PUBLIC ACCOUNTS COMMITTEE

(2016-2017)

ANDHRA PRADESH LEGISLATURE

REPORT (SIXTH)

ON

THE REPORT OF THE COMPTROLLER AND AUDITOR GENERAL OF INDIA (G & SSA) OF GOVERNMENT OF ANDHRA PRADESH
FOR THE YEAR 2013-14 PERTAINING TO
HEALTH, MEDICAL AND FAMILY WELFARE DEPARTMENT

(Presented to the Legislature on 23.03.2017)

ANDHRA PRADESH LEGISLATURE (PAC)
SECRETARIAT, VELAGAPUDI-522503.

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COMMITTEE ON PUBLIC ACCOUNTS

(2016-17)

(Constituted on 22-04-2016)

1.	Sri B.Rajendra Nath	:	Chairman
2.	Sri Thota Trimurthulu	:	Member from Assembly
3.	Sri T. Sravana Kumar	:	”
4.	Sri B.K. Partha Sarathi	:	”
5.	Sri Gadde Ramamohan	:	”
6.	Sri B. Uma Maheswara Rao	:	”
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9.	Sri Dadisetti Ramalingeswara Rao (Raja)		”
*10.	Sri T.D.Janardhan	:	Member from Council
11.	Sri B.Chengal Rayudu	:	”
12.	Sri Subhash Chandra Bose Pilli		”

LEGISLATURE SECRETARIAT :

1. Sri K. Satyanarayana Rao, Secretary (i/c.)
2. Sri P. Balakrishnamacharyulu, Deputy Secretary
3. Sri P.V. Subba Reddy, Assistant Secretary
4. Sri K.V.V. Satyanarayana, Section Officer

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* Vacant – w.e.f 13.01.2017

INTRODUCTION

I, the Chairman of the Committee on Public Accounts (2016-17) having been authorized the Committee to present the Sixth Report, on their behalf, do present this report on the Report of the Comptroller and Auditor General of India (G &SSA) of Government of Andhra Pradesh for the year 2013-14 pertaining to **Health, Medical and Family Welfare Department**.

2. The Report of the Comptroller and Auditor General of India (G &SSA) for the year 2013-14 was laid on the Table of the House on 26-03-2015.

3. The Committee examined the report of the Comptroller and Auditor General of India (G &SSA) of Government of Andhra Pradesh for the year 2013-14 pertaining to Health, Medical and Family Welfare Department at their sitting held on 1st and 19th July, 3rd and 23rd August, 28th October, 7th and 24th November, 2016 and the Committee approved and adopted the Report at its meeting held on 08.03.2017.

4. A statement showing the Summary of Observations/ Recommendations of the Committee is appended to this Report.

5. The Committee placed on record their appreciation of the assistance rendered to them by the Principal Accountant General (G & SSA), Andhra Pradesh and their officers and staff; Secretary to State Legislature (i/c) and their Officers and Staff in examination and preparation of the Report. The Committee would like to express their thanks to the officers of Health, Medical and Family Welfare Department and other Officers and Staff of the Government of Andhra Pradesh for the Co-operation in giving information to the Committee.

Velagapudi,
Dated: 08 -03-2017.

B. RAJENDRANATH ,
CHAIRMAN,
Public Accounts Committee.

Report of the Public Accounts Committee on the Report of the Comptroller and Auditor General of India for the year 2013-14 (G&SSA)

Government of Andhra Pradesh

Health, Medical and Family Welfare Department

1. Chapter 2 Page 11 of Audit Report 2013-14

Andhra Pradesh Health Sector Reform Programme

1.1 Government implemented a Department for International Development (DFID)[1] supported Health Sector Reform Programme (APHSRP) during July 2007 to June 2010. APHSRP was within mission period of National Rural Health Mission (2005-12) and most of the outputs and key reform measures initiated by the State Government under APHSRP were aspirations outlined in NRHM.

Audit scope involved a review of various interventions of State Government in health sector and implementation of various programmes in pursuance of the reform process as well as areas of convergence with NRHM during the period 2009-14. Based on a pilot study in the capital district of Hyderabad, six districts were selected for audit sample – two each from the three regions (Andhra, Telangana and Rayalaseema) of composite State of Andhra Pradesh. (*Of these, four districts i.e.,* ***Chittoor, East Godavari, Kurnool and Visakhapatnam relate to the residuary State of Andhra Pradesh.)***

Audit findings in this regard are given in the succeeding paragraphs:

2.3.1 Primary health care

PHC, headed by a Medical Officer, is the key unit in primary health care system. It was conceived to provide medical care

[1] Government of United Kingdom

and family welfare services, including maternity and child health (MCH) services, immunization programme, promote health education, training, lab-testing for diagnosis of diseases, etc.

Health care services are extended to village level through Sub-centres, with each PHC providing for about 6 - 10 SCs within its jurisdiction. As per NRHM guidelines, there should be one SC for a population of 5,000 (3,000 in tribal areas), one PHC for 30,000 (20,000 in tribal areas) and one CHC for one lakh population (80,000 in tribal areas). Audit scrutiny revealed shortage of health care units at all levels as can be seen from the number of health care units existing *vis-à-vis* norms as of March 2014 given below:

Table-2.2

Health facility	Requirement as per population norms		Units as of 1 April 2005 (starr of NRHM)		Units as of 31 March 2014		Shortfall	
	Plain Areas	**Tribal Areas**	**Plain Areas**	**Tribal Areas**	**Plain Areas**	**Tribal Areas**	**Plain Areas**	**Tribal Areas**
Sub-centres	15733	1973	12522	NA	11167	1355	4566	584
Primary Health Centres	2622	296	1570	NA	1465	244	1157	73
Community Health Centres	787	74	215	NA	277	31	510	40

Source: Report of Common Review Mission and Outcome Budget 2013-14

NA: Not available

Despite the shortfall (29 *per cent* in plain areas and 30 *per cent* in tribal areas), no new SCs were set up in the State during the entire mission period of NRHM (2005-12). Only 139 new PHCs were established during the last five years, resulting in 42 *per cent* shortfall (44 *per cent* in plain areas and 25 *per cent* in tribal areas) *vis-à-vis* norms. Similarly, only 64 *per cent* CHCs (65 *per cent* in plain areas and 54 *per cent* in tribal areas) were functioning against the requirement as per population norm.

There were shortages in PHCs and SCs in all the sampled districts. Shortage of PHCs was high in Visakhapatnam district (53 *per cent*) followed by East Godavari and Kurnool (48 *per cent*) districts. In respect of SCs, shortage was high in Visakhapatnam (45 *per cent*) followed by Kurnool (38 *per cent*).

With regard to tribal areas, shortage of PHCs and SCs was high in Chittoor district (100 *per cent*) followed by Mahabubnagar (44 and 58 *per cent*) and Warangal (37 and 39 *per cent*) districts.

Government stated (December 2014) that in the case of PHCs and CHCs it was proposed to fill the gap in a phased manner duly observing the procedural requirements. Also district level exercise was currently being carried out to address this problem.

In Explanatory Notes, Government stated that 1264 PHCs are required for 3.74 crore of Rural and Tribal population in the Residuary State of Andhra Pradesh. Of these, 1156 PHCs were already established; 3 were under construction and proposals are under pipeline for establishment of 105 remaining PHCs.

2.3.1.1 Lack of amenities in Primary Health Centres

In 56 *per cent* PHCs, transport facility was not available to facilitate access to emergency referral services and 53 *per cent* of PHCs do not have telephone facility to answer emergency calls. Further, generators/inverters were not available in 25 *per cent* PHCs, drinking water was not available in 16 *per cent* PHCs, Operation Theatres were not in use in 30 *per cent* PHCs and labour room with facilities were not available in 16 *per cent* PHCs.

Government sanctioned upgradation of 1,224 SCs and 249 PHCs under NRHM during 2005-14. However, only 654 SCs and 114 PHCs have been upgraded.

Government replied (December 2014) that the Government is operating 108-Ambulance services and 104-Fixed Day Health services to reach out to the need on highways, in rural and tribal belts and also provided mobile phone facility and internet connectivity to almost all the PHCs and with these measures, there was no dearth for transport and communication facilities at PHC level.

However, from the information furnished to Audit by Director of Health, it is evident that referral facility was not available in 56 *per cent* of PHCs.

In Explanatory Notes, Government replied that all the PHCs had been equipped with Generators / Invertors; provided drinking water facility and Labor rooms in PHCs have been modernized with essential equipment.

2.3.3 Tertiary health care

Medical colleges attached to teaching hospitals form part of tertiary health care. Medical Council of India (MCI) prescribed norms for infrastructure, manpower, equipment and drugs and medicines required in medical colleges and their teaching hospitals. Test-check of seven medical colleges and their attached teaching hospitals revealed that most of these colleges do not comply with prescribed norms (***Appendix-2.2***).

Government replied (December 2014) that it was seized of the issue of shortage of certain equipment in some of the Government teaching hospitals and enumerated the various steps/measures taken for all round improvement in the provision of essential equipment in all the Teaching (District) hospitals.

No mention was made in the Explanatory Notes, in this regard.

2.4 Physical infrastructure

Audit scrutiny of infrastructure in health care facilities *vis-à-vis* IPHS norms revealed shortages. Details with regard to test checked health centres are tabulated below.

Table-2.3

Sl No.	Facilities	SCs	PHCs	CHCs/ DHs/AHS*
	Total number audited	**248**	**134**	**30**
1.	No. where Ambulance was not available	NA	NA	17
2.	No. with no electricity connection	112	Nil	Nil
3.	No. without standby power supply	248	55	7
4.	No. where separate ward for male and female was not available	NA	118	3
5.	No. where waiting rooms were not available	NA	57	5
6.	No. where there was no water supply	98	15	Nil
7.	No. without telephone connection	206	73	5
8.	No. where no residential accommodation was available for staff	159	233**	12
9.	No. where prescribed quantity of medicines were not available	248	134	30

**includes data in respect of 18 CHCs, seven Area Hospitals (AHs) and five District Hospitals (DHs)*

***residential accommodation not available in respect of MOs in 119 PHCs and Staff Nurses in 114 PHCs;* NA: Not applicable

None of the test checked units complied with the requirement of equipment as per norms. Non-compliance was especially high with regard to standard surgical sets in CHCs, Treadmill,

CTG Monitor, 500 M.A. X-ray machines, Dehumidifier in AHs and ECG, CTG monitors, Paediatric operation table, etc. in DHs. Details are given in ***Appendix-2.3.***

Government replied (December 2014) that the IPHS norms are advisory in nature and to a certain extent these have been fulfilled in the health care institutions. Government also assured that necessary steps would be taken to provide the physical infrastructure and equipment to the health care units.

