1.6 lakh new-born to be visited under HBNC in Delhi, the achievement was only 55,593 (33.17 *per cent*) during 2020-21.

7.5.4.7 Implementation of Severe Acute Malnutrition (SAM) programme

Severe acute malnutrition is defined as very low weight-for-height/length, or a mid-upper arm circumference < 115 mm, or by the presence of nutritional edema. Lack of exclusive breast feeding, late introduction of complementary feeds, feeding diluted feeds containing less amount of nutrients, repeated enteric and respiratory tract infections, ignorance, and poverty are some of the factors responsible for SAM. Children with SAM have nine times higher risk of dying than well-nourished children.

As per NFHS-5 (2019-21), 21.8 *per cent* of under-5 children were underweight (weight-for-age), 30.9 *per cent* were stunted (height-for-age) and 11.2 *per cent* wasted (weight-for-height) and 4.9 *per cent* children were severely wasted (weight-for-height). Further, as per NFHS-5 (2019-21), 69.2 *per cent* of children in age group 6 months-59 months were anaemic.

As per guidelines, every district should have one Nutrition Rehabilitation Centre (NRC). Eight NRCs were operational (against the requirement of 11) since 2017-18. In March 2019, GoI directed that NRC should be 10 bedded. As per revised norms, only two NRCs (August 2022) remained operational in Delhi and the remaining six NRCs did not fulfil this criterion but no other facility fulfilling the criteria was designated as NRCs by the Department. Thus, as per revised norms there were only two NRCs in 11 districts of Delhi.

Further, posts of Medical Officer, Cook cum Caretaker, Attendant and Medical Social Worker were not filled-up in these two functional NRCs, as required under guidelines of SAM.

7.5.4.8 Implementation of Rashtriya Bal Swasthya Karyakram under NHM

The Government of India launched (February 2013) the Rashtriya Bal Swasthya Karyakram (RBSK) which envisages setting up of District Early Intervention Centres (DEIC) at the district hospital level. As per scheme

guidelines, at least three dedicated Mobile Health Teams in each block would be engaged to conduct screening for children in the age group of 6 to 18 years.

Audit found that GoI approved RoP in 2018-19 for implementation of RBSK through Comprehensive New-born Screening (CNS) wherein the Department had set target (2020-21) of operationalising three District Early Intervention Centres. Audit noted that no DEIC/ Mobile Health Team was constituted (May 2022).

Further, the Delhi Government launched (January 2020) the Neonatal Early Evaluation Vision (NEEV) program which is for screening of around 1.5 lakh new-born babies in two years for visible functional and metabolic defects. However, Mission NEEV became functional only in November 2021 and only 21,237 children were screened (March 2022). The cases were referred for appropriate follow-up.

Department stated (May 2022) that it will establish one Centre of Excellence – Early Intervention Centre at LNH and three DEICs at other hospitals to cover identified health conditions for early detection.

Recommendation 7.4: Effort should be made to ensure that care envisaged under the scheme for new-born are provided in a timely manner.

7.5.5 Discrepancies in Child Death Review (CDR)

Child Death Review is an important strategy to understand the geographical variation in causes leading to new-born and child deaths, and thereby initiating state-specific child health interventions. Analysis of child deaths provide information about the medical causes of death, helps to identify the gaps in health service delivery and social factors that contribute to child deaths.

As per operational guidelines of Child Death Review, First Brief Investigation (FBI) shall be conducted for all child deaths. The FBI should be done within two weeks after the notification of death and report should be submitted to Block Medical Officer (BMO) within one month of notification of death. Further, reports prepared by office of the District Nodal Officer (DNO) were to be shared every month in the meeting of the District Child Death Review Committee[7] (DCDRC). Subsequent to DCDRC meeting, the DM shall review a sample of cases submitted to him by the DNO/CMO.

Further, a State Level Task Force (SLTF) headed by Principal Secretary (Home and Family Welfare) was constituted in April 2017 for circulation of key decisions to all stakeholders with clear timeline for action. The SLTF was to meet every six months or earlier. State Nodal Officer (SNO) will compile

[7] Consisting of Chief Medical Officer/Civil Surgeon (Chairperson), Additional Chief Medical Officer, District Nodal Officer (Member Secretary), Pediatrician, Obstetrician/Gynecologist etc.

reports from all districts for onward transmission to the national level in the State level Reporting Form (Form 5d).

Audit noted the following:

i) First brief investigation was conducted in 798 cases (3.65 *per cent*) out of 21,870 child deaths reported during 2017-18 to 2020-21. Further, no review of child death was conducted by DMs as required under the guidelines.

The Department stated (May 2022) that the family of the deceased child moves to their ancestral village after death of child. It also stated that review by DM was not possible as in some districts, DCDR committee was not formed.

Reply is not acceptable, as it is the responsibility of the State Government to obtain the medical causes of death within two weeks after the notification of death.

ii) During 2017-18 to 2020-21, only 17 DCDRC[8] meetings were conducted by eight districts for analysis of death cases.

The Department stated (May 2022) that prescribed number of meetings could not be held due to delay in formation of DCDR committees in few districts.

iii) Only one meeting was held by SLTF during 2017-21 which indicates that lessons learnt from child death reviews were not being circulated amongst stakeholders for necessary corrective action.

The Department stated (May 2022) that multiple mails were sent to the districts and compiling of State reports could be initiated only from October 2020.

Reply confirms inadequacy in reviewing child deaths and delay in taking corrective action.

iv) Audit noted that the SNO did not compile CDR Reports of all districts and so did not forward the same to national programme managers in the Ministry of Health and Family welfare during 2016-21. Further, the Department instructed in March 2018 that RCH Nodal Officers of all districts are required to ensure reporting on CDR and its submission on 5th of every month to the State headquarters, but Districts had started sharing CDR reports only from October 2020, which was sent to GoI after Compilation.

The Department stated (May 2022) that there was delay in reporting from hospitals.

[8] North East (4), South East (2), Central (1), South (4), South West (2), East (1), New Delhi (1) and West (2)

The reply is not acceptable, as the Department was responsible for ensuring timely receipt of reports from the hospitals for compilation and submission to GoI.

7.5.6 Child Immunisation

Routine immunization is an important strategy for child survival, focusing on preventive care to reduce morbidity against preventable diseases. As per HMIS portal, coverage of children up to one year of age during April 2016 to September 2022 in respect of some vaccines was much less than the desired 100 *per* cent, such as BCG (82.70 *per cent*), OPV-0 (70.03 *per cent*), DPT-1 (3.87 *per cent*), Measles (89.48 *per cent*) and Hepatitis-B (66.86 *per cent*). The coverage of immunization in other age groups (i.e above one year) could not be ascertained as data in this regard was not furnished by the DSHS. Further, all children in the age group of nine months to five years were required to be administered nine Vitamin 'A' doses. However, only 13.80 lakh (65.03 *per cent*) out of 21.22 lakh children were administered the first dose and information on number of infants who were given remaining Vitamin-A doses (except doses 5 & 9) was not captured at the State level.

Reply of the Department was awaited.

7.5.7 Comprehensive Abortion Care

According to RMNCH+A guidelines, eight *per cent* of maternal deaths in India are attributed to unsafe abortions. Besides this, women who survive unsafe abortion are likely to suffer long-term health complications. Therefore, safe and comprehensive abortion care is an essential component of overall pregnancy care. Under NRHM, 24x7 PHCs were to provide abortion by Manual Vacuum Aspiration (MVA) facilities and medical methods, whereas comprehensive Medical Termination of Pregnancy (MTP) services were to be available at all district hospitals and Sub-district level hospitals with priority given to Community Health Centres as delivery points.

Audit observed that MTP services were not provided in seven (16 *per cent*) out of 44 sub-district/district level hospitals and 20 (87 *per cent*) out of 23 CHCs. Thus, the Government failed to ensure adequate facilities as envisaged under RMNCH+A for safe abortion.

Department stated (July 2022) that Comprehensive Abortion Care (CAC) in Delhi is being provided through all district and sub-district hospitals that were serving as delivery points. Regarding existing maternity homes in Delhi, designated as CHC Non-FRU, only three maternity homes were providing CAC services.

The reply is not acceptable as the Department was well aware of the shortage of CAC services and as such, these services should have been provided through more maternity homes.

7.5.8 Achievement of targets for Sterilization and spacing methods

Family planning has undergone a paradigm shift and emerged as a key intervention to reduce maternal and infant mortalities and morbidities. It is well-established that the States with high contraceptive prevalence rate have lower maternal and infant mortalities. Greater investments in family planning can thus help mitigate the impact of high population growth by helping women achieve desired family size and avoid unintended and mistimed pregnancies. Further, contraceptive use can prevent recourse to induce abortion and eliminate most of these deaths. The target and achievement of various components of family planning services in NCT of Delhi is given in **Table 7.5**.

Table 7.5: Targets and achievements of Sterilization and Spacing methods in State of NCT Delhi (2016-21).

Family Planning services	Target	Achievement	Achievement (%)
Vasectomy	7,600	3,131	41
Tubectomy	1,00,000	76,375	76
IUCD insertion	3,95,000	3,97,213	101

Source: Information supplied by Department

Above tables show that there was maximum achievement in IUCD insertion (more than 100 *per cent*); while the minimum achievement was in vasectomy services (41 *per cent*). Delhi was lagging behind in achieving the target under different segments of family planning programmes highlighting the inadequacy in implementation of the programme. Reasons for shortfall were not on record. This indicated that implementation of family planning programme in the State was not adequate and effective.

7.6 Accredited Social Health Activist (ASHA)

ASHA works as an interface between the community and the public health system to promote health care at household level. ASHAs would reinforce community action for universal immunisation, safe delivery, new-born care and prevention of waterborne and other communicable diseases. As per guidelines, ASHA must be primarily in the age group of 25 to 45 years and literate with formal education up to Eighth Class. Further, GoI prescribed two levels of training for ASHAs, viz. induction training (in module I to V, of 23 days over 12 months) and capacity building (in module VI to VII, in four rounds of five days each).

Audit observed that there was a marginal shortage of five *per* cent (309 out of 6,345) of ASHA as of March 2021. 196 ASHA's did not have the desired education of upto 8th standard. Training to ASHAs was also inadequate as only 2,446 (40.52 *per cent*) ASHAs were provided induction training (module I to V).

Further, Home Based Care for Young Child training was due for 3,989 (66.08 *per cent*) ASHA's and non-communicable disease (NCD) training was due for 2,165 (35.87 *per cent*). However, 96 *per cent* ASHAs were imparted capacity building training (Modules 6 and 7).

Department's reply was awaited (December 2022).

7.7 Lapses in data collection and reporting system under HMIS

Health Management Information System (HMIS) is a Government to Government (G2G) web-based management information system that has been put in place by Ministry of Health & Family Welfare (MoHFW), GoI to monitor NHM and other Health programmes. HMIS has been utilised in grading of health facilities, identifications of aspirational districts, review of State Programme Implementation Plan (PIPs), etc. Further, HMIS captures facility-wise information i.e. service delivery on monthly basis, training data on quarterly basis and Infrastructure on annual basis.

As per HMIS report, for 2020-21[9], shortfall in reporting on portal was noticed in health centres such as Community health Centres (50 *per cent)*, sub-district hospitals (28 *per cent)* and district hospitals (14 *per cent*).

Common validation rules for HMIS data provides that number of doses of OPV1, OPV2 and OPV3 vaccines administered should be equal to that of DPT1, DPT2 and DPT3 respectively. Audit noted that against 14.86 lakh OPV1 vaccine administered during 2016-17 to 2020-21, the number of DPT1 was only 65,169 which raises questions regarding accuracy of the data.

7.8 National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)

7.8.1 NCD Clinics, Cardiac Care Unit (CCU) and Day Care Facilities for cancer patients not established

As per Operational Guidelines of NPCDCS, 2013 issued by DGHS, MoH&FW, GoI, all districts shall have regular Non-Communicable Diseases (NCD) clinic for screening, management and counselling and awareness generation etc. Four bedded Cardiac Care Units (CCUs) were to be established/strengthened in identified district hospitals. Identified district hospitals were to provide a day care chemotherapy facility for the cancer patients on simple chemotherapy regimens alongwith necessary equipment.

Audit noted that the Government did not establish any of the above institutions/facilities in Delhi even after nine years thereby depriving the people of Delhi of adequate treatment facilities. Audit noted that Department had not proposed for establishment of clinics in the PIPs for approval by the MoH& FW, GoI.

[9] Reports for the period 2016-17 to 2019-20 was not available.

Department accepted (August 2022) that NCD Clinics could not be established. With regard to CCUs, department stated that CCUs were not established due to absence of a dedicated fund and day care chemotherapy facilities for cancer patients were not provided as major hospitals provide such facilities.

The reply is not acceptable as proposals for setting up CCUs were not taken up by the Department in the PIPs with the GoI. Further, day care chemotherapy facilities envisaged were over and above those available in major hospitals.

7.8.2 Training of Medical and Para Medical Staff

As per operational Guidelines of NPCDCS 2013, State NCD Cell is responsible for organizing state and district level trainings for capacity building. Training was to be provided to Medical Officers, Medical Specialists, ANMs/Health Workers, Programme Officer, Programme Coordinator, Finance cum Logistics Officer, DEO etc.

During 2018-19 to 2020-21, ₹ 36 lakh was sanctioned for training against which only ₹ 0.73 lakh was incurred. Audit noted that only six trainings programmes were organized at state level and 10 at district level during 2016-21. Only 10 *per cent* (84 out of 806) Medical Officers and 16 *per cent* (281 out of 1759) ANMs were given training.

Department stated (August 2022) that trainings could not be organized due to unavailability of dedicated fund, delay in receipt of ROP and COVID 19.

Reply is not acceptable as sufficient funds were available with DSHS during 2018 to 2021.

Recommendation 7.5: Arrangement for proper trainings for doctors and para medical staff should be ensured as prescribed.

7.8.3 Public Awareness Activities not conducted

The State NCD Cell is responsible to conduct public awareness regarding health promotion and prevention of NCDs. For Information, Education & Communication (IEC) activities, ₹ 50 lakh was approved each year for 2018-19 to 2020-21.

Audit noted that only ₹ 5.46 lakh (3 *per cent)* was incurred during the period 2018-19 to 2020-21. Thus, adequate efforts were not made to create awareness about the Scheme amongst general public.

Department stated (August 2022) that funds were not utilized due to Record of Proceeding being received in last week of August and June for the years 2018-19 and 2019-20 respectively and also due to Covid-19 in 2020-21. Department further stated that due to frequent change of State Programme Officer (SPO) as also the main focus being on Population based screening (Pilot Project) during 2019-20, sufficient budget could not be utilised.

Despite late receipt of approval, Department could have made efforts to utilize the funds available for IEC activities as and when received.

7.8.4 Review meetings

State NCD Cell is responsible for monitoring the programme through review meetings on a quarterly basis to assess physical and financial progress and discuss constraints in implementation of the programme. Review meetings were to be held every quarter to monitor the programme.

During 2016-17 to 2020-21, only eight review meetings were held against the prescribed 20 meetings.

Department stated (August 2022) that review meetings could not be held due to administrative reasons, frequent change of SPO and Covid-19 pandemic.

The reply is not acceptable as reasons cited are purely administrative in nature.

7.8.5 Shortage of staff for implementing of NPCDCS

All posts proposed in the PIP and approved in ROPs every year by the Government of India are to be filled up by Delhi State Health Mission.

For these posts, first time recruitment rules were to be finalized by the DSHM, which was not done.

Audit noted that the posts of State Programme Officer, State Programme Coordinator and Finance-cum-Logistics Consultant were vacant and the work was being looked after by officials from other offices as additional charge. At district level also, the posts of District Programme Officer, District Programme Coordinator and Finance-cum-Logistics Consultant were vacant.

Department stated (August 2022) that the proposal for filling up sanctioned post under the programme was initiated, however, it was not approved due to pending finalization of recruitment rules for the sanctioned posts.

Reply is not acceptable, since Department was responsible for timely finalization of recruitment rules.

7.9 National Programme for Control of Blindness

National Programme for Control of Blindness & Visual Impairment (NPCB&VI) was launched in the year 1976 with the goal of reducing the prevalence of blindness. Audit noted the following:

7.9.1 Training of Eye surgeons, Nurses not conducted

Para 3 of Pattern of Assistance, NPCB&VI envisaged training of personnel, supply of high-tech ophthalmic equipment, strengthening follow up services and regular monitoring of services by which programme objectives were to be achieved. Audit noticed that no trainings for Eye Surgeons and Nurses were conducted during 2016-21.

District Programme Officer (North West) stated (April 2022) that due to shortage of staff and administrative reasons, trainings could not be conducted and needful would be done in due course.

7.9.2 Screening Camp for Refractive error detection and free distribution of spectacles

Para 3 of Pattern of Assistance, NPCB&VI envisaged reduction in the backlog of blindness through identification and treatment of blind and organize screening of school children for detection of refractive errors and other eye problems and provide free glasses to poor children. Screening of school going children would go a long way in controlling occurrence of blindness through early detection

Audit noticed that regular annual screening was not done by all three selected districts (New Delhi, North West and South East) during 2016-17 to 2020-21. No teacher was trained by any of the three IDHSs for screening of school children for refractive errors during 2016-21.

DPO (North West) stated (April 2022) that due to administrative reasons, teacher's training could not be organised and needful would be done in due course.

As regards free distribution of spectacles, Department had distributed free spectacles to only 37 *per cent* (17,106 out of 46,300) children targeted during 2016-22.

DPO (North West) stated (April 2022) that due to unavailability of spectacles on GEM portal, the same could not be distributed.

Reply is not acceptable, as Department could have explored other sources for procurement.

Recommendation 7.6: Efforts should be made to ensure the implementation of National Programme for Control of Blindness & Visual Impairment.

7.9.3 Data/information on MIS portal not updated

A web portal has been designed by GoI for NPCB&VI to enter data/information at Central Level, State level and District level.

Audit examination of the portal revealed that the necessary data/information e.g. number of patients, details of hospitals, details of NGOs, details of screening camps etc. has not been entered completely. The portal was also not updated at State level/District level.

DPO (North West) stated (April 2022) that due to administrative reasons and shortage of staff MIS portal could not be updated and needful would be done in due course.

7.9.4 District Ophthalmic Board and Redressal Committee not found

As per guidelines of NPCB&VI, a District Ophthalmic Board consisting of Eye Specialists was to be constituted to examine children and adolescents admitted to blind schools. The State Government was also required to constitute a Redressal Committee for all disputes pertaining to programme implementation including NGO participation.

Audit observed that Redressal Committee was not constituted by DSHS and the selected three IDHSs did not form District Ophthalmic Board.

DPO (North West) stated (April 2022) that due to administrative reasons, Ophthalmic Board could not be formed and needful would be done in due course.

Recommendation 7.7: The Government should ensure arrangements for proper training of doctors, para medical staff etc under each disease programme as prescribed in the Operations Guidelines of diseases programme under NHM.

Recommendation 7.8: Ensure prompt formation of Redressal Committee and District Ophthalmic Board under NPCB.

7.10 National Tobacco Control Programme

The main objectives of the National Tobacco Control Program (NTCP) are awareness/sensitization/training and enforcement of tobacco control Acts (Cigarette and Other Tobacco Product Act 2003). Other activities include implementing tobacco control in coordination with various department like police, transport, food safety, etc. to make Delhi tobacco free.

Audit noted the following:

- **State Level Coordination Committee and Tobacco Cessation Centres (TCCs)**

As per National Tobacco Control Program (NTCP) guidelines 2015, every State is required to form a State Level Coordination Committee[10] (SLCC). This committee would be responsible for the overall implementation of National Tobacco Control Programme and provisions of Cigarette and Other Tobacco Product Act 2003, in the State. The Guidelines further provide for quarterly meetings to be held to review the progress of work.

Audit noted that State Level Coordination Committee (SLCC) was not constituted (May 2022).

DSHS had to set up Tobacco Cessation Centres (TCCs) to help those people who wish to quit tobacco consumption in any form. Audit noted that DSHS has targeted setting up of 33 Tobacco Cessation Centres (three in each district)

[10] Headed by Chief Secretary or his nominee and Pr. Secretary/Secretary (Health) as member secretary

during 2019-20 and 11 additional TCCs (one in each district) during 2020-21. However, only one Tobacco Cessation Centre[11] was established against the targets of 44 TCCs (July 2022).

Department stated (November 2022) that SLCC has been constituted. As regards TCCs, it was stated that work for establishment of TCCs in other districts is under process.

- **Enforcement squads/ teams not formed**

As per NTCP guidelines 2015, every district is required to constitute an enforcement squad for monitoring compliance with tobacco control laws in their jurisdiction and for taking action against any violation in the district.

Audit noted that none of the three selected districts (South, New Delhi and North West) had constituted enforcement squad team during 2016-21 (except North West District which constituted the squad only for the year 2016-17).

Department stated (November 2022) that Delhi is one of few States/UTs which has its own tobacco law since 1997 and all the districts have teams for enforcement of tobacco laws and their constitution may be different from the constitution prescribed in the guidelines.

Reply is not acceptable as no documentary evidence in support of the reply was attached.

- **Lack of monitoring of Challan Books distribution**

As per NTCP 2015 operational guidelines, Challan books should be printed at State level or as decided by the State and distributed to all concerned authorities[12] in the State to impose and collect fine against violation of Cigarette and Other Tobacco Product Act (COTPA). The amount so collected should be used for tobacco control activities. Enforcement and monitoring of provisions of COPTA 2003 was to be ensured by State Tobacco Control Cell (STCC).

Audit noted that total number of Challan books printed with allotted series at State Tobacco Control Cell (STCC) was not on record. Further, the system of distribution of Challan books to all concerned authorities in the State during the period 2016-21 was also defective, as printed Challan books were not serially distributed to the agencies concerned and 231 Challan books were missing. Moreover, there was no mechanism set up by STCC for reconciliation of issued Challan books and total fine recovered. As per records made available to audit, STCC had collected fine of ₹ 81.47 lakh during 2019-20 whereas Delhi Police had collected fine of ₹ 90.17 lakh during

[11] TCC at RML Hospital under IDHS, New Delhi

[12] Director/Medical Superintendent of Hospitals, all Gazette officers of State/Central Government, Head of College/School/Institution, police officers not below the rank of SI, etc.

eight months period (May 2019 to December 2019). STCC also failed to provide sufficient number of Challan books to Delhi Police and Delhi Police got printed four thousand Challan books from May 2018 to July 2020 (about two years). As per record, no consent was taken by Delhi Police from State Tobacco Control Cell for printing of Challan books.

Thus, the possibility of misuse of the challan books and fine collected from the violators cannot be ruled out. Moreover, there was no record about revenue actually generated from challan books and the amount utilized for tobacco control activities.

- **Irregular running of Hookah bars**

As per study report[13], Hookah produces high toxic substances and gases like carbon monoxide, tar, metals and other carcinogenic chemicals which can increase the risk of cancer and heart problems and is just as much harmful as cigarette smoking. The Cigarettes and Other Tobacco Products Act is being implemented by STCC.

Audit noted that STCC was pursuing the matter of illegal hookah bars in restaurants with Delhi Police since April 2014. Examination of STCC records revealed that 20 restaurants/eating houses (June 2016) were serving hookah bars without license. STCC (July 2017) had found presence of significant amount of nicotine in the seized samples. Audit found that records relating to action taken against such hookah bars was not available with State Tobacco Control Cell. Moreover, STCC has not maintained any register of inspection/surprise checks in hotels/restaurants.

Government stated (November 2022) that action against hookah bar is being taken by the STCC/DTCC in coordination with Delhi Police.

Reply is not acceptable as documents regarding action taken by STCC/DTCC against illegal hookah bars running in these restaurants/eateries/hotels, were not found in the records during audit nor furnished with reply.

Recommendation 7.9: Ensure timely establishment of Tobacco Cessation Centers (TCCs) for providing facilities to common people.

7.11 National Leprosy Eradication Programme

As per National Health Policy 2017, the proportion of Grade-2 cases amongst new cases will become the measure of community awareness and health systems capacity to carry out leprosy elimination, keeping in mind the global goal of reduction of Grade-2 disability to less than one per million by 2020. The policy envisaged proactive measures targeted towards elimination of leprosy from India by 2018**.**

[13] Center for Disease Control and Prevention.

Audit observed that Grade-2 cases amongst new cases remained above 10 per million during 2016-17 to 2019-20 but came down to 4.50 per million in 2020-21. Although this shows a significant improvement, the occurrence was still much above the desired level of one per million. In spite of this, GNCTD did not implement Leprosy Case Detection Campaign (LCDC) instituted by GoI in August 2016 aimed at elimination of leprosy by 2018. Activities under LCDC included two days State level workshop, Orientation training for field level workers etc. which would have facilitated early detection of Leprosy cases and prevention of Grade-2 disabilities. GoI had also written (May 2018) to GNCTD that the incidence of Grade-II disability in Delhi were consistently high during the last three years and requested for conducting LCDC activities. However, GNCTD did not conduct any activity and no annual target was fixed for leprosy control/eradication.

Reply of the Department was awaited.

7.12 National Mental Health Programme (NMHP) not implemented

As per paragraph 4.7 National Health Policy 2017 on mental health, it is required to work on the main fronts which include increasing/creation of specialists trough public financing and develop special rules to give preference to those willing to work in public systems, create network of community members to provide psycho-social support to strengthen mental health serves at primary level facilities and leverage digital technology in a context where access to qualified psychiatrists is difficult. Para 13.4 of National Health Policy also provides that training community members to provide psychological support to strengthen mental health services in the country. Collaboration with Government would be an important plank to develop a sustainable network for community/locality towards mental health.

Audit observed from the accounts of the DSHS that there was an opening balance of ₹ 92.20 lakh on 1 April 2016. Further, DSHS earned interest of ₹ 21.32 lakh during 2016-21, but nil expenditure was incurred and whole amount of ₹ 1.13 crore remained unspent as of 31 March 2021. This clearly shows that the above programme has not been implemented by the Society. The reasons for non-implementation of the programme are awaited.

7.13 Implementation of National Programme for the Health Care for the Elderly (NPHCE)

The Ministry of Health & Family Welfare had launched the "National Programme for the Health Care of Elderly" (NPHCE) during 2010-11 to address various health related problems of elderly people. The National Programme for the Health Care for the Elderly (NPHCE) is an articulation of the international and national commitments of the Government as envisaged under the UN Convention on the Rights of Persons with Disabilities (UNCRPD), National Policy on Older Persons (NPOP) adopted by the

Government of India in 1999 and Section 20 of "The Maintenance and Welfare of Parents and Senior Citizens Act, 2007" dealing with provisions for medical care of senior citizen. The programme is State oriented and basic thrust of the programme is to provide dedicated health care facilities to the senior citizens (>60 year of age) at various levels of primary, secondary and tertiary health care.

As per PIPs, RoPs and consolidated utilization certificates, the budget provision and expenditure incurred on National Programme for Health Care of the Elderly (NPHCE) by NHM, NCT of Delhi during the period 2016-17 to 2021-22 is as given in **Table 7.6**.

Table 7.6: Budget provision and expenditure under NPHCE in State of NCT Delhi

(₹ in lakh)

Period	Amount Proposed in PIPs	Amount Approved by GoI in RoPs	Opening Balance as Balance Sheet	Fund Received from GoI	Interest Received	Total Expendi-ture incurred	Un-spent Balance
2016-17	352.75	259.34	0.00	34.50	0.08	0.00	34.58
2017-18	41.80	41.80	34.58	0.00	2.45	0.00	37.04
2018-19	90.80	49.80	37.04	0.00	1.31	0.17	38.18
2019-20	115.40	36.80	38.18	0.00	1.32	0.00	39.49
2020-21	21.90	21.90	39.49	0.00	1.21	0.00	40.71
2021-22	21.90	21.90	40.71	0.00	1.20	8.00	33.90
Total	**644.55**	**431.54**	**----**	**34.5**	**7.57**	**8.17**	**----**

From the above table, it is evident that DSHS received ₹ 34.50 lakh against approved amount of ₹ 431.54 lakh. However, DSHS has incurred only ₹ 8.17 lakh (1.89 *per cent*) against the ₹ 431.54 lakh approved during the period 2016-22. As per the Records of Proceeding (RoP) of DSHS for the period 2020-21, GoI approved 38 posts of Nurses for Geriatric Care (22), Physiotherapist/Occupational Therapist (04) and Consultant Medicine (MD) (12) under the NPHCE, but all the posts remained vacant as of March 2021.

Chapter VIII

Adequacy and effectiveness of the regulatory mechanisms

Chapter VIII

Adequacy and effectiveness of Regulatory mechanisms

Delhi Medical Council (DMC) has not conducted any surprise inspection to identify Quacks and also failed to register FIRs against persons who were found practicing medicine unauthorisedly. DMC also did not take prompt action on complaints of misconduct/medical negligence by medical practitioners. Nursing Council did not conduct inspection of health institutions and failed to verify the credentials of nurses working in health facilities at regular intervals and Pharmacy Council also did not conduct inspection of pharmacies.

The Department could not ensure National Accreditation Board of Laboratories (NABL) certificate for its Drug Testing Laboratory (DTL) as well as for various laboratories functioning in hospitals to ensure accuracy and reliability of test results. It also could not ensure National Accreditation Board for Hospitals & Healthcare Providers (NABH) accreditations to its hospitals.

Drugs Controller of Delhi which regulates manufacture of drugs & cosmetics and sale of drugs in Delhi has only one Drug Testing Laboratory (DTL) with a restricted capacity. There was delay in furnishing test reports by DTL due to which the department was not in a position to promptly prevent inferior quality drugs from being consumed. DTL was lacking in modern equipment, space and manpower. There were huge shortfalls in mandatory inspections of drug selling and manufacturing units as also Blood Banks by the Drug Controller Department. The Government could not upgrade DTL in spite of a detailed plan for upgradation and availability of funds. Thus, the Government could not ensure availability of safe, effective and quality drugs to the general public.

DGHS was ill-equipped to plan, implement and monitor Bio Medical Waste (BMW) Rules in Delhi and further failed to impart training to all health care workers every year as envisaged under BMW Rules.