However, the instances of lack/shortage of equipment pointed out in Audit pertain to essential equipment required as per IPHS norms.

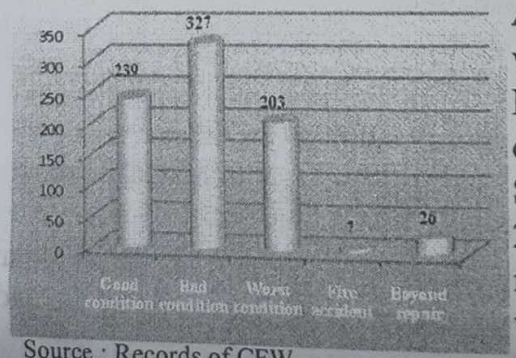
In Explanatory Notes, Government stated that necessary basic amenities and sufficient stocks of all medicines and surgicals were provided in all the PHCs.

2.6.1 Scheme implementation

2.6.1.1 Replacement of ambulances

MoU of September 2011 envisaged replacement/refurbishment of ambulances yearly in order to provide uninterrupted emergency services. Scrutiny of records relating to status/ condition of ambulances during 2012-13 available with CFW revealed the following.

Chart 2.1 : Number of vehicles



Source : Records of CFW

Although replacement of vehicles was envisaged in MoU, CFW could replace only 220 between September 2012 and May 2013. Further analysis revealed that 66 vehicles were still on road even

after their replacements. Scrutiny also revealed that there were non-operational (off-road) ambulances ranging from 111 to 330 for period August 2009 to February 2012 due to accidents/ breakdowns/ refurbishments/ minor body repairs.

During the Exit Conference, Government's response (November 2014) to the issue of a large number of off-road vehicles (in 108 service) due to repairs/non-replacements, was that efforts were already on to replace the off-road vehicles. Further, an action plan has been drawn up to procure 278 new ambulances to substitute old ambulances requiring replacement.

In Explanatory Notes, Government stated that all the 440 ambulances had been refurbished in 2012-13. Further, it stated that an action plan had been drawn up to procure 278 new ambulances to substitute the old ones.

2.6.2 Releases to service provider

As per MoU, funds should be released to service provider in advance on a quarterly basis, in respect of operational expenses (OPEX) which should be based on actuals and subject to ceiling limit envisaged in the schedules appended to MoU. It was also stipulated in MoU that average percentage of on-road vehicles per day should not be less than 90 *per cent* (i.e. 722) of total vehicles.

It was however, observed that no specific saving clause was incorporated in MoU in case of shortfall in number of on-road vehicles against the stipulation. It was also observed that there is no consistency in the information/data available with CFW and the database submitted by the service provider about average number of on-road vehicles for the years 2012-13 and 2013-14.

Due to inconsistency in number of on-road vehicles, actual deployment of vehicles could not be vouchsafed in Audit. With regard to releases of funds, CFW is making payments by limiting the claim amount to maximum admissible amount. As releases were not linked with number of vehicles deployed and were being made as per SoEs, genuineness of claims admitted could not be vouchsafed.

Government in its reply (January 2015) stated that the number of on-road vehicles could vary due to difference between actual 'ready to ply' vehicles and number of vehicles assigned. It was further stated that payments are made strictly as per MoU.

Reply is not satisfactory since as per the MoU, maximum admissible amount was worked out per ambulance per month basis. However, the SoEs submitted by EMRI included lump sum amounts expended under various components[2] and did not contain number of vehicles operated. In this scenario, Government was left with the only option of relying on SoEs and restrict the releases to maximum number of operational ambulances (i.e. 752). It is thus evident that the payments were being made on the basis of SoEs without linking to actual number of vehicles operated.

In Explanatory Notes, no mention was made in this regard.

2.6.2.1 Deficiencies in inspection of Ambulances

As per CFW instructions (May 2012), DM&HOs of respective districts are required to inspect at least 25 *per cent* of ambulances in their jurisdiction and submit reports to CFW regarding status of vehicle, deficiencies/shortage of equipment/ medicines.

[2] viz., ambulance repair and maintenance, fuel cost, expenses for tyres, salaries, administrative expenses,etc.

Scrutiny however, revealed that no such reports were received in CFW from DM&HOs. Audit scrutiny in the sampled districts revealed the following.

(i) In Visakhapatnam district no supervision was undertaken by DM&HO till date.

(ii) Though DM&HOs, East Godavari and Kurnool districts, stated (June 2014) that ambulances were being inspected, inspection reports were not furnished to Audit.

Government replied (January 2015) that, during the recent past the DM&HOs are submitting the inspection reports in the prescribed format indicating the status of the ambulances.

In Explanatory Notes, Government had not offered any explanation for not conducting inspections. It stated that all the ambulances are being fitted with GPS and monitored on real time basis through a dedicated website.

2.7 Aarogyasri Health Insurance

One of the key reforms envisaged under State health sector reform programme was health insurance. Provision of health insurance was also one of the requirements of NRHM.

Rajiv Aarogyasri (RA) was unveiled in April 2007 as a flagship health insurance scheme of State Government with the objective of providing cashless quality medical care to all BPL families for treatment of identified diseases involving hospitalisation, surgeries and therapies through empanelled network hospitals by providing financial protection up to Rs.2 lakh in a year for treatment of serious ailments. In August 2007, Aarogyasri Health Care Trust (AHCT) consisting of Minister

for HM&FW, Secretaries (HM&FW, Finance and Rural Development departments), Commissioners (Family Welfare and APVVP), Directors (Medical Education, Health and Nizam's Institute of Medical Sciences), Financial advisor and CEO, AHCT was set up under the Chairmanship of the Chief Minister for effective implementation of this scheme.

Initially (April 2007), 163 diseases in six systems[3] were identified for coverage under this scheme. This number was later extended (July 2008) to 330 in 13 systems[4] under Aarogyasri-I (AS-I) through insurance coverage mode[5]. Subsequently, AS-II was launched (July 2008) with an additional 612 surgical and medical diseases taking the total number of treatments to 942 under the scheme. As regards treatments facilitated under AS-II, payment was being released by Trust directly to empanelled hospitals. Against Rs.6,574 crore made available to the Trust since inception of the scheme in 2007 to 2014 (up to March 2014) funds amounting to Rs. 6,164 crore were expended.

2.7.1 Scheme implementation

2.7.1.1 Empanelment of Network Hospitals

Health Care Institutions (HCIs), which fulfil prescribed criteria relating to infrastructure, manpower and equipment, and conform to service and quality standards, become eligible for empanelment with AHC Trust. As of April 2014, 478 HCIs

[3] Heart, Cancer, Neurosurgery, Renal Diseases, Burns and Poly trauma cases not covered by Motor Vehicle Act.

[4] Hear, Lungs, Liver, Pancreas, Renal diseases, Neurosurgery, Paediatric congenital Malformations, Burns, Post Burns contracture surgeries for factual improvement, Cancer treatment-(a) Surgery, (b) Chemo therapy, (c) Radio therapy, Poly trauma, Prosthesis (Artificial limbs), Cochlear Implant Surgery with Auditory-Verbal therapy

[5] Star Health and Allied Insurance Company, Chennai was selected as the Insurance Company for providing insurance cover for treatments

(Government: 152, Private: 326) have been empanelled by the Trust (referred to as network hospitals (NWHs)).

Records of 100 NWHs were test checked in Audit to verify their compliance with prescribed criteria and the modalities followed by AHC Trust in empanelling these. Findings of test-check are given below:

(i) In eight hospitals, infrastructure requirements like functioning of obstetric unit, labour room with support services of paediatrician, ICU, post-operative ward, etc. were not complied with. These institutions should not have therefore, been empanelled.
Government in its reply (November 2014) stated that, out of eight hospitals mentioned, four were in Government sector and that the criterion was slightly liberal to give a boost for increased participation of maximum number of Government hospitals in the scheme.

(ii) *In Explanatory Notes, Government replied that notices have been issued to four private hospitals for updating infrastructure and equipment. In respect of Government Hospitals, Government reiterated the reply given during the Audit.* Trust did not prescribe any periodicity for inspection of empanelled hospitals. Further, renewal of empanelment is not linked with inspection. Inspection reports were not signed by the Trust authorities in respect of eight hospitals.
Government stated (November 2014) that detailed guidelines for empanelment were formulated and empanelment would be done only after registration of online application and physical inspection. It was further stated that instructions have been reiterated among all concerned to submit inspection reports with due authentications.

In Explanatory Notes, Government replied that surprise inspection would be conducted by the field officials in order to ascertain the infrastructure, manpower, equipment and services offered by the Hospitals.

Two cases of network hospitals are illustrated below.

PES Medical Institute and Research Hospital, Kuppam (Chittoor): This hospital, which was empanelled for treatment under 24 categories[6], was providing treatment only under 11 categories[7] due to non-availability of super specialists in other categories. Scrutiny also revealed that twenty seven patients who were undergoing Haemodialysis in this hospital under Aarogyasri were not treated since November 2012 due to non-availability of doctor with Masters Degree (MD) in Nephrology.

Government confirmed (November 2014) the non-availability of dialysis treatment in the hospital due to absence of Nephrologist (mandatory for performing dialysis to the patients) and stated that the hospital has been advised to engage a Nephrologist.

In Explanatory Notes, Government replied that as per online records, it was found that in-house Nephrologist was available in that Hospital, in contrary to the reply given during the course of Audit.