Thus, various organs of GNCTD, which constitute the overall regulatory framework of health care sector, were not carrying out their mandated duties for ensuring that health care facilities/professionals adhere to the prescribed standards of service.

8.1 Introduction

Regulation is an important function in healthcare sector. Regulations are necessary to standardize and supervise healthcare, ensuring that healthcare bodies and facilities comply with public health policies and that they provide safe care to all patients and visitors to the healthcare system.

Regulatory agencies thus monitor individual and corporate healthcare practitioners and facilities, inform the government about changes in the way the healthcare industry operates, ensure higher safety standards, and attempt to improve healthcare quality and compliance with local, state, and federal guidelines.

8.2 Implementation of norms and regulations by Regulatory bodies

8.2.1 Delhi Medical Council

Delhi Medical Council (DMC) is a statutory body constituted in September 1998 through Delhi Medical Council Act, 1997 by the Government of NCT of Delhi. Delhi Medical Council is vested with powers, duties and functions of regulating the practice of modern scientific system of medicine in NCT of Delhi. All medical practitioners are required to renew their registration every five years. 56,742 out of total 1,34,958 Registered Medical Practitioners (RMPs), constituting 42 *per cent*, had not renewed their registration as of May 2022.

8.2.1.1 Action against Quacks

As per Section 26 of the Act, any person who falsely claims to be registered with the DMC, on conviction, shall be punished with a fine up to rupees five thousand. Further, Section 27 of the Act envisages that any person practicing modern medicine without getting registered, shall be punishable with rigorous imprisonment up to three years or fine up to rupees twenty thousand or both.

Complaints against quacks received in DMC Office are forwarded to Chief District Medical Officer (CDMO) to carry out inspection and send the reports to DMC. Disciplinary Committee, DMC requests police authority concerned to register FIRs against persons found practicing modern medicine without having proper authorization.

Test check of records revealed that no survey/inspection was carried out by the CDMOs concerned in 14 complaints[1] out of 928 received between February 2017 and January 2022 even after delays of 126 to 2289 days.

Audit noted that during 2016-2022 (up to September 2022), police had registered FIRs against 40 persons (12 *per cent*) out of 335 persons who were practicing medicine without required qualifications. DMC did not actively pursue cases where action was not initiated by the police.

Further, Anti-Quack Response Team (AQRT) of DMC had not conducted any surprise raid/inspection to prevent practice of modern scientific system of medicine by unauthorized persons.

Such inaction allows the quacks to operate with impunity as the envisaged deterrence is non-existent.

[1] Case IDs – 48317, 2144, 42265, 44319, 48356, 43256, 44222, 55178, 302428, 302414, 302426, 302420, 302588 and 302584

DMC stated (November 2022) that complaints could not be disposed of timely due to delay in inspection/ survey by the CDMOs concerned against unqualified medical practitioners/ quacks. DMC further stated that police is requested to register FIRs against such persons who are practicing medicine without holding required qualification but in spite of repeated requests police failed to register the FIRs.

Reply is not acceptable as it is the overall responsibility of the DMC to prevent unqualified persons from practicing medicine in Delhi.

8.2.1.2 Laxity in disposal of complaints (misconduct/medical negligence) made against Medical Practitioners

Under section 21 of the Act, DMC was to setup a Disciplinary Committee of six members chosen from members of council to conduct enquiry of misconduct/ medical negligence of registered medical practitioners against whom complaints are made. DMC may enquire into complaints against medical practitioners either suo-moto or on the basis of any complaint through the Disciplinary Committee. As per instructions of Medical Council of India (MCI), all complaints received against registered medical practitioners related to unethical practice shall be resolved within six months from date of receipt of such complaints by all state medical councils.

During the years 2016-17 to 2020-21, DMC received 1451 complaints out of which 49 complaints, 42 complaints and 120 complaints were still pending even after delays of 181-360 days, 361-660 days and above 660 days respectively whereas 26 complaints, 689 complaints and 118 complaints were disposed of after delay of 181-360 days, 361-660 days and above 660 days respectively.

DMC stated (November 2022) that complaints against doctors could not be disposed of timely or are still pending due to delay in constitution of the council amid COVID pandemic.

The reply is not acceptable as most of the complaints pertain to pre COVID period when Council was in existence.

8.2.2 Delhi Nursing Council

Delhi Nursing Council Act, 1997 (DNC Act) along with Delhi Nursing Rules was notified in June 2001. Section 3 of DNC Act stipulates constitution of Delhi Nursing Council with members to be notified by the State Governments. Further, as per Section 4 (1), the term of office of a member (other than ex officio member) shall be three years from the date of nomination or until a successor has been duly nominated, whichever is earlier. GNCTD was required to notify the election for members of the council. The Delhi Nursing Council (DNC) was to maintain the data base of available practicing nurses in the state and to serve as an agency to develop nursing staffing norms, recruitment policy and other nursing related policies.

Delhi Nursing Council's main responsibilities were:

- To conduct election of council members
- To provide registration to nurses and renew their registration every five years
- To provide registration to newly setup nursing institutions
- To conduct periodical inspection of nursing institutions
- To verify credentials of nurses working in health Institutions in Delhi

It was observed in audit that although DNC was initially constituted in June 2001, it was not reconstituted regularly by holding elections and notifying fresh members after three years. As a result DNC was not constituted from June 2004 to January 2006, January 2009 to August 2013, August 2016 to July 2017 and from July 2020 to May 2022. Thus, in 21 years after the Act came into effect, DNC was not in existence for more than eight years to carry out the functions mandated by the DNC Act.

DNC replied (November 2022) that elections for members of the Council were conducted in 2020 but declared null and void by GNCTD due to some irregularities in the election process and fresh elections have been initiated.

Thus DNC, which was to develop nursing staffing norms, recruitment policy and other nursing related policies was almost dysfunctional which may have resulted in other deficiencies as given below:

- As per Section 19 of DNC Act, the registrar was to print and publish the names of registered nurses, midwives, auxiliary nurse midwives/ female health workers and female health assistants/ health supervisors every year but DNC had not published the above list since its establishment in May 2002.

  DNC stated (November 2022) that there was no online facility for general public/nurses/employers of nurses to apply for registration and verification of registration. The process of online registration/renewal/verification etc. will be started once the vendor for it is selected through GeM portal.

- Section 17 the of DNC Act stipulates that only persons registered under the Act shall practice as a nurse. Further, as per Section 26 (1), any person who acts in contravention to this shall, on conviction, be punished with fine up to two thousand rupees for first offence, five thousand rupees for second offence, and ten thousand rupees for subsequent offence. The nursing institutions/organizations/homes are required to send the list of nurses working in their establishment to DNC every year for verification of their credentials.

  Audit observed that out of 1229 nursing homes/hospitals/institutions employing nurses for providing health care services to public, 48 to 1044

institutions sent the list of nurses for verification during the years 2016 to 2022 and 780 upto September 2022.

DNC stated in November 2022 that it has issued circulars from time to time, for registration and renewal of license of nurses to practice in Delhi. DNC received verification of registration certificates from various institutions and the same were verified by it. Though the situation improved in the years 2021-22 and 2022-23 (up to September) but it remained laggard during the period 2016-21.

- Guidelines issued under Sections 22 (1) & (3) of DNC Act also envisage inspection of the institutes to assess its suitability with regard to physical infrastructure, clinical facility and teaching faculty in order to give permission to start the programme and thereafter, every year till the first batch completes the programme. Permission is to be given year by year till the first batch passes out and thereafter every three years to ensure that the institution is functioning as per the prescribed standards.

  Audit noted that there were 37 nursing training institutions functioning in Delhi out of which 20 institutes were inspected with delays of seven to 41 months **(Annexure VI)**. Out of the six new institutes affiliated with DNC during the audit period, prescribed number of annual inspections of four institutes was not carried out.

The regulatory mechanism to ensure quality nursing services was hampered during the period DNC did not exist. Due to lack of periodic monitoring of healthcare institutions employing nurses, it could not be ensured if only qualified persons were employed. Further, due to shortfall in inspections of nursing training institutions by DNC, assurance could not be derived on the functioning of these institutions.

DNC stated in its reply (November 2022) that due to COVID pandemic, inspections were put on hold as institutions were working online. The reply is not acceptable as most of the inspections pertained to pre-COVID period.

Recommendation 8.1: The Government may ensure (i) timely constitution of DNCs (ii) only registered nurses are employed by health care institutions; and (iii) all institutes imparting training to nurses are inspected regularly to ensure adherence to quality standards.

8.2.3 Delhi Pharmacy Council

The Delhi Pharmacy Council (DPC), constituted in the year 1959 under the Pharmacy Act, 1948, registers pharmacists and regulates pharmacy services in Delhi. Pharmacy Practice Regulations (PPR) were notified by GoI in January 2015 for regulating and enhancing the status and practice of pharmacy profession in the country. It seeks to lay down a uniform code of pharmacy ethics, responsibilities of pharmacists towards patients, job requirements of a pharmacist, role of a community pharmacist, etc. Section 29 of the Pharmacy

Act requires the State Government to maintain a register of pharmacists in Delhi. All the pharmacists are to renew their registration every year for which the required fee is to be paid.

Audit noted the following:

- DPC was not functional since July 2018 as it had failed to hold elections for the council. DPC replied (December 2022) that election was held in November 2021
- Even after seven years of notification by GoI in 2015, Pharmacy Practice Regulations were not notified by GNCTD. DPC replied (December 2022) that the said regulations can only be implemented after re-notification in Delhi Gazette which is still pending with the GNCTD.
- DPC had not maintained updated data of pharmacists. DPC replied (December 2022) that after initiation of online process, updated data of pharmacists will be maintained.

Recommendation 8.2: The Government may notify PPR without further delay and also ensure that an updated register of pharmacists is maintained by DPC.

8.2.4 Drugs Controller of Delhi

The Drugs Control Department (DCD) is headed by Drugs Controller of Delhi. It regulates manufacture of drugs and cosmetics and sale of drugs in Delhi. It is also responsible for enforcement of Drugs and Cosmetics Act 1940, and Drugs and Cosmetics Rules 1945.

Drug Policy of NCT of Delhi was framed in 1994 to ensure availability of safe and effective drugs, good quality control and assurance system. It provided for strengthening of Drug Inspectorate Units and Quality Control Laboratory for withdrawal from circulation of products found to be of sub-standard quality. Rules 51 and 52 of Drugs and Cosmetics Rules, 1945 stipulates all premises licensed for manufacture and sale of drugs, cosmetics and homeopathic medicines have to be inspected not less than once a year.

Besides, Blood banks were required to be inspected annually by a team of Drug Inspectors (DI) of Central Drugs Standard Control Organization (CDSCO) and State Licensing Authority.

Audit noted the following deficiencies during 2016 -17 to 2022-23 (Up to September 2022):

- There was overall shortage of 52 *per cent* staff in different cadres including 63 *per cent* shortage in key staff of Drug Inspector.

  Drug Control department stated (December 2022) that steps are being taken to fill 26 vacant posts of Drug Inspector from UPSC. UPSC has already published advertisement on 08 October 2022 for the same.

- The overall shortage of inspection of drug selling units and drug manufacturing units was more than 85 *per cent* and 61 *per cent* respectively.

  DCD accepted (August 2022) that there was severe shortage of staff and steps have been taken for filling up of vacant posts of Drugs Inspectors.

- Only 169 inspections out of required 448 inspections of 74 to 78 Blood banks was conducted by the team.

  DCD accepted (August 2022) the shortfall in inspections and attributed this to shortage of staff. It also stated that efforts are being made to increase the number of inspections of Blood banks.

Such shortage in technical staff in carrying out the mandated work of DCD of collecting, testing and analyzing drug samples severely compromised the ability of DCD in performing these functions.

Recommendation 8.3: The Government may provide adequate manpower to DCD for effectively discharging its mandated functions.

8.2.4.1 Drug Testing Laboratory

The Drug Testing Laboratory (DTL), DCD started functioning from 2002 and conducts testing of drugs and cosmetic products for quality control. The testing capacity of Lab was 2950 samples (2020-21). Further, DTL is notified for testing only non-biological products and biological products are sent to Regional Drugs Testing Laboratory (RDTL) Chandigarh. Gap Analysis Report[2] (November 2018) had recommended upgradation and capacity enhancement of the existing laboratory (5000 samples per annum) and development of new microbiological drug testing laboratory. It also recommended 60 technical staff for enhancing the testing capacity.

Audit findings in respect of DTL are as under:

- NABL provides government, industry associations and industry in general with a scheme of Conformity Assessment Body's Accreditation which involves third-party assessment of the technical competence of testing including medical and calibration laboratories, proficiency testing providers and reference material producers. Audit noted that DTL was not accredited by NABL as of August 2022.

Government stated (December 2022) that it has already started documentation work required as per ISO-17025 (accreditation standard) and that the laboratory will be NABL accredited after its upgradation. The fact remains that DTL was yet to be accredited by NABL though it was established in 2001.

[2] GAP analysis report submitted by the Committee constituted in association with Director of Regional Drugs Testing Laboratory, CDSCO, Government of India, Chandigarh

- DTL had not established microbiological drugs testing laboratory nor it had increased the capacity of existing lab up to 5000 tests per annum.

  The Government stated (December 2022) that as per the request made by it to The Central Government, an emergency arrangement for testing of such samples of drugs has been made and accordingly only a limited sample was sent to RDTL Chandigarh. Regarding targeted capacity for testing of 5000 samples per annum it was stated that it can be achieved only after completion of both the phases of upgradation as per Gap Analysis Report.

- Against the sanctioned strength in 16 technical posts, only 9 staff were available (September 2022).

The Department informed (December 2022) that the process for filling up of vacant posts has been initiated.

Recommendation 8.4: The Government may take immediate action to upgrade and enhance the capacity of DTL to strengthen the drug testing regime.

8.2.4.2 Sample testing by the Drugs Control Department

i. Further, Expert Committee[3] had *inter alia* recommended (November 2003), that States should plan to take more samples to check the quality of drugs manufactured and sold in the market. It was observed that the samples were being collected mainly to keep surveillance on the quality of drugs moving in the market and on receipt of specific complaints about the quality of a particular drug.

[3] Expert Committee constituted by Ministry of Health and Family Welfare, GoI, to examine all the aspects regarding the regulatory infrastructure and extent and problem of spurious/substandard drugs in the country.

Table 8.1: Details of samples tested

Period	Number of Licenced Firms			No. of samples tested						No. of samples failed					
	Sales Establishments	Manufacturing Establishments	Total (2+3)	At DTL, GNCTD(% of sample tested with respect to total no. of licenced firms)		At RDTL, Chandigarh(% of sample tested with respect to total no. of licenced firms)		Total (5+6)		At DTL, GNCTD (% of sample failed with respect to no. of total sample tested)		At RDTL, Chandigarh(% of sample failed with respect to no. of total sample tested)		Total	
				Sales Establishments	Manufacturing Establishments	Sales Establishments	Manufacturing Establishments	Sales Establishments	Manufacturing Establishments	Sales Establishments	Manufacturing Establishments	Sales Establishments	Manufacturing Establishments	Sales Establishments	Manufa-cturing Establishments
2016-17	24474	851	25325	Data not available as records are not available after fire incident occurred on 05.07.2019 at DGHS. New Sample Register has been maintained w.e.f. July 2019.											
2017-18	26053	911	26964												
2018-19	28113	914	29027												
2019-20	30464	921	31385	433 (1.42)	13 (1.41)	28 (0.09)	3 (0.32)	461 (1.51)	16 (1.74)	13 (3.00)	2 (15.38)	6 (21.43)	3 (100.0)	19 (4.12)	5 (31.25)
2020-21	33454	691	34145	460 (1.37)	14 (2.03)	59 (0.18)	12 (1.74)	519 (1.55)	26 (3.76)	23 (5.00)	3 (21.43)	8 (13.56)	9 (75.0)	31 (5.97)	12 (46.15)
2021-22	32947	827	33774	595 (1.80)	2 (0.0)	82 (0.25)	4 (0.73	677 (2.05)	6 (0.73)	6 (1.09)	0 (0.0)	16 (19.51)	3 (50.0)	22 (3.25)	3 (50.0)
2022-23 (Till Sept 2022)	36363	861	37197	253 (0.69)	19 (2.21)	0 (0.0)	0 (0.0)	253 (0.68)	19 (0.05)	1 (0.39)	1 (5.26)	0 (0.0)	0 (0.0)	1 (0.53)	1 (0.05)

Source: Information provided by DTL

ii. It can be seen from **Table 8.1** that in comparison to the total number of licensed firms (sales and manufacturing establishments), the number of samples tested at DTL was 0.73 to 1.76 *per cent* and at Regional Drug Testing Laboratory (RDTL), Chandigarh, ranged upto 0.25 *per cent* during 2019-20 to 2022-23 (till Sept 2022).

iii. In respect of samples collected from manufacturing establishments and sent for testing at DTL, failure rate ranged from 15.38 *per cent* (2019-20) to 21.43 *per cent* (2020-21) whereas the failure rate of samples collected from sales establishments ranged up to five *per cent* during 2019-20 to 2021-22. The samples sent for testing of biological products at RDTL, Chandigarh were miniscule compared to the number of units/ establishments dealing with biological products. The failure rate of biological samples tested at RDTL, Chandigarh for the period 2019-20 to 2021-22 was up to 21.43 *per cent* for sales establishments and between 50 *per cent* and 100 *per cent* for manufacturing establishments. During 2022-23 (upto 30 September 2022) no sample was sent for testing to RDTL Chandigarh. It is pertinent to mention that biological products include vaccines, blood and its components, etc. which tend to be heat sensitive and susceptible to microbial contamination. A small amount of contamination can destroy a whole batch and cause serious health problems if consumed.

Government stated (December 2023) that the Drugs and Cosmetics Act and Rules framed thereunder do not necessitate drawing of samples of drugs from

each and every licensee unit. Moreover, the Department is working with meager strength of Inspectorate staff against the recommended strength. It further stated that they have taken steps for filling up of vacant posts of Drugs Inspectors from UPSC. Regarding sending of limited samples to RDTL, Chandigarh, it was stated that samples of biological products were taken for test and analysis only on complaint basis.

The reply has to be viewed in the light of the recommendations of the expert committee stating *inter alia* that States should plan to take more samples to check the quality of drugs manufactured and sold in the market.

As regard to complaint based practise of testing biological products, this may not be an optimal measure to ensure the quality of biological products available in the market.

Recommendation 8.5: The Government may take immediate action for ensuring lifting and testing of adequate number of samples from all units that are manufacturing/dispensing medicines including biological samples as per National Blood policy.

8.2.4.3 Lack of compliance to National Blood Policy

Objective 3.1 of the National Blood Policy (NBP) stipulates setting up of Vigilance Cell under DCD to ensure minimum standards for testing, processing and storage of blood and its components. Audit noted that Vigilance Cell was not set up by DCD (September 2021). Thus the objective for ensuring minimum standards for testing, processing and storage of blood and its components could not be achieved.

DCD stated (August 2022) that after filling up the vacant posts of Inspectors, a dedicated Vigilance Cell for Blood banks will be set up.

Similarly, objective 8.4 of NBP prescribes creation of a separate Blood Cell with trained officers/inspectors for proper inspection of Blood banks and enforcement of conditions mentioned in the license. Audit noted that DCD, NCT of Delhi had not created separate Blood Cell (September 2021).

DCD stated (August 2022) that after filling up the vacant posts of Inspectors, a separate Blood Cell for Blood banks will be set up.

8.2.4.4 Huge pendency of test reports of samples

As per Sub-rule (1) of Rule 45 of the Drugs and Cosmetics Rules 1945, the government Analyst shall cause to be analyzed or tested such samples of drugs and cosmetics as may be sent to him by Inspector or other persons under the provisions of Chapter IV of the Act and shall furnish the reports of the results of test or analysis in accordance with these rules within a period of sixty[4] days of the receipt of the sample. Audit noted that during the years 2019-20 to

[4] Inserted by GSR 103 (E), dated 2nd February 2017

2021-22, test results of 1,463 samples were received in DCD after the prescribed time period (60 days).

Delay in testing of samples increases the probability of sub-standard drugs getting distributed and consumed by unsuspecting general public with potential harm to the persons consuming the same.

DCD stated (August 2022) that due to renovation of infrastructure in Delhi Testing Laboratory, testing was delayed along with non-availability of protocol/method of analysis, working standards, chemicals required for the tests and non-functioning of instruments required for analysis. As on date, there is no untested pending sample received in DTL, Delhi.

Recommendation 8.6: Government may ensure that reports of tests or analysis of samples are furnished by DTL promptly so that immediate action can be taken to prevent consumption of sub-standard drugs by general public.

8.2.5 Accreditation status of test checked hospitals

National Accreditation Board for Hospitals & Healthcare Providers (NABH) is a constituent board of Quality Council of India, set up to establish and operate accreditation programme for healthcare organisations. In the selected hospitals, neither LNH nor RGSSH was accredited by NABH.

NABL provides for third-party assessment of quality and technical competence of testing and calibration laboratories.

None of the four labs of LNH/MAMC were accredited by NABL. In case of RGSSH two out of three labs were not accredited. In the absence of proper accreditation of Clinical Establishments (CEs), running of CEs in Delhi without ensuring minimum standards of health care facilities and services cannot be ruled out.

Government replied (December 2023) that process for NABL accreditation of Bio-chemistry lab has been initiated.

Recommendation 8.7: The Government may strive to ensure NABH/NABL accreditation of hospitals and laboratories.

8.2.6 Bio Medical Waste Management

The Bio-Medical Waste (Management & Handling) Rules, 1998 were notified by GoI in 1998 which was amended and superseded by the Bio-Medical Waste Management Rules, 2016 (BMW Rules). These Rules *inter alia* lay down the procedures for collection, handling, transportation, disposal and monitoring of BMW with clear roles for waste generators and Common Bio Medical Waste Treatment Facility (CBMWTF). The Delhi Pollution Control Committee (DPCC) has been designated as prescribed authority to implement these rules in the National Capital Territory of Delhi.

In order to implement the BMW Management Rules, a Bio-medical Waste Management Cell (BMW Cell) was formed in 2001 in the Directorate General of Health Services for promoting, facilitation and monitoring the Biomedical Waste (Management & Handling) Rules 1998 in the health care facilities in Delhi.

In order to successfully implement BMW Rules, it was imperative for DGHS to maintain a detailed database of number and category of occupiers/health care providers operating in Delhi. As per Section 4 (g) of BMW Rules, all health care workers and others, involved in handling of BMW were to be provided training at the time of induction and thereafter at least once every year by the respective organisations. Rule 3C of BMW Rules stipulate that hospitals generating BMW should obtain authorization from DPCC and also send an annual report of quantity of BMW generated and disposed to DPCC.

Audit noted that

- DGHS/BMW Cell did not maintain details of health care facilities available in Delhi to plan, implement and monitor its activities relating to management of BMW. Department stated (December 2022) that inventorisation of occupiers and data on bio medical waste generation, treatment & disposal is done by DPCC as per the list of prescribed authorities and the corresponding duties under schedule-III of BMW Rules, 2016. Audit is of the view that in order to create coordination between various agencies for successful implementation of BMW Rules it is imperative for DGHS/BMW cell to maintain a detailed database of number and category of occupiers/health care providers operating in Delhi. Moreover, the Health Secretary is the chairman and DGHS is one of the members of the Advisory Committee formed for overseeing implementation of BMW Rules in Delhi.
- All deviations from the prescribed procedure for management of BMW by CBMWTFs were to be reported by every CDMO to Delhi Pollution Control Committee (DPCC) and DGHS twice a month. DGHS did not maintain records relating to receipt of any such report nor did it develop a monitoring mechanism for compliance to BMW rules. Department (December 2022) accepted the facts.
- As per the Outcome Budget of GNCTD, Annual Reports of DGHS and reply furnished by the Government (February 2023), number of healthcare workers under DGHS who were provided BMW management training during 2016-17 to 2021-22 ranged between 24.91 *per cent* and 78.05 *per cent*. For 2020-21, Department stated (December 2022) that training was organized through online mode due to Covid-19 pandemic.

Government stated (December 2023) that every district has constituted an independent District Level Monitoring Committee under the chairmanship of District Magistrate to oversee the implementation of BMW rules.

Reply is not acceptable as DGHS/BMW cell is overall responsible for implementation of BMW rules.

Recommendation 8.8: DGHS should evolve a mechanism for monitoring the daily functioning of CBMWTFs. DGHS should also ensure regular training to all its BMW workers.

8.2.7 Medical and Death Audit Committee(s) not constituted

As per IPHS, review of mortality that occurs in the hospital shall be done on fortnightly basis. As per the Standard Operating Procedure (SOP) issued by the DSHM, each hospital has to constitute an Internal Medical and Death Audit Committee. The committee was set up in LNH (July 2020), RGSSH and JSSH (May 2020) and CNBC (January 2022) for examining Covid deaths only. Even in Covid death cases, 707 deaths (March to June 2020) in LNH and 42 deaths (March to May 2020) in RGSSH were not subjected to such audit, thereby depriving hospitals the feedback for making informed decisions in clinical care.

Government did not offer any comment in its reply dated 13 December 2023.

Chapter IX

Sustainable Development Goals-3

Chapter IX

Sustainable Development Goals-3

An examination of individual indicators relating to 'SDG-3-Good Health and well being' revealed Delhi was seriously lacking under two indicators, viz. case notification rate of Tuberculosis[1] and suicide rate. Audit observed various deficiencies in implementation of Revised National Tuberculosis Control Programme (RNTCP) such as shortcomings in creating awareness about TB, Non-formation/ delay in formation of District DR-TB Committees, inadequate monitoring of implementation of the scheme, shortage of staff for TB incidence/treatment related activities, etc. which may have contributed towards the weak performance of Delhi in this regard.

9.1 Introduction

The Sustainable Development Goals (SDG) adopted in September 2015 set out a vision for a world free of poverty, hunger, disease and want. *SDG-3, "Good Health and Well-Being"*, calls on countries to ensure healthy lives and promote well-being for all at all ages and aims to ensure that people enjoy a level of health that enables them to lead a socially and economically productive life. It also aims to end preventable deaths across all ages from communicable and non-communicable diseases.

9.2 Implementation and monitoring of SDG-3

In Delhi, various health programmes are implemented by District Programme Officers (DPOs) under the supervision of State Programmme Officers (SPOs). DFW stated that several committees/boards were monitoring schemes related to healthcare services for achieving SDG-3 goals.

An examination of individual indicators revealed Delhi was seriously lacking under two indicators, viz. case notification rate of Tuberculosis[2] and suicide rate. Total case notification rate of Tuberculosis (TB) per lakh population in 2019-20 was as high as 544 against the SDG target of 242 cases and an average of 177 cases in India. The TB cases in last five years, as informed by DSHS were as shown in the **Table 9.1**.

[1] The number of TB cases (new and relapse) notified to the national health authorities during a specified period of time per 100,000 population.

[2] The number of TB cases (new and relapse) notified to the national health authorities during a specified period of time per lakh population.

Table 9.1: TB cases notified during the last five years

Year	Population	Total TB cases notified by DGHS	TB cases per lakh as Niti Ayog
2016-17	1,87,78,254	62,706	333.92
2017-18	1,91,38,797	55,200	288.42
2018-19	1,95,06,262	90,580	464.36
2019-20	1,98,80,782	1,08,225	544.37
2020-21	2,02,62,487	88,018	434.38

Source: Figure furnished by DSHS

Further, suicide rate per lakh population in Delhi was 12.7 as compared to national average of 10.4 and SDG target of 3.5 (2020). Since there was no monitoring mechanism for watching achievement of goals under SDG-3, audit could not ascertain as to whether adequate attention was being given to these two aspects of SDG-3.

In its reply the DFW stated (August 2022) that all the processes are being implemented as per the National and State Policy directives.

Audit observations regarding deficiencies in implementation of schemes for reducing case notification rate of tuberculosis, viral hepatitis infections and neo-natal mortality rate are discussed in the succeeding paragraph.

9.3 Revised National Tuberculosis Control Programme (RNTCP)

The Ministry of Health and Family Welfare, GoI issued technical and operation guidelines for Tuberculosis Control 2016 and guidelines on Programmatic Management of Drug Resistant TB (PMDT) 2017 under RNTCP.

Deficiencies noticed in implementation of the Programme were as under:

- **Awareness activities not conducted by State TB Cell:** Information, Education and Communication (IEC) activities/advocacy campaign is very important and an integral part of the action plan to eliminate TB through which awareness is created amongst all stakeholders and general public about TB and directly observed therapy.

  Audit noted that although State TB Cell planned to conduct/execute IEC activities during 2016-17 to 2020-21, proposals for the same were never finalized and no IEC activity was conducted during 2016-17 to 2020-21. The budget for IEC activities for 2016-21 was ₹ 642.15 lakh against which an expenditure of only ₹ 16.10 lakh was incurred.

  In its reply, the SPO (RNTCP) stated (July 2022) that all the IEC activities could not be carried out during 2016-21 due to administrative delay.

  Government stated (December 2022) that due to COVID in 2020-21 and 2021-22 mass public gatherings could not be held for general public awareness.

  Reply is not acceptable as IEC activities were not conducted even prior to Covid-19.

- **Not-forming/delay in formation of District DR-TB Committee:** PMDT guidelines 2017 provides for a district DR-TB Committee to be formed in chest clinics of all district DRTB Centres. DR-TB Centres are responsible for initiation and management of uncomplicated DR-TB patients like RR-TB or H mono/poly DR-TB in a district.

  Audit observed that out of 25 chest clinics in DRTB Centres, five chest clinics did not constitute DR-TB Committee (June 2022) and four chest clinics had formed committee with delays ranging from 12 to 36 months. Reasons for not conducting regular meeting on monthly basis was attributed (May 2022) to Covid-19, but the reply was silent about the period before Covid-19.

  Government stated (December 2022) that constitution of district TB Committee is under process.

  Further, as per instructions issued by GoI (25 June 2018), all State Governments were required to create TB Forum (by 31 October 2018) to end TB by 2025.