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[6] (i) General Surgery (ii) ENT (iii) Gynaecology and Obstetrics (iv) Orthopaedics (v) Ophthalmology (vi) Surgical Gastroentrology (vii) Paediatric Surgery (Viii) Genito Urinary Surgery (ix) Neuro Surgery (x) Plastic Surgery (xi) Polytrauma (xii) Prostheses (xiii) Critical care (xiv) General Medicine (xv) Infectious Diseases (xvi) Paediatric Intensive care (xvii) Neonatal Intensive Care (xviii) Paediatric General (xix) Cardiology (xx)Nephrology (xxi) Neurology (xxii) Pulmonology (xxiii) Dermatology and (xxiv) Gastroenterology

[7] Nos. (i), (ii), (iii), (iv), (viii), (xi), (xiii), (xiv), (xvi), (xvii) and (xviii) in footnote above

2.8 Community Volunteers (ASHAs)

One of the core components of NRHM and adopted by State Government in its health sector reforms is provision of a trained female community health worker called Accredited Social Health Activist (ASHA) in every village. ASHAs are to be engaged in every village in the ratio of one per 1,000 people so as to act as an interface between the community and public health system.

As of March 2014, against the requirement of 84,666 ASHAs as per norms, 70,700 posts of ASHAs were sanctioned by Government against which, 64,827 ASHAs were in position leaving a shortfall of 19,839 ASHAs (23 *per cent*) in the State.

All the sampled districts had shortfall in number of ASHAs *vis-à-vis* norms except for Visakhapatnam district. The shortfall ranged from 6 *per cent* (Mahabubnagar and Warangal) to 74 *per cent* (Hyderabad).

Government in its reply (January 2015) stated that the shortage in ASHA positions has been appropriately addressed by filling up the vacancies. Reply is not factual.

No mention was made by the Government in the Explanatory Notes..

2.9 Institutional Mechanisms for Community Participation

2.9.1 Village Health and Sanitation Committees

As a part of Health Sector Reforms in the State, Village Health and Sanitation Committees (VHSCs) were to be formed to ensure (i) Optimal use of health services in villages (ii) improve

participation of VHSCs in maintaining quality health and sanitation services and (iii) prevent occurrence of epidemics in villages. Scrutiny revealed that 21,916 VHSCs were formed covering all villages/Gram Panchayats/Wards in the State.

2.9.1.1 Budget and Expenditure

A budgetary requirement of Rs. 115.64 crore was proposed in PIPs for the years 2009-10 to 2013-14. An amount of Rs.106.56 crore was sanctioned and against this, Rs.102.24 crore was released and Rs.86.62 crore was expended.

Audit scrutiny revealed that, during the five year period 2009-14, 15 to 57 *per cent* of funds released were not utilised. In the sampled districts, unspent balances ranged between 7 and 36 *per cent*. Non-utilisation of funds released indicate that various activities as envisaged were not being undertaken by VHSCs.

Further, as per guidelines, grants should be released to VHSCs in two instalments based on their performance. Performance reports were however, not produced to Audit despite specific request. It was observed that although unspent balances remained at the end of each year, further funds were being released to VHSCs resulting in accumulation of balances.

Government stated (December 2014) that with the introduction of PFMS (Public Financial Management System) and the existing system of online transfer, there was more access to review and monitor utilisation of funds released for the intended purpose.

In Explanatory Notes, no relevant reply furnished by the Government.

2.9.2 Hospital Development Services

As a part of Health Sector Reforms in Andhra Pradesh and as per Government orders of December, 2006, Hospital Development Societies (HDS) are to be formed by all Teaching Hospitals, District Hospitals, Area Hospitals, CHCs and PHCs, to take care of hospital development services. Accordingly, HDSs were formed in all the institutions in the State.

As per Government orders, all receipts on account of hospital stoppages, miscellaneous receipts, etc. are to be credited to bank account of HDS. The HDS is empowered to incur expenditure from this fund for providing basic amenities, minor repairs, purchase of essential drugs, etc., after approval by HDS Committee. The Committee was to meet at least once in a quarter to review society's performance including utilisation of funds. Against Rs.90.84 crore received, an amount of Rs.68.52 crore (75 *per cent*) was expended. Non-utilisation of allocated funds indicate that various activities as envisaged were not being undertaken by HDSs.

No mention was made by Government in Explanatory Notes with the regard to above observation.

2.9.2.1 Deficiencies in HDSs

Test-check of HDS records revealed the following:

- In nine[8] institutions, HDSs meeting were not conducted quarterly.

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[8] Gandhi Hospital, Secunderabad; Osmania General Hospital, Hyderabad; **Government Hospital for Mental Care, Visakhapatnam; Government General Hospital, Anantapuram;** Niloufer Hospital; Hyderabad; DCHS, Mahabubnagar; Modern Government Maternity Hospital, Petlaburj, Hyderabad; **District Hospital, Chittoor;** MGM Hospital, Warangal

Institutions attributed the non-conduct of HDS meetings to a variety of reasons, *viz.*, retirements and camping of Medical Superintendents, pre-occupation of the Chairman/ members, lack of quorum, etc.

- In eight[9] institutions, accounts were not audited by Chartered Accountants and were in arrears for one to nine years.
- In four[10] hospitals HDS funds amounting to Rs.48.87 lakh were lying in FDRs/Savings account without utilisation. Hospitals attributed non-utilisation of funds to non-conduct of HDS meetings and assured that the matter would be brought to the notice of Director of Medical Education.
- In Gandhi Hospital, Secunderabad, EMD/SD register was not maintained by HDS. As a result, EMD of Rs.10 lakh was wrongly refunded to a person who was not entitled to it. Government did not offer specific remarks with regard to recovery of the amount. Government attributed (December 2014) the non-conduct of HDS meetings to expiry in 2011 of the tenure of heads of the HDS committees. It was also stated that the need for timely convening of HDS meeting for taking up the mandated activities for utilising the earmarked amounts has been impressed upon all concerned.

[9] Gandhi Hospital, Secunderabad; Osmania General Hospital, Hyderabad; **Government Hospital for Mental Care, Visakhapatnam; Government General Hospital, Anantapuram; Government General Hospital, Kakinada;** DCHS, Mahabubnagar; **District Coordinator for Health Service, Chittoor;** MGM Hospital, Warangal

[10] **Government Hospital for Mental Care, Visakhapatnam (`28.23 lakh);** Government Nizamia General Hospital (Unani), Hyderabad (`7.01 lakh); **Regional Eye Hospital, Visakhapatnam (`4.07 lakh); District Coordinator for Health Services, Chittoor (`9.56 lakh)**

It was assured that necessary steps would be initiated to conduct the audit of the accounts of HDS by Chartered Accountants.

In Explanatory Notes, no relevant reply was furnished by the Government.

2.10 Manpower planning

2.10.1 Primary Health Centres

As per IPHS, PHCs conducting less than 20 deliveries per month should be provided with one Medical Officer (MO) and three Staff Nurses, and those conducting 20 and above should be provided with two MOs and four Staff Nurses. Audit observed that in the test checked PHCs though there was no shortfall in MOs, there was a shortfall of 67 *per cent* in the cadre of Staff Nurse. Shortage of Staff Nurse was high in Hyderabad district (88 *per cent*) followed by Visakhapatnam (63 *per cent*) and East Godavari (46 *per cent*) among the sampled districts.

Scrutiny of records of 134 test checked PHCs in the seven sampled districts revealed that shortage in posts of Pharmacists was high in Hyderabad (84 *per cent*), followed by Chittoor (31 *per cent*).

In Explanatory Notes, Government replied that necessary steps would be taken to fill up the vacancies.

2.10.1.1 Sub-centres

As against 25,044 Auxiliary Nurse Midwife (ANM) and 12,522 Multi-Purpose Health Assistants (MPHAs) required for 12,522 Sub-centres in the State, 7 *per cent* ANM posts and 62 *per cent* MPHAs posts were vacant.

Norm	Status
Auxiliary Nurse Midwife (ANM)	Against 248 ANMs 110 ANM
Each SC should be provided with two ANMs.	posts were vac an t
Multi-Purpose Health Assistant (MPHA) - Male One MPHA (Male) should be provided for each SC.	MPHA (Male) was not available in 170 (69 per cent) out of 248 test checked Sub-centres.

Scrutiny of records of **248 Sub-centres (SCs)** test checked in the six sampled districts revealed the following.

There was no mention in Explanatory Notes in this regard.

2.10.2 Secondary Health Care

Andhra Pradesh Vaidya Vidhana Parishad (APVVP) was established (November 1986) by an Act (Act 29 of 1986) solely to manage secondary level hospitals in the State. Under APVVP, 233 hospitals[11] (including 26 dispensaries) are functioning in the State as of March 2014.

Against the requirement of 20,006 posts in all cadres in the State as per IPHS norms, in 207 hospitals, only 12,907 posts (65 *per cent*) were sanctioned by Government. Out of these, only 9,472 posts were filled up. Thus, there was a shortage of 10,534 posts (53 *per cent*) *vis-à-vis* norms. Vacancies in key posts are shown in Table below.

[11] District Hospitals (17); Area Hospitals (59); Community Health Centres (121); Speciality Hospitals (10) and Dispensaries (26)

Table-2.7

Sl. No.	Cadre	requirement (as per norms)	Sanctioned	Men in Posi-tion	Vacancy w.r.t. norms (percentage)
1.	Civil Surgeon	923	400	226	697 (76)
2.	Civil Assistant Surgeon	3063	1567	955	2108 (69)
3.	Staff Nurse	6536	3828	3351	3185 (49)
4.	Pharmacist	654	565	414	240 (37)
5.	Head Nurse	1074	543	449	625 (58)
6.	Radiographer	340	228	167	173 (51)
7.	Lab-Technician	1080	282	188	892 (83)
8.	Dark Room Assistant	340	228	101	239 (70)
9.	Physiotherapist	92	12	5	87 (95)
10.	Theatre Assistant	654	168	88	566 (87)
11.	Male/Female Nursing Orderly (MNO/FMNO)	1735	1123	834	901 (52)

Source: Records of APVVP

Status of manpower in key posts of Civil Surgeons, Civil Assistant Surgeons, paramedical officers, etc., in the test checked districts in given below :

- Vacancies in Civil Surgeons posts was high in Warangal district (89 *per cent*) followed by East Godavari and Mahabubnagar (84 *per cent*).