  Audit noticed that no district TB Forum was constituted in two chest clinics and these were constituted with delays of 8 to 26 months in 18 chest clinics. Moreover, not even a single meeting was held in 15 chest clinics to discuss such an important issue.

- **Monthly performance review meetings not conducted:** As per RNTCP guidelines, performance review meeting was required to be conducted by District TB officer (DTO) on monthly basis.

  Audit observed that only 111 performance review meetings were conducted by the DTOs against the prescribed 180 meetings, during 2017-21.

  Reasons for short conducting of meeting was attributed (May 2022) to Covid-19, however the reply is silent to period prior to Covid-19.

- **Inadequate evaluation visits to districts:** Operational guidelines 2016 provides for the State Internal Evaluation Team to evaluate at least two districts per quarter with an aim to cover all districts at least once in 3-4 years and to review the overall performance of the district and to give their valuable suggestions/recommendations so that specific areas which need improvement in the quality of program could be achieved. Audit noticed that internal Evaluation Team had visited and evaluated only 13 out of 25 chest clinics located in 11 districts during 2016-20 against the prescribed 32 (two districts per quarter) visits. Audit further observed that 13 chest clinics have never been evaluated by the internal Evaluation Team during 2016-17 to 2019-20 whereas as per guidelines all districts were to be covered at least once in 3-4 years.

Government stated (December 2022) that quarterly visits were conducted, but during COVID-19, these evaluations visits could not be conducted.

Reply is not acceptable as no documents/reports of quarterly visit reports were available with them.

- **Inadequate monitoring of PMDT activities:** As per PMDT Guidelines, 2017, activities of PMDT were to be monitored and supervised through visits to Designated Microscopic Centres (DMCs)/ TB units etc. periodically by supervisory staff. As per the guidelines, district TB officers were required to visit TB units 3 to 5 days a week, Medical Officers of District Tuberculosis Centre were to visit TB units every month and DMCs/CHCs/PHCs every quarter and Medical Officers- TB Control were required to visit DMCs every month. It was observed that these prescribed supervisory visits were not conducted by any of the designated officers.

  DTO stated (May 2022) that it was not feasible for the DTO to conduct supervisory visits. Further, due to shortage of Medical Officers- TB Control, these activities could not be conducted.

- **Shortage of staff in DDR-TB Centre and Tuberculosis Units:** As per technical and operation guidelines for Tuberculosis Control 2016, one permanent Senior Treatment Supervisor (STS) and one Senior Treatment Laboratory Supervisor (STLS) was to be posted in Tuberculosis Units (TU) per 1.5 to 2.5 lakh population for appropriate monitoring.

  Audit observed that in the selected districts, NDMC chest clinic and South-East district was having only one STS and two STLS against requirement of four STSs/STLS. Further, posts of District PPM Coordinator, District Programme Coordinator and District Accountant and Driver were also vacant and no full time Medical Officer - Tuberculosis Control (MOTC) was recruited/posted. Also, there was no post of Counsellor in the clinic.

  DTO accepted (May 2022) that there was a need to create a post of Counsellor for DDR-TB Centre and due to non-availability of Counsellor, the mental health assessment of TB patients was not carried out.

  Government stated (December 2022) that the concerned authority has been repeatedly apprised of vacant positions and the need for recruitments as per the National Tuberculosis Elimination Programme guidelines.

- **Status of training of District Tuberculosis Officers (DTOs) at national level:** As per RNTCP structure organogram, DTOs posted in each district should be trained at national level and are responsible for the overall planning, training, supervision and monitoring of the programme in the district.

  Audit observed that out of the three selected districts, only two DTOs had received the training at national level.

- **Drugs not tested for quality:** As per the protocol developed by Central TB Division, random samples of second-line Anti TB Drugs were required to be picked up from all stocking points in the field and sent for testing by an approved independent drug testing laboratory to ensure that quality of drugs is continuously maintained and remains the same throughout the supply chain of drugs.

  Audit noted that in the three selected districts, no random samples of second-line Anti TB Drugs were ever picked from the stocking points and tested for quality during the period under audit.

- **Absence of contract for pest control:** PMDT guidelines stipulate that the drug store should be free from all types of pests, rodents etc. and a contract for pest control should be entered into by the Government.

  Audit observed that the State TB Cell, Gulabi Bagh had no contract for pest control with any pest control agency or done through any other source. The same situation was found in NDMC chest clinic, Nehru Nagar chest clinic and Dr. BSA chest clinic, Rohini also. In the absence of pest control, it could not be ensured in audit whether medicines/ drugs were kept safe from pests and rodents.

  Government stated (December 2022) that a caretaking agency which provides such services in premises where State drug store and district drug store is available.

  Reply is not tenable as no documentary evidence was furnished to Audit in support of the reply.

- **Hygro-thermometers not installed:** As per technical and operation guidelines for Tuberculosis Control 2016, Hygro-thermometers were to be installed in District Drug Stores (DDS) to monitor humidity and temperature on a daily basis for storage of second-line Anti-TB drugs by the Store in-charge.

  Audit observed that second line drug store of State[3] and districts[4], had installed Hygro-thermometer, but the records to monitor humidity and temperature were not maintained by the Store in-charge and never reviewed by the Officer-in-charge. Therefore, it could not be ascertained in audit whether the second line Anti-TB drugs were kept at the required temperature so that efficacy of drugs could be ensured.

  Audit also observed that Air Conditioners and Hygro-thermometre were not installed at the BSA chest clinic which shows that second line Anti-TB drugs were not kept at the required temperature.

[3] Second Line Drug Store at Dwarka
[4] DTO, NDMC Chest Clinic, New Delhi, MCD Chest Clinic & Hospital, Nehru Nagar

- **Autoclave not procured:** State TB Cell proposed (November 2018) for procurement of 96 laboratory consumable-autoclaves for Chest Clinics/PHIs which were approved by the competent authority in December 2018.

  Audit noted that autoclaves have not been procured (May 2022) due to insufficient fund.

- **Nutritional support incentive not paid to notified TB patients:** Under the scheme of Nikshay Poshan Yojana (NPY), all notified TB patients are to be benefited @ of ₹ 500 per month (minimum) with effect from April 2018 as most of the patients were suffering from malnutrition mainly due to poverty. Nutrition support increases the ability to fight the disease. Audit observed that payment of ₹ 72.94 crore to 2.60 lakh beneficiaries was pending for the period 2018-19 to 2022-23 (November 2022).

  Further, in NDMC chest clinic, New Delhi, out of total 22,793 beneficiaries eligible for incentives for nutritional support, payments were made to only 13,241 beneficiaries and payment of ₹ 1.48 crore was still to be made to 9,552 beneficiaries. Similarly, in MCD chest clinic and hospital, Nehru Nagar, payments were made to 38,890 beneficiaries and payment of ₹ 4.22 crore was still to be paid to the 38,272 beneficiaries (as of May 2022).

  Government stated (December 2022) that due to non-availability of funds and non-availability of bank details of patients from outside Delhi, there has been delays in fund disbursement.

  Reply is not tenable as sufficient funds were lying unspent with DSHS.

- **Spittoon, disinfectant and reusable masks not provided to TB Patients:** As per technical and operation guidelines for Tuberculosis Control 2016, spittoons, disinfectants and reusable masks were to be provided to TB patients.

  Test check of records of NDMC chest clinic and MCD chest clinic and hospital revealed masks were not provided to patients thereby compromising with hygiene in these clinics.

- **Post treatment follow-up not conducted and feedback not obtained:** Scrutiny of treatment cards of TB patients revealed that no follow up of clinical, sputum and chest X-ray of treated patients was conducted after 6, 12, 18 and 24 months by NDMC chest clinic and MCD chest clinic and hospital, Nehru Nagar during the period 2016-2021. Further, in these clinics, no feedback was obtained from 2587 Drug Resistance (DR) TB patients, as required in PMDT guidelines 2017.

  Government stated (December 2022) that all patients are advised for regular follow up after therapy, but few come and feedback is not being taken from the patients.

- **Audit of death due to TB not conducted:** As per RNTCP guidelines 2016, Death audit of deaths of all TB Patients was required to be conducted by Medical Officer. The guidelines further provide that District Tuberculosis Officer (DTO) has to conduct death review of all MDR (Multi Drug Resistant) TB patients who died, with a view to understand the cause leading to death and to take appropriate action to prevent them. It was observed that 1188 deaths occurred in the selected three chest clinics during 2016-21, out of which 108 died due to MDR-TB. However, Death audit was not conducted in these Clinics nor any MDR-TB cases reviewed by the DTO.

  Government stated (December 2022) that verbal Death audit is being done at most of the chest clinics.

  The reply is not tenable as, in the absence of proper records, it would not be possible to analyse causes and take appropriate action.

The above deficiencies in implementation of RNTCP indicates that adequate attention is not being given to achievement of SDG in this regard by the Government.

Recommendation 9.1: The Government should strive to reduce the case notification rates of TB in Delhi by conducting awareness activities amongst all stakeholders and general public about TB and Directly Observed Therapy. Besides, activities mandated under RNTCP should be implemented by the State Government.

9.4 Lapses in implementation of National Viral Hepatitis Control Program

India is committed to progressively move towards elimination of viral hepatitis B and C and control other virus induced hepatitis which is in line with India's global commitment towards achieving SDG-3 by 2030. With this end in view, Government of India launched National viral hepatitis Control Program (NVHCP) for prevention and control of Viral Hepatitis. Audit noted that neither budget was demanded by the Delhi State Health Mission nor fund were released by the GoI (except ₹ 62.00 lakh released by the GoI under NVHCP during 2019-20 which remained unspent).

9.5 Private Hospitals/Nursing Homes for providing critical care to new born babies not empanelled

The SDG-3 targets to end preventable deaths of newborns by 2030, by reducing neonatal mortality rate to at least as low as 12 per 1,000 live births. As per NFHS 2019-21, the neo-natal mortality rate and infant mortality rate of NCT of Delhi was 17.5 and 24.5 per 1,000 live births respectively which is still high as compared to many other States/UTs in India.

The guidelines issued vide Office Memorandum (OM) dated 9 October 2019 by the DGHS states that NABH accredited hospitals with 100 beds or more having

more than five ICU beds & NABH accredited standalone nursing homes for new born care having at least 10 NICU beds are to be empanelled by DAK for providing critical care (NICU/PICU/ICU) to eligible patients. In this regard, empanelled hospitals/centres shall be paid at package rates fixed by DAK.

Audit noted that despite lapse of more than two and a half years from the date of issue of OM, no private hospital/nursing home was empanelled for providing critical care to the new born babies.

DAK stated (July 2022) that despite all efforts, none of the private hospitals turned up for empanelment and that the issue shall be taken up in the next meeting of the Governing Body. Government further stated (February 2023) that another request letter for the same will be issued to all hospitals after approval from the competent authority.

Reply is not acceptable as besides initial circulation of above mentioned OM, only a single request letter was issued by Delhi Arogya Kosh[5] in February 2020, to all private hospitals for empanelment. This shows insensitivity of the Department towards taking a step further in reducing neo-natal mortality rate by providing advanced medical care/facilities to eligible patients.

[5] Society set up by GNCTD for providing financial assistance to poor patients suffering from life threatening diseases.

Chapter X

Implementation of Programmes, schemes/projects/services of GNCTD

Chapter X

Implementation of programmes, schemes/projects/services of GNCTD

There was no monitoring of identified private hospitals by DGHS to ensure free treatment of EWS patients. There were cases of denial of free treatment coupled with poor complaint redressal mechanism. 19 government hospitals have not created special reference centres even after a delay of more than 15 years since pronouncement of judgement in this regard. 28 government hospitals referred only 43,951 patients whereas total 13.89 crore patients have taken treatment in Delhi government hospitals. Even after the Lieutenant Governor's directions, system of online Aadhar-based/biometric tracking of patients is yet to be implemented, indicating non-seriousness of the Department to ensure proper follow-up and develop a fool proof mechanism to rule out financial malpractices.

Very few people benefited from the schemes run by Delhi Arogya Kosh (DAK) due to lack of awareness about the schemes. There was a waiting period up to three and eight months respectively for various diagnostic tests and surgeries in LNH even though facilities for referring these cases to private empanelled hospitals was available under DAK scheme. Submission of certificate regarding, no payment made by the patient for the test/surgery was not ensured compulsorily by DAK before making reimbursements to the private hospitals/diagnostic centres. No mechanism was evolved by DAK for obtaining information regarding coverage of patients under any government/private medical insurance scheme before making payment to the hospitals concerned. There was lack of coordination between DAK and various health care agencies in Delhi for smooth implementation of DAK schemes.

Health Department planned about 30 projects/schemes/services during 2016-21 for improving health care services in Delhi. Audit requisitioned records relating to 15[1] projects/schemes/services out of which Department responded in respect of nine schemes only. Two major initiatives instituted by the Delhi government are free treatment for Economically Weaker Sections (EWS) and Delhi Arogya Kosh (DAK). Implementation of various projects/schemes and deficiencies observed therein are discussed in the succeeding paragraphs.

[1] Free Non- Radiological Diagnostics, Tele-Radiology, Tele-medicine/ medical facility, Up gradation of Dental Services at Bhagwan Mahavir Hospital, Jaldhara Point/ Water ATMs with free Wifi connectivity, Augmentation of Dental Department of GTBH, Kitchen and Dietary services by Bharat Aashara Social Organisation (BAS), Deployment of Patient Welfare officers in Delhi Govt. Hospitals on outsourced mode, CUG and standard handsets, Installation of Mobile Towers in institutions under H&FW, Jan Aushadhi Generic Pharmacy at Indraprastha Apollo Hospital Sarita Vihar, Hospital Information Management System (HIMS), Academic Programmes abroad for the in service Medical Professionals/ Paramedicals/ Nursing staff of the GNCTD, Installation of Smart Cameras in Delhi Govt. Hospitals, Health Card and Health Helpline

10.1 Free treatment to Economically Weaker Section (EWS)

High Court of Delhi, in a judgment[2], instructed all private hospitals which were allotted land on concessional rates by various government land owning agencies (DDA/LDO) to provide 25 *per cent* of their OPD facilities and reserve 10 *per cent* IPD beds for EWS patients. All the facilities including medicines, diagnostics services, surgery etc. were to be provided free of cost to these EWS patients.

10.1.1 Treatment of EWS patients by Identified Private Hospitals[3]

As per High Court orders, each Government Hospital (GH) was to set up special referral centres to refer EWS patient to Identified Private Hospitals (IPH) within two weeks (i.e. 5 April 2007). The IPHs were required to send a detailed report to DGHS after providing treatment to EWS patients. Audit noted that 19 out of 47 GHs[4] in Delhi had not established referral centres even after a delay of more than 15 years (as of June 2022). Apart from this, the EWS Cell under DGHS was also issuing referral letters to EWS patients.

10.1.2 Underutilisation of OPD and IPD facilities in IPH for EWS

There were total 9,116 beds available in 60 IPHs out of which 925 beds were to be reserved for EWS patients. Thus, there were 22.80 lakh bed-days available in IPHs for EWS patients during the period from January 2016 to September 2022. Information about the total OPD patients treated by these IPHs were not provided by DGHS.

The number of EWS cases referred by the Government Hospitals/ DGHS during the years from 2016 to 2022 (September) are given in **Table 10.1**.

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2 W.P.(C) 2866/2002 dated 22.03.2007

3 Private hospitals identified by State government for providing free treatment to EWS category patients.

4 JPN Apex Trauma Centre, Maulana Azad Institute of Dental Sciences, Ram Manohar Lohia Hospital, Smt. Sucheta Kriplani Hospital (LHMC), Hindu Rao Hospital, Kanti Nagar Maternity Hospital, Poor House Hospital, Sushruta Trauma Centre, All India Institute of Medical Sciences, Kalawati Saran Children Hospital, Safdarjung Hospital, Girdhari Lal Maternity Hospital, Kasturba Hospital, M.V.I.D. Hospital, NDMC Charak Palika Hospital, Palika Maternity Hospital, Rajan Babu TB Hospital, Swami Dayanand Hospital, Base Hospital

Table 10.1: Number of EWS patients referred to IPH

Sl. No.	Period/Year	Number of cases referred by Govt. hospitals	Number of cases referred by DGHS/ EWS branch	Total EWS cases referred
(1)	(2)	(3)	(4)	(5 =3+4)
1.	2016	771	448	1,219
2	2017	5,251	958	6,209
3	2018	15,146	5,338	20,484
4	2019	11,569	10,199	21,768
5	2020	4,486	7,670	12,156
6	2021	4537	11844	16381
7	2022 (September)	2191	13392	15583
	Total	**43,951**	**49,849**	**93,800**

Source: DGHS

Audit observed that utilisation of free facilities available for EWS patients at IPH was very poor. Even if it is presumed that all the patients referred to IPH were for IPD and each patient was admitted for average seven days, the bed-days utilization would be 6.56[5] lakh indicating that only about 28.77 *per cent* of the facilities available were utilised. The underutilisation of free OPD and IPD services at IPH needs to be viewed seriously especially in view of the fact that total 13.89 crore patients[6] have taken treatment in Delhi GHs in the same period i.e. 2016-17 to 2021-22.

Audit also examined consolidated data of utilization of EWS facilities in IPHs for a period of six months (January to June 2022) compiled by EWS cell, DGHS from information provided by IPHs. It was observed that only 60,192 (36 *per cent*) of total 1,67,425 EWS bed-days[7] and only 2,85,882 (52 *per cent)* of total 5,49,818 mandated free EWS OPD services were availed

In spite of quality OPD and IPD service being available at IPHs free of cost, the same could not be utilised due to inadequate referral system.

10.1.3 Strengthening of referral system

GNCTD had decided to deploy (April 2015) Liaison Officers (LO) in IPHs and linked Government Hospitals to facilitate treatment of EWS patients and maintain a record of complaints received from EWS Patients and to forward the same to the concerned departments and also send monthly/quarterly report to DHS (HQ). Additional Secretary (H&FW) and In-charge of EWS Cell had also directed (October 2017) that GHs should ensure that the number of referral from government hospitals be increased exponentially and directed LOs posted in IPHs to facilitate outdoor and indoor treatment and admission of EWS Patients. IPHs were also required to admit EWS patients directly for treatment in

5 93800x7

6 Source- Annual Report of Directorate General of Health Services for the period 2016-17 to 2020-21

7 925 EWS beds reserved in 60 IPHs *multiplied* by number of days

emergency. The nodal officer of the linked[8] government hospital was required to visit and verify the genuineness of the EWS patient admitted in emergency.

Audit noted that only 22 LOs were appointed for 43 IPHs (December 2020) with 12 LOs supervising more than one IPH. No LO was appointed in 14 hospitals. Audit also noted that LOs were not sending monthly and quarterly reports of EWS patients to DGHS on regular basis. Records relating to complaints received from EWS patients were also not maintained by LOs. The LOs posted in IPHs did not maintain the daily round register.

Besides, LOs were to be imparted training by DGHS for effective implementation of duties. Audit noted that no training was given to LOs.

10.1.4 Deficiencies in Separate Referral Centre in DGHS

No separate staff or space was earmarked by DGHS for the referral centre. Existing staff of EWS Cell was assigned the referral work also. There was lack of basic facilities like sitting arrangement, availability of water, toilet etc. Patients and their relatives were seen sitting on the stairs as shown in the **Picture 10.1**.

Picture 10.1: EWS patients or their relatives waiting to get referral letter

10.1.5 Record management of EWS patient by DGHS/IPHs

As per guidelines (September 2011) framed in compliance to Delhi High Court order, IPHs were to furnish EWS patient details to DGHS, such as name, father's name, age, whether referred or admitted on their own, Diagnosis, etc. on daily basis through email. It was also to maintain, *inter alia,* records of identification and verification of EWS patients. Such records should be produced to the officers designated by the GNCTD for monitoring free treatment to the eligible category of EWS patients in the IPD and OPD. However, it was observed that IPHs were not submitting the reports to DGHS as per guidelines.

In the absence of essential records, audit could not ascertain compliance of free treatment of EWS patients in IPHs as per the High Court judgement.

[8] To ensure compliance of the directions of the Hon'ble High Court of Delhi vide judgement dated 22.03.2007 in W.P.(C) No. 2866/2002 Identified Private hospitals were linked with the Government Hospitals.

10.1.6 Monitoring

With the aim of ensuring availability of free OPD/IPD facilities to EWS patients in hospitals (IPH and Government Hospitals), DGHS assigned (September 2016) Additional Directors and CDMOs of DGHS to visit particular Government hospital/IPHs. At least one hospital was to be visited every day and every night beginning, 19th September 2016 and continued until further notice. The report of the visit should be e-mailed by noon next day on the email address: dirdhs@nic.in. Audit noted that only one visit was conducted against the required 56,840[9] visits.

Further, a monitoring committee was constituted by the Government to monitor the implementation of free treatment to EWS patients in IPHs in accordance with Court direction.

Audit noted that only 23 inspections in respect of 20 IPHs (out of 60) were conducted during the audit period. The inspection proforma included important items such as free facilities available in the hospital, whether there is a separate ward for EWS patients, number of patients admitted at the time of inspection, total number of dialysis in the previous month etc. Audit observed that these were not filled completely.

Moreover, inspection reports were neither communicated to the IPH concerned nor follow up visit was conducted to ensure compliance. Thus, absence of required visits coupled with inadequate follow-up of visits shows that the work of the monitoring committee was deficient.

10.1.7 Inadequate complaint redressal mechanism

As per reply given to an RTI application by DGHS, 10,30,352 complaints were received[10] in EWS Branch up to December 2021. There was no system to watch timely disposal of complaints. Thus, the number of EWS complaints received and disposed could not be ascertained in audit. No oversight mechanism was in place to watch the redressal of complaints.

Examination of complaint files revealed that most complaints pertained to refusal of free treatment, not providing medicines/drugs, charging for bed/diagnosis/consultation etc. The reply of the complaints received from IPHs were forwarded to the complainants without verifying its correctness. LOs posted in the IPHs were not directed to verify complaint and reply.

Audit test checked complaint files of 18 IPHs. It was observed that:

- Complaints of 39 patients were pending for 132 to 1661 days for reply from IPHs **(Annexure VII)**.

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9 1960 days X 29 visits = 56,840 (14 Doctors were required to conduct at least one day visit and one night visit of designated IPHs/Government hospitals whereas one doctor was required to conduct at least one day visit of Government Hospital during the period 19.09.2016 to 31.01.2022)

10 via Hard Copy, PGMS, CPGRAMS and LG Listening against all IPHs

- 21 patients had complained about denial of free treatment and incurring expenditure (**Annexure VII**).
- 32 patients complained that they were denied free medicine.
- Two patients had complained of harassment.

10.1.8 Lack of awareness programmes

Audit noted that no awareness program was carried out during last five years by the DGHS/GNCTD to create awareness among all stakeholders. There was lack of awareness amongst doctors including resident doctors regarding provision of free treatment, free medicines and consumables being provided in IPHs.

10.1.9 Referral of EWS patients in LNH

During January 2016 to June 2022, only 3,362 patients and 209 patients were referred for OPD and IPD respectively to IPHs by LNH. Thus, LNH had referred an average of one EWS patient daily for OPD and one EWS patient per month in IPD. During the same period, LNH had provided treatment to 3,116 average OPD patients daily and 7,607 average per month in its IPD facilities.

Despite high OPD cases per doctor and high bed occupancy, LNH did not identify and refer eligible EWS patients to IPH for treatment.

10.1.10 Dialysis facility for EWS Patient in IPH

The Department had directed (October 2017) all IPHs to furnish to DGHS details such as number of dialysis machines and number of sessions performed by each machine per day to earmark 25 *per cent* of total machines or 25 *per cent* of the total sessions in each IPHs for EWS patients. No action was prescribed in the said direction in case of non-compliance by IPHs.

Audit noted that none of the IPHs has furnished the requisite information to DGHS.

10.1.11 IPD beds for EWS patients not earmarked

In order to facilitate indoor admission of EWS patients and to prevent the IPHs from earning unwarranted profit from the beds reserved for such patients, Health department, GNCTD had directed all IPHs to earmark and label 10 *per cent* bed across all facilities as "FREE BED" in a permanent and conspicuous manner. All IPHs should ensure that no paid patient is admitted on the earmarked beds. Compliance was to be ensured by Medical Director based on vetting by LO/Nodal officer.

Audit noted that no compliance report was forwarded by LO/Nodal officer concerned.

10.1.12 Display board for EWS

Each IPH shall affix at least one board (size 10 feet x 6 feet) between main entry and exit gate on the external boundary of the hospital in vernacular language regarding free treatment to EWS patients to the extent of 10 *per cent* IPD and 25 *per cent* OPD. The compliance report along with photograph was to be sent by each hospital to EWS cell latest by 1 November 2017.

Audit noted that none of the IPHs had furnished the compliance report.

10.1.13 Real Time occupancy of free bed through website as well as display board

Every IPH's reception area, emergency waiting area and admission counter must display real time availability of free beds. The same information must also be shown in the website of hospital concerned. A compliance report in this regard was to be sent to DGHS latest by October 2017. Audit noted that no compliance report was available with DGHS.

Thus, due to inefficient referral system, weak monitoring and poor complaint redressal mechanism, the Government could not ensure the full utilisation of free treatment facilities available to EWS patients in IPHs.

Government did not offer any comment in its reply dated 13 December 2023.

Recommendation 10.1: The Government should strengthen the referral system and ensure that IPHs comply with all the orders and instructions for optimum utilization of free OPD/IPD services for EWS.

Recommendation 10.2: The Government should set up an oversight mechanism to watch redressal of the complaints.

Recommendation 10.3: Government should widely publicise the benefit of the scheme among all stake holders.

10.2 Treatment of patients under Delhi Arogya Kosh (DAK)

Delhi Arogya Kosh (DAK) was constituted (September 2011) as a society to provide Financial Assistance (FA) to poor patients suffering from life threatening diseases. As per the eligibility criteria, bonafide residents of Delhi for the last 3 years and having National Food Security Card or income certificate of upto ₹ 3 Lakhs per annum issued by the Revenue Department of GNCTD are covered under DAK.

DAK was initially provided grant of ₹ 100 crore for creation of a corpus fund, to be deposited in an interest earning deposit. The interest earned on this fund was to be utilised for providing financial assistance to the eligible patients from the financial year 2012-13. Further, ₹ 10 crore was also separately provided for providing FA to beneficiaries during 2011-12.

Subsequently, four new schemes viz. (a) Free surgeries to eligible patients scheme, (b) Free high-end diagnostics scheme, (c) Free treatment to

medico-legal victims of road traffic accident, acid attack and thermal burn injury scheme, and (d) free dialysis scheme, were also started during 2017 and 2019. For implementing these schemes GIA of ₹ 50 crore per year was granted by GNCTD during 2018-19 to 2020-21.

During 2016-17 to 2021-22, DAK had incurred ₹ 175.22 crore for providing benefits to 3,83,629 patients under these schemes as detailed in **Table 10.2**.

Table 10.2: Expenditure incurred under DAK Scheme

Year	Grant (including Interest) (₹ in crore)	Expenditure (₹ in crore)	Number of Beneficiaries
2016-17	9.93	4.99	529
2017-18	6.86	24.58	49,004
2018-19	58.51	32.09	66,588
2019-20	62.16	40.34	86,697
2020-21	56.24	31.76	66,492
2021-22	6.57	41.46	1,14,319
Total	**200.26**	**175.22**	**3,83,629**

10.2.1 Non-maintenance of patient wise data benefitting from schemes

During 2016-17 to 2021-22, DAK had incurred ₹ 175.22 crore for providing benefits to eligible patients under these schemes[11]. As per pattern of assistance, DAK was required to maintain proper account of the amounts received and assistance rendered including the details of beneficiaries.

Audit however noted that DAK had not maintained scheme-wise details of beneficiaries. Similarly, DAK did not regularly seek UCs and details of unspent amount lying with government hospitals. On being pointed out, DAK replied (August 2022) that scheme wise details of beneficiaries are not being prepared due to shortage of staff and utilization of the financial assistance is now being updated as and when UCs are received. The Government further informed (February 2023) that now the patient-wise details for all the schemes are being maintained.

The reply is not acceptable. DAK should follow up receipt of pending UCs when due and seek remittance of unspent balances. Moreover, in the absence of records of beneficiaries to whom treatment was rendered, amount expended under different schemes could not be verified.

Recommendation 10.4: DAK should maintain scheme-wise details of beneficiaries and regularly seek UCs and details of unspent amount lying with government hospitals.

[11] Financial assistance for treatment in government hospital scheme include allocation of funds for the treatment of deserving patients in Government hospital where such facilities are not available free in the Government Hospitals, Free surgeries to eligible patients scheme, Free high-end diagnostics tests scheme, Free treatment to medico-legal victims scheme and Free dialysis to eligible patients scheme.

10.2.2 Aadhar-based/biometric tracking of patients

The Lieutenant Governor of Delhi had directed (16 January 2018) to develop a system of online Aadhar-based/biometric tracking of patients to ensure proper follow-up and to prevent any malpractices. GNCTD had also approved (August 2019) development of an online mobile application for tracking of patients and record maintenance.

Audit noted online Aadhar-based/biometric tracking of patients was not implemented as of February 2023.

Recommendation 10.5: DAK should take concrete steps for developing a system of online Aadhar-based/biometric tracking of patients to ensure proper follow-up and to prevent any malpractice.

10.2.3 Non-maintenance of information on transfer of medico-legal victims

As per DAK guidelines[12] all private nursing homes/hospitals were to provide cashless treatment to medico-legal victims of road accident, acid attack and thermal burn injury, where the incident has occurred in NCT of Delhi. If nursing homes/hospitals are not equipped to handle such cases, they should transfer victim to an appropriate higher centre with requisite facilities and accordingly inform DAK within 24 hours. In case the transfer/referral is not found satisfactory, DAK may issue Show Cause Notice under Delhi Nursing Homes Registration Act, 1953 as to why registration of the private nursing home/hospital concerned should not be cancelled.