- Vacancies in Civil Assistant Surgeon posts were high in **East Godavari** and Mahabubnagar (**79** ***per cent***) followed by **Kurnool** (**76** ***per cent***).

- Physiotherapists were not available in any of the sampled districts.

- Vacancies in Theatre Assistants was higher in Visakhapatnam (95 *per cent*) followed by East Godavari and Mahabubnagar (88 *per cent*).

- Against the requirement of 540 posts of MNOs in the sampled districts, 269 posts (50 *per cent*) were vacant.

Government response was (November 2014) that necessary proposals to fill up the vacant posts in all cadres on regular/ contract basis had been submitted by the department in December 2013 and that action would be taken to obtain proposals afresh for sanction of additional posts as per IPHS norms.

No mention was made in this regard in the Explanatory Notes

2.10.3 Tertiary Health Care

Requirement of posts as per MCI norms, sanctioned by Government and actually operated is given below.

Table-2.8

Posts	Number of Posts			
	Sanctioned	**Men in position**	**Vacancy***	**Percentage**
Teaching posts				
Professor	757	584	173	23
Associate Professor	634	474	160	25
Assistant Professor	2081	1573	508	24
Tutor	150	58	92	61
Total	**3622**	**2689**	**933**	**26**
Para Medical				
Nursing Staff	5831	4810	1021	18
Others (Pharmacist, Lab Technician, Radiographer, Theatre Assistant, etc.)	3919	2282	1637	42

*Source: Records of DME *Vacancy with reference to sanctioned strength*

Scrutiny of records of seven test checked medical colleges and teaching hospitals revealed that there was shortage in the cadre of Professor in S.V. Medical College, Tirupati (30 *per cent*) followed by Kurnool Medical College (25 *per cent*) and Kakatiya Medical College, Warangal (22 *per cent*). Shortages in the cadre of Associate Professor ranged from 9 *per cent* in Osmania Medical College, Hyderabad to 47 *per cent* in S.V. Medical College, Tirupati and shortages in the cadre of Assistant Professor ranged from 9 *per cent* in Andhra Medical College, Visakhapatnam to 27 *per cent* in Kakatiya Medical College, Warangal.

Government accepted (January 2015) that there were vacancies in some cadres and attributed the same to seniority matters and some other disruptions in the State. Government however, assured that direct recruitment process is being undertaken to fill the maximum number of vacancies in different categories.

In Explanatory Notes, Government stated that most of the vacancies had already been filled and the remaining vacant posts would be filled soon.

2.12 Procurement and supply of drugs

Government entrusted (1998) the procurement and supply of drugs and equipment to hospitals as well as construction of hospitals to Andhra Pradesh Medical Services Infrastructure Development Corporation (APMSIDC). APMSIDC is headquartered at Hyderabad with Central Medicine Stores (CMS) in all district headquarters for distribution of drugs to various hospitals.

2.12.1 Allocation and expenditure

During the period 2009-2014, APMSIDC received Rs.1,466.11 crore towards procurement of drugs and surgical items and Rs.1,351.88 crore was utilised there against. Of this, medicines/ drugs valuing Rs.1,037.11 crore were issued to health units. Audit observations in this regard are given below.

2.12.1.1 Delayed receipt of drugs/surgical from the suppliers

As per agreement conditions, every firm has to supply the agreed quantity of drugs within 60 days. For delays up to ten days, a penalty of 0.5 *per cent* of the value of items not delivered within 60 days is to be levied. In case items are not delivered even after 70 days, the PO is deemed to have been cancelled.

There was delay in supply of drugs/equipment for period ranging from beyond 60 days to more than six months as shown below.

Table-2.9

Year	Total No. of supplies received	Supplies made in			Total delayed supplies	Percentage of delayed supplies
		>60 and > 90 days	< 90 and < 180 days	> 6 months		
2009-10	31911	6906	6450	1016	14372	45
2010-11	31605	6425	4845	803	12073	38
2011-12	42755	10869	8320	847	20036	47
2012-13	23104	4509	3386	414	8309	36
2013-14	29507	9005	5881	310	15196	51
Total	158882	37714	28882	3390	69986	44

Source: Records of APMSIDC

Except levy of liquidated damages for delayed supplies, there was no evidence of cancellation of RC agreements with the firms or blacklisting of the firms. Non-receipt/belated receipt of ordered medicines/drugs/surgicals resulted in APMSIDC purchasing these items at higher rates from the market/ defaulting firms as no other firm was willing to supply at L1 rate.

During the Exit Conference (November 2014), Government confirmed that there were delays in receipt of drugs and stated that penalties are being levied for the delay in supply of drugs.

In Explanatory Notes, Government replied that liquidated damages were levied on the manufacturers for delayed supplies. It was further stated that supply period for supply of medicines are being mentioned scrupulously along with the rates of penalty for the delay of supplies, if any.

2.12.2 Stock Management

APMSIDC should maintain stocks required for supply to user institutions/hospitals. Audit observations in this regard are discussed in succeeding paragraphs.

2.12.2.1 Non-maintenance of drugs under Essential and Additional Medicines List

Central Medicine Stores should maintain three months stock of medicines in Essential Medicines List (EML) and Additional Medicines List (AML). During 2009-13, APMSIDC entered into Rate Contracts (RCs) with suppliers for certain items for procurement of drugs and surgicals, after following the due tendering process.

Audit scrutiny revealed that 165 items (September 2011) of drugs and 128 items (April 2013) in EML and AML that figured in those lists were not available in the test checked CMS. Date from which medicines were not available could not be verified in Audit due to non-availability of relevant data with APMSIDC. APMSIDC replied that buffer stock could not be maintained due to delay in finalisation of rate contract.

Further, it was noticed that several number of drugs and surgical items[12] which figured in lists of EML and AML that were required to be maintained at all levels of health care units were not included in the rate contract.

[12] 2009-10-11 items; 2012-13-147 items in respect of drugs and 2008-09-54 items in respect of surgicals

In Explanatory Notes, Government stated that the system was streamlined and buffer stocks were made available in all the CMSs after the implementation of E-Aushadhi from June 2015.

2.12.5 Drug Control Administration

Drug Control Administration regulates manufacture, sale and distribution of drugs in the State. Its primary objective *inter alia* is to ensure that drugs made available to people are of required standards in terms of quality, purity and strength. Against a budget provision of Rs. 72.77 crore during 2009-14, an expenditure of Rs.70.97 crore was incurred.

Audit findings are discussed in the succeeding paragraphs.

2.12.5.1 Drugs Testing Laboratories

Government established two Drugs Control Laboratories (DCLs) in Hyderabad (1981) and Vijayawada (1986). Audit scrutiny revealed outdated/non-functional equipment in these two DCLs. Although equipment required for analysis of drug samples were not working since May 2011 - September 2012, the department has not initiated any corrective action in this regard.

Government replied (January 2015) that equipment which needed repairs has been identified and action was on hand to get the same repaired and put to use. With regard to repairs to the equipment, Government contention that the repairs did not affect the testing activity is at variance with the documentary evidence regarding the analysis of drug samples, which reveals consistent shortfall every year.

Government further replied that fresh proposal has been submitted to GoI for its clearance for availing the assistance.

In Explanatory Notes, Government replied that budget allocations were made during 2016-17 for strengthening the Drug Control Laboratory.

2.12.5.2 *Shortfall in testing and analysis of drugs samples*

Analysis of drugs samples plays an important role in determining compliance with prescribed quality standards, prevention of consumption of sub-standard, adulterated and spurious drugs. According to Functionary Manual of Department, a minimum of five samples of drug/cosmetic are to be analysed by a Junior Scientific Officer and a Junior Analyst has to analyse not less than 20 samples per month. As of March 2014, there was a shortfall of 45 *per cent* (7,343 analysed as against a total of 13,275 cases) in analysing of the samples received.

Government attributed (January 2015) the shortfall in analysis and testing of drugs samples to shortage of personnel for analysis of drug samples in Drugs Control Laboratory and stated that laboratory would be equipped with required men and equipment.

In Explanatory Notes, Government stated that engaging required manpower was in process.

2.12.5.3 *Non-issue / renewal of licences to Blood Banks*

Drug Controller, Directorate General of Health Services, New Delhi issues licences to Blood Banks, only after verifying and carrying out a joint inspection along with DG, DCA. Due to non-conducting of joint inspections with Central Drug Control Standard Organisation (CDCSO), Hyderabad and non-pursuance with Central Licensing Approving Authority, New Delhi, pendency was noticed in 62 cases for grant of licence (11) and renewals (51) to Blood Banks in the State as of March 2014. During the intervening period till grant of renewal of licence, Blood Banks continue to function without valid licence and without complying with the requisite norms endangering the lives of donors/recipients.

Government attributed (January 2015) the delays in grant/ renewal of licences to stringent procedural regulations, joint inspections, compliance verification and dual licensing system requiring approval of Drug Controller General of India and stated that a proposal has been submitted to the Drugs Consultative Committee to dispense with the second joint inspection and simplify the procedure.

Appendix-2.2
(Reference to paragraph 2.3.3.)