Audit observed that no information regarding transfer of medico-legal victims to another medical establishment was being sent by the nursing home/hospitals and no mechanism was developed for receiving information of such transfers from private nursing homes/hospitals.

In four complaint cases, referring hospitals had transferred patients without intimation to DAK. Audit noted that in these cases no action was initiated by DAK.

DAK stated (July 2022) that due to shortage of staff, monitoring of transfer of medico-legal victims of road accident from one private hospital/nursing home to another higher medical establishment could not be ensured and staff handling the complaint cases shall be assigned this work from now onwards. Thus in the absence of monitoring mechanism treatment of medico-legal victims during golden hour carries the risk of denial.

The Government assured (February 2023) that online database will be available soon for tracking such patients.

[12] OM No. E. 4125/10665-10681 dated 15 February 2018 issued by DAK

10.2.4 Awareness on Schemes run by DAK

Memorandum of Association of DAK provides for communication of health education activities, preparation and distribution of publicity material relevant to the basic aims and objectives of the Society.

The status of beneficiaries in the five schemes during 2016-17 to 2021-22 is given in **Table 10.3**.

Table 10.3: Status of beneficiaries in the five schemes during 2016-17 to 2021-22

Name of the scheme	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	Total
Financial Assistance to patients	529	1,025	887	863	801	1,081	**5,129**
Free treatment to medico-legal victims	Nil	Nil	1,800	4,299	6,233	5,483	**17,788**
Free high-end diagnostics	Nil	46,364	61,638	78,867	56,758	1,03,918	**3,47,813**
Free surgeries to the eligible patients	Nil	1,615	2,263	2,250	1,459	2,149	**9,737**
Free dialysis to the eligible patients	Nil	Nil	Nil	418	1,241	1,688	**3,347**
	529	49,004	66,588	86,697	66,492	1,14,319	**3,83,629**

Source: Annual Reports of DGHS

Audit noted that publicity of basic aims and objectives of the Society was carried out on three occasions (2014, 2017 and 2019) through distribution of catalogue/booklets/advertisement in newspaper/website. Orders for displaying information of the schemes in government hospitals was issued only once in 2017. Besides, the Department failed to show any efforts made by it for publicity of free dialysis scheme.

DAK stated (July 2022) that advertisement for creating awareness in general public was done widely through leading newspapers on 2 March 2019. As regards advertisement of free dialysis, it stated that the scheme was initiated as a temporary measure till the time 100 additional dialysis machines are procured. Government further replied (December 2022) that dialysis was a part of free surgery scheme and was included in the package adopted by DAK. Accordingly, no separate advertisement was done for dialysis. Government further stated (February 2023) that during September 2022, articles regarding the schemes of DAK was published in leading newspapers.

Reply is not tenable as regular publicity needs to be made through various modes.

Recommendation 10.6: DAK should take concrete steps for educating public as well as medical staff by doing more publicity of these schemes so that number of people benefitting from these schemes could be increased.

10.2.5 Inadequate referral of patients under free high-end diagnostic test and surgery scheme

Free surgery scheme of DAK provides for sending eligible patients from identified Delhi government hospitals to empanelled private hospitals when the allotted date for specified surgery is beyond one calendar month or when the specified surgery is not performed in the government hospital. Similarly, in Free high-end diagnostic test scheme, patients from identified Delhi government hospitals, polyclinics, Delhi government dispensaries and mohalla clinics are referred to empanelled diagnostic centres.

DAK did not carry out any assessment to verify the effectiveness of steps taken to reduce waiting period, by referring the patients to the empanelled hospitals and diagnostic centres. However, examination of records of the selected hospitals revealed that patients had to wait up to eight months in case of surgery and upto three months for diagnostic purpose, as discussed in paragraphs 3.2.4.1 and 3.5.1 of this report. Government stated (February 2023) that sensitization meeting/training regarding schemes was held with all Nodal officers of GNCTD in the month of September 2022.

Recommendation 10.7: DAK should increase referral of patients to the empanelled hospitals and diagnostic centres to reduce waiting period in government Hospitals.

10.2.6 Irregular reimbursement to empanelled hospitals/diagnostic centres

As per a condition of DAK authorisation form, patients concerned shall certify on the bill of the diagnostic centre/hospital regarding no payment made by him/her for the test/surgery.

Audit noted that 437 bills (27 *per cent)* out of 1600 did not bear the required certificate of 'No payment'. Thus, reimbursement was made to the hospitals/ diagnostic centres without ensuring the same.

Proper authorisation of payment in all cases were not followed to prevent exploitation of needy eligible patients by private empanelled hospitals and diagnostic centres.

The DAK stated (August 2022) that 'No payment' certificate shall be ensured.

10.2.7 Payment to medico-legal victims without ensuring their medical insurance status

Reimbursement of bill for treatment to Medico-legal victims of road traffic accident, acid attack and thermal burn injury was subject to admission of the victim in lowest economy category throughout their period of stay and the victim not being covered in any insurance scheme.

17,815 patients had availed the benefits (2018-19 to 2020-21) for which payment of ₹ 28.97 crore was made to the hospitals concerned.

Audit noted that no mechanism was in place to check whether patients were under any government/private medical insurance scheme before making payment to the hospitals concerned.

Government while referring to OM dated 15 February 2018 stated (February 2023) that no such condition was mentioned in the Cabinet Decision and the approval of Hon'ble Lieutenant Governor. Hence, information regarding insurance status was not sought from the hospitals/victims.

Reply of the Government is incorrect as the issue flagged in the OM referred above is related only to amendment in the eligibility criteria in respect of domicile and income status of the victim for receiving cashless treatment and did not exempt the Department from ascertaining the status of patients with regard to coverage under health insurance schemes.

Recommendation 10.8: DAK should compulsorily ensure medical insurance status of the patient before making payment.

10.2.8 Grievance Redressal Mechanism

DAK did not furnish any complaint register/data showing patient wise complaints received physically or through email for the audit period. Complaints received through PGMS, emails and in physical form were not recorded in any register and were dealt in a file separately.

DAK stated (August 2022) that all complaints received physically as well as through email are now being recorded in a register and it is making all efforts to address these grievances in a time bound manner.

Government further replied (December 2022) that most of the complaints of DAK are received through online mode on PGMS/CPGRAM/LG Listening posts and only few are being received on hard copy. A record of PGMS complaints, CPGRAM & LG Listening was shared with the Audit Team. Till March 2022, a total number of 810 grievances were received in PGMS and disposal by this Branch was 100 *per cent*.

Reply is not acceptable as DAK in its reply dated August 2022 has expressed inability to submit the records of complaints due to a fire incident in July 2019 and misplacing of complaint file thereafter. Through reply dated June 2022 it was also stated that data of complaints received through CPGRAMS & LG Listening post could not be provided due to non-availability of downloading facility in the respective portal. Data of complaints received physically or through email was also not provided as the same was not being prepared. As far as year wise PGMS complaints are concerned, only number of complaints received and disposed of were provided instead of year wise complete details and action taken thereof as requisitioned by audit.

10.2.9 Comparison of Ayushman Bharat and DAK schemes of GNCTD

Cost of funding of PM-JAY (Ayushman Bharat) is shared between Central and State Governments. The primary objectives of PM-JAY are to provide comprehensive coverage for catastrophic illnesses, reduce catastrophic out-of-pocket expenditure, improve access to hospitalization care, reduce unmet needs, and to converge various health insurance schemes across the States. The scheme provides a defined health benefit cover of ₹ 5 lakh per family per year for hospitalised treatment including three days of pre-hospitalization and 15 days of post-hospitalization expenses. Services include approximately 1,387 procedures covering all the costs related to treatment, including but not limited to drugs, supplies, diagnostic services, physician's fees, room charges, surgeon charges, OT, and ICU charges.

Eligibility for benefits under the scheme is based on the Socio-Economic and Caste Census data 2011 and include categories such as washermen/chowkidars, ragpickers, mechanics etc. in urban areas.

A comparison of Ayushman Bharat in three states with DAK schemes of GNCTD is given in **Table 10.4**.

Table 10.4: Comparison of Ayushman Bharat and DAK scheme of GNCTD

Name of the State	Population of the State (as per 2011 census)	Registered members	Hospital admission authorized amount (₹ in crore)	No of hospital admission/ beneficiaries	Amount spent per thousand registered /eligible population (₹ in lakh)	Beneficiaries per thousand registered/ eligible members
Ayushman Bharat						
Haryana	2,53,51,462	85,41,800[13]	1260.38	8,92,786[14]	14.76	105
Uttrakhand	1,00,86,292	51,76,228	1592.19	8,46,161	30.76	163
Punjab	2,77,43,338	79,06,006	2020.59	16,47,674	25.56	208
Delhi Arogya Kosh						
Delhi	1,67,87,941	72,75,809[15]	229.45	5,48,992[16]	3.15	75

It can be seen from **Table 10.4** that the beneficiaries covered per thousand registered members under Ayushman Bharat scheme in three states were significantly higher than the beneficiaries covered per thousand eligible population under the DAK scheme. Similarly, amount spent per thousand registered population in Ayushman Bharat scheme was also higher than expenditure per thousand eligible population in DAK scheme.

[13] Total registered members in respect of Haryana, Uttarakhand and Punjab under Ayushman Bharat (August 2023)

[14] Ayushman Bharat figures in respect of Haryana, Uttarakhand and Punjab from the launch of the scheme in September 2018 to August 2023.

[15] Number of members provided Food Security as on August, 2023 as per website of Department of Food, Supplies and Consumer Affairs, GNCT of Delhi

[16] DAK scheme figures covered period from April 2018 to July 2023.

Government confirmed (December 2023) audit findings with regard to implementation of DAK scheme.

10.3 Jan Aushadhi Generic Pharmacy not established

Setting up a Jan Aushadhi Pharmacy at Indraprastha Apollo Hospital was approved by GNCTD (June 2016) with the objective of providing drugs/logistics/consumables and improved pharmacy services to the Economically Weaker Section (EWS) patients undergoing treatment. However, Jan Aushadhi Generic Pharmacy was not established at Indraprastha Apollo Hospital as of July 2022.

DGHS replied (July 2022) modalities for operationalization of the proposed pharmacy could not be finalized. Reply of the Department shows its insensitivity towards the EWS patients.

10.4 Health Helpline Services not established

GNCTD had announced (June 2018) a 24x7 health helpline for providing health advice and counselling service by doctors/ paramedics/counsellors to people of Delhi. Budget provision of more than ₹ one crore was made during 2017-18 to 2021-22. Audit noted that no expenditure was made on the scheme as tendering process was not finalised (June 2022).

DGHS stated (March 2022) that helpline would be integrated in the proposed Delhi Health Information Management System (DHIMS). The fact remains that a service envisioned in 2018 is yet to be implemented.

10.5 Health Card Scheme not implemented

During 2015-16 to 2020-21, Delhi Government *inter alia* had repeatedly announced in its budget speeches (2015-16, 2016-17 and 2020-21) implementation of individual Health Card to people of Delhi for registration and treatment in different Delhi government hospitals. The Card would include demographic and clinical details and would be helpful in facilitating enrolment in health schemes of GNCTD. Notice inviting expression of Interest was issued in February 2018. Audit however noted that the scheme could not be implemented (June 2022) as tenders were not finalised.

10.6 Delay in implementation of Health Information Management System

Delhi government in its budget speech (2016-17) had proposed implementation of Health Information Management System (HIMS) in Delhi for connecting all government hospitals, poly-clinics, mohalla clinics etc.

Audit noted that the work was awarded only in June 2022. An amount of ₹ 5.31 crore was incurred for conducting feasibility study and preparation of scope of work etc. Thus, the Department could award the work only after a gap of seven years from announcing the same.

10.7 Hospital Management Information System/e-Hospital not established

Government of India urged (December 2015) all State government hospitals to implement 'e-Hospital' application developed by NIC. Accordingly, in October 2017, Department of Health & Family Welfare, GNCTD directed all hospitals to implement e-Hospital to automate all major functional areas.

Audit noted that none of the test checked hospitals had implemented e-Hospital/HMIS. In LNH, although 35 computers were purchased (January 2021), the implementation of e-Hospital/HMIS was still pending.

LNH stated (May 2022) that implementation of separate HMIS is in process in the Department. The fact remains that the hospital is yet to establish the system or an alternative.

10.8 Delhi Healthcare Corporation (DHC)

With the aim of shifting non-clinical and administrative work such as tendering, contract management, etc. from the doctors including specialists and paramedics in government hospitals, the Delhi Healthcare Corporation (DHC) was incorporated (May 2016) as a public limited company to provide these support services in all health units of GNCTD.

Audit noted that DHCL had not started operation. Besides, ₹ 5 crore was given to DHCL from Delhi Aarogya Kosh (DAK) scheme in 2016-17 and interest accrued thereon remained unutilized (March 2022).

10.9 Tele-medicine facility

Department of Health, GNCTD took up (Febuary 2016) a project for implementation of Tele-medicine network in NCT of Delhi, being funded by the Department of Information Technology (DeitY), GoI. Despite availability of budget, audit noted that no expenditure was incurred in the scheme since its inception due to delays in finalization of space for tele-consultation centers in peripheral hospitals (March 2022).

10.10 Tele-Radiology Services

GNCTD had proposed (2016-17) setting up of Tele-radiology service to facilitate image transmission and reporting of X-ray films in all radiological/ imaging diagnostic facilities for further timely action. It was also envisaged that this service will be useful where there is shortage of man power, especially Radiologists, in the peripheral hospitals.

Audit noted that the scheme was not implemented even after a gap of five years since the proposal due to not furnishing requisite details i.e. the numbers, age analysis, functionality and human resources deployed by all the concerned hospitals of Delhi government.

DGHS stated (February 2022) that the draft tender documents is being prepared.

10.11 Lack of coordination and seriousness while facilitating health care facilities

10.11.1 Lack of coordination between DGHS and GNCTD hospitals

During audit, it was noticed that there was lack of coordination in Government within their own agencies, departments and institutions providing health facilities. DGHS has a Hospital Coordination Cell (HCC), coordinating with Delhi government hospitals on day-to-day basis for sharing/ seeking information. Audit noticed that despite having HCC, DGHS could not get complete information required (July 2016) to assess the status of existing radiology equipment available in the Delhi government's hospitals with regards to numbers, age analysis, functionality etc., as only 29 out of 38 hospitals had responded (February 2022) in spite of repeated reminders. Thus, DGHS could not ascertain the number and status of CT and MRI machines, which are high end radiology equipment in GNCTD hospitals.

10.11.2 Lack of seriousness regarding response to Audit queries for health care facilities

During audit, records and information related to Delhi Health Corporation Ltd. was requested (March 2022) from the DGHS, CPA office and Department of Health and Family Welfare. DGHS had forwarded (dated 16 March 2022) the Audit requisition to the Department and to CPA, with a request to submit the respective replies, information and records to Audit Party. Similarly, Department had forwarded the audit requisition to DGHS (March 2022) with a request to look into the matter and submit the reply immediately along with the copy to Audit. This attitude of the offices shows a lack of seriousness in response to Audit queries.

Chapter XI

AYUSH

Chapter XI

AYUSH

Number of IPD and OPD patients visiting AYUSH hospitals had declined during the 2016-22. Pathology lab, maternity ward and radiology department in one of test checked hospital were not functional/partially functional. There was huge shortage of essential medicines in both the test checked hospitals.

Savings were noticed under the heads 'Supply & Medicine' and 'Machinery & Equipment' despite shortage of medicines and equipment in both the test checked hospitals. The overall shortage of staff in AYUSH Departments was 57.97 *per cent*. Shortages in the cadres of doctors (51.89 *per cent*), paramedical staff (55.93 *per cent*) and nurses (32.21 *per cent*) were noticed in the four[1] medical colleges with attached hospitals.

Four equipment costing ₹ 45.98 lakh procured (March 2018) for Pathology lab in one of test checked hospitals was not put to use and was lying idle.

GNCTD did not set up a State AYUSH Society nor did it submit State Annual Action Plan to GoI for availing financial benefit under National AYUSH Mission from 2016-17 onwards. An amount of ₹ 3.83 crore was still lying unutilized with GNCTD/Directorate of Ayush from the grant received under National Ayush Mission during 2014-16.

There was shortfall in conducting mandatory inspections of manufacturing and selling units of Ayurveda and Unani drugs.

Delhi Bhartiya Chikitsa Parishad (DBCP) constituted for providing registration of medical practitioners of Indian Systems of Medicines was not reconstituted since July 2015. Delhi Homoeopathy Anusandhan Parishad (DHAP) constituted to develop and coordinate research in Homoeopathy was not functional since 2017-18.

11.1 Introduction

The Government of National Capital Territory of Delhi (GNCTD) established (May 1996) a separate Directorate of Indian Systems of Medicine and Homoeopathy (ISM&H) under the Health and Family Welfare Department (DH&FW) to encourage the use of alternative systems of medicines such as Ayurveda, Yoga, Unani, Siddha and Homoeopathy (AYUSH) in healthcare delivery and to ensure propagation of research and education in these systems. The ISM&H was renamed as Directorate of AYUSH (Directorate) in the year 2013.

[1] Ayurveda & Tibbia College, SHMC, NHMC and CBPACS

This Directorate provides healthcare facilities through 188 dispensaries (51 Ayurvedic, 23 Unani, and 114 Homeopathic) and through four hospitals attached to four Ayush medical colleges[2] . It also provides medical education in Ayurvedic, Unani and Homoeopathy through undergraduate and postgraduate courses at four educational institutions. Besides, the Directorate is responsible for licensing and implementing regulations under Drugs and Cosmetics Act; issuing approval to laboratories for testing of Ayurveda/Unani medicines through Drugs Control Cell; conducting market survey to check quality of available Ayurveda/ Unani medicines; and creating awareness among masses. Drug Control Department (DCD) under the DH&FW grants/renews licenses to sellers and manufacturers of homoeopathic medicines.

For the purpose of audit of AYUSH, records for the period from 2016-17 to 2022-23 of four[3] autonomous bodies of the Directorate, two Ayurveda/ Unani/Homoeopathic medical colleges with attached hospitals[4], Directorate of AYUSH, Drugs Control Cell (Ayurvedic & Unani medicines) and the Drugs Control Department[5] were examined.

11.2 Organizational Structure of AYUSH

The Directorate, headed by a Director, functions under the overall supervision of the Secretary, Department of Health and Family Welfare. The Director is assisted by a Joint Director, two Deputy Directors, Assistant Directors. Drug Control Cell of Ayurveda and Unani is responsible for licensing the manufacturers. Drugs Control Department of allopathic drugs is also entrusted with the drug controlling functions of homoeopathic drugs.

11.3 Adequacy of funding

Proper financial management entails budgeting of funds on realistic assessment of requirement and effective utilization of available funds to ensure that operational activities do not suffer for want of funds. The State government allocated funds of ₹ 1033.35 crore against which ₹ 934.39 crore (90 *per cent*)

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2 i) Ayurvedic & Unani Tibbia College and Hospital (Tibbia College and hospital), (ii) Dr. B.R. Sur Homeopathic medical College Hospital and research centre (SHMC) (iii) Nehru Homoeopathic Medical College & Hospital (NHMC) and (iv) Choudhary Brahm Prakash Ayurvedic Charak Sansthan (CBPACS)

3 Board of Homoeopathic System of Medicine, Delhi Bhartiya Chikitsa Parishad (DBCP), Examining Body for Para Medical Training for Bhartiya Chikitsa Delhi, and Delhi Homoeopathic Anusandhan Parishad (DHAP)

4 (i) Ayurvedic & Unani Tibbia College and Hospitals (Tibbia College and hospital), (ii) Dr. B.R. Sur Homoeopathic medical College Hospital and research centre (SHMC)

5 The Drugs Control Department (DCD) headed by Drugs Controller of Delhi regulates manufacture and sale of allopathic and Homoeopathic drugs in Delhi. The functioning of Drug Control Department and overall shortfall in inspections, drug sample testing etc. has already been covered in Chapter VIII of this Audit Report. It did not hold separate inspection data of homoeopathic units and separate quality testing data of homoeopathic drugs.

was utilised for the management of AYUSH activities during the period 2016-22 as per the details given in **Table 11.1**.

Table 11.1: Budget allocation and utilisation 2016-2022

(₹ in crore)

Department	Budget Allocation/ Grant received	Expenditure incurred
Ayurveda and Unani		
Directorate of AYUSH[6]	201.30	150.33
A & U Tibbia College	212.04	181.46
Choudhary Brahm Prakash Ayurvedic Charak Sansthan (CBPACS)	200.91	198.17
Homoeopathy		
Homoeopathic Wing	221.23	214.57
BR Sur Homoeopathic Medical College & Research Centre (SHMC)	74.20	72.27
Nehru Homoeopathic Medical College and Hospital (NHMC)	123.67	117.59
Total	**1033.35**	**934.39**

11.3.1 Sub-optimal utilization of funds

(i) Utilization of funds under important heads in Tibbia College & Hospital: A & U Tibbia College was allocated budget of ₹ 16.55 crore under the head 'Supply & Material' and 'Machinery & Equipment' out of which only ₹ 9.41 crore was utilized during the period 2018-19 to 2021-22 leaving ₹ 7.14 crore (43 *per cent*) unutilised.

Budget was not allotted under the head 'Machinery & Equipment' during the year 2016-17 and 2019-20. Audit noted that during 2018-19 to 2021-22, there were savings ranging from 15 *per cent* to 96 *per cent* under two heads as detailed in **Table 11.2**.

Table 11.2: Savings in AU Tibbia College and Hospital

(₹ in lakhs)

Year	Head	Budget	Total Expenditure	Savings	Saving in *per cent*
2018-19	S&M	700	337.75	362.25	52
	M&E	100	85.21	14.79	15
2019-20	S&M	650	485.48	164.51	25
2020-21	M&E	25	5.05	19.95	80
2021-22	S&M	150	5.81	144.18	96
	M&E	30	21.92	8.07	27
Total		**1655**	**941.23**	**713.77**	**43**

Department stated (May 2023) that funds could not be utilised due to conversion of hospitals to Covid Care Centre and Covid Vaccination Centre.

[6] Includes budget for Ayurveda and Unani dispensaries, drug control cell of Ayurveda and Unani.

Reply is not tenable as savings were noticed under the heads 'Machine & Equipment' and 'Supply & Material' despite lack of essential equipment during pre and post Covid period.

(ii) Under-utilisation of funds for Machinery and Equipment in hospitals: Audit noted that during five out of seven years under audit scrutiny, the unutilized funds under the head 'Machinery and Equipment' in SHMC ranged between 23.12 *per cent* and 77.45 *per cent* (upto December 2022). There were savings despite the fact that SHMC had no working Ultrasound machine during the entire audit period, whereas, working X-Ray machine was not available since 2019-20. This indicates lackadaisical approach of the hospital in acquiring the essential equipment for providing service to patients.

Similarly, in NHMC, ₹ 51 lakh out of ₹ 90 lakh (57 *per cent*) under the head Machinery and Equipment could not be utilized during the period under audit.

Government attributed (December 2023) sub-optimal utilization of funds to non-materialization of procurement by the CPA due to technical reasons till 2017-18 and non-completion of codal formalities due to shortage of time in 2019-20 and 2021-22.

GNCTD and hospitals failed to utilize the allotted funds and they should make realistic plans to ensure optimum utilization of funds.

(iii) Publicity of Ayush: One of the vision of Directorate is to popularize AYUSH system through school education programmes and media. Directorate spent only ₹ 9.81 lakh out of ₹ 34.66 lakh (28 *per cent)* for publicity of Ayurveda and Unani systems during the period 2016-2023.

11.3.2 Rush of Expenditure in closing months of financial year

Rule 56(3) of GFR states that rush of expenditure beyond 15 *per cent*, particularly in the closing months of the financial year shall be regarded as a breach of financial propriety and shall be avoided.

Audit noted that during 2016-22, 15 *per cent* to 100 *per cent* expenditure in A& U Tibbia hospital and SHMC were incurred in the month of March under three heads viz. M &E, S&M and OE in contravention of the above rule.

In the case of SHMC, the Government attributed (December 2023) it to last minute approval of proposals for procurement and settlement of pending claims. It was further stated that all nodal officers and branch in-charges have been directed to ensure that all proposals are finalized in a time bound manner. In respect of A&U Tibbia College, Department assured (May 2023) that the GFR will be adhered to in future.

Recommendation 11.1: Directorate and the GNCTD should prepare realistic budgetary plan and the hospitals should expedite the procurement to ensure timely utilization of funds received under 'Supply & Medicine' and 'Machinery & Equipment'.

11.4 Availability and Management of AYUSH Healthcare Infrastructure

Health infrastructure is an important indicator for understanding the health care policy and welfare mechanism in a State. It signifies the investment priority regarding creation of health care facilities. Infrastructure has been described as the basic support for delivery of public health activities. Examination of records disclosed inadequacies in infrastructure, as discussed in the succeeding paragraphs.

11.4.1 Inadequate built up area of the departments of A & U Tibbia College

Indian Medicine Central Council (Minimum Standard Requirements of Ayurveda Colleges and attached Hospitals) Regulations, 2012, prescribes built up area of departments of an Ayurveda College. There were shortfall in the built up area of departments of Tibbia College as given in the **Table 11.3**.

Table 11.3: Built up area of various departments of Tibbia College

Sl. No.	Department	Required built up area (Sq. Mtr.)	Available built up area (Sq. Mtr.)
1	Agad Tantra & Vidhi Vaidyak	100	60
2	Kaya Chikitsa	150	75
3	Shalya Tantra	150	60
4	Shalakya Tantra	150	60
5	Prasuti and Stri Rog	100	65
6	Kaumarbhritya	75	40

Less space than the minimum prescribed area could hamper functioning of departments.

A& U Tibbia College stated (May 2023) that the college is functioning from a heritage building and there are restrictions to modify the building. Further it stated that it has planned to build a multi-storeyed building for academic departments.

11.4.2 Lack of monitoring mechanism for Physical and Financial progress of work

During 2016-17 to 2022-23, 116 works relating to repair/maintenance/ construction amounting to ₹ 17.12 crore were sanctioned to PWD by A& U Tibbia College.

Audit noted that PWD neither submitted any physical/financial progress or completion certificate to the hospital nor was requested by the hospital. Similarly, SHMC had completion certificates in respect of only nine out of 20 works which were carried out. Thus, there was no monitoring mechanism in hospitals to ensure timely completion of works.

The hospitals stated (May 2023) that monitoring of work and regular meetings with the PWD authorities are being done. In the case of SHMC, Government

stated (December 2023) that completion certificates in respect of the works have been called from PWD.

Reply is not acceptable as no documents related to monitoring of work and regular meeting by hospitals with PWD authorities was annexed with the reply.

11.4.3 Delay in completion of works in hospitals

Audit noted that in respect of A & U Tibbia College & Hospital only 48 out of 61 civil works[7] sanctioned were completed during 2016-17 to 2022-23. Out of 48 works completed, two works were completed on time whereas 25 works costing ₹ 2.91 crore were completed with delays up to six months, 18 works costing ₹ 3.92 crore were completed with delays of six to 12 months and three works of ₹ 99.80 lakh were completed with delays of more than one year.

In respect of remaining works, two works were foreclosed, one work pertained to year 2016-17 was not taken up as plan was not approved and one work pertained to 2018-19 could not be taken up as permission for the work was not obtained from Delhi Jal Board. Nine works pertaining to year 2021-22 to 2022-23 are still in progress even after expiry of stipulated date of completion. Delay in completion of work could have affected the quality of services being provided.

Hospital stated (May 2023) that delays were due to Covid and suspension of works and adherence to DPCC guidelines to control pollution.

Reply is not acceptable as delay in completion of works were noticed during pre and post Covid period.

Recommendation 11.2: Hospitals should monitor the works in an efficient manner to avoid delay in completion of works.

11.4.4 Inadequate facilities for storing drugs

Directorate of AYUSH has no proper drug store for keeping Ayurvedic medicines procured for dispensaries as medicines were temporarily stored in a guest house of A&U Tibbia College & Hospital.

Similarly, in A&U Tibbia College & Hospital, there was no permanent store for storage of Ayurvedic and Unani medicines. Medicines were being kept in three places i.e. Canteen and two temporary tin sheds without assessing whether these structure met drug storage standards. It was also noticed that medicines were kept without having the facilities of racks were touching the floor and walls, rendering them susceptible to damage.

[7] Works related to maintenance/renovation of the building/facilities.

Picture 11.1: Medicines kept in temporary tin shed

Picture 11.2: Medicines kept in guest house of A& U Tibbia College

As suitable site was identified for constructing Drug store for the Directorate and for Tibbia College and Hospital and preliminary estimate amounting to ₹ 3.49 crore was intimated by the PWD in March 2020 for approval which was revised to ₹ 4.11 crore (December 2022) .

Audit noted that the proposal was not approved by the competent authority.

Government intimated (December 2023) that a temporary Drug store of around 4000 sq.feet has been constructed for storage of medicines.

However, the reply was silent on the approval of the preliminary proposal by the competent authority and start of construction thereafter.

Recommendation 11.3: Directorate should develop permanent storage facility with proper racks to keep medicines.

11.4.5 Unavailability of canteen/kitchen facilities in test checked hospitals

As per Indian Medicine Central Council (Minimum Standard Requirements of Ayurveda Colleges and attached Hospitals) Regulations, 2012, there should be canteen facility with sitting arrangement for about hundred persons in the college premises with built up area of 150 sq. meter (for intake of 61-100 students) . Similarly, Schedule I (B) (Infrastructure Requirement of College) of MSR, 2013 provides for canteen facility in the Homoeopathic college premises.

A& U Tibbia College with an annual intake of 189 students has total enrollment of 800 students and 123 staff (March 2023). Besides, on an average 550 patients had visited the hospital per day during 2021-22. Similarly, SHMC has total enrollment of 315 students and 86 college staff.

Audit noted that no canteen/kitchen facilities were available in both the test checked hospitals and the premises earmarked for Canteen in A & U Tibbia College were being utilized for storage of medicines.

Government stated (December 2023) that the process for establishment of canteen in SHMC has since been initiated by uploading the tender on GeM. With regard to A&U Tibbia hospital, it was stated that the process of starting canteen service has been initiated.

The fact remains that canteen facility did not exist in either the hospitals.

11.4.6 Unavailability of Cadavers in Tibbia College

A&U Tibbia College and Hospital is a prestigious medical institution of GNCT of Delhi providing undergraduate and postgraduate education to the students in Ayurveda and Unani. The curriculum of their course and Medical College Standards issued by the GoI requires teaching of Anatomy and dissection of cadavers to students.

Audit noted that no cadaver/mummified body was available in the Anatomy Department of Tibbia college since 2020 and the Hospital had initiated the process to obtain cadaver in November 2022 only, after a delay of more than two years.

The Department stated (May 2023) that efforts are being made to get the cadaver for study purpose.

11.4.7 Running unauthorized Private Pharmacy in the premises of the Hospital

Audit noted that A&U Tibbia Hospital had allotted a space of 20 Sqm to a private agency[8] for running a medical shop in June 2012 at a monthly lease amount of ₹ 3000. The lease deed of the pharmacy was cancelled (July 2014) and eviction process initiated by the hospital. The eviction process was halted by the ADM (April 2016) as the lease deed did not contain any clause for termination. Subsequently, the hospital filed a case in District Court in April 2019 against the order passed by the ADM after almost three years. It was observed that the case was rejected by the Court as the case was not filed on time.

Due to administrative delay on the part of the hospital, the pharmacy could not be evicted (December 2022) and was running unauthorized in the hospital premises since July 2014. Moreover, audit noted that patients were compelled to buy medicines from the private pharmacy as most of the medicines were either not available in the hospital or were available for small periods of time during the year 2018-19 to 2019-20.

A & U Tibbia College stated (May 2023) that efforts are being made to evict the unauthorized pharmacy from the premises of hospital but hospital remained silent on the other issues.

[8] M/S Apex charitable Trust

11.5 Availability of Medicines and Equipment

11.5.1 EDL for Ayurveda, Yoga, Unani, Siddha and Homoeopathy medicines not updated on regular basis

In order to provide essential medicines free of cost to the people visiting its health facilities, the Government of NCT of Delhi framed (April 1994) a Drug Policy based on the essential medicines concept. The objective of the policy was to make available a limited number of good quality medicines to be procured at reasonable prices, thus enabling the medicine budget to be used for a much larger number of patients. Audit noted that the policy aimed at preparation of a list of drugs, every year, by a Special Committee.

Audit noted that EDL of Ayurveda, Unani and Homoeopathy drugs for dispensaries were updated only once in 2018 during the period under audit and the EDL of A& U Tibbia College & Hospital was not updated after 2015.

Government stated (December 2023) that based on the National List of Essential Ayush Medicines published by Ministry of Ayush in 2022, the Department has reviewed and adopted the new EDL for Ayurveda and Unani medicines. Regarding homoeopathy, updated EDL is under submission for approval of the competent authority.

11.5.2 State Drugs Testing Laboratory not set up

One of the objectives of National Ayush Mission (NAM), GoI is to provide Grants-in-aid to State Drug Testing Laboratories (SDTL) for testing of Ayurveda, Unani, Sidda and Homoeopathic drugs.

Audit noticed that no proposal was initiated by the Directorate of AYUSH (December 2022) for establishing SDTL whereas the Directorate had assured to set up the same in response to audit observations incorporated in the CAG Audit Report for the year ended March 2017. Moreover, ₹ 95 lakh released by GoI to set up a drug testing lab for Indian System of Medicine was also not used and was refunded to GoI.

Audit noted that Directorate of AYUSH had got tested 6940 samples of Ayurvedic and Unani drugs from 11 government approved labs and incurred ₹ 6.90 crore for testing of Ayurvedic and Unani medicines during the years 2016-17 to 2022-23. Homoeopathic drug samples are being sent for testing to Pharmacopoeia Commission for Indian Medicine and Homoeopathy, Ghaziabad, in a routine manner even though the same has been declared (22 March 2021) as an Appellate laboratory for testing of drugs by Central Government.

The Government stated (December 2023) that setting up of a laboratory is not cost-effective due to limited number of samples.

Reply is not acceptable, as it did not share cost-benefit analysis report with audit in view of the fact that on an average, more than ₹ one crore a year was being incurred on testing of samples.

11.5.3 Quality testing mechanism of AYUSH drugs

11.5.3.1 Sample testing not done for Ayurvedic, Unani and Homoeopathic drugs purchased

Operational Guidelines for Free Drugs Service Initiative issued (June 2015) by M/o Health and Family Welfare, GoI, stipulates that on receipt of test reports from empanelled laboratories, the batches which 'Pass' the testing are to be released for further distribution.

During the period 2016-18, Drug Control Cell did not conduct quality testing of batch-wise samples of drugs before distribution to dispensaries as envisaged in above said guidelines. Audit noticed that Directorate of AYUSH purchased Ayurvedic and Unani medicines amounting to ₹ 22.22 crore for supply to dispensaries during the same period. Similarly, the test checked Homoeopathic College (SHMC) distributed the medicines procured on the basis of quality reports provided by the supplier along with the supply.

Government stated (December 2023) that the medicines were procured from government agencies during the reported period and presently all supplied medicines are being tested before distribution to dispensaries. In case of SHMC it was stated that guidelines/SOP has been received (September 2023) from Directorate of AYUSH and assured to comply with it.

The fact remains that the Directorate of AYUSH did not adhere to the guidelines regarding quality testing of medicines procured for ensuring the efficacy and safety of drugs distributed to patients.

Recommendation 11.4: Directorate and hospitals should regularly test the quality of all batches of medicines used in its health facilities to ensure quality of drugs.

11.5.3.2 Not conducting drugs test according to standards of Ayurvedic and Unani Drugs

As per Rule 168 of Drugs and Cosmetics Rules, 1945, standard for identity, purity and strength as given in the edition of Ayurvedic Pharmacopoeia of India are to be complied. State Licensing Authority, Directorate of AYUSH had granted license to approved labs for carrying out tests of identity, purity, quality and strength of drugs.

Test check of bills for drugs testing of Ayurvedic and Unani medicines revealed that only three tests for microbiology, specific pathogens and heavy metals were conducted whereas tests to establish the identity and purity of raw materials and strength were not being conducted.

Government stated (December 2023) that due to the complex nature of Ayurvedic and Unani medicines, raw material testing is feasible only before preparation and strength testing is not available, only qualitative testing is available.

However, the fact remains that the Government did not ensure the purity, quality and strength of drugs at their own level.

11.5.3.3 Non-adherence to quality assurance guidelines

Operational Guidelines for Free Drugs Service Initiative issued (June 2015) by M/o Health and Family Welfare, GoI, stipulates that the labels details viz. manufacturer's name, manufacturing license number, logo or monogram of the company on the medicine samples will be concealed by indelible ink, coded with a secret number and would be sent to one of the NABL accredited empanelled Laboratory for analysis.

It was, however, observed that the samples of medicines for distribution in dispensaries were sent to the laboratory by Drugs Store, for testing, without concealing the details of the manufacturers, thereby, compromising with the provisos of the guidelines.

Department stated (May 2023) that labelling is done as per rule 106 A of Drug and Cosmetics Rules, 1945.

The reply is not tenable as the said rule deals with labelling and packing of Homoeopathic medicines whereas audit observation is regarding the procedure to be adopted while sending the samples to lab for testing.

11.5.3.4 Avoidable expenditure on quality testing of Ayurvedic and Unani drug samples

It was observed that as per the terms & conditions of tenders for purchase of Homoeopathic medicines, Homoeopathy Wing, Directorate of AYUSH recover the cost of samples testing of Homoeopathy drugs from the suppliers of medicines. However, it was noticed that no such condition was incorporated in the tender document issued for purchase of Ayurvedic and Unani medicines resulting in the cost of sample testing of Ayurvedic and Unani medicines being borne by the Directorate.

Directorate incurred an amount of ₹ 93.40 lakh during the period from 2019-20 to 2022-23 for testing of samples supplied by the manufacturer.

Government stated (December 2023) that testing was being done from the budget earmarked for testing of market and complaint samples.

Reply is not acceptable as the Directorate could have recovered the cost of testing of Ayurveda and Unani samples had it incorporated the similar clause in its tender document.

11.5.4 Availability of Essential Drugs in test checked Hospitals

(i) A & U Tibbia Hospital: Directorate of Ayush approved (last updated 2015) Essential Drug List of 117 Ayurveda and 92 Unani medicines for Ayurveda/Unani hospitals as per their requirement, which should be available with hospitals/pharmacies at all times in adequate quantity.

It was noticed that only 44 to 81 (38 to 69 *per cent*) out of 117 Ayurvedic medicines and 25 to 69 (27 to 75 *per cent*) out of 92 Unani medicines were available in Tibbia College & Hospital annually during the audit period 2016-17 to 2022-23.

Further, it was noticed that almost all the stock of medicines exhausted twice, in January 2019 and February 2022, but the hospital procured medicines only in March 2020 and November 2022, after a delay of 14 and nine months respectively. Audit also noticed that due to unavailability of drugs, Tibbia Hospital procured some medicines in crude form in March 2019 to make alternative arrangement for the patients.

(ii) SHMC: There were 200 Essential Drugs approved by the Directorate for Homoeopathic hospitals. Audit noted that 37 drugs/medicines were not available in the hospital for very long periods **(Annexure VIII)** despite being part of the EDL list.

A & U Tibbia Hospital stated (May 2023) that the medicines could not be procured due to cancellation of tenders and also due to blacklisting of L1 firms. In case of SHMC, the Government stated (December 2023) that besides keeping a buffer stock of frequently prescribed medicines, digital database of essential medicines has also now been prepared to mitigate the problem of stock-outs. Moreover, medicines which were not available have now been purchased.

The fact remains that the hospital management failed to ensure availability of sufficient quantity of medicines in the hospitals.

Recommendation 11.5: Government should ensure timely procurement and availability of essential drugs in all AYUSH hospitals.

11.5.5 Loose dispensing of medicines

EDL (Ayurveda) guidelines published by the GoI discourage loose dispensing of medicines and suggested to procure medicines in standard pack sizes based on the weekly requirement of medicines for the patients as medicine quality gets altered when these are distributed in envelops due to the presence of salt in medicines, and medicines in big containers also get spoiled due to moisture in the environment.

Audit noted that 27 Unani and 22 Ayurvedic crude medicines **(Annexure IX)** procured in bulk and processed and prepared by the A & U Tibbia Hospital were distributed to the patients in loose form which was neither safe from moisture nor hygienic/safe to carry.

Hospital accepted the fact and stated (May 2023) that due to cancellation of tenders, the packed medicines could not be procured, hence, some alternative arrangement was made by procuring medicines in crude forms.

11.5.6 Unavailability of essential equipment in Ayush Hospitals

11.5.6.1 Shortage of essential equipment/tools in the Hospital

Equipment and tools play a vital role in the functioning of a hospital. They help healthcare professionals to provide accurate diagnoses, effective treatments, and safe surgical procedures, as well as ensure infection control and patient comfort.

During 2017-18, departments of A & U Tibbia Hospital were directed (July 2017) to submit requirement of essential instruments/ equipment (Consumable/ Non Consumable) for procurement. 14 departments had assessed requirement of 855 quantities of 184 different items.

Audit noted that against the above requisition, A & U Tibbia hospital had purchased (July and October 2018) only 177 quantities of 44 items after delay of 12 to 15 months. Thus, 43 to 87 *per cent* of items required in different departments were not purchased affecting patient health care services in the hospital. The hospital authority had not made any efforts to procure balance quantity of items since 2018.

Department stated (May 2023) that some equipment had been procured during the last year and rest are being procured.

Fact remains that the hospital did not have all the essential instruments/ equipment necessary for providing due care to patients.

11.5.6.2 Medical equipment in AU Tibbia College & Hospital not utilized

A & U Tibbia Hospital had procured four equipment costing ₹ 45.98 lakh in March 2018 with two year free AMC and five year guarantee period and same were installed in the pathology lab as per the details given in the **Table 11.4**.

Table 11.4: List of equipment purchased by Tibbia Hospital

(₹ in lakhs)

Sl. No.	Name of Item	Quantity	Cost
1	Fully Automatic Biochemistry Analyzer	01	17.57
2	Hematology Analyzer	01	17.57
3	Electrolyte Analyzer	01	0.98
4	Immunoassay CLIA System	01	9.85
	Total		**45.98**

Audit noted that although the equipment were installed in the lab, no test was conducted by the hospital. The free AMC and guarantee period had also expired.

Further, it was also noticed that 31 different items[9] in the pathology lab were out of order since March 2018 which affected the complete functioning of pathology lab in the hospital and no functional machine/equipment/chemical kits were available in the pathology lab.

Similarly, it was noticed that in maternity ward, two equipment i.e. Foetal doppler and patient monitor amounting to ₹ 6.69 lakh were not put to use since its purchase (September 2018).

Department stated (May 2023) that the equipment could not be utilized due to Covid pandemic. Reply is not acceptable as it was found that these equipment were lying idle before and after the Covid period.

Government stated (December 2023) that purchase of reagents for pathology lab is in final stage.

Recommendation 11.6: Tibbia College & Hospital should take immediate measures to install the idle equipment in pathology and maternity departments to run these departments in a full-fledged manner.

11.5.6.3 Idle stock of Ventilators in Tibbia Hospital

A & U Tibbia hospital had received 34 Ventilators in September and November 2021 during COVID.

Audit noted that the ventilators were not installed and were lying in the store of the hospital due to lack of experts and facilities such as medical gas pipeline. Moreover, the hospital has not taken any steps to handover these ventilators to other needy institutions.

The hospital stated (May 2023) that ventilators were received during third wave of Covid for constituting ICU in the hospital. Due to decline of Covid, the same could not be utilized.

Government stated (December 2023) that the hospital had sent email to medical superintendents of all hospitals to handover ventilators but no reply was received. With regard to installation of medical gas pipeline, demand for budget has been sent.

Fact remained that ventilators were not put to use and were lying idle in A&U Tibbia college.

[9] Blood cell counter, Centrifuge machine, BP instrument, Blood bank pharmaceutical refrigerator, Bio chemistry semi analyzer, Centrifuge machine 8 tube, ESR analyzer 20 channel, Elisa reader, Fully automated bio chemistry analyser, Fully automatic cell counter, Hot plate, Heat convector, Hb Bill meter, Lab refrigerator, Microscope binocular, Matic binocular microscope, Needle discarder , Mixed oxidant, Nycocard reader, Dx insta check, Refrigerator pharma, Sample rolator, Urine analyser, Ultra sonic cleaner, Weight machine, Blood bank pharmaceutical refrigerator, Auto haematology analyser, Pharmaceutical refrigerator, Electrolyte analyser, Auto chemistry analyser and Maglumi 800

11.6 Human Resource Management

For effective and efficient functioning of a health institution, adequate number of motivated, empowered, trained and skilled human resource is essential. Human resource planning is a must before investing in other components like infrastructure, equipment, drugs etc. The requirement of staff in terms of General Duty Medical Officers (GDMOs), Specialists, nurses, allied health professionals, administrative and support staff etc. has to be assessed taking into consideration health facility requirements of the people to which the health institution caters to. Availability of manpower and related issues has been discussed in the succeeding paragraphs.

11.6.1 Shortage of staff in AYUSH

There was huge shortage of staff in Ayush Directorate and its four colleges and hospitals. Overall shortage of staff in the Ayush departments was 57.97 *per cent* as of March 2023 as given in **Table 11.5**.

Table 11.5: Staff position in Medical Colleges and Hospitals

Name of the unit	Sanctioned strength	No. of staff posted	Shortage of staff	Vacancy in *per cent*	No. of outsourced staff
Directorate of AYUSH	229	118	111	48.47	48
Homoeopathic Wing	359	188	171	45.63	110
A & U Tibbia College	271	123	148	54.61	5
BR Sur Homoeopathic Medical College & Research Centre	141	62	79	56.02	30
Choudhary Brahm Prakash Ayurvedic Charak Sansthan	445	95	350	78.65	207
Nehru Homoeopathic Medical College and Hospital	211	110	101	47.86	10
Total	**1656**	**696**	**960**	**57.97**	**410**

Thus, health facilities under AYUSH Directorate were not equipped with adequate human resources to provide efficient and effective healthcare services.

11.6.2 Shortage of staff in Medical College Hospitals

- **Shortage of doctors, nurses and paramedical staff**: Significant staff shortages in the cadres of doctors (51.89 *per cent*), paramedical staff (55.93 *per cent*) and nurses (32.21 *per cent*) were noticed in the four[10] medical colleges with attached hospitals as detailed in **Table 11.6**.

[10] Ayurveda & Tibbia College, SHMC, NHMC and CBPACS

Table 11.6: Staff position of doctors, nurses, pharmacists in Medical College Hospitals

Category	Tibbia College		CBPACS		SHMC		NHMC		Total		Shortage of staff	
	SS	MIP	SS	MIP	SS	MIP	SS	MIP	SS	MIP	Nos.	%
Doctors	90	41	101	60	55	27	97	37	343	165	178	51.89
Paramedical staff	26	6	55	19	15	11	22	16	118	52	66	55.93
Nurses	60	19	47	46	13	11	28	25	149	101	48	32.21

- The only posts of Physiotherapist and Dentist and all the five posts of house Physicians in SHMC remained vacant during the audit period.
- The only posts of O.T Technician, ECG Technician and Laboratory assistant were vacant in SHMC as of March 2023. In NHMC, the only post of Physical Training Instructor, Assistant Dietician, Biochemist, Operation Theatre Technician etc. were found vacant during the audit period.

SHMC and Tibbia Hospital stated (May 2023) that filling of the vacancies is under process.

11.6.3 Shortage of teaching faculties in Medical Colleges

There are four AYUSH medical colleges in which undergraduate and postgraduate courses in Ayurveda, Unani and Homoepathy are offered as per student intake given in **Table 11.7**.

Table 11.7: Student intake in AYUSH Medical Colleges

Sl. No.	Name of college	No. of seats available	
		Undergraduate	Postgraduate
1	A&U Tibbia College	158	31
2	Dr. BR Sur Homoeopathic Medical College	63	Nil
3	Nehru Homoeopathic Medical College	125	9
4	Choudhary Brahm Parkash Ayurvedic Charak Sansthan	125	51

There were huge shortage of teaching faculties in the medical colleges under AYUSH. The vacancy position as of March 2022 is given in **Table 11.8**.

Table 11.8: Staff position of teaching faculties in Medical Colleges

Category	Tibbia College		CBPACS		SHMC		NHMC		Total		Overall Shortage of staff	
	SS	MIP	SS	MIP	SS	MIP	SS	MIP	SS	MIP	Nos.	%
Principal	1	0	1	0	1	1	1	0	4	1	3	75%
Professors	17	Nil	14	6	13	10	18	7	62	23	39	63%
Asso. Professors/ Readers	24	Nil	21	13	-	-	-	-	45	13	32	71%
Asstt. Professors	49	41	23	21	15	6	26	14	113	82	31	27%

- The post of Principal remained vacant in three out of four colleges. There was overall shortage 63 *per cent* of Professors, 71 *per cent* of Associate Professors and 27 *per cent* of Assistant Professors in the medical colleges. There were 100 *per cent* vacancies of Professor and Associate Professor in A & U Tibbia College.
- Though the seats for students were enhanced from 128 to 158 (25 *per cent*) from academic session 2019-20 in A & U Tibbia College, teaching staff was not increased proportionate to the increased number of seats.
- It was noticed that in place of regular faculty, 15 General Duty Medical Officers were deployed for teaching purpose in SHMC.

Shortage of teaching staff in medical colleges may adversely impact on the quality of medical education and also on healthcare delivery.

The Government stated (December 2023) that the process of filling of vacant posts has already been undertaken in Homoeopathic wing. In the case of Ayurveda and Unani wings, medical officers and pharmacists have joined the department and the remaining vacant posts have been notified to UPSC and DSSB for recruitment.

Recommendation 11.7: GNCTD and Directorate should take immediate measures to fill the vacant posts of medical officer, teaching staff, nurses and paramedical staff.

11.7 Healthcare Services under AYUSH

To deliver quality health services in public health facilities, adequate and properly maintained healthcare infrastructure and equipment are of critical importance.

The number of OPD patients in hospitals during 2016-22 is given in **Table 11.9**.

Table 11.9: OPD patients in Hospitals

Year	A & U Tibbia	SHMC	NHMC	CBPACS	Total
2016-17	2,96,727	61,630	1,84,159	3,33,595	8,76,111
2017-18	3,18,117	61,139	1,75,492	3,37,272	8,92,020
2018-19	2,65,393	64,469	1,65,436	3,83,986	8,79,284
2019-20	1,66,623	64,439	1,75,655	4,35,830	8,42,547
2020-21	29,432	29,960	12,916	31,758	1,04,066
2021-22	1,63,162	40,491	89,078	1,46,279	4,39,010
2022-23 (upto Dec 22)	1,54,494	41,521	1,18,492	1,90,676	5,05,183

Examination of records disclosed inadequacies in healthcare infrastructure, as discussed in the succeeding paragraphs.

11.7.1 Enquiry window in SHMC not available

SHMC provides health care through General OPDs and special clinics in pediatrics, geriatrics, gynecology and family planning, lifestyle disorders, thyroid disorders, psychiatry, arthritis, respiratory disorders, skin diseases, renal stones, eye, ENT and physiotherapy. The annual patient turnover in OPD ranged from 61,630 (2016-17) to 42,285 (2022-23 till 24 January 2023).

Audit noted that the hospital did not provide any enquiry window for OPD to facilitate and help patients seeking information about hospital services.

Government stated (December 2023) that an enquiry window has now been opened for OPD.

11.7.2 Deficiency in Citizens Charters

Citizens' Charters initiative is a response to the quest for solving the problems which a citizen encounters, day in and day out, while dealing with organisations providing public services.

Citizen Charter of SHMC did not provide information on availability of family welfare, maternity and childcare services, immunisation services and ambulance services. Further, Citizen Charter of SHMC was not available in local language.

Government stated (December 2023) that Citizen Charter has been revised and submitted to the PWD for preparation of boards.

11.7.3 Indoor Patients Department (IPD) in hospitals

IPD refers to the areas of the hospital where patients are accommodated after being admitted, based on doctor's/specialist's assessment, from the Out-Patient Department, Emergency Services and Ambulatory Care. In-patients require a higher level of care through nursing services, availability of drugs/diagnostic facilities, observation by doctors, etc.

11.7.3.1 Declining trend of IPD patients and low bed occupancy in AYUSH Hospitals

The number of patients admitted in IPDs in the four hospitals was as given in **Table 11.10**.

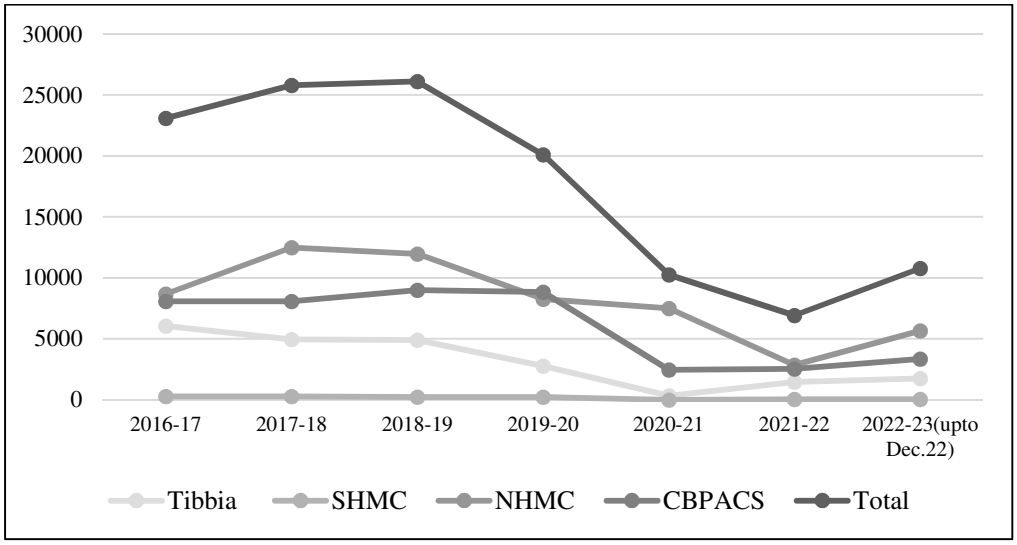
Table 11.10: IPD Patients in AYUSH Hospitals

Year	Tibbia	SHMC	NHMC	CBPACS	Total
2016-17	6068	275	8692	8073	23108
2017-18	4958	272	12498	8071	25799
2018-19	4909	232	11972	8990	26103
2019-20	2786	217	8261	8834	20098
2020-21	324	0	7490	2452	10266
2021-22	1466	44	2859	2550	6919
2022-23 (upto December 2022)	1744	46	5653	3344	10787

It can be seen from **Table 11.10** that number of patients visiting IPD declined during the audit period from 23,108 in 2016-17 to 20,098 in 2019-20 (pre-covid period) and further decreased to 10,226 (2020-21), 6,919 (2021-22) and 10,787 (upto December 2022).

The trend of patients visiting the IPD during the period 2016-17 to 2022-23 (upto December 2022) is given in **Chart 11.2**.

Chart 11.2: IPD patients in Medical College Hospitals



Government stated (December 2023) that due to Covid pandemic, hospitals were declared as a Covid Healthcare Centre and most of the staff was diverted to other Covid quarantine centres and IPD services were closed for general public.

Reply is not acceptable as the patient footfall in Tibbia Hospital and SHMC had declined prior to Covid 19 also.

11.7.3.2 Low bed occupancy in AYUSH Hospitals

Number of IPD beds available in Tibbia College, CBPACS, SHMC and NHMC were 240, 210, 50 and 100. Bed occupancy rate in AYUSH Hospitals was very low as depicted in **Table 11.11**.

Table 11.11: Bed occupancy in hospitals

Year	No. of bed days available				No. of beds occupancy days (Bed occupancy rate)			
	Tibbia (365 x240)	CBPACS (365x210)	SHMC (365x50)	NHMC (365x100)	Tibbia	CBPACS	SHMC	NHMC
2016-17	87,600	76,650	18,250	36,500	34301(39)	56994(74.35)	254(1.39)	8760(24)
2017-18	87,600	76,650	18,250	36,500	28792(33)	59606(77.76)	250(1.37)	12410(34)
2018-19	87,600	76,650	18,250	36,500	26305(30)	59058(77.05)	214(1.17)	12045(33)
2019-20	87,600	76,650	18,250	36,500	13783(16)	58298(76.05)	199(1.09)	8395(23)
2020-21	87,600	76,650	18,250	36,500	1875(2.14)	21625(28.21)	Nil	13870(38)
2021-22	87,600	76,650	18,250	36,500	8493(9.70)	22691(29.60)	40(0.22)	4745(13)

During the period from 2016-17 to 2021-22, bed occupancy rate ranged from 2.14 to 39 *per cent* in A&U Tibbia Hospital, 28.21 to 77.76 *per cent* in CBPACS, 0.22 to 1.39 *per cent* in SHMC and 13 to 38 *per cent* in NHMC.

Thus, the infrastructure in AYUSH hospitals was not optimally utilized. Absence of essential facilities like operation theatre (Paragraph 11.7.14), ultrasound (Paragraph 11.7.5), staff shortage (Paragraph 11.6.2) and absence of casualty ward (Paragraph 11.7.13) in hospitals could be reasons for underutilization of IPD facilities.

Recommendation 11.8: Ayush hospitals should develop all essential infrastructure and should provide patient care services with diagnostic and emergency facilities to attract more patients towards Ayush.

11.7.4 Absence of Medical Record Department (MRD) in A & U Tibbia Hospital

Chapter XII of Hospital Manual states that medical record keeping has importance in efficient patient health care. Medical Record Department (MRD) should maintain complete records in all respects in safe custody and compile a monthly report of medical statistics required for hospital administration. Ayurveda & Unani Tibbia hospital did not have an MRD in the absence of which mandatory data such as patient attendance record, observation and follow-up record, referral record within and outside hospital, treatment record etc. were not being maintained as per Hospital Manual.

Tibbia College accepted (May 2023) the audit observation and stated that MRD could not be set up as there was no post sanctioned for MRD.

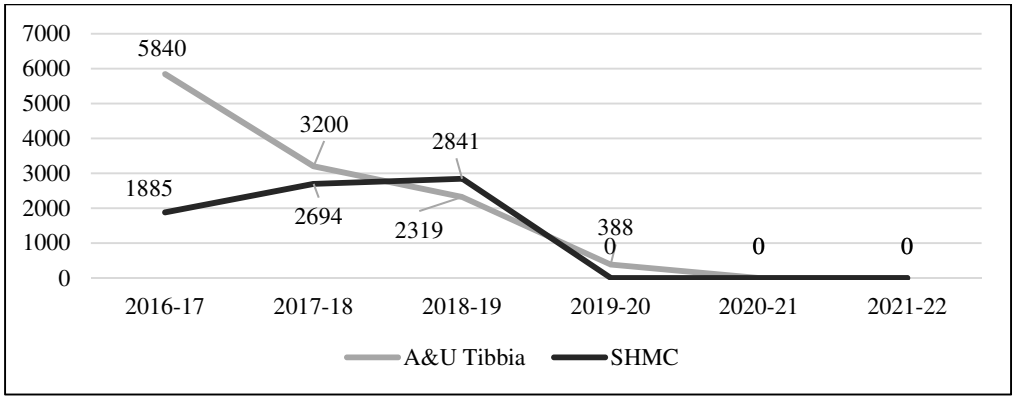
11.7.5 Non-functional Radiology Department in Hospitals

Radiology department is an essential part of any hospital, playing a critical role in the diagnosis and treatment of many medical conditions. However, radiology diagnostic facilities were not available in the test checked hospitals due to unavailability of functional equipment.

Only one X-ray machine was functional in A&U Tibbia Hospital during the period 2016-17 to 2019-20 and in SHMC from 2016-17 to 2018-19.