(a) Shortage of equipment in test checked medical colleges)

Sl. No.	Department	Name of the Equipment	Number of Colleges not having equipment
1.	Anatomy	Drill Machine	6
		Plastic Tanks for Storage for storing soft and dissection parts	4
2.	Physiology	Electric Time Makers	6
3.	Bio-Chem	Autoclave	7
4.	Pathology	Freezing Microtome	3
		Autoclave Electric	4
5.	Forensic	Distillation Plant	7
		Digital Spectrometer	7
		Digital PH Meter	7
6.	Community Medicine	Barometer	6
		Autoclave	6
		Extraction Apparatus	7
		Electrical Steriliser	5
		Spirit Hydrometer	6

(b) Shortage of equipment in test checked teaching hospitals

Sl. No.	Department	Name of the Equipment	Number of Hospitals not having equipment
1.	Paediatrics	Multistix	3
		Biopsy Needles	4
2.	General Surgery	Over Head Projector	2
		Incubators/ Transport Incubators	7
3.	Orthopaedics	Portable X-ray Machine	3
4.	Radiotherapy	Related items	3
5.	Anesthesiology	Manual Suction Machine	3

Appendix-2.3

(Reference to paragraph 2.4)

(a)Shortage of equipment in test checked Sub-centres

Sl. No.	Equipment	Number of SCs not having equipment
1.	Examination Table	54
2.	Stethoscope	37
3.	Medicine Chest	154

(b)Shortage of equipment in test checked Primary Health Centres

Sl. No.	Equipment	PHC not having equipment
1.	Baby Cots	124
2.	Equipment for Assisted Vacuum Delivery	114
3.	Laryngoscope & Endotracheal Tubes	107
4.	Manual Vacuum Aspiration	115
5.	Radiant Warmers	94
6.	Assisted Forceps Delivery	89
7.	Suction Machine	79
8.	Stretcher on Trolly	78
9.	Microscope	62
10.	Functioning of OT	69
11.	Wheel Chair	50

(c) Shortage of equiptment in test checked Community Health Centres

Sl. No.	Equipment	CHCs not having equipment in full
1.	Standard Surgical Set-II	18
2.	IUD Insertion Kit	18
3.	Standard Surgical Set-III	18
4.	Standard Surgical Set-IV	18
5.	Standard Surgical Set-V	18
6.	Standard Surgical Set-VI	18
7.	Equipment for anaesthesia	18
8.	Equipment for Neo-natal resuscitation	18

(d) Shortage of equipment in test checked Area Hospitals

Sl. No.	Equipment	AHS not having equipment
Total number audited		7
Labour Ward and Neo-natal Equipment :		
1.	Room Warmer	6
2.	Cardio Tocograph (CTG) Monitor	7
Immunization Equipment :		
3.	Room Heater / Cooler	6

	ENT Equipment :	
4.	Operating Microscope	6
5.	Impedance Audiometer	7
6.	Mastoid Set	7
7.	Micro Ear Set Myringo Plasty	7
8.	Otoscope	6
	Eye Equipment :	
9.	Auto Refractometer	7
10.	Flash Autoclave	6
	Operation Theatre Equipment :	
11.	Operating Table non-hydraulic field type	6
	Lab Equipment :	
12.	Distilled water plant	7
13.	Cell Counter Electronic	6

(e)Shortage of equipment in test checked District Hospitals

Sl. No.	Equipment	DHs not having equipment
1.	**Cardiopulmonary Equipment** Cardiac Monitor	3
2.	**Labour ward/Neo-natal/SNCU-** Cardio Toco Graphy Monitor	5
3.	**Immunization Equipment-5** KVA Generator	4
	ENT	
4.	Impedance Audiometer	4
5.	Laryngoscope fibreoptic ENT	4
6.	Otoscope	4
	Operation Theatre Equipment	
7.	Operating Table non-hydraulic field type	4
8.	Ultra violet lamp philips model 4 feet	5
9.	**Laboratory Equipment**	
10.	Distilled water plant	5
11.	Cell Counter Electronic	4
12.	Hot Plates	4
13.	Floatation Bath	4
14.	Automatic Blood Gas Analyser	4
15.	Histopathology Equipment	4

1.2 **Initiating the discussion**, the Principal Accountant General (PAG) explained the gist of the Audit Paras and the Explanatory notes furnished by the Government, starting with the shortages of Primary Health Centres (PHCs), Community Health Centres (CHCs) and the Sub-Centres (SCs).

1.3 The Committee observed that there was shortage of health facilities in the State and enquired about the action plan of the Government to fill the gap between the number of Sub-centres, PHCs, and CHCs required as per population norms and that available in the State.

1.4 The Principal Secretary, Health, Medical and Family Welfare (Principal Secretary) explained that starting a new PHC would need a non-recurring expenditure of Rs.3.5 crore to Rs. 4.00 crore besides land cost and the recurring expenditure towards salaries of 30 - 35 employees. However, the Government had been sanctioning new PHCs every year and the situation was better compared to that in 2010-11. The Principal Secretary also explained that there were 7683 Sub-centres in the State and all of them were running in rented buildings. Government was planning to address the issue and construct buildings for all the Sub-centres, in a phased manner, through World Bank aid.

1.5 On this, the Committee sought specific explanation in connection with the shortfall of SCs, PHCs and CHCs.

1.6 The Principal Secretary explained that there were no shortfalls in PHCs and however, accepted that there were some gaps in Sub-centres with reference to population norms of NRHM. The Director, Medical Education informed that there were no shortages of Sub-centres in the State.

1.7 On an enquiry by the Committee whether the number of PHCs included Urban PHCs, the Principal Secretary clarified that there were no Urban PHCs in the State and the Government was going to start UPHCs.

1.8 When the Committee enquired about shortage of Sub Centres and PHCs in East Godavari, Kurnool and Visakhapatnam districts, the Principal Secretary stated that there were shortages of PHCs and explained that they had computed the requirement of SCs, PHCs and CHCs based on the district wise population in the residuary State; whereas the shortfalls mentioned by audit relate to the combined State in the year 2010-11.

1.9 The Principal Secretary, while admitting that there were shortages of amenities, stated that unlike in other departments like R&B, funds were not given to the PHCs and CHCs for maintenance of buildings and other infrastructure like generators, inverters, drinking water facility etc. provided to them.

1.10 On an enquiry of the Committee about the norms of Rs. 10,000 given to Sub-centres and Rs.50,000 given to PHCs, the Principal Secretary explained that the funds were meant only for rendering the service and not for maintenance of buildings.

1.11 With regard to maintenance of the buildings, the Chairman opined that the Government buildings usually gather a lot of dirt and dust on the roof due to not cleaning them regularly which results in logging of rain water and seepage of ceiling and thereby entire Hospital atmosphere would be polluted. Hence, a standard protocol (SOP) should be adopted for cleaning and maintaining the Government buildings.

1.12 The Chairman mentioned that the Committee had visited the PHC, Chandragiri in August 2016 and observed that there was only one doctor in the PHC and the problems in that PHC were similar to that of other PHCs. The Committee observed that in the Explanatory note, the Government stated that all the equipment was provided to all the PHCs and expressed doubts on correctness of the statement.

1.13 In reply, the Principal Secretary admitted that everything would not be fine all the times at all places and expressed regrets for giving such reply and assured the Committee not to recur such things in future.

1.14 The Committee expressed anguish over non-furnishing of the factual information and observed that certain amount of time should be spent on preparation of Explanatory Notes and replies to be furnished the Committee.

1.15 The Committee also sought institution wise details of infrastructure and other amenities like generator, inverter, drinking water facility etc. available in PHCs and CHCs in the State and whether they were in working condition or not.

1.16 The Principal Secretary assured to obtain the details and furnish to Committee.

1.17 Observing that shortage of funds was the main reason for non-maintenance of the buildings, equipment and other infrastructure in SCs, PHCs and CHCs, the Committee decided to recommend to Government that 2 per cent of the department's budget to be allocated for maintenance of buildings, other

infrastructure and amenities in the healthcare facilities and 1 per cent for energy charges of the department. An SOP should be defined for maintenance of buildings, other infrastructure and amenities in the health care institutions. An officer of sufficient rank in each health care institution should be made responsible for this.

1.18 The Committee observed that the Government had not furnished any explanation with regard to non-compliance of MCI norms in providing medical equipment in medical colleges and the attached teaching hospitals, in the Explanatory Note submitted to the Committee.

1.19 In reply, the Principal Secretary admitted that the explanation was missing and also admitted that MCI norms were not complied with fully and however, they had been watching to ensure that medical seats were not lost due to the lapses. The Principal Secretary also stated that although equipment was provided by and large to the Medical colleges / teaching hospitals, there were issues relating to the faculty. Although Government accorded permission to recruit Specialist doctors at the Assistant Professor level, they could not be filled due to litigation over division of doctors between the States of Andhra Pradesh and Telangana. The division had been recently completed and once a clear picture comes as to how many doctors would come to the State of Andhra Pradesh, vacancy position can be arrived, promotions can be effected and recruitments also can be made.

1.20 On a specific enquiry about the gaps in infrastructure and equipment, the Principal Secretary stated that Government had spent hundreds of crore of rupees on this account and assured to furnish teaching hospital wise details.

1.21 The Chairman directed the Principal Secretary to furnish the teaching hospital wise details of requirement of infrastructure and equipment as per MCI norms, availability and shortfalls. The Chairman also mentioned that there would be shortage of infrastructure and equipment in the teaching hospitals generally and asked the Principal Secretary for reasons.

1.22 In reply, the Principal Secretary explained that in rural areas, there was a hierarchy of PHCs and CHCs for delivering services whereas there were gaps in service delivery in urban areas. As there were no primary and secondary health care centres in urban areas, the patients approach the teaching hospitals directly thereby overloading them. The Principal Secretary also stated that Government had recently sanctioned 222 Urban PHCs under NHM. The Principal Secretary also stated that there was need to discourage reference of small cases which could be treated in Area Hospitals also to the teaching hospitals.

1.23 The Committee recollected their visit to the CMC, Vellore and mentioned that CMC was stressing on community health as a preventive measure, and also mentioned that Maharashtra State had good system in connection with the community health. The Committee further mentioned the good practice followed by the CMC that they were providing nursing care at the residences of the patients after their discharge from the hospital to ease the load on bed strength so that in-patient treatment could be given to more number of patients.

1.24 The Committee also recollected their visit to Visakhapatnam Institute of Medical Sciences (VIMS) and opined that since the civil works to accommodate 500 beds were already completed, it should have concentrated to commence operations with 500 beds at a time.

1.25 While knowing that all the staff working in the VIMS were on deputation, Chairman opined that VIMS should have procured the staff through recruitment on its own as deputation from other Hospitals would reduce the availability of staff, particularly doctors in other Hospitals leading to shortage of services in those hospitals.