The hospital authorities failed to procure the above equipment even though sufficient funds were available under the head Machine and Equipment in respect of SHMC (2016-22) and A&U Tibbia Hospital (2018-22) as stated in para 11.3.1. Number of X-rays conducted in both hospitals during the audit period is as shown in C**hart 11.3**.

Chart 11.3: No. of X-ray Conducted



Absence of radiology equipment in a hospital may adversely impact diagnosis services. This may also discourage patients from availing treatment through Indian System of Medicine.

Hospital stated (May 2023) that initiative is being taken to make the radiology department functional. In case of SHMC, Government stated (December 2023) that as on date, X-Ray machine with CR system has been installed, however, license to operate the same is awaited from AERB.

Recommendation 11.9: Hospitals should make functional radiology department with X-ray facility to facilitate the diagnosis and treatment of illness.

11.7.6 Pathology lab in A&U Tibbia Hospital not functioning

Pathology lab is an integral part of any hospital or medical facility. These labs play a critical role in diagnosis, treatment, and management of diseases.

The number of lab tests conducted at A & U Tibbia Hospital was as given in **Table 11.12**.

Table 11.12: Number of lab tests conducted in A & U Tibbia Hospital

Sl. No.	Year	No. of test conducted
1	2016	1,63,095
2	2017	2,03,229
3	2018	1,89,717
4	2019	7,084
5	2020	1,344
6	2021	3,488
7	2022	8,021

It can be seen from **Table 11.12** that the number of tests conducted during the period 2016-22 have significantly declined from the year 2019. Audit noted that out of 44 types of lab tests that were being conducted up to 2018, only 12 tests were being conducted as of February 2023 due to unavailability of required chemicals and functional equipment.

A&U Tibbia College stated (May 2023) that the number of lab tests decreased due to COVID during 2019-2022 and the hospital had outsourced lab tests

during the said period. It further stated that efforts are being made to make the lab fully functional. Government stated (December 2023) that process of purchasing kits/reagents for pathology lab is in the final stage.

The fact remains that despite availability of pathology equipment (para 11.5.6.2) the Government could not provide pathology services. (December 2023)

11.7.7 Non-functional Maternal and Child Health (MCH) unit in the Hospital

Maternity wards are important in hospitals because they provide specialized care for women during pregnancy, childbirth and postpartum. It provides prenatal care, including check-ups, ultrasounds, and other tests to monitor the health of the mother and baby and also provide care after delivery, including breastfeeding support, postpartum check-ups for the mother, and care for the newborn.

Audit noticed that MCH ward was not functioning in the A & U Tibbia Hospital since March 2021 and the number of pregnant women admitted for delivery has continuously declined since 2016-17 as can be seen from **Table 11.13**.

Table 11.13: Performance of Maternity and Child Health Ward in Tibbia Hospital

Year	Number of pregnant women registered	Number of Normal delivery done in the hospital	Number of referred cases
2016-17	913	330	71
2017-18	606	249	74
2018-19	464	195	54
2019-20	489	152	29
2020-21	29	08	3
2021-22	Nil	Nil	Nil
2022-23	Nil	Nil	Nil

Tibbia Hospsital stated (May 2023) that the Maternity and Child Health Services were discontinued during COVID period and the building was handed over to PWD for renovation and to set up oxygen beds.

Fact remains that the MCH unit is still not functional even after the decline of the Covid pandemic and no alternative arrangement was made for MCH units during the renovation period.

Recommendation 11.10: Tibbia College & Hospital should take immediate measures to repair or replace the non-functional equipment and should re-start the pathology and maternity facilities in a full-fledged manner.

11.7.8 Computerized Central Registration System in hospitals not implemented

A computerized central registration system is an essential component of hospital management, as it helps streamline the patient registration process and ensures accurate record-keeping and saves a lot of time.

During the scrutiny of records provided by the Department, it was noticed that online registration system was not established for OPD and IPD registration and pharmacy counters in the selected hospitals i.e. Tibbia Hospital and SHMC.

Hospitals stated (May 2023) that suitable action is being initiated for post creation and for computerization of registration counters. Government stated (December 2023) that a proposal has been submitted to the competent authority for creation of four computerized counters of registration in SHMC. With regard to A&U Tibbia hospital, study has been done for creation of computerized central registration.

11.7.9 Shortfall in optimal utilization of seats in Medical Colleges

A & U Tibbia College offers both Bachelor of Ayurvedic Medicine and Surgery (BAMS) and Bachelor of Unani Medicine and Surgery (BUMS) courses where as CBPACS offers only BAMS course. Similarly, SHMC and NHMC offers BHMS course in their college. There were shortfall in admission against the sanctioned seats during the period from 2016-17 to 2022-23 in the undergraduate courses offered by the Medical colleges per the details given in **Table 11.14**.

Table 11.14: Vacant seats in medical colleges

Sl. No.	Name of College	Course	Seats	Maximum vacant seat in *per cent*
1	A & U Tibbia College	BUMS	61 to 75	23
2	CBPACS	BAMS	100 to 125	14
3	NHMC	BHMS	100 to 125	35
4	SHMC	BHMS	50 to 63	34

A&U Tibbia college stated (May 2023) that in the case of BUMS, reserved seats for SC/ST were not filled as most of the SC/ST applicants did not possess the mandatory qualification of studying Urdu subject at the level of 10th Class.

With regard to BHMS course, Government stated (December 2023) that the seats remained vacant due to migration of students.

Recommendation 11.11: GNCTD should take suitable action for optimum utilisation of seats.

11.7.10 Non accreditation of Hospital and Laboratories from NABH and NABL

National Accreditation Board for Hospitals & Healthcare Providers (NABH) is a constituent board of Quality Council of India, set up to establish and operate accreditation program for healthcare organizations. Accreditation results in improved quality of care and patient safety.

National Accreditation Board of Laboratories (NABL) certificate provides a ready means for patients to identify and select reliable testing, measurement and calibration services that are able to meet their needs. It also provides increased

confidence in testing/calibration reports issued by the testing, calibration and medical testing laboratories which emphasize on accuracy and reliable results.

A&U Tibbia Hospital and SHMC were not accredited by NABH and its laboratories were not accredited by NABL.

A & U Tibbia College stated (May 2023) that it has applied (August 2022) for NABH accreditation. Government informed (December 2023) that process for NABL and NABH accreditation has been initiated in SHMC.

11.7.11 Yoga and Naturopathy System of treatment

Yoga focuses on the prevention of diseases and treatment of many lifestyle related disorders. Naturopathy aims to eliminate diseases and morbid matter from body to restore health through natural methods including alternative therapies. National Health Policy, 2017 envisages introduction of Yoga much more widely in schools and work places as part of promotion of good health as adopted in National AYUSH Mission (NAM).

AYUSH Directorate under GNCTD has not introduced or implemented any programme for encouraging yoga practice among school children and general public. Further, Directorate has not appointed yoga instructor in any of its dispensaries.

Government stated (December 2023) that State Advisory Board for Yoga and Naturopathy has now been constituted. Due to COVID pandemic, the meeting of Board could not be held and efforts are being made to introduce Yoga and Naturopathy in school education.

Recommendation 11.12: Directorate should take suitable measures to promote yoga and to appoint yoga instructors in its healthcare facilities.

11.7.12 Deficiencies in Hospital Disaster Management

As per Disaster Management Act (DMA), 2005 the Department has to operationalize medical response plan and deployment of Quick Response Team (QRT) during any crisis (earthquake, fire, flood, building collapse etc.) to mitigate the suffering and providing quality emergency medical response and care to save lives and minimize the effect of injuries. For this, regular mock drills are to be conducted to keep the staff trained and well prepared for any untoward incident so that they can handle the situation efficiently and minimize casualties.

It was, however, seen that only one mock drill (March 2023) was held in SHMC during the entire audit period.

Joint physical inspection and scrutiny of the records in SHMC revealed the following shortcomings:

(i) First floor balcony obstructs the way for entry of the fire fighting vehicle.

(ii) Smoke detectors were not found functional at seven places, whereas, it was not installed in one room.

(iii) Evacuation plan routes for fire exit were not found displayed in the hospital.

Government informed (December 2023) that fire related deficiencies have now been corrected, evacuation plan routes displayed and functional smoke detectors installed, in all places.

11.7.13 Unavailability of Emergency/Casualty ward in the Hospital

A casualty ward, also known as an emergency department, plays a crucial role in a hospital as it provides immediate medical attention to patients who are in urgent need of medical care.

As per Indian Medicine Central Council (Minimum Standard Requirements of Ayurveda Colleges and attached Hospitals) Regulations, 2012, a hospital shall have minimum eight OPDs including Aatyayika (Emergency).

Audit noted that no Aatyayika (Emergency) ward was functioning in the A & U Tibbia Hospital.

Hospital stated (May 2023) that in case of emergency, patients are being referred to nearby allopathic government hospital.

The fact remains that A & U Tibbia hospital does not have its own emergency and causality unit.

11.7.14 Unavailability of Operation Theatre Unit

Schedule I (A) of MSR 2013 (Requirement of an attached hospital to Homoeopathic colleges) provides that there should be an operation theatre unit in the hospital consisting of operation theatre, preparation room, post-operative recovery room, space for Sterilized Linen, labour room, rooms for surgeon/obstetrician/assistant and nursing staff room. Further, in schedule III of MSR, 2013, it is also stated that a well-equipped and functioning operation theatre shall be provided for day to day working. However, the above mentioned facilities were not available in SHMC.

Government stated (December 2023) that due to space constraints, limited resources and non-availability of accident and emergency services, OT unit could not be established.

11.8 National Ayush Mission

11.8.1 GNCTD is not implementing programmes under National Ayush Mission (NAM)

GoI provides grant under National Ayush Mission (NAM) for upgradation/construction of AYUSH hospitals/dispensaries, supply of medicines, setting up of OPD clinics at Primary Health Centres/hospitals etc. It also provides grant for upgradation of government/government aided medical colleges and for creation of new colleges. The main objectives of the Mission are providing preventive, promotive, curative and rehabilitative health care.

Support is also provided for Yoga Wellness Centre, Tele-medicine, Sports medicine, IEC activities, Training and capacity building for staff etc. under the flexible component of the grant.

During 2014-15 & 2015-16, ₹ 7.26 crore was released to GNCTD under NAM. Audit noted that only ₹ 3.43 crore was utilized and ₹ 3.83 crore was lying unutilized with GNCTD/Directorate and the Directorate did not submit Utilization Certificate to GoI (December 2022).

GNCTD was required to set up State AYUSH Society for implementing the NAM and submit State Annual Action Plan for receiving funds from GoI. Audit noted that GNCTD did not set up State AYUSH society nor did it submit State Annual Action plan for availing financial benefit for improving the infrastructure and health services under AYUSH.

Further, there was no State Public Health Schemes under AYUSH of GNCTD for providing preventive, promotive, curative and rehabilitative health care on musculoskeletal disorders particularly osteoarthritis, non-communicable diseases, maternal & neo-natal care, mobile medical services, geriatric & palliative care, and promotion of healthy lifestyle in schools. The citizens in Delhi also could not avail the benefit of these services covered under NAM as the same was not implemented.

Directorate stated (May 2023) that the refund of unutilized amount is under process. Regarding constitution of State Ayush Society, the Government stated (December 2023) that as per policy decision of GNCTD, the society was not constituted. It further stated that the matter regarding setting up of State Ayush Society shall be processed again.

11.8.2 Health Wellness Centres under NAM not established

Union Cabinet approved operationalization of 12,500 AYUSH Health and Wellness Centres (AHWCs) under Ayushman Bharat Scheme for implementation through National AYUSH Mission with a financial outlay of ₹ 3399.35 crore for a period of 5 years from 2019-20 to 2023-24.

The main objectives of AHWCs are to establish a holistic wellness model based on AYUSH principles and practices to empower masses for self-care to reduce the disease burden, out of pocket burden and to provide informed choice to the needy public.

For upgradation of Ayush Dispensaries to AHWCs, Central Government had earmarked a fund of ₹ 6.85 lakh as non-recurring cost and ₹ 9.37 lakh per annum as recurring cost per Ayush dispensary. Funds were provided for appointing yoga instructors, conducting refresher courses to medical officers, IEC, IT networking and establishing herbal garden etc. in each Ayush Dispensary.

Audit noted that GNCT of Delhi did not implement the Ayushman Bharat and National Ayush Mission schemes and hence did not avail the funds for establishing AYUSH Health Wellness Centers.

Directorate stated (May 2023) that a proposal for establishing State Ayush Society under NAM is under consideration.

Recommendation 11.13: GNCTD should take necessary measures to implement National Ayush Mission scheme in Delhi for the overall development of AYUSH healthcare facilities and for the benefit of citizens of Delhi.

11.9 Regulatory mechanism

Regulation is an important function in healthcare sector. Regulations are necessary to standardize and supervise healthcare, ensuring that healthcare bodies and facilities comply with public health policies and that they provide safe care to all patients and visitors to the healthcare system.

11.9.1 Inadequate inspections of manufacturing and selling units

Drugs Control Cell of Directorate of AYUSH ensures the quality of Ayurvedic and Unani drugs by testing samples of drugs at government approved labs. Section 162 of the Drugs and Cosmetics Act, 1940 envisages that it shall be the duty of an inspector authorized to inspect all the premises licensed for manufacture of Ayurvedic or Unani drugs within the area allotted to him not less than twice a year and to satisfy himself that the conditions of the license and the provisions of the Act and Rules made thereunder are being observed.

As of March 2023, there were 114 units manufacturing and selling of Ayurveda and Unani medicines registered with Drugs Control Cell.

The number of inspections conducted during 2016-22 is detailed in **Table 11.15**.

Table 11.15: Number of inspection of manufacturing units

Year	No. of mandatory Inspections were to be done	No. of inspections conducted	Shortfall (in *per cent)*
2016-17	104	89	15(14)
2017-18	130	126	4(3)
2018-19	138	108	30(22)
2019-20	138	109	29(21)
2020-21	172	116	56(32)
2021-22	210	115	95(45)
2022-23	228	93	121(53)
Total	**1120**	**756**	

It can be seen from **Table 11.15** that Drugs Control Cell had conducted only 756 inspections (67.5 *per cent*) against 1120 mandatory inspections in respect of units manufacturing and selling Ayurveda and Unani medicines. There was an increasing trend in shortfall of inspection which was high as 53 *per cent* in 2022-23 Thus, the monitoring mechanism to ensure quality of drugs was inadequate.

Further, the Drugs Control Department of DGHS responsible for inspection of manufacturing units of homoeopathic drugs did not furnish the inspection data.

Therefore, audit could not examine regulatory mechanism in respect of homoeopathic system of medicine.

Government replied (December 2023) that the mandate of two inspections per year was reduced to one inspection in five years as per Ministry of Ayush notification in October 2021.

The reply is not acceptable as the referred amendment is regarding verification of conditions of licence whereas inspection of manufacturing units were required to be conducted twice in a year as per Section 162 of the Drug and Cosmetics Act, 1940.

Recommendation 11.14: Directorate should ensure adequate number of inspections of the manufacturing units to ensure quality.

11.9.2 Delhi Bhartiya Chikitsa Parishad

Delhi Bhartiya Chikitsa Parishad (DBCP) was established in January 2001 for providing registration of medical practitioners of Indian Systems of Medicine. It has to maintain live register of practitioners, prepare a code of ethics to regulate professional conduct of practitioners, inquire into the complaints and to take suitable action against practitioners and also to check practice of Bhartiya Chikitsa by unqualified persons in NCTD.

21 member DBCP is headed by a President and assisted by the Registrar who is the Chief Executive Officer of DBCP. 683 Ayurvedic practitioners and 266 Unani practitioners have been registered with DBCP during 2022-23.

Audit noticed the following irregularities in the functioning of DBCP.

GNCTD had dissolved the DBCP in July 2015 and DBCP was not re-constituted (December 2022). The essential activities for regulating the practice of Indian System of Medicine such as disciplinary action against practitioners, inquiring into complaints against quacks etc. were not being performed. As per practice, the complaints received were forwarded to the Anti-Quackery Cell, DGHS, GNCTD for necessary action.

It was noticed that seven posts of staff including one Registrar was approved by the Lt. Governor in March 2008, but Recruitment Rules (RRs) for the post of registrar and other staff have not yet been framed/approved (March 2023).

Further the DBCP has not prepared audited annual accounts since 2017-18 and has not maintained cash book since 2018-19.

11.9.3 Examining Body for Para Medical Training in Bharatiya Chikitsa

GNCTD under the provisions of Section 33 of the Delhi Bharatiya Chikitsa Parishad (DBCP) Act, 1998, constituted an 'Examining Body for Para Medical Training for Bharatiya Chikitsa, Delhi' in March 2011 for the purpose of holding qualifying examination for para-medical training and prescribing the courses of study and training for the said examination and other matters related

to para-medical training such as pharmacists, nursing courses, panchkarma technicians etc.

Audit noticed the following irregularities in the functioning of Examining Body for Para Medical Training for Bharatiya Chikitsa:

a) Although GNCTD sanctioned 15 posts (July 2018) of different categories, the Recruitment Rules (RRs) were not finalised and approved by GNCTD (March 2023).

b) Examining Body in its meeting in November 2014 finalised the bye-laws and syllabus of six para medical courses[11], but the same has not been finally approved by the GNCTD (December 2022).

c) As per pattern of assistance, Examining Body shall raise resources to work on self-sustaining basis within a period of 3-5 years from the date of release of first grant-in aid (GIA). However, it has not achieved this goal. It received grant from GNCTD during 2016-17 to 2021-22.

Thus, even after 12 years of formation of 'Examining Body for Para Medical Training for Bharatiya Chikitsa, Delhi', the objectives of DBCP Act could not be achieved.

11.9.4 Delhi Homoeopathic Anusandhan Parishad (DHAP)

DHAP was constituted as an autonomous body to initiate, aid, develop and coordinate research in homoeopathy and registered under the Registrar of Societies, Delhi. It was noticed that DHAP was not functional since 2017-18 and no financial aid or activity was performed. Likewise, no meetings of DHAP were held during 2016-17 to 2022-23.

Government stated (December 2023) that the proposal for decision regarding functioning of DHAP has since been submitted to competent authority.

Recommendation 11.15: GNCTD should strengthen the regulatory bodies of Ayush i.e. DBCP, Examining Body and DHAP by timely constituting the bodies, conducting regular meetings and recruiting staff.

11.9.5 No mechanism to regulate practices of paramedics of Ayurveda and Unani

There is no regulatory mechanism to register the pharmacists, nurses and panchkarma technicians of Ayurveda and Unani and to regulate their practice in Delhi. A Registration Regulations Committee had been constituted by Examining Body in December 2022 for formulating the Regulations for

[11] A (1) Diploma in Ayurveda Pharmacy (2) Diploma in Panchkarma Technicial (3) Diploma in Ayurveda Nursing and Midwifery.
B (1) Diploma in Unani Pharmacy (2) Diploma in Ilaj-bil-tadbeer technician (3) Diploma in Unani Nursing and Midwifery.

registering para-medics of Ayurveda and Unani. However, the Regulations were not formulated (March 2023).

11.9.6 Inspection of units selling Ayurvedic and Unani medicines not conducted

To check the sale of Ayurvedic and Unani medicines which are manufactured without a valid license, Department used to lift samples of Ayurvedic and Unani medicines from the retail/wholesale shops. Audit noted that the Department did not conduct surveys and raids to seize random drug samples for quality checking since June 2020. Resultantly, GNCTD was not in a position to ensure the quality of Ayurvedic and Unani medicines sold in the region.

Recommendation 11.16: Directorate should conduct surveys and raids regularly to regulate the sale of Ayurvedic and Unani medicines in Delhi.

11.9.7 Shortfall in training of health care workers on Bio Medical Waste Management

As per Sec 4 (g) of the Bio Medical Waste Management Rule, 2016, it will be the duty of the occupiers to provide training to all its health care workers and others involved in handling of bio medical waste at the time of induction and thereafter at least once every year. There was shortfall in training of health care workers ranging from 16 to 44 *per cent* during the audit period in SHMC.

Government stated (December 2023) that on the basis of suggestion of audit, training of all staff members has been conducted in batches. It was further stated that henceforth training of all staff members shall be ensured at the time of induction and at least once in a year.

11.9.8 License for procurement of alcohol/spirit not obtained

The Homoeopathy Central Council (Minimum Standards Requirement of Homoeopathic Colleges and attached Hospitals) Regulations 2013, provides for obtaining of license/permission (and its renewal) for procurement of alcohol/spirit. Since the Homoeopathic medicines contain alcohol which in turn acts as one of the pharmaceutical vehicles, it is imperative for SHMC to obtain license for its procurement. Scrutiny of records, however, revealed that the requisite license is yet to be obtained by SHMC from the authority concerned.

Government stated (December 2023) that license has been obtained. However, copy of the same was not found attached with the reply.

11.9.9 Footfall of patients in SHMC below the minimum standards required for Homoeopathic College

As per the Homoeopathy Central Council (Minimum Standards Requirement of Homoeopathic Colleges and attached Hospitals) Regulations 2013, a minimum per day average of patients in IPD is required to be 30 *per cent* of IPD beds[12] in

[12] 50 IPD beds

the previous year. It was however, noted that except for 2016 wherein the average number of patients per day in IPD touched the benchmark, i.e. 15 (30 *per cent*), in the remaining period, the average number of patients per day ranged between two (four *per cent*) and 14 (28 *per cent*).

Regulations further provide for a minimum of 200 patients in OPD during last one calendar year (365 days) in Colleges having intake capacity of students ranging between 61 and 100. It was however, noted that the average number of patients in OPD ranged between 114 and 167 during 2020 to 2022.

Government stated (December 2023) that efforts to increase footfall has now been taken by restarting physiotherapy unit, starting dietary consultation, admitting patients in day care in IPD along with organizing various outreach community activities on a regular basis.

New Delhi **(AMAN DEEP CHATHA)**
Dated: 22 August 2024 **Principal Accountant General (Audit), Delhi**

Countersigned

New Delhi **(GIRISH CHANDRA MURMU)**
Dated: 10 September 2024 **Comptroller and Auditor General of India**

Annexures

Annexure I
(Referred to in paragraph 2.2)
A. Details of Nursing staff in the hospitals as of March 2022

Sl. No.	Name of the Hospital	Sanctioned Strength	Present Strength	Shortage	Shortage in percentage
1.	Acharya Shree Bhikshu	117	107	10	8.54
2.	Aruna Asaf Ali	101	86	15	14.85
3.	Attar Sain Jain Eye and General Hospital	11	11	00	00 (Dec 2023)
4.	Babu Jagjiwan Ram Memorial	137	119	18	13.13
5.	Bhagwan Mahavir	220	146	74	33.63
6.	BR Sur Homeopathic	13	11	02	15.38
7.	Central jail	71	70	01	1.40
8.	Deen Dayal Upadhyay	693	528	165	23.80 (Dec 2023)
9.	Deep Chand Bandhu	147	119	28	19.09
10.	Dr. Hedgewar Arogya Sansthan	163	128	35	21.47
11.	Dr. Baba Saheb Ambedkar	453	418	35	7.07 (Dec 2023)
12.	Dr. NC Joshi Memorial	56	48	08	14.28
13.	GB Pant	1154	760	394	34.14
14.	Guru Nanak Eye Centre	119	102	17	14.28
15.	Guru Teg Bahadur	1377	983	394	28.61
16.	Guru Gobind singh	125	113	12	9.6 (Dec 2023)
17.	Jag Pravesh Chander	144	111	33	22.92 (Dec 2023)
18.	Lok Nayak Hospital	1644	1315	329	20.01
19.	Lal Bahadur Shastri	166	119	47	28.31
20.	Maharishi Valmiki	108	108	0	0 (Dec 2023)
21.	Nehru Homeopathic Medical	28	26	02	7.14
22.	Pt. Madan Mohan Malviya	110	98	12	10.90
23.	Rao Tula Ram Memorial	97	94	03	3.09
24.	Sanjay Gandhi Memorial	263	229	34	12.92
25.	Satyawadi Raja Harish Chandra	134	121	13	9.70
26.	Sardar Vallabh Bhai Patel	91	87	04	4.39
27.	Sri Dadadev Maitri Avum Shishu Chikitsalya	90	89	01	1.11
28.	A&U Tibbia College & Hosp.	28	20	08	28.57

B Details of Para Medical staff as of March 2022

Sl. No.	Name of Post	Sanctioned Strength	Present Strength	Shortage	Shortage in percentage
1.	Occupational/Physiotherapist	102	70	32	31
2.	Speech Therapist	12	06	6	50
3.	Refractionist	34	19	15	44
4.	Audiometric Assistant	23	13	10	43
5.	Dietician	58	30	28	48
6.	Dark Room Artist	63	32	31	49
7.	Laundry staff	05	02	03	60
8.	Post Mortem Assistant	37	04	33	89
9.	Library staff	26	00	26	100
10.	Perfusionist	03	00	03	100
11.	Chair side Assistant	10	02	08	80
12.	Technical Assistant Ophthalmology	15	04	11	73
13.	Orthoptist	04	01	03	75
14.	LA/LT PCR Hepatitis	02	00	02	100
15.	Psychiatric Social worker	48	06	42	87
16.	Lab Technician	1422	820	602	42
17.	OT Technician	832	562	270	32
18.	Radiographer	296	159	137	46
19.	Medical Record Technician	28	3	25	89

C Details of Non-teaching Specialist in the hospitals/Units as of March 2022

Sl. No.	Name of Hospital/Units	Sanctioned Strength	Present Strength	Shortage	Shortage in percentage
1.	Acharya Shree Bhikshu (ABGH)	21	14	07	33.33
2	Deen Dayal Upadhyay (DDUH)	69	47	22	31.88 (Dec 23)
3	Deep Chand Bandhu (DCBH)	29	16	13	44.82
4	Dr. Baba Saheb Ambedkar (DBSAH)	71	44	27	38.02 (Dec 2023)
5	Guru Teg Bahadur (GTBH)	21	22	NA	NA
6	Lok Nayak Hospital (LNH)	69	41	28	40.57
7	Sanjay Gandhi Memorial (SGMH)	35	27	08	22.85
8	Satyawadi Raja Harish Chandra (SRHCH)	23	10	13	56.52
9	Aruna Asaf Ali (AAAGH)	26	21	05	19.23
10	Attar Sain Jain Eye and General Hospital (ASJEH)	04	02	01	50.00 (Dec 2023)
11	Babu Jagjiwan Ram Memorial (BJRMH)	25	14	11	44
12	Bhagwan Mahavir (BMH)	24	22	02	8.33
13	Central Jail (CJH)	13	07	06	46.15
14	Dr. Hedgewar Arogya Sansthan (DHAS)	25	21	04	16
15	Govind Balabh Pant Hospital (GBPH)	01	00	01	100
16	Guru Gobind Singh Government Hospital (GGSGH)	24	17	07	29.16
17	Guru Nanak Eye Centre (GNEC)	03	02	01	33.33 (Dec 2023)
18	Jag Parvesh Chander (JPCH)	25	19	06	24 (Dec 2023)

Sl. No.	Name of Hospital/Units	Sanctioned Strength	Present Strength	Shortage	Shortage in percentage
19	Lal Bahadur Shastri (LBSH)	25	21	04	16
20	Maharishi Valmiki (MVH)	18	11	7	38.88 (Dec 2023)
21	Dr. NC Joshi Memorial (NCJMH)	14	09	05	35.71
22	Pt. Madan Mohan Malviya (PMMMH)	23	18	05	21.73
23	Rao tula Ram Mem. (RTRMH)	20	13	07	35
24	Sri Dadadev Maitri Avum Shishu Chikitsalya (SDDMASC)	14	10	04	28.57
25	SHS (DHS)	05	01	04	80
26	Sardar Vallabh Bhai Patel (SVBPH)	21	14	07	33.33
27	CDMO (ND)	03	00	03	100

Annexure II
(Referred to in paragraph 2.10)
Details of Radiological services (X-rays)

Name of the hospital	Number of X-Ray Machine	Technician	SR/Specialist
B R Sur Homeopathic	0	2	0
A&U Tibbia	0	1	0
Acharyaa Shree Bhikshu Hospital	1	11	2
Rao Tula Ram Memorial Hospital	1	5	0
Rajiv Gandhi Super Speciality Hospital	7	0	6
Guru Gobind Singh Govt. hospital	2	9	0
SRHC Hospital	2	9	0
Sanjay Gandhi	5	14	1
GTB hospital	5	40	20 (December 2023)
Lok Nayak Hospital	10	50	30
Deep Chand Bandhu Hospital	5	10	0
Chaudhary Brahm Prakash Ayurved Charak Sansthan	1	0	0

Annexure III
(Referred to in paragraph 4.2.6.2)
List of inferior quality drugs consumed in hospitals

Sl. No.	Name of Tablet	Date of receiving in Store	Batch No.	Quantity received	Date of Expiry	Quantity replaced	Qty. of Inferior quality consumed	Sample receiving date by drug deptt.	Test report receiving date by hospital
	LNH								
1.	Diclofenac Sodium 50mg	22.04.20	DIC-1920	900000	02/23	554020	345980	27.10.20	24.02.21
2.	Ibuprofen IP 400mg	25.04.16	LT 5092	100000	02/18	91980	8020	26.04.16	08.08.16
3.	Diclofenac Sodium 50mg	22.04.20	DIC-1920	900000	02/23	554020	345980	27.10.20	24.02.21
4.	Ibuprofen IP 400mg	25.04.16	LT 5092	100000	02/18	91980	8020	26.04.16	08.08.16
5.	Inj Glycopyrrolate	2018	DL 350	9000	-	-	9000	-	24.05.18
6.	Inj Bupivacain	2018	5K50431	1060	-	-	1060	-	24.05.18
7.	Inj, Labetalol	2018	LB1H5 B2	225	-	-	225		24.05.18
8.	Inj. Gentamycin	2018	150538	15000	-	-	11941	-	24.05.18
9.	Inj. Pantaprazole	2018	ADG021	60000	-	51577	8423	-	24.05.18
10.	Inj Labetalol	2018	LBG682	293	-	-	293	-	24.05.18
11.	Inj Amino Acid 10%	2018	17GAM 001	460	-	-	460	-	24.05.18
12.	Inj. paracetamol	2018	2491127	15000	-	1368	13632	-	24.05.18
13.	Inj. Iron sucrose	2018	317 1097	1284	-	-	1284	-	24.05.18
14.	Tab Azithromycin 500mg	2018	AZT 15007	3000	-	-	3000	-	24.05.18
15.	Tab Azithromycin 500mg	2018	AZT 15008	3000	-	-	3000	-	24.05.18
16.	Tab Azithromycin 500mg	2018	AZT 16002	15000	-	-	15000	-	24.05.18
17.	Calcium with D3	2018	616-702	2000	-	-	2000	-	24.05.18
18.	Neosporin skin ointment	03/17 and 05/17	G16035	1382	07/18	630	752	-	05/17
19.	Ranitidine 150mg	03.05.19 03.08.19	RAN-1903 RAN-1920	617000 600000	07/20 07/20	572200 600000	44800 -	-	-
20.	Acetazolamide 250 mg	28.11.18	T-1859007	50000	03/19	26580	23420	-	-
	CNBC								
21.	Diclofenac Sodium 50mg ₹	06.01.18	DFT170 21	5000	10/19	-	5000	06.08.18	02.01.19
22.	Enalapril Maleate IP 2.5mg	07.04.18	T15884	1000	12/19		630	06.08.18	02.01.19
23.	Acetazolamide, 250mg	16.11.18	T-185900 7	2000	02/20		1000		05.12.18

Sl. No.	Name of Tablet	Date of receiving in Store	Batch No.	Quantity received	Date of Expiry	Quantity replaced	Qty. of Inferior quality consumed	Sample receiving date by drug deptt.	Test report receiving date by hospital
24.	Calcium Carbonate D3 (Syp)	25.11.19	KR 7018 & 7021	7100	04/21		2024	05.12.19	14.01.20
25.	Ceftrixone, 1gm/vial	08.08.15	150669	6300	11/16		2080		05.11.15
26.	Promethazine	20.03.17	DL-017	15000	02/19		10100		21.11.17
27.	Gentamycine, 40 mg	29.06.15	150538	300	10/16		200		26.08.15
28.	Antacid Gel	16.07.16	22-66BHD 10&9	3960	05/18		3960		21.12.16
29.	Levocetrizine	16.07.16	01026-BDH10	10000	05/18		10000		
30.	ORS	12.09.16	1916-316	2325	06/18		2325		

Annexure IV
(Referred to in paragraph 4.4.1)
Unavailability of Essential Drugs in hospitals

(i) LNH, JSSH, CNBC

Sl. No.	Month	Name of the medicine	Balance in the beginning of the month	Quantities demanded by depart-ments	Quantities issued in the month	Remarks
			LNH			
1.	May 2017	Ramipril, 5mg	1400	35000	Nil	30000 received on 22.06.17
2.	May 2017	Amlodipine, 5mg	20650	116000	20000	Not received during the year
3.	May 2017	B. Complex	970	107200	Nil	63000 quantities received on 30.06.17 and issued 5100 only against the May 17 indents.
4.	May 2017	Amitriptylline, 10mg	0	10000	Nil	Fresh stock of 4000 tablets on 03.08.2017 and 15000 tablets on 28.08.2017 were received
5.	May 2017	Amitriptylline, 25mg	400	11000	Nil	Fresh stock of 5000 tablets was received on 23.05.2017 but no quantity was issued in this month.
6.	May 2017	Pyridoxine, 10mg	0	2000	Nil	First stock of this tablet was received on 10.06.2017 of 200 tablets.
7.	May 2017	Bethistine, 8mg	1920	21200	1200	New stock of 30000 tablets was received on 06.09.2017.
8.	May 2017	Atorvastatin, 10mg	190	10050	50	Fresh batch of10000 tablets were received on 08.07.2017.
9.	January 2021	K. Bind Sachet	450	400	350	
10.	January 2021	Syp. DPH	214	500	200	
11.	January 2021	Syp. Iron	232	117	87	
12.	January 2021	E/d Clotrimazole	Nil	50	Nil	
13.	January 2021	Amoxycillin	568	188	168	
14.	January 2021	Sup.Cefixime	Nil	200	Nil	
15.	Feb 2020	Glycerol	876	1124	804	300 bottles were received in the store on 29.02. 2020
16.	Feb 2020	Sterillium	1954	3698	2958	2000 bottles were received on 15.02.2020. 1100 bottles were received on 29.02.2020.

Sl. No.	Month	Name of the medicine	Balance in the beginning of the month	Quantities demanded by depart-ments	Quantities issued in the month	Remarks
17.	Feb 2020	Hydrogen Peroxide (H2O2)	270	546	486	250 quantities were received on 15.02.2020 and 200 quantities were received on 29.02.2020.
18.	Feb 2020	Vitamin D3 drops	20	50	30	10 bottles were receives on 11.02.2020. Indent of 20 bottles was given by Ch. Med. W-13A&16, but not given. 05 bottles were received on 25.08.2020, after a gap of almost 06 months.
JSSH						
19.	Dec-2018	Tab. Glimperide 1mg	Nil	54000	Nil	Not received during the month
20.	Dec-2018	Tab. Glimperide 2mg	Nil	200000	Nil	Not received during the month
21.	Dec-2018	Tab. Glimperide 4mg	Nil	208000	Nil	Next supply against indent received was executed on 22/04/19
22.	Dec-2018	Tab. Methylcoblamine 500mg	Nil	200000	Nil	Not received during the month
23.	Dec-2018	Tab. Betahistine 8mg	Nil	10000	Nil	Next supply against indent received was executed on 06/03/19
24.	Dec-2018	Tab. Allupurinol 100mg / Zylonic	2000	45000	2000	Not received till March 2022
25.	Dec-2018	Tab. Donezepil 5mg	568	5000	Nil	Next supply against indent received was executed on 02/04/19
26.	Dec-2018	Tab. Warferine 5mg	Nil	5000	Nil	Next supply against indent received was executed on 06/03/19
27.	Dec-2018	Tab. Escitalopram 10mg	Nil	20000	Nil	Not received till March 2020
28.	Dec-2018	Tab. Doxophylline 400mg	Nil	30000	Nil	Next supply against indent received was executed on 24/04/19
29.	Feb-2020	Tab. Digoxin 0.25mg	Nil	5000	Nil	Tab. was out of stock since December 2019 and next supply against indent received was executed on 15/10/2020
30.	Feb-2020	Tab. Domperidone 10 mg	Nil	60000	Nil	Tab. was out of stock since December 2019 and next supply against indent received was executed on 24/06/2020

Sl. No.	Month	Name of the medicine	Balance in the beginning of the month	Quantities demanded by depart-ments	Quantities issued in the month	Remarks
31.	Jan-2021	Tab. Montelucast 10mg	Nil	5000	Nil	Tab. was out of stock since December 2020 and next supply against indent received was executed on 26/08/2021
32.	Jan-2021	Tab. Voglibose 0.3mg	Nil	100000	Nil	Tab. was out of stock since December 2020 and next supply against indent received was executed on 03/03/2021
33.	Jan-2021	Tab. Carbamezipine 200mg	Nil	40000	Nil	Tab. was out of stock since Oct-2020 and next supply against indent received was executed on 03/03/2021
CNBC						
34.	May 2017	Acyclovir, 200mg	150	3000	100	1500 received on 28.07.17 and only 300 issued
35.	May 2017	Enalpril melete, 5mg	0	5000	Nil	2000 received on 31.05.17 and only 1000 issued on 07.06.17
36.	May 2017	Diclofenic Sodium, 50 mg	0	4000	Nil	5000 quantities received on 19.05.17 and issued 3000 only against the May 17 indents.
37.	May 2017	Adapaline, 15mg	0	1000	Nil	Not received during the year.
38.	May 2017	Sodium Bicarbonate, 500mg	50	3000	Nil	9950 tablets were received on 19.07.2017.
39.	May 2017	Betamethsone, 20mg	0	1000	Nil	New stock of only 100 tablets was received on 19.08.2017.
40.	December 2018	Inj. Heparin 25000 IU	10	40	10	
41.	December 2018	Calcium Carbonate, 500mg	5430	10000	3000	
42.	December 2018	Cefexime, 200mg	4200	8000	3000	
43.	December 2018	Folic Acid, 5mg	330	6000	200	
44.	December 2018	Metronedazole, 400mg	100	3000	50	
45.	December 2018	Phenobaritone, 30mg	150	1000	150	
46.	July 2019	Anti Rabis Vaccine	60	100	20	

Sl. No.	Month	Name of the medicine	Balance in the beginning of the month	Quantities demanded by depart-ments	Quantities issued in the month	Remarks
47.	July 2019	Przosin, 5mg	500	2000	300	
48.	February 2020	Vitamin D3 6000 units	340	1000	100	
49.	February 2020	Adrenaline	9980	2000	500	
50.	January 2021	Inj. Midazolam	175	1200	125	
51.	January 2021	Vitamin K 10mg	350	100	50	
52.	January 2021	Lactulose, 100ml	90	1000	40	
53.	January 2021	Mensa	6	30	6	
54.	January 2021	Amlodepine 5mg	1830	2000	730	

(ii) List of medicines which were not available in RGSSH

Sl. No.	Name of the Items not available	From	To	Indenting department	Appx. Period for which medicine not available
	RGSSH				
1.	Normal Saline 500 ml	22.10.2016	21.11.2016	CCU	1 months
2.	Inj. Lignocaine2%	22.05.2017	07.03.2018	Cath Lab	9 months
3.	Inj. Heparin 25000 IU	22.05.2017	05.04.2018	,,	10 months
4.	Normal Saline 100 ml	26.05.2017	19.11.2017	Emergency	6 months
5.	Inj. Lasix/Furosemide	26.05.2017	06.07.2017	,,	1 month
6.	Inj. Cleaxin/Enoxaparin 0.4 ml	26.05.2017	20.09.2017	,,	4 months
7.	Inj. Tramadol 50mg	26.05.2017	09.07.2017	,,	1½ months
8.	Inj. Pan top 40mg	26.05.2017	06.07.2017	,,	1 month
9.	Inj. Rantac/Ranitidine 50mg	26.05.2017	06.07.2017	,,	1 month
10.	Inj. Ketamine	22.05.2017	12.09.2017	Endoscopy	3½ months
11.	Inj. Pantoprazole 40mg	22.05.2017	06.07.2017	,,	1½ months
12.	Inj. Tramadol 50mg	22.05.2017	09.07.2017	,,	1½ months
13.	Inj. Nor-Adrenaline	22.05.2017	09.07.2017	,,	1½ months
14.	Inj. Deriphyline/Theophylline	22.05.2017	18.12.2017	,,	7 months
15.	Inj. Metoclopramide	22.05.2017	04.02.2019	,,	8½ months
16.	Inj. Hyoscine Bromide	22.05.2017	04.03.2018	,,	9½ months
17.	Tab. Amlodipine 5mg	22.05.2017	09.07.2017	,,	1½ months
18.	Tab. Bisacodyl 5 mg	22.05.2017	09.07.217	,,	1½ months
19.	Inj. Adrenaline	20.12.2018	04.02.219	,,	1½ months
20.	Inj. Calcium Gluconate	31.12.2018	04.02.2019	Pulmo Ward	1 month
21.	Inj. Soda bicarbonate	31.12.2018	04.02.2019	,,	1month
22.	Inj. Soda bicarbonate	18.12.2018	04.02.2019	ICU	1½ months
23.	Inj. STK/Streptokinase	13.01.2021	19.03.201	ICU	2 months
24.	Inj. Adenosine	13.01.2021	19.03.2021	ICU	2 months
25.	Inj. Piptaz/Piperacillin 4.5 mg	14.01.2021	16.02.2021	Pulmo Ward	1 month
26.	Inj. Gentamycin	14.01.2021	18.03.2021	,,	2 months
27.	Inj. Linezolid	14.01.2021	06.10.2021	,,	8½ months
28.	Inj. Trenexa/Tranexamic Acid	14.01.2021	11.05.2021	,,	4 months
29.	Inj. Mucomix/N- Acetyl cysteine	14.01.2021	17.01.2022	CTV ICU	1 year
30.	Inj. Adenosine	20.01.2021	19.03.2021	IUC	2 months
31.	Beta din Solution	27.01.2021	14.06.2021	R.U.C.U.	4½ months
32.	Tab. Monteleukast 10 mg	27.01.2021	19.03.2021	,,	1½ months
33.	Inj. Scanline	27.01.2021	06.05.2021	O.T.	3 months
34.	Inj. STK/Streptokinase	29.01.2021	19.03.2021	CCU	1½ months
35.	Inj. Adenosine	29.01.2021	19.03.2021	CCU	1½ months
36.	Inj. Hepatitis B Immunoglobulin	30.01.2021	28.04.2021	Endoscopy	3 months

Annexure V
(Referred to in paragraph 5.2.7)
Health Facilities like Hospitals/Dispensary after the allotment of land to the DGHS not developed

Sr. No.	Location of land	Date of Allotment	Cost of land (Amount in lakh)	Date of Possession	Time lapse for Possession after date of allotment (in Months)	Time lapse for Possession after date of Payment (in Months)	Land Owning Agency	Remarks
1.	A plot measuring 3 Bigha 17 Biswa at Vill. Kutubgarh **(Dispensary/ Polyclinic yet to be decided)**	19.08.2015	No Cost Basis	09.11.2015	2	Not Applicable	Panchayat Department	DGHS failed to decide the health facility (Dispensary or polyclinic) to be provided at the land after 75 months from the allotment date.
2.	A plot measuring 1 Bigha 11 Biswa at Vill. Nijampur **(Dispensary/ Polyclinic yet to be decided)**	19.08.2015	No Cost Basis	09.11.2015	2	Not Applicable	Panchayat Department	DGHS failed to decide the health facility to be provided at the land after 75 months from the allotment date.
3.	A plot measuring 9 Biswa at Vill. Mundka **(Dispensary/ Polyclinic yet to be decided)**	01.09.2015	No Cost Basis	Not Available with Department	-	Not Applicable	Panchayat Department	DGHS failed to decide the health facility to be provided at the land after 74 months from the allotment date.
4.	A plot measuring 2 Bigha 8 Biswa at Vill. Bakkarwala **(Dispensary/ Polyclinic yet to be decided)**	07.08.2015	No Cost Basis	Not Available with Department	-	Not Applicable	Panchayat Department	DGHS failed to decide the health facility to be provided at the land after 75 months from the allotment date.
5.	A plot measuring 11 Biswa at Vill. Shafipur Ranholla **(Health Facility)**	01.09.2015	No Cost Basis	30.12.2015	74	Not Applicable	Panchayat Department	DGHS failed to start the health facility to be provided at the land after 74 months from the allotment date.

Sr. No.	Location of land	Date of Allotment	Cost of land (Amount in lakh)	Date of Possession	Time lapse for Possession after date of allotment (in Months)	Time lapse for Possession after date of Payment (in Months)	Land Owning Agency	Remarks
6.	A plot measuring 1000 Sq. Mtrs. at Vill. A- Block , Shastri Park (Near Buland Masjid) **(Dispensary)**	06.08.2008	18.85	20.05.2010	21	141	DDA	DGHS failed to start the health facility at the land after 138 months from the date of possession and even 141 months of the payment of the land on 17.2.2010.
7.	A plot measuring 1000 Sq. Mtrs. at Gandhi Vihar **(Dispensary)**	08.06.2009	52.33	25.1.2011	19	137	DDA	DGHS failed to start the health facility at the land after 130 months from the date of possession and even 137 months of the payment of the land on 31.05.2010
8.	A plot measuring 1685.2 Sq. Mtrs. at Kapashera **(Dispensary)**	01.05.2012	22.64	23.5.2014	24	100	DDA	DGHS failed to start the health facility at the land after 90 months from the date of possession and even 100 months of the payment of the land on 15.07.2013.
9.	A plot measuring 1000 Sq. Mtrs. at Sec-04, Rohini Extn **(Dispensary)**	14.11.2012	47.67 28.36 (Add. Land Cost)	19.6.2014	19	105	DDA	DGHS failed to start the health facility at the land after 89 months from the date of possession and even 105 & 79 months of the payment of the land on 11.02.2013 & 09.04.2015.
10.	A plot measuring 1685.2 Sq. Mtrs. at Dariyapur Kalan **(Dispensary)**	17.05.2012	34.86	5.7.2013	13	108	Panchayat Department	DGHS failed to start the health facility at the land after 114 months from the date of possession and even 108 months of the payment of the land on 19.11.2012.

Sr. No.	Location of land	Date of Allotment	Cost of land (Amount in lakh)	Date of Possession	Time lapse for Possession after date of allotment (in Months)	Time lapse for Possession after date of Payment (in Months)	Land Owning Agency	Remarks
11.	A plot measuring 797 Sq. Mtrs. at CS/OCF-2, Sector-23 **(Dispensary)**	29.04.2013	60.59	9.6.2015	25	83	DDA	DGHS failed to start the health facility at the land after 102 months from the date of possession and even 83 months of the payment of the land on 19.12.2014.
12.	A plot measuring 360 Sq. Mtrs. at Neb Sarai **(Dispensary)**	06.09.2011	7.43	1.6.2012	8	115	Panchayat Department	DGHS failed to start the health facility at the land after 122 months from the date of possession and even 115 months of the payment of the land on 31.03.2012 stating the reason that the construction work of boundary wall was not allowed by owners of the adjacent plot claiming that this plot belongs to them.
13.	A plot measuring 6951 Sq. Mtrs. at Jhatikara **(Hospital)**	30.01.2008	47.57	30.9.2009	20	158	Panchayat Department	Vide letter dt. 26.05.2011 DDA informed that Construction of hospital not allowed as per MPD 2021 norms. DGHS, however, enquired about change in land use and possibility of construction of Mohalla Clinic only on 17.10.2016. No correspondence was made by DGHS with the concerned Block Development Officer after 8.11.11 for having a joint inspection to identify the suitable piece of land by the dept. in the village or its

Sr. No.	Location of land	Date of Allotment	Cost of land (Amount in lakh)	Date of Possession	Time lapse for Possession after date of allotment (in Months)	Time lapse for Possession after date of Payment (in Months)	Land Owning Agency	Remarks
								neighboring areas for construction of 100 bedded maternity cum health centre.
14.	A plot measuring 14534 Sq. Mtrs. at Bamnoli**(Hospital)**	18.09.2008	300.65	21.1.2010	16	Not Available	Panchayat Department	Vide letter dt. 26.5.2011 DDA informed that Construction of hospital not allowed as per MPD 2021 norms being part of Green Belt. DGHS, however, enquired about change in land use only on 17.10.2016. No correspondence was made by DGHS with the concerned office to allot another land in the nearby area in lieu of the existing allotted land after 7.7.2011 and for refund of money prior to 17.11.2020.
15.	A plot measuring 3960 Sq. Mtrs. at Molarband**(Hospital)**	27-12-2006	27.1	28.6.2007	6	Not Available	Panchayat Department	DGHS vide letter 24.8.2007 had requested DDA for NOC regarding change of land use. DDA vide letter 30.12.2014 refused to accede with the request for change of land use as the land was earmarked as 'River and Water Body' as per Zonal Development Plan of Zone. However, no correspondence was available prior to 10.4.2015 with Panchayat Office for allotment of an alternative plot. No Govt. hospitals in the entire belt in South East district and nearest

Sr. No.	Location of land	Date of Allotment	Cost of land (Amount in lakh)	Date of Possession	Time lapse for Possession after date of allotment (in Months)	Time lapse for Possession after date of Payment (in Months)	Land Owning Agency	Remarks
								Govt. Hospital is either AIIMS, Safdarjang or Pt. Madan Mohan Malviya Hospital, all of which are more than 16 kms from the proposed site.
		Total	**648.05**					

Annexure VI
(Referred to in paragraph 8.2.2)
Details of Nursing Institutions

Sl. No.	Name of Institute	Previous Inspection conducted	Date of inspection to be conducted	Date of inspection conducted	Delay in inspection (Months)
1.	Akanksha Institute of Nursing RZ-C-117, Gopal Nagar, Najafgarh, New Delhi – 43	Nov 2017	Nov 2020	Feb 2022	14
2.	Apollo School of Nursing SaritaVihar New Delhi 110044	May 2017	May 2020	Oct 2021	17
3.	Ahilya Bai College of Nursing Lok Nayak Hospital, New Delhi	July 2015	July 2018	Oct 2019	15
4.	Brahm Shakti School of Nsg U-1/78 BudhiVihar, Main Kanjhawala Rd, Delhi-86	June 2018	June 2021	Feb 2022	08
5.	Dharamshila Naryana Super Specialty Hospital	October 2018	Oct 2021	No inspection till may 2022	07
6.	Ginni Devi Action School of Nursing FC-34-A-4, PaschimVihar, New Delhi-63	Jan 2016	Jan 2019	Feb 2022	37
7.	Holy Family Hospital College of Nursing Okhla Road, N.D.110025	Apl 2016	April 2019	No inspection till may 2022	37
8.	LHMC College of Nursing Connaught Place, New Delhi, Delhi 110001	Feb 2015	Feb 2018	July 2019	17
9.	Lady Reading Health School Bara Hindu Rao Delhi 110007	Mar 2014	Mar 2017	Oct 2019	31
10.	National Heart Institute, Delhi	May-15	May 2018	october 2021	41
11.	RajmataVijayaraje Scindia Nursing School Swami Dayanand Hospital Dilshad Garden, Delhi 110095	Feb 2016	Feb 2019	April 2022	38
12.	RAK College of Nursing Lajpat Nagar III, New Delhi -110024	Apr-16	April 2019	No inspection till may 2022	37
13.	Dr. Ram Manohar Lohia Hospital College of Nursing New Delhi 110001	August 2017	Aug 2020	No inspection till may 2022	21
14.	Rufaida College of Nursing, Jamia Hamdard Nagar New Delhi 62,	Nov 2014	Nov 2017	Feb 2019	15
15.	Rural Health Training Centre Najafgarh New Delhi 110073	Jan 2014	Jan 2017	June 2019	29
16.	Salokaya College of Nursing Plot No. 1147 Near Rithala Metro Station Delhi-85	May 2013	May 2016	Feb 2019	33
17.	College of Nursing, St. Stephen's Hospital Near Tis Hazari, Delhi-110054	May 2017	May 2020	Oct 2022	29
18.	Sant Parmanand Hospital School of Nursing Sant Nagar, Burari, Delhi 110084	October 2018	October 2021	No inspection till may 2022	07
19.	School of Nursing, Tirath Ram Shah Hospital 1, Isher Das Sahney Road, Rajpur Road, Delhi 54	Jan 2016	Jan 2019	No inspection till may 2022	40
20.	College of Nursing VMMC and Safdarjung Hospital Ansari Nagar Delhi	May 2016	May 2019	No inspection till may 2022	36

Annexure VII
(Referred to in paragraph 10.1.7)
Improper/Non providing free treatment to EWS Patients by Identified Private Hospital

Sl. No.	Name of EWS patient treated	Name of IPH	Amount paid by patient (₹)	Case	Remarks
1.	Sh. Ram Lal Singh	Batra	30,000	Not provided free treatment under EWS Category	The patient claimed that hospital authority had refused to treat him free under EWS Category and charged payment of Rs. 30000/- for treatment. The complaint was forwarded to Hospital on 19.10.2021 but reply is still pending even after delay of 132 days.
2.	Sh. Hatam Singh	Batra	1,31,851	Not provided free treatment under EWS Category	Patient was admitted in the Hospital with Heart Ailments but Hospital to treat free Under EWS Category and torn my referral Letter by the staff of hospital. The hospital stated in its reply patient had not shown EWS documents at the time of admission and treatment. Hence patient was considered in paid category. The Reply is not acceptable as patient belonged to EWS Category and hospital author has not incurred any extra expenditure on his treatment as the service is free to EWS Patient that to be provided to Cash/Paid Patient as per the directions of High court.
3.	Md. Nazir	Batra		Delay and not providing proper treatment	The Patient was suffering from cancer and his condition was deteriorating very fast and hospital authority was not paying attention towards patient and was giving prolong date (as stated by Patient on 13.11.2019). The complaint was forwarded to Hospital 19.11.2019 but no reply received till date even after delay of 830 Days.
4.	Sh. Khan Chand	Batra	2,66,866	Refused for treat under EWS	Patient claimed that he was not treated under EWS Category and hospital had charged from him instead providing free treatment. Hospital responded in its reply that patient has not revealed his EWS Category at the time of admission. The reply is not acceptable as Patient belonged to EWS Category as per documentary evidence.
5.	Sh. Jasbir Singh	Batra	6,42,902	Not provided free treatment under EWS Category	Patient was admitted in Batra Hospital in emergency due to Brain hemorrhage but hospital had refused to provide free treatment under EWS Category. The Complaint was forwarded to Hospital on 02 April 2019 but no reply received till date even after delay of 1065 days.
6.	Sh. Suresh Kumar	Batra	NA	Delay in Treatment	Patient complained that he was suffering from Severe Kidney Problem and required urgent Dialysis on regular basis and condition was deteriorating but hospital told your turn would come in 6-7 months. Hospital responded that effort were being made to accommodate him for Dialysis. The reply seems not true as patient urgently required dialysis on regular basis.
7.					A lot of complaints against batra Hospital regarding non availability of drugs/medicines, providing long date for treatment/ Diagnostic investigation, non-treatment of EWS Patients properly and misbehaving with the patients, non-appointment of Nodal Officer by the hospital, non-earmarked EWS rates have been received from Area MLA,

Sl. No.	Name of EWS patient treated	Name of IPH	Amount paid by patient (₹)	Case	Remarks
					Liaisoning officer concerned and union of Batra Hospital which emboldend complaint made by the other Patients in this regard but DGHS has not initiated any enquiry/investigation itself to verify genuineness of Complaints merely depends on hospitals response which may be biased and no instructions/advisory was issued to hospital to improve Healthcare services being provided to EWS Patients to minimize complaints in future.
8.	Smt. Ram Pyari	Mata chanan Devi	45000	Not providing free medicine	Complaint filed on 18.09.2018, Forwarded by EWS branch to concerned hospital for reply on 24.9.2018 but no reply furnished by hospital even after delay of **1230 days**(till Jan. 2022)
9.	Smt. Preeti	Mata chanan Devi	12,082	Refused for treat under EWS	Complainant stated in his complain the hospital authority misbehaved and charged money at the time of discharge. Hospital responded that the patient has obtained to avail paid services. Reply is not acceptable as EWS bed were vacant at the time of admission of the patient. LO/EWS did not verify the facts of reply and simply communicated to the Patient. As per High court instructions all facility to be provided to EWS Patient at free of cost that being given to paid patient.
10.	Sh. Manoj	Mata chanan Devi		Complaint regarding not providing free ultrasound facility and no further treatment under free category	Complaint forwarded by EWS branch to concerned hospital for reply on 20.10.2020 but no reply furnished by hospital even after delay of **469 days(** till Jan.2022).
11.	Sh. Gulshan	Indian Spinal Injury	15,000	Not providing treatment under EWS	Hospital has not furnished specific reply regarding charging from Patient.
12.	Sh. Brijmala	Indian Spinal Injury		Not providing treatment under EWS	Patient complained that she was not operated for Spine injury even after passing of many months and facing a lot of problem in Walking and siting. Hospital replied that no bed was available at that time without furnishing Bed occupancy details and was silent for not providing treatment even after many months. The facts were also not verified by LO/NO/EWS Cell why patient was not treated on time.
13.	Mr. Mohd. Tahir	Indian Spinal Injury		Refused for treat under EWS	Complainant said that he met with an accident(16.01.20190 and got emergency treatment in government hospital in Chandigarh after that he went to Indian Spinal Injury for further treatment but hospital did not provide any treatment for over 02 months and the condition of his leg deteriorated very fast. Hospital replied that bed was not available at the time of admission (02.02.19). Without furnishing details of Bed Occupancy of that date and was silent for not providing free bed even in 02 months and

Sl. No.	Name of EWS patient treated	Name of IPH	Amount paid by patient (₹)	Case	Remarks
					11 days. LO/NO/EWS Cell had not made any effort to help him in getting treatment as soon as possible.
14.	Ms. Sakina	Indian Spinal Injury		Not providing treatment under EWS	Patient said that she was suffering from hip injury and required immediate treatment but no treatment was provided by the hospital and given medicine for 04 months instead of operating it. Complaint forwarded by EWS branch to concerned hospital for reply on 16.10.19 but no reply furnished by hospital even after delay of **836** days.
15.	Mr. Munawar Rasheed	Pushpawati Singhania (PSRI)		Not providing free medicine and test	No mention of charge of medicine by the hospital in its reply.
16.	Mr. Hiralal Singh	Pushpawati Singhania (PSRI)		Not providing free Medicines post renal transplant	Hospital stated that Patient should follow up and get medicine from AIIMS where he got his kidney transplanted. Reply is not correct as EWS Patient is free to get medicine from any IPH.
17.	Ms. Ramesh Devi	Mahraja Agarsen		Refused for free treatment	Even after the patient was referred by LNJP hospital in emergency to Maharaja Agrasen Hospital but hospital had denied to admit the patient under EWS Category in emergency(Suffering from Interstitial Lung Disease and grappling under Heavy Pain). As complainant said in this case the referral procedure of emergency Patient was not adhered by both Govt as well as private hospital. Complaint forwarded by EWS branch to concerned hospital for reply on 10.6.21 but no reply furnished by hospital even after delay of **235** Days.
18.	Ms. Asha	Mahraja Agarsen	NA	Not providing free treatment and charging fees.	EWS patient complained that she has incurred over 2 lakh rupees on her treatment in the hospital and did not have more money for further treatment. Hospital authority has offered 30% discount on bill in spite of that it has charged from her 38000/- for shifting in General ward from ICU Complaint forwarded by EWS branch to concerned hospital for reply on 10.10.18 but no reply furnished by hospital even after delay of 1207 days(till Jaqn.2022)
19.	Ms. Kamla Rani	Mool chand		Not provided medicine.	The patient claimed that medicines were not being provided by the IPH. Complaint forwarded by EWS branch to concerned hospital for reply on 2.4.19 but no reply furnished by hospital even after delay of 1034 days.(Jan. 2022)
20.	Naseem Jahan	Mool chand		Not provided medicine.	The patient claimed that medicines were not being provided by the IPH. Complaint forwarded by EWS branch to concerned hospital for reply on 2.4.19 but no reply furnished by hospital even after delay of 1034 days.(Jan. 2022)
21.	Ms. Gita Devi	Mool chand		Refused for treat under EWS	The patient claimed that medicines were not being provided by the IPH. Complaint forwarded by EWS branch to concerned hospital for reply on 31.5.19 but no reply furnished by hospital even after delay of 975 days(Jan 2022)