1.26 The Committee, while observing that all the laboratory services in the hospital were outsourced, opined that instead of outsourcing the laboratory services, the VIMS could have bought the equipment by itself and outsourced the required manpower.

1.27 Finally, the Chairman expressed view that the Government had an obligation to provide health care to all the people and that education and health care should be treated as an investment and not an expenditure as the educated and healthy people could contribute their mite to the economy.

1.28 In this background, the Chairman suggested to enhance bed strength in PHCs and CHCs for post-operative care so as to minimize patients' stay in tertiary level Hospitals so that more patients can be treated in them.

1.29 The Principal Secretary stated that as per NHM norms, the patient has to stay in the hospital for two days in case of normal delivery and for seven days in case of caesarean delivery. However, the Principal Secretary informed that they would study the models suggested by the Committee.

1.30 The Director of Medical Education added that the shortfalls in teaching hospitals was also due to increase in number of seats on par with which the infrastructure and equipment had not been enhanced.

1.31 The Committee decided to recommend to the Government to lay emphasis on community health care for prevention of diseases by providing a separate wing so as to reduce load on the system.

1.32 The committee desired to know about the action plan for replacement of ambulances and how many of the old ones were in working condition.

1.33 The Principal Secretary explained that there are 465 ambulances (439 operational plus 26 reserve) in the State. Government had procured 128 ambulances in 2013 and 337 vehicles procured in 2007-08 required replacement.

1.34 The Managing Director, APMSIDC explained that 202 vehicles were already procured and tenders could not be finalised for another 70 vehicles (Advanced Life supporting vehicles) as there was a single bidder. The MD further explained that Government was going for re-tendering.

1.35 The Chairman pointed out the issue of breakdown of the ambulances during emergency situation due to bad condition of tyres and battery. In this regard, the Chairman suggested that while entering into agreement for procurement of ambulances, specific condition to change the tyres after running of every 50000 km should invariably be added in the agreement.

1.36 The Committee observed that though there was a condition in MoU that the on-road vehicles per day should not be less than 90 *per cent* of total vehicles, there was no specific penal clause incorporated in the MoU in case of shortfall in number of on-road vehicles against the stipulation.

1.37 In connection with the releases to the service provider, the Principal Secretary explained that penal clauses, in cases of not maintaining 90 per cent of vehicles on road, were now incorporated in the agreement.

1.38 The Chairman opined that specific clause to make payments for the vehicles actually on-road during the month should be included in the MoU and there should be an SOP to fix responsibility and accountability on the District Medical & Health Officer concerned who should certify the actual on-road vehicles during a particular period.

1.39 In connection with the empanelment of hospitals under 'Arogyasri' scheme, the Director General, Drug Control Administration (DG, DCA) explained that out of the eight hospitals mentioned in the Audit Paragraph, four were Government hospitals and two of them were in the residuary State of Andhra Pradesh. DG opined that Government hospitals might had been empanelled with relaxed standards to encourage them to serve more public. He also informed that the department had been trying to fill the gaps by utilising the revolving fund as well as the Hospital Development Society funds. Government had also done an exercise in some hospitals by providing the necessary latest equipment.

1.40 In respect of private hospitals, the Director, IPM stated that they had verified the IT records on line to check whether they had matched the criteria required for empanelment at present and issued show cause notices wherever they had not matched. The DG also stated that the facilities like ICU facility etc. were found available in the private hospitals pertaining to the residuary State of Andhra Pradesh pointed out in Audit.

1.41 The Committee enquired as to what were the criteria for empanelment of the hospitals for which the Director, IPM stated that it would be based on the speciality for which the hospital is to be empanelled.

1.42 The Committee desired to know whether it would be ascertained by the Trust that all the norms were fulfilled by the hospitals before submission of application for empanelment.

1.43 The Director, IPM confirmed that and added that the hospital would be registered only after submission of all the evidences.

1.44 The Committee observed that the hospital was empanelled only after verification by the Trust and the Audit had noticed the deficiencies after empanelment of the hospital; and desired to ascertain whether the hospital had rectified the defects after audit observations.

1.45 The Committee took a serious view about allowing the hospitals that were empanelled by furnishing incorrect information. The Committee observed that instead of penalising these hospitals, they were allowed sufficient time for rectification.

1.46 The Director, IPM accepted that action should have been taken immediately on receipt of the Audit Report, however, he had inspected the hospitals recently and found that all the facilities were available.

1.47 The Chairman observed that the hospitals were empanelled based on false declaration; rectified the defects and

established all the facilities at a later date. The Chairman also observed that the Inspection was delayed almost by three years.

1.48 The Director, IPM explained that the shortcomings in respect of Speciality doctors were mainly due to migration / transfers of doctors from one hospital to another. The absence of doctors would not be informed to the Trust either by the Hospitals or by the doctors. Probably, such incidences might have happened during the time of audit. He also informed that in the absence of a Speciality doctor, the corresponding ICU facility would be de-panelled.

1.49 The Chairman enquired about the deficiencies of equipment in ICU.

1.50 The Director, IPM stated that the Audit Report pertains to 2011-12 and accepted that there were lapses at that time. He also stated that corrective action should have been taken immediately. However, the proposal of delisting of a hospital totally would not be justifiable in public interest in view of the healthcare to be provided to the public.

1.51 The Director, IPM also stated that the Trust was going for a separate IT tender incorporating all kinds of authentications like finger prints. They had a lot of learning experiences and they wanted to improve and ensure that the past mistakes do not recur.

1.52 The Chairman asked what would be the case if any beneficiary wanted to avail the facility in the empanelled hospital in Kuppam where there were no nephrologists.

1.53 The Director, IPM submitted that it would be verified for authentication at the time of the claim made by the hospital. The Director, IPM also stated that there was shortage of Specialist doctors in some areas, particularly in Rayalaseema area, and the people had no access to healthcare. The dialysis facility was not available in the area; many patients were dying due to lack of this facility and patients of this area were going either to Bangalore or to Chennai for treatment. However, he stated that based on the audit observations and by experience they were trying to incorporate conditions.

1.54 The Committee enquired whether the defective faculty would only be delisted in case of failure in fulfilment of the criteria or the hospital as a whole would be delisted.

1.55 The Director, IPM stated that the cases of false declaration by the hospital would be viewed seriously and there is an 'Empanelment and Disciplinary Committee' with an Officer of the rank of Additional Director of Medical Education to enquire such complaints. If the treatment protocol is not followed, complaint would be made to the Director of Medical Education for enquiry; show cause notices would be issued to the hospital management; fine would be imposed, de-listed. In respect of private doctors, matter would be referred to the Medical Council of India.

1.56 The Committee expressed anguish and observed that Inspections were not conducted immediately and action was not taken to file a complaint with the Medical Council. And now the inspection was conducted belatedly and rectified the defects now. The Committee also observed that the Officer at that time who had to conduct inspection had failed.

1.57 The Chairman observed that it amounted to falsification of records and falsification of facts; and the defect would continue till it was caught. The Chairman also observed that it matters how long the defect existed without notice and questioned as to what was the penalty to be imposed in such cases.

1.58 The Chairman enquired whether there was any possibility to check the claims made during the period. The Committee enquired if any hospital claimed ICU charges without ICU facility.

1.59 The Director, IPM stated that evidences were available from 2007 and assured that he would check if there were any such cases and file criminal cases if any such instances were noticed. The Director, IPM further stated that the NTR Vaidya Seva Trust team who visit the empanelment hospitals needs to be trained and Empanelment team needs to be strengthened updated with the advanced technology such as cardiology and cardio plastic surgery etc. However, he submitted to the Committee that with the new tenders, the systemic errors would be rectified to a large extent.

1.60 The Chairman pointed out that voluntary disclosure of lack of facilities or Specialist doctors was one angle and opined that there should be periodical check at the Government level to see that everything was in order.

1.61 The DG, DCA stated that the department manual did not prescribe any periodicity for inspection of empanelled hospitals and renewal of empanelment was not linked with inspection.

1.62 When the Chairman questioned whether there was no check on the hospital once empanelment was done, the DG, DCA stated that the Manual was silent on that.

1.63 The Chairman requested the Principal Secretary to note the issue which was agreed by the Principal Secretary as a serious lapse. The Principal Secretary stated that Government was about to bring in some changes in this regard in addition to some other measures. The Principal Secretary also stated that the department had taken up inspection of all the hospitals and they had alerted the vigilance also to verify them independently and also agreed that strict inspection of the empanelled hospitals was to be there in the scheme.

1.64 The Chairman expressed deep concern and anguish over the fall in responsibility and trust levels in some private hospitals, especially in neo natal units for children's treatment. The babies were given unnecessary treatment and parents would not even be allowed in side to see the babies and to know what treatment was given.

1.65 The Principal Secretary, in this connection, stated that they had recently visited Ram Manohar Lohia Hospital where mothers were allowed inside even in to NICU units. The mothers are given a 'SOP' and also a uniform to go inside and they can stay for any long time. Both the father and mother are allowed inside the hospital and are trained about what to do when the baby is taken back to home. The Principal Secretary also stated that the SOP was approved by the Government and was going to be implemented in the Government hospitals. The Principal Secretary

also stated that Government was planning to make it a condition to follow the protocol even in the private hospitals under NTR Vaidya Seva.

1.66 The Committee enquired as to what were the measures taken for improvement of equipment and infrastructure in Government hospitals.

1.67 The DG, DCA stated that he had written letters to the Medical Superintendents in this regard and the Superintendents had furnished the list of gaps / deficiencies in their respective hospitals. The gaps would be filled by utilising the revolving fund and the Hospital Development Society fund. In consultation with the Director of Medical Education and the Commissioner, AP Vaidya Vidhana Parishad, they had initiated the process of filling the gaps in respect of NTR Vaidya Seva patients and services.

1.68 The Committee enquired as to what was the percentage of the amount given for the hospital development out of the money given by the NTR Vaidya Seva.

1.69 The DG, DCA informed that 35 *per cent* of the package amount goes to the doctor and his team including staff nurse, anaesthetist etc; 45 *per cent* to the Hospital development Society fund and 20 *per cent* to the revolving fund.