Sl. No.	Name of EWS patient treated	Name of IPH	Amount paid by patient (₹)	Case	Remarks
22.	Ms. Sarita	Mool chand		Not provided medicine.	The patient claimed that medicines and injections were not being provided by the IPH. Complaint forwarded by EWS branch to concerned hospital for reply on 9.8.19 but no reply furnished by hospital even after delay of 905 days(Jan2022)
23.	Ms. Anita	Mool chand		Not provided medicine.	The patient claimed that medicines were not being provided by the IPH. Complaint forwarded by EWS branch to concerned hospital for reply on 9.8.19 but no reply furnished by hospital even after delay of 905 days(Jan2022)
24.	Ms. Arti Goyal	Mool chand		Not provided medicine.	The patient claimed that medicines were not being provided by the IPH. Complaint forwarded by EWS branch to concerned hospital for reply on 9.8.19 but no reply furnished by hospital even after delay of 905 days(Jan2022)
25.	Mr. Birender Mishra	VIMHANS		Mis-behave with EWS patient	The patient claimed that he was being harassed at various level during his treatment from registering under EWS to provide medicine, diagnostic test/investigations/consultancy and there was big discrimination between paid and free patient, only junior doctor were treating the EWS patients and no senior doctor being provided for treatment of EWS Patient. Complaint forwarded by EWS branch to concerned hospital for reply on 23.1.19 but no reply furnished by hospital even after delay of 1103 days(Jan 2022)
26.	Mr.Tintu Ram	VIMHANS	80663	Refused for treat under EWS	The patient was admitted in emergency ward but treatment was not provided under EWS Category and was forced to made payment of Rs. 80663 for treatment provided by the hospital. Hospital replied that Patient had not shown EWS document at the time of admission.
27.	Ms. Shahida Begam	Max Patparganj		Not proper treated to EWS patient	The patient complained that she did not getting bed in hospital in critical condition. Complaint forwarded by EWS branch to concerned hospital for reply on 11.3.21 but no reply furnished by hospital even after delay of 325 days(Jan 2022)
28.	Ms. Shamshad	Max Patparganj		Refused for treat under EWS	The Patient claimed that he was suffering from Heart ailments and undergone treatment in this hospital but now hospital has refused to provide any medicine and diagnostic investigation. The condition of patient was deteriorating day by day but hospital authority was not paying any heed on his suffering. Complaint forwarded by EWS branch to concerned hospital for reply on 26.3.21 but no reply furnished by hospital even after delay of 310 days(Jan. 2022)
29.	Mr. Shiv Ratan	Max Patparganj		Delay in providing treatment	The patient claimed that he was suffering from cancer but was not able to get the bed for radiation therapy. No diagnostic investigation date was provided to get date for the test. Hospital told that the date for investigation to be given in 15 days but even after delay of 2-3 months no date was provided Complaint forwarded by EWS branch to concerned hospital for reply on 20.7.21 but no reply furnished by hospital even after delay of 195 days(Jan. 2022)

Sl. No.	Name of EWS patient treated	Name of IPH	Amount paid by patient (₹)	Case	Remarks
30.	Ms. Sushmita Sen	Max Patparganj		Refused for treat under EWS	The patient claimed that she was not provided treatment in emergency ward, the patient was suffering from stone ailments. No operation date was provided even after meeting with senior authorities and every time put her name in waiting list. The condition was deteriorated and suffered from heavy pain. Complaint forwarded by EWS branch to concerned hospital for reply on 3.8.21 but no reply furnished by hospital even after delay of 181 days.
31.	Ms. Sandhya Shukla	Max Shalimar Bagh	4133	Refused for treat under EWS	The patient was admitted in emergency ward on 04.07.2017 but refused to treat under EWS Category with plea that EWS bed not available and charged for Diagnostic investigation. Later the patient was admitted self to Saroj hospital after refused by Max Hospital. Complaint lodged to EWS branch on 27.7.2017 but the same had not forwarded by EWS branch to concerned hospital for reply even after delay of 1648 days(Jan. 2022)
32.	Mr. Rammurat Singh	Max Shalimar Bagh		Non providing treatment to EWS Patients properly	The patient claimed that he needed to get his ear operated but hospital authority not given date for same even after multiple visits to Nodal officers. Date of complaint 28.07.2017, complaint forwarded to IPH by EWS 10.08.2017. No reply received from IPH till date even after delay of 1661 days.
33.	Ms. Dimple Jain	Max Shalimar Bagh		Non providing treatment to EWS Patients properly	The patient claimed that she was referred by Government Hospital to Max to get her Hernia operated but hospital has not provided date for operation even after multiple visits of the same. The condition of patient was deteriorating and need urgent operation. Date of complaint 13.09.2017, complaint forwarded to IPH by EWS 15.09.2017. No reply received from IPH till date even after delay of 1616 days.
34.	Ms. Geeta	Max Shalimar Bagh		Non providing treatment to EWS Patients properly	The relative of patient claimed that she needed to admit in emergency but doctor refused to even check the patient condition and told they do not EWS bed. After many requests she was admitted in emergency. The next day hospital staff told in morning we do not have beds and take out patient from here that day was Sunday and we again requested them that we are trying to get bed in other hospitals as well and requested hospital authority to provide treatment till patients is shifted to other hospital. Being Sunday we were not able to find bed in any nearby hospitals and patient was not in position to move anywhere as treating doctors told us. For not providing treatment properly and timely Patient ultimately expired. Date of complaint 18.08.2017, complaint forwarded to IPH by EWS 15.09.2017. No reply received from IPH till date even after delay of 1626 days. In this case seems that in Audit hospital had not adhered High Court instructions while admitting and treating patient in emergency/casualty.
35.	Ms. Anju	Max Shalimar Bagh	238414	Non providing free treatment to EWS Patients	The relative of patient claimed in his complaint that patient was not treated free under EWS Category by the IPH and charged fees for treatment provided by it. Date of

Sl. No.	Name of EWS patient treated	Name of IPH	Amount paid by patient (₹)	Case	Remarks
					complaint 26.09.2017, complaint forwarded to IPH by EWS 24.10.2017. No reply received from IPH even after delay of 1558 days(Jan. 2022)
36.	Mr. Dharmbeer	Max Shalimar Bagh	533022	Non providing free treatment to EWS Patients	Patient claimed that he was admitted in emergency. Being EWS Patient hospital has not provided free treatment and charged from him. Hospital stated that patient came in emergency with gunshot in forearm and was admitted in ICU after surgery and he had not shown EWS Documents for free treatment. The reply of hospital does not seems true as it is silent on bed occupancy of that date. If bed was available under EWS Category he has to provide free treatment under EWS Category even he failed to show document at the time of admission as per High Court instructions.
37.	Mr. Narayan prasad	Max Shalimar Bagh	350000	Non providing free treatment to EWS Patients	The patient claimed that he was not provided free treatment under EWS Category by the hospital. Date of complaint 23.02.2018, complaint forwarded to IPH by EWS 26.02.2018. No reply received from IPH till date even after delay of 1462 days.
38.	Mr. Sandeep Kumar	Max Shalimar Bagh		Non providing free treatment to EWS Patients properly	The patient claimed that he was not admitted in the Hospital even after multiple visits to get his hand operated injured in an accident, he was harassed in various way by staff for not giving date for operation and liaison officer posted in concerned hospital also did not help to patient get timely and proper treatment. Date of complaint 01.08.2018, complaint forwarded to IPH by EWS 10.08.2018. No reply received from IPH till date even after delay of 1268 days.
39.	Mr. Faizan Akhtar	Venkatesh war		Non providing free treatment to EWS Patients	The patient suffering from kidney disease and needs dialysis at regular intervals but hospital did not provide injections for 3-4 months and asked to arrange. Three injection are required in a week and cost of per injection is 1200/-Date of complaint 22.02.2018, complaint forwarded to IPH by EWS 26.02.2018. No reply received from IPH till date even after delay of 1457 days (Feb. 2022)
40.	Ms. Shama Khan	Action Care		Delay in providing dates for surgery	The patient claimed that she was suffering from cancer and operated upon urgently and hospital being not provided date for operation. Date of complaint 11.08.2018, complaint forwarded to IPH by EWS 14.08.2018. No reply received from IPH till date even after delay of 1465 days.
41.	Mr. Devender Singh	Action Care		Delay in Treatment	Patient was referred from government hospital DDU to get treatment of stone disease. The hospital told the Patient that surgery would perform when patient will feel the pain. He had visited more than 2 times but no treatment was provided to him and suffering from disease being enhanced as day passes. Date of complaint 22.12.2017, complaint forwarded to IPH by EWS 24.01.2018. No reply received from IPH till date even after delay of 1465 days(Till Jan 2022)
42.	Ms. Malti	Max Saket		Non providing free medicine	The patient claimed that hospital did not provided medicines and asked the patient to purchase from outside at his/her cost. Date of complaint 30.09.2019, complaint

Sl. No.	Name of EWS patient treated	Name of IPH	Amount paid by patient (₹)	Case	Remarks
					forwarded to IPH by EWS 25.10.2019. No reply received from IPH till date even after delay of 822 days(Jan 2022)
43.	Ms. Sunita verma	Max Saket		Refusal to provide treatment	The patient was suffering from disease and needed urgent treatment and condition was very critical. The hospital refused to admit the patient and asked to visit elsewhere. Date of complaint 02.06.2021, complaint forwarded to IPH by EWS 07.06.2021. No reply received from IPH till date even after delay of 238 days(Jan 2022)
44.	Ms. Uma Rani	St. Stephen	8,52,659	Refusal to provide free treatment	The patient claimed that he was admitted in emergency ward, Being EWs no free treatment was provided even pleading for the same. The hospital responded that patient sought treatment under the paid category and never informed to authority abouth their EWS Category. Audit in view that the if patient was admitted in emergency ward IPH would not sought any document from the patient and inform to concerned Govt hospital which in turn to verify eligible criteria within 48 hours, no need to show EWS Documents at the time of admission in concerned government hospital will check eligibility criteria within 48 hours of its admission. But in this case this procedure was not followed by IPH as well as IGH.
45.	Ms. Pooja	St. Stephen		Refusal to provide free treatment	The patient was admitted in emergency ward due to critical condition. The hospital authority refused to treat the patient under EWS Category and charged fees from her. The Hospital replied that patient had not shown EWS document at the time of admission. Reply of Hospital is not true as patient belongs to EWS category. No extra expenditure was incurred on patient if bed was available at the time of admission as healthcare facility is same for free and paid patient in accordance with High Court order
46.	Ms. Paro	St. Stephen		Refusal to provide free treatment	The patient claimed that ultrasound facilities was not provided to her during the pregnancy. Date of complaint 06.03.2020, complaint forwarded to IPH by EWS 12.03.2020. No reply received from IPH even after delay of 324 days(Jan. 2022)
47.	Ms. Hamza	St. Stephen		Refusal to provide free treatment	The patient claimed that she did not get free treatment under EWS Category. Date of complaint 02.04.2021, complaint forwarded to IPH by EWS 15.04.2021 No reply received from IPH even after delay of 291 days.(Jan 2022)
48.	Mr. Madan Lal	Golden Jaipur	849307	Refusal to provide free treatment and charging from the Patient	The relative of patient claimed that he was admitted in emergency ward , later shifted in ICU and kept on ventilator, Being EWS patient hospital did not provide free treatment and charged for treatment provided during emergency. During the treatment the patient was harassed to pressurize for making the payment of balance amount and threatened to stop medicine and shifted from ICU if not deposited the required money. The patient expired during the treatment. The hospital replied that patient had not revealed EWS status during the treatment. The reply is not true as patient belonged to EWS Category.

Sl. No.	Name of EWS patient treated	Name of IPH	Amount paid by patient (₹)	Case	Remarks
49.	Ms. Shanti Devi	Golden Jaipur		Non providing proper treatment and admission	The relative of Patient claimed that he went in the hospital and asked to admit the patient in emergency ward, as condition was very critical but hospital authority refused to admit her as no EWS bed was available. Later they went to Deen Dayal Upadhyay due to critical condition and patient died same day. Date of complaint 10.06.2019, complaint forwarded to IPH by EWS 20.06.2019. No reply received from IPH even after delay of 955 days.
50.	Mr. Jitender kumar	Dharmshila		Refusal to provide free treatment	The patient claimed that he was suffering from cancer and hospital did not provide free treatment under EWS Category and asked to get treated under Cash category. Date of complaint 05.03.2020, complaint forwarded to IPH by EWS 24.03.2020. No reply received from IPH even after delay of 677 days(Jan 2022)
51.	Mr. Surender Singh	Dharmshila		Refusal to provide free treatment	The patient was suffering from kidney disease and not getting free treatment from hospital under EWS category Complaint forwarded to IPH by EWS 16.12.2019. No reply received from IPH even after 776 days (Jan 2022)
52.	Ms. Kanti	Dharmshila		Refusal to provide free treatment	The patient claimed that he visited hospital many times but hospital authority refused to provide free treatment under EWS Category. The hospital replied that we are not aware about this patient.
53.	Ms. Noor Khan	Dharmshila		Not providing free treatment	The patient was suffering from cancer and was being treated in hospital, the patient required surgery and hospital demanded 200000 for surgery and said that treatment will be continued otherwise get treated in elsewhere hospital. The hospital stated that patient required plastic surgery that was not available in hospital, therefore patient was suggested to visit other hospital. The reply is not true, as per instruction of High Court is not available in concerned IPH it will enquired other hospital where the facility is available the patient will be transferred in such hospital after consultation with concerned doctors.
54.	Mr. Shivkumar Verma	Agrasen , Dwarka	45469	Refusal to provide free treatment and charging from the Patient	Date of complaint 09.09.2019, complaint forwarded to IPH by EWS 19.09.2019. No reply received from IPH even after delay of 864 days.
55.	Ms. Mansha	Dharamshila		Refusal to provide free treatment	Date of complaint 16.09.2021, complaint forwarded to IPH by EWS 02.07.2021. No reply received from IPH till date. Complainant said that hospital had refused to admit the Cancer patient later the patient was shifted to AIIMS in emergency in serious condition
56.	Priyanshi	Ganga Ram		Not getting treatment under EWS Category	The Patient said that she was suffering from Knee Problem and needed urgent operation and felt pain in walking. The complaint was forwarded to Hospital on 22.09.2017 but reply is still awaited even after delay of 1591 days. (Jan 2022)

Sl. No.	Name of EWS patient treated	Name of IPH	Amount paid by patient (₹)	Case	Remarks
57.	Salman	Ganga Ram	6,00,000	Not getting free treatment under EWS Category	The patient claimed that he was admitted in emergency ward with leg injury and profusely bleeding at the time of admission. The hospital authority had charged the treatment provided by them under EWS Category. The hospital responded that the patient was admitted under Paid category and patient did not show EWS Documents at the time of admission. The reply is not correct, if bed is available and patient belongs to EWS Category even he/she failed to show EWS Documents at the time of admission will not charge any fees from him/her for treatment provided as per High Court order.
58.	Jhilmil	Ganga Ram	3,80,000	Not getting free treatment under EWS Category	The child (1 Month Old) was admitted in the emergency ward after referred by Hindu Rao and Kalawati Hospital as no bed was available. The relative claimed that the hospital authority was demanding 3,74,000 to discharge patient. Due to failure of paying the amount the Hospital authority harassed the patient and threaten them. The Hospital responded that the patient admitted under the paid category and did not show EWS Documents at the time of admission. The reply is not correct as patient was admitted in emergency after not getting bed in 02 hospitals
59.	Prem Kumar along with 72 patients	Ganga Ram		Harassment, discrimination, Misbehaving and not providing medicine with EWS Patient	A joint complaint against this hospital has been filed by 74 Patients including an Area MLA regarding Harassment, discrimination, Misbehaving and not providing free medicine. They also claimed that EWS Registration and OPD was not functioning properly and the timing for pharmacy was also reduced due to which a lot of patients failed to get medicine prescribe by the doctors on the same day. Patients have to visit multiple times to get OPD Consultancy and medicine. The hospital authority did not pay heed to the problems faced by the patients and patients faced various types of discrimination and harassment during the treatment. The protocol of treatment to be provided was not being adhered by the Hospital. The DGHS had not initiated any enquiry to look into the irregularities pointed out by the Patients and no instructions/directions was issued to the hospital to improve the service and adhered the High Court directions so that EWS Patients not to be harassed at the time of getting Healthcare facilities
60.	Anil Kumar	Ganga Ram		Not admitting patients in emergency	The patient claimed he visited the hospital in emergency condition but hospital authority refused to admit claiming that bed was not available without giving bed occupancy detail. The compliant was registered on 04.11.2020 but reply is still awaited even after delay of 453 days (Jan 2022)
61.	Jasbir	Shanti Mukund	95,618	Refusal to treat free under EWS Category	The patient claimed that he was suffering from Kidney Disease and treated in Safdarjang Hospital due to non-availability of Dialysis facility in hospital and told to visit somewhere else to get dialysis facility after that he visited this hospital under emergency condition and the Hospital authority refused to provide treatment under EWS Category as bed was not available. Hence the patient was admitted in Paid Category because the

Sl. No.	Name of EWS patient treated	Name of IPH	Amount paid by patient (₹)	Case	Remarks
					condition of patient deteriorated very fast. The Hospital responded that Patient was admitted in Casualty, the patient did not sought treatment under EWS Category. The reply is not true as patient belonged to EWS Category and should have been treated under EWS Category
62.	Raj Kumar	Shanti Mukund	12689	Refused to treat patient under EWS Category	The patient stated that he was denied free treatment under EWS Category by the hospital. Other EWS patient also suffered from same problem. The hospital responded that the BPL card was issued by the concerned authority without verifying the facts as patients did not fall under EWS Category
63.	Ms. Meera	Shanti Mukund	890	Refused to treat patient under EWS Category	The Patient was suffering from stone problem and hoping that he would get free treatment under EWS Category but authority denied free treatment. The hospital responded that patient opted treatment under paid category and did not show EWS documents. The reply is not true as patients belonged to EWS Category and treatment should have been provided for free.
64.	Manohar Lal	Shanti Mukund	2,60,000	Refused to treat patient under EWS Category	The relative of patient claimed that he was denied of treatment by Max, Shanti Mukund but kosmos hospital admitted in emergency for which it charged, later the patient expired. The hospital authority responded that the patient had not visited the hospital.
65.	Ms. Hazra	Shanti Mukund		Not provided free medicines	The patient was admitted in emergency ward under EWS Category after making a lot of efforts but hospital authority not provided free medicine and injections during the treatment. The hospital responded that the patient neither objected nor mentioned EWS Category at the time of purchasing medicine. The reply is not acceptable as patient was admitted and being treated under EWS Category
66.	Ms. Vidya Devi	Shanti Mukund		Not provided free medicines and diagnostic investigations	The patient complained that Hospital did not provided free medicine and diagnostic investigation.
67.	Mr. Vijay Kumar	Shanti Mukund		Harassment by the hospital	The patient claimed that he was harassed during the treatment in emergency and denied free treatment by the hospital. The hospital responded that the patient was not harassed during the treatment.

Annexure VIII
(Referred to in paragraph 11.5.4)
Unavailability of Essential Drugs in SHMC

Sl. No.	Medicine Name	Non availability Period	Total unavailability
1.	Kali Muriaticum Biochemic 6x	12.12.2018-04.02.2019 (23 days) 22.08.2019-17.11.2019(47 days) 18.02.2020-04.01.2021(10 month 7 days) 11.10.2022- 03.04.2023(4 month 23 days)	17 month 10 days
2.	Magnesium Phosphoricum Biochemic 6x	26.09.2016-24.11.2016 (1 month 29 days) 11.12.2016-29.12.2016(19 days) 17.05.2017-23.08.2017 (2 month 36 days) 14.10.2017-23.01.2018(1 month 39 days) 29.11.2018-04.02.2019 (2 month 6 days) 07.09.2019-17.11.2019 (1 month 40 days) 12.02.2020-04.01.2021 (10 month 23 days) 21.09.2021-10.10.2021 (20 days)	24 month 2 days
3.	Aurum Mur. Nat. 3x Trituration	20.11.2005-23.08.2017 (140 month 34 days) 30.08.2017-24.08.2018 (11 month 26 days) 07.09.2018-10.03.2019 (5 month 34 days) 15.09.2020-05.08.2021 (10 month 21 days) 18.03.2022- 03.04.2023 (11 month 6 days)	173 month 1 days
4.	Ova Tosta 3x Trituration	27.12.2011-23.08.2017 (67 month 28 days) 20.09.2019-30.12.2020 (14 months 41 days)	83 month 9 days
5.	Arnica Montana Ointment	26.09.2016-09.01.2017 (3 month 14 days) 24.08.2017-23.01.2018 (4 month 29 days) 01.02.2018-25.02.2018 (25 days) 15.08.2018-12.10.2018 (1 month 28 days)	11 month 3 days
6.	Calendula Officinalis Ointment	26.09.2016-14.11.2016 (1 month 19 days) 13.11.2016-09.01.2017 (1 month 27 days) 24.08.2017-23.01.2018 (4 month 29 days) 01.02.2018-25.02.2018 (25 days)	9 month 10 days
7.	Cantharis Ointment	06.02.2016-14.11.2016 (9 month 9 days) 13.11.2016-09.01.2017 (1 month 27 days) 22.07.2017-25.02.2018 (7 month 3 days)	18 month 9 days
8.	Rhus Toxicodendron Ointment	26.09.2016-14.11.2016 (1 month 19 days) 24.08.2017-23.01.2018 (4 month 29 days) 01.02.2018-25.02.2018 (25 days) 29.07.2018-12.10.2018 (2 month 15 days) 04.07.2019-19.11.2019 (4 month 17 days)	14 month 15 days
9.	Cineraria Maritima Eye Drops	24.08.2017-23.01.2018 (4 month 29 days) 01.02.2018-25.02.2018 (25 days)	5 month 24 days
10.	Euphrasia Eye Drops	20.12.2016-23.08.2017 (8 month 4 days) 26.10.2017-23.01.2018 (2 month 28 days) 01.02.2018-25.02.2018 (25 days) 17.07.2018-12.10.2018 (2 month 27 days) 22.09.2019-22.11.2019 (2 month 1 days)	16 month 25 days
11.	Mullein Ear Oil	08.03.2016-23.08.2017 (17 month 6 days) 20.01.2018-23.01.2018 (4 days) 01.02.2018-12.10.2018 (8 month 12 days) 15.09.2018-20.02.2019 (5 month 6 days) 04.07.2019-13.11.2019 (4 month 9 days)	35 month 7 days
12.	Alfalfa Mother Tincture (Internal)	16.10.2020-30.12.2020 (2 month 10 days)	2 month 10 days
13.	Allium Sativa Mother Tincture (Internal)	21.10.2014-17.01.2017 (26 month 28 days)	26 month 28 days
14.	Aralia Rac. Mother Tincture (Internal)	20.12.2016-23.08.2017 (8 month 4 days) 08.06.2022- 03.04.2023 (9 month 19 days)	17 month 23 days

Sl. No.	Medicine Name	Non availability Period	Total unavailability
15.	Arnica Montana Mother Tincture (Internal)	Till 25.02.2018, drug was not available in the stock.	
16.	Aspidosperma Mother Tincture (Internal)	22.06.2021-03.02.2022 (7 month 13 days)	7 month 13 days
17.	Berberis Vulgaris Mother Tincture (Internal)	29.06.2016-14.11.2016 (4 month 16 days) 29.11.2017-23.01.2018 (1 month 26 days) 07.09.2019-17.11.2019 (2 month 11 days)	8 month 23 days
18.	Blatta Orientalis Mother Tincture (Internal)	26.09.2016-14.11.2016 (4 month 13 days) 31.12.2016-17.01.2017 (18 days)	5 month 1 days
19.	Cantharis Mother Tincture (Internal)	31.01.2016-25.02.2018 (1 month 26 days) 14.07.2019-13.11.2019 (3 month 29 days)	5 month 25 days
20.	Carduus Marianus Mother Tincture (Internal)	21.10.2014-08.07.2016 (20 month 19 days)	20 month 19 days
21.	Cephlandra Indica Mother Tincture (Internal)	06.02.2016-17.01.2017(11 month 11 days) 17.10.2017-06.02.2018 (3 month 20 days) 07.09.2019-17.11.2019 (2 month 10 days) 03.11.2020-30.12.2020 (1 month 27 days) 20.02.2021-19.04.2021 (2 month) 19.10.2021-03.02.2022 (3 month 16 days) 16.07.2022- 03.04.2023 (8 month 18 days)	33 month 12 days
22.	Chelidonium Majus Mother Tincture (Internal)	14.09.2017-23.01.2018 (4 month 10 days) 01.02.2018-25.02.2018 (25 days) 20.09.2019-04.01.2021(15 month 15 days) 20.02.2021-20.05.2021 (4 month) 19.10.2021- 03.04.2023 (18 month 16 days)	43 month 6 days
23.	Cratagus Oxy. Mother Tincture (Internal)	06.02.2016-14.11.2016 (9 month 8 days) 31.12.2017-06.02.2018 (1 month 7 days)	10 month 15 days
24.	Grindelia R. Mother Tincture (Internal)	06.02.2016-14.11.2016 (11 month 8 days) 11.12.2016-17.01.2017 (1 month 8 days) 26.10.2017-23.01.2018 (2 month 29 days) 30.11.2018-23.06.2019 (5 month 24 days) 04.07.2019-13.11.2019 (4 month 10 days) 21.11.2019-04.01.2021(13 month 14 days)	39 month 3 days
25.	Hydrastis Canadensis Mother Tincture (Internal)	16.11.2012-17.01.2017 (50 month 1 day)	50 month 1 day
26.	Janosia Asoka Mother Tincture (Internal)	22.06.2017-06.02.2018 (7 month 14 days)	7 month 14 days
27.	Passiflora Incarnata Mother Tincture (Internal)	26.09.2016-17.01.2017 (3 month 22 days)	3 month 22 days
28.	Rauwolfia Serpentina Mother Tincture (Internal)	26.10.2017-23.01.2018 (2 month 28 days) 15.08.2018-12.10.2018 (1 month 28 days) 07.09.2018-20.02.2019 (5 month 14 days) 22.08.2019-18.11.2019 (2 month 27 days) 30.01.2020-30.12.2020 (11 month)	24 month 7 days
29.	Sabal Serrulata Mother Tincture (Internal)	29.11.2017-25.02.2018 (2 month 27 days) 10.11.2019-19.04.2021 (17 month 10 days) 14.05.2021-27.07.2021 (2 month 14 days) 05.08.2022- 03.04.2023 (7 month 29 days)	30 month 20 days
30.	Syzygium Jambolanum Mother Tincture (Internal)	16.07.2022- 03.04.2023 (8 month 19 days)	8 month 19 days
31.	Calendula Officinalis Mother Tincture (External)	02.08.2017-17.11.2019 (27 month 15 days) 25.01.2020-19.01.2021 (11 month 26 days)	39 month 11 days
32.	Thuja Occidentalis Mother Tincture (External)	17.07.2018- 03.04.2023 (56 month 17 days)	56 month 17 days

Sl. No.	Medicine Name	Non availability Period	Total unavailability
33.	Kreosote Mother Tincture (External)	Till 13.11.2019, drug was not available in the stock.	
34.	Plantago Mother Tincture (External)	Till 17.11.2019, drug was not available in the stock.	
35.	Acid Phosphoricum	18.01.2017-25.02.2018(13 month 8 days)	13 month 8 days
36.	Digitalis Pre.	17.11.2015-18.01.2017 (14 month 2 days) 02.08.2017-12.10.2018 (2 month 11 days)	16 month 13 days
37.	Natrum Mur.	31.12.2017-12.10.2018 (9 month 13 days)	9 month 13 days

Annexure IX
(Referred to in paragraph 11.5.5)
List of medicines purchased in bulk and distributed loose in Tibbia Hospital

Unani		Ayurvedic	
Name of Medicine	**Quantity (Kg)**	**Name of Medicine**	**Quantity(Kg.)**
Suboos-e-isaphgol	10	Giloy	70
Gul-e-tisu	15	Ashwagandha	30
Mako-e-Khushk	10	Shatawari	30
Tukhm-e-Kasni	15	Saariva	7
Tukhm-e-Kasus	8	Bala	25
Charaita	10	Gokshru	35
Mundi	15	Haritaki	50
Khar-e-Khask	15	Bhibhitaki	50
Tukhm-e-Khayarain	5	Amalaki	50
Tukhm-e-Kharpaza	5	Saunth	20
Zanjabeel	15	Maricha	10
Ravend Chini	10	Pippali	10
Asghandh	15	Vidanga	5
Darcheeni	10	Nagarmotha	20
Maghz-e-bhelgiri	20	Kantakaari	20
Sanamakki	12	Ativisha	8
Ustokhudus	12	Katuki	5
Kishneez-e-Khushk	12	Karkatashrangi	8
Filfile-siyah	5	Arjuna Chaal	30
Asrol	6	Shigru	20
Barg-e-adusa	12	Dashmool	10
Mochras	10	Lodhra	50
Sang-e-jarahat	7		
Satawar	15		
Musli safaid	10		
Gulezoofa	10		
Amla Khushk	20		

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