1.70 The Committee mentioned that bills of the private hospitals are cleared early and bills of the Government hospitals are not cleared so early and mentioned the example of SVIMS stating that it was number one in the State and treating more number of patients under the NTR Vaidya Seva.

1.71 The DG, DCA submitted that Government hospitals were given priority. However, after performing of the surgery by the Specialist surgeon, it was the duty of the Data Entry Operator (DEO) to take all the evidences like photographs, discharge summary etc. scan them and upload. There was also a time line of 30 days for uploading of these evidences failing which payments are not made to the hospital. Payments are made to the hospitals after verification of these evidences by the NTR Vaidya Seva audit team. In Government hospitals like KGH, Visakhapatnam, GGH, Guntur, patients were treated for multi specialities but they were unable to upload the documents in time. The employment of sufficient number of DEOs was the major issue. There were issues like whether DEOs remuneration could be paid from HDS funds, whether Medical Superintendent is empowered to appoint them etc. to be settled and they were trying to sort out these issues in consultation with District Coordinators for Health Services.

1.72 The Principal Secretary stated that they had conducted meetings with the managements of private hospitals in the first phase and going to conduct a meeting with Medical Superintendents in the next phase. As suggested by the Committee, it would be encouraging to Government hospitals if payments were made immediately after conducting the procedures. Government was empanelling all the Area Hospitals and District Hospitals at least for certain procedures. Otherwise, many issues would arise due to lack of knowledge about empanelment, lack of time and staff etc.

1.73 Further, the Principal Secretary explained that recently, Cabinet had approved 'In-sourcing' policy and explained with an example case that Dr. Gokhale and his team, who were doing open

heart surgeries and transplantations in private hospitals was doing the surgeries in Government hospitals also. As a result, the Government hospitals also get some amount besides the team and helps improvement in hospital infrastructure.

1.74 The Principal Secretary further stated that Government was trying to encourage the doctors working in Government hospitals by providing necessary infrastructure. Government was trying to open website where people can show their interest and contribute either money or their services to the hospitals. Government would come up with a policy within one or two years for encouragement of Government hospitals to do more procedures.

1.75 The Committee, then, observed that as of now Government had not achieved more than 20 to 22 *per cent* of the target.

1.76 The DG, DCA stated that as per the Key Performance Indicators of the NTR Vaidya Seva, the target given was 40 *per cent* so that 40 *per cent* of the budget should be recycled and ploughed back to Government sector.

1.77 On an enquiry about the achievement as of now, the DG, DCA stated that it stood at 27 *per cent*.

1.78 The Committee observed that it would not be more than 23 *per cent* as several bills were pending due to lack of Data Entry Operators. The Committee further observed that how could the DEOs be selected if many officers like the DM&HO; Director, SVIMS; Hospital Superintendent for selection in one hospital like maternity

hospital, Tirupati. The Committee suggested that the Trust itself could select a team and appoint them in each hospital.

1.79 The DG, DCA submitted that the recruitment falls within the purview of the District Collector.

1.80 The Committee questioned as to what would be the fate of the hospital if the District Collector did not fill the posts.

1.81 The DG, DCA stated that the matter was taken to the notice of the District Collectors during the HDS meetings every month and the Collectors were also addressed in this regard.

1.82 The Committee suggested that the timeline of 30 days prescribed for uploading of evidences in support of procedures for claiming the money may be relaxed and more time could be given for Government hospitals.

1.83 The DG, DCA stated that there were HR problems in Government hospitals and they were coming up with the list of lapsed cases; and the Trust was considering creation of separate IT enabled process for Government hospitals.

1.84 The Committee mentioned that in private hospitals, the Data Entry Operator gets 2 *per cent* on each case.

1.85 The DG, DCA stated that in private hospitals, they were incentivized whereas in Government hospitals they were recruited on consolidated payment of Rs.15,000.

1.86 The Chairman observed that some problems were there in cases where recruitment was under purview of the District Collector due to his busy schedule and they were not able to spare time for recruitment process.

1.87 The Principal Secretary stated that the District Collectors were the Chairpersons of the HDS of teaching hospitals.

1.88 When the Chairman suggested to find a way out to fill the vacancies directly, the Principal Secretary assured to review the matter.

1.89 The Committee suggested the Principal Secretary to visit SVIMS, Tirupati to sort out the problems there for which the Principal Secretary agreed to.

1.90 The Committee observed that the cases which would not fall under purview of NTR Vaidya Seva were also being done in the KGH, Visakhapatnam and the highest number of cases was done by only one Professor. The Data Entry Operators informed that they would be in trouble if they did not follow instructions of the higher officers. There was no scope to assure that an incident like that happened in GGH, Guntur would not recur here. Both the students and the Assistant Professors were also afraid of filing a complaint.

1.91 The DG, DCA submitted that all the cases done by that Professor were taken out and the Trust had constituted a special team of experts within the Trust to look in to the matter.

1.92 The Principal Secretary stated that the matter was discussed in the Ministry very seriously, and action would be taken to protect the image of the Government institution keeping in view that ultimately poor people should not suffer.

1.93 The Committee observed that the Arogyasri scheme was first introduced in 2007 in three districts; when the scheme was extended throughout the State, the package rates were reduced by 10 percent. Now, when the Employees Health Insurance Scheme was introduced, the package rates were not reduced. The same higher packages were honoured for employees also.

1.94 The DG, DCA stated that this was the demand from the employees, pensioners and was agreed to by the Hospital service providers also.

1.95 The Committee enquired whether medical services would be provided if any patient having an Arogyasri card was referred to Hyderabad for treatment. The DG, DCA stated that NIMS was providing facilities on payment from the Government.

1.96 The Chairman enquired whether the system would agree if payments were made to the hospitals prior to their empanelment.

1.97 The DG, DCA informed that as per Government orders, all the Government hospitals were empanelled under the scheme and were provided with user ID and password. However, they had to follow certain procedures. As there was lack of information from the data entry operators, the doctors took a lot of effort to treat BPL cases.

1.98 The Committee mentioned that there was no co-operation from the Superintendent and the Director of SVIMS when they were addressed that operation services were not being availed at the maternity hospital, Tirupati due to lack of data entry operators. As a result, the District Collector was also not co-operating. The Committee directed the Principal Secretary to take up recruitment of data Entry operators in Government Hospitals.

1.99 The Committee after discussion of overall issue of empanelment of Network Hospitals, expressed serious concern over the Department's attitude for not exercising any checks in the empanelled Hospitals immediately after Audit pointed out the lapses. Further, Committee found fault with the department's explanation that no lapses were found during the inspection in the subject Hospitals after lapse of more than three years from the period of Audit. The Committee opined that there should be effective system to monitor the availability and continuity of infrastructure facilities as was stated during the time of empanelment of hospitals. A medical team comprising of various specialists should be formed and inspect the Network hospitals at periodical intervals. Stringent action should be taken on the empanelment hospitals for not adhering the prescribed criteria relating to infrastructure, manpower and equipment.

1.100 The Principal Accountant General explained that AHSA workers were to be recruited at the ratio of one for each 1000 population. As per norms, 8666 ASHAs were to be there whereas only 70700 posts were sanctioned. As of March 2014, there were only 64827 ASHAs were in position. Thus, there was shortfall of 19839 workers in the State.

1.101 The Director, Health & Family Welfare department explained that previously there was shortfall of 32 per cent and now, it was only 6 per cent. Against the sanctioned strength of 42681, there were 39976 were in position, vacancy position was about 2705.

1.102 When the Committee enquired whether it pertains to 2011 Census, the Principal Secretary stated that it was the latest status.

1.103 The Committee observed that the figures had been given without any reference to the population.

1.104 The Principal Secretary explained that the number of posts sanctioned under NHM was 42681 in the 13 districts of the State. In reply to the enquiry about any time frame for filling up of all the vacancies, the Principal Secretary replied that all the vacancies would be filled at the earliest and directions would also be given to all the District Collectors in this regard; but could not give any definite timeframe.

1.105 The Committee enquired whether it could be completed by end of 2016 for which the Principal Secretary mentioned that about 40 days were only left out in the year 2016.

1.106 The Committee suggested that the District Collectors could be given a prior notice of one week so that they could fill up the vacancies.

1.107 The Chairman observed that the vacancy position was 23 per cent in the combined State at the time of audit and now it was 32 per cent.

1.108 The Principal Secretary stated that there were some problems on ASHAs in the State because NRHM did not give them salary but remuneration was paid on 'per case' basis. Further, they would take only the maternity and health cases. Principal Secretary further added that there were some more issues in this regard, Government was doing an enquiry and was planning to bring out a more effective system.

1.109 The Chairman enquired whether there was any standardized recruitment system or guidelines for the entire State or districts for recruitment of ASHAs; and when was the last recruitment done. The Chairman also mentioned that merit was being followed and taken in to consideration, for ASHAs and ANMs.

1.110 The Principal Secretary explained that the two were different cases. ANMs were government employees whereas the ASHAs were just case workers. The guidelines whichever were issued would be uniform throughout the State. There is a strong recruitment procedure for recruitment of nurses. A notification has to be given for recruitment, rule of reservation has to be followed and a merit list has to be exhibited. All the District Collectors had been instructed accordingly.

1.111 The Chairman suggested that there should be some sort of check measure in cases of future recruitments.

1.112 The Principal Secretary informed that Government was trying to make the recruitment process computer based so that there would be minimum clerical or client involvement.

1.113 The Chairman observed that the District Collectors were at pressure and very often, there was no transparency in the system of fixation of merit. The Chairman also opined that the system of fixation of merit should be known public and the candidates who were not selected should know on what basis they were not selected.

1.114 The Principal Secretary submitted that the procedure laid down for recruitment of nurses was quite transparent and almost 1000 candidates were recruited last year. She had explained that the availability of nurses in the State was large in number and there was huge competition for Government jobs; recruitment was made based on many criteria including the rule of reservation due to which some meritorious people who were not selected were not able to understand why they were not selected.

1.115 The Chairman enquired whether there was any possibility of centralized recruitment instead of district wise selection. The Chairman also enquired whether the nurses' recruitment process could be often monitored a little more at the Government level.

1.116 The Principal Secretary explained that the nurses' recruitment was made as per the six point formula and generally contractual employment. Nurses' posts were not State level posts and centralized recruitment was not made unless they are State level posts. The Principal Secretary also explained that the recruitment of the 1000 nurses was done in a very transparent manner strictly.

1.117 The Committee sought clarification as to how the shortfall reduced from 23 per cent in the combined State and 32 per cent in the 13 districts (of the residuary State) now, to 6 per cent.

1.118 The Principal Secretary clarified that Audit had calculated the shortfall as per NRHM norms based on population. Although NRHM guidelines required the number of posts 'per thousand' of population, they had sanctioned only these many (42681) posts. Hence, Government had computed the shortfall (6 per cent) based on sanctioned posts and not on the population.

1.119 The Chairman observed that Audit had taken the observation with reference to NHM guidelines, and the shortfall pointed out was based on the requirement of posts.

1.120 The Committee observed that the requirement was more but the sanction of posts was very less. The unfilled vacancies were 6 per cent of the posts sanctioned.

1.121 The Principal Secretary stated that, Government had found the ASHA system not useful. The Staff Nurses, being qualified people, should be removed from ASHA and posted in PHCs so that PHCs would function more effectively. Number of ANMs should be increased as they were qualified people whereas the ASHAs were not qualified. Principal Secretary also mentioned that there was no ASHA system in Tamilnadu. However, the department was thinking on humanitarian grounds.

1.122 The Committee decided that it should be recommended to the State Government to get administrative sanction from the Central Government as per norms as required based on the relevant population as per Census and also to fill the unfilled vacancies of the sanctioned posts.

1.123 On an enquiry by the Committee on the quantum of expenditure on procurement of medicines, the MD, APMSIDC submitted that it was about Rs. 400 crore.

1.124 The Committee observed that in one hospital, CMC, alone it was Rs. 350 crore and were supplying medicines to the public at 20 per cent less than the MRP.

1.125 The MD, APMSIDC stated that they were procuring generic medicines, which were 150 per cent less in price.

1.126 The Chairman asked whether the quantity of procurement was sufficient in the State while one hospital CMC itself was procuring medicines worth Rs. 350 crore. The Chairman also desired to know the reasons for shortage.

1.127 The MD, APMSIDC stated that the medicines were supplied as per the indents placed by the Heads of Departments and buffer stock was also maintained to meet emergencies. The MD also submitted that they had a mechanism for diversion of medicines from one hospital to another in cases of shortages.

1.128 The Principal Secretary stated that Government should increase funding on medical check-ups of the people. There was shortage of funds for procurement of medicines and funds for the purpose were not released in time and there was a huge gap. The Principal Secretary brought the difficulty in providing services with limited resources, to the notice of the Committee. The Principal Secretary further explained that they were not able to provide even proper diet to the patients admitted in hospitals, even cases where the haemoglobin content was to be maintained at 14.5 minimum.

1.129 The Chairman while noting that there was shortage of utilization of funds with regard to Village Health & Sanitation Committees (VHSCs) enquired whether the VHSC had really been working or were they there only on paper.

1.130 The Director, Medical & Health submitted that the sanitation committees had been formed in villages and they had been taking part in the 'war against mosquitoes' programme that had been recently taken up by the Government. This is a large scale awareness campaign to prevent Dengue and Malaria.

1.131 The Committee enquired about the role of the Village Sarpanch in the VHSCs and whether the funds could be drawn without signature of the Sarpanch.

1.132 The Director, Medical & Health informed that the Sarpanch was the Chairman of the Committee and joint signature of the Sarpanch and the ANM were required for drawl of funds.

1.133 The Committee mentioned that there were instances where the doctors and other had been drawing funds and the issue was raised by the Srapanches several times in Mandal meetings.

1.134 The Principal Secretary explained that the issue might be in respect of 'Untied funds'. The Untied funds are given to the Sub-Centre under NHM for general up keep of the institute and the equipment in the Sub-centre. From VHSC fund (also from NHM) also, an amount of Rs.10,000 is given to the Sub-Centre for which joint signature of the Sarpanch and the ANM are required for drawl.

1.135 The Chairman enquired about constitution of the VHSCs.

1.136 The Director, Medical & Health informed that Sarpanch was the Chairman, ANM would be the member Secretary, ASHA worker and Self Help Group leaders would be the members. The Principal Secretary added that the Committee was supposed to meet once in a month.

1.137 The Chairman observed that the programme has to be linked to the Gram Panchayat functioning and the Sarpanch as he is accountable to the people by virtue of his post. More of the responsibility would rest with the Sarpanch as he has an office in the village for conducting of any meetings etc. and also answerable to the people.

1.138 The principal Secretary had stated that Government was also seriously considering the issue. Government was going to bring the 'Mosquito Control Act' in which the responsibility of sanitation and cleanliness would be entrusted to the local bodies, and also strengthening the local bodies.

1.139 The Chairman stated that in minor Gram Panchayats, the entire responsibility lies with the Sarpanch but Sarpanch would not have and financial or other support. He would be dependent only on the GoI grants. The Chairman expressed serious concern about lack of manpower support to the Panchayat Secretary as a result of which the tax revenue collection was poor in minor Panchayat, and had to depend only on central Government grants. He also expressed concern as to how the programmes could be implemented without funds. He also observed that Sarpanch should be entrusted with responsibility of implantation of all the programmes relating to the village as he is answerable to the villagers; and the Panchayat Secretary should be made accountable.

1.140 The Principal Secretary informed that Government was going to recommend that and also going to enact the Prevention of Mosquito Breeding Act and the money would go to the local bodies concerned. The Principal Secretary also informed that there was only one Panchayat Secretary for two to three villages and they were discussing the issue with Panchayat Raj Department.

1.141 The Principal Accountant General explained the gist of the Para stating that the main concern was the shortfall in utilization of funds by the VHSCs. During the period 2009-14, 15 to 57 *per cent* of funds released were not utilized. In the sampled districts, the unspent balances ranged between 7 and 36 *per cent*.

1.142 The Chairman enquired about the source of funding and whether the funds were distributed to VHSCs. He also enquired for reasons for non-utilisation in the situation of online transfer of funds and the online monitoring system Public Financial Management System (PFMS) was available as stated by Government.

1.143 The Principal Secretary explained that PFMS was introduced only in 2014 and stated that the unspent money during 2009-14 was sent back to respective bank accounts.

1.144 On an enquiry from the Chairman about the old money, the Principal Secretary informed that the money had lapsed.

1.145 On an enquiry by the Committee about the accounts in which the money was deposited and how many accounts were there, the Director, Medical & Health informed that there were about 13000 accounts in all the Gram Panchayats in various banks. However, as of now under PFMS, the money is deposited directly in the bank accounts.

1.146 The Chairman observed that although there were unspent balances in the bank accounts at the end of the year, further funds were being released to VHSCs leading to accumulation of funds and enquired about reasons for non-utilisation.

1.147 The Principal Secretary explained that either the responsible persons might not know about the funds or they might not know how to utilize the funds. Principal Secretary also stated that after introduction of PFMS, it was stabilized.

1.148 The Director, Medical & Health explained that the money would be used for anti-larvae operation etc. The Director, Public Health stated that it was about 78 *per cent* in Visakhapatnam district, where they had conducted four rounds of trainings and expressed hope of increase in incurring expenditure.

1.149 The Committee mentioned a previous incident wherein one Panchayat Secretary and one health department official were suspended when 43 malaria cases were recorded in a Gram Panchayat. The Committee also observed that there was no money in the Gram Panchayats now and opined that if the 14th Finance Commission funds were increased by 50 *per cent*, 25 *per cent* of the money could be spent on health related activities. Further, 10 *per cent* of the 25 *per cent* funds could be utilized on sanitation. The Committee also observed that the Panchayat Secretary is responsible for all these issues,

1.150 The Principal Secretary also stated that protection of the public was the responsibility of the local body.

1.151 The Committee decided to recommend that Sarpanch should be entrusted with responsibility of implementation of all the programmes relating to the village and the Panchayat Secretary should be made accountable. Active participation of the departmental officials should also be ensured.

1.152 The Committee also decided to recommend that VHSC funds to be allotted to the Gram Panchayats so as to find a solution to ensure effective utilization of the funds.

1.153 The Committee while observing that the functioning of HDS was not up to mark questioned as to what steps were taken to improve functioning of the HDSs, status of the audit of HDS accounts as of now.

1.154 The Director, Medical & Health explained that there were some political disturbances in the State at the time of audit. Previously, the political nominees were the Chairmen of the HDSs; however, after bifurcation of the State, a new Government Order was issued according to which the District Collector is the Chairman of the HDS of the Teaching Hospital. Eminent persons (who worked in the field of Medical and Health or acquired some knowledge in that field) are nominated by the District Collector in respect of PHCs, CHCs, Area Hospitals and District Hospitals. As of now, Chairmen were appointed for all the HDSs and the meetings were being conducted regularly. The accounts were also being audited by the audit team of the Commissioner of Family Welfare regularly.

1.155 The Committee enquired whether the HDSs were constituted for all the Hospitals in Visakhapatnam for which the Director, Medical & Health informed that they were all constituted.

1.156 The Chairman observed that appointment of any eminent persons to the hospitals in their areas would be known to Hon'ble MLAs of the Constituencies concerned and however, they were not aware of such appointments. The Committee observed that all Government officers such as the Executive Director of HPCL

refinery, Commissioner of GVMC, and some Government Doctors were appointed as members of the HDS in Visakhapatnam about which the local MLA was not even aware of. The Chairman also expressed concern as to how would the problems be known if all the members were Government Officers and stated that Government officials and public representatives should be there in equal numbers. Involvement of the local MLA, local Deputy Chairman, Zilla Parishad Chairman should be there and the participation of local public representatives should be ensured.

1.157 The Committee also observed that the people would bring several problems in the hospitals to the notice of the local MLAs and it was not correct to make appointment to the HDSs without information to the Public representatives of the area.

1.158 The Chairman enquired about the Government orders about constitution of the HDS and further questioned that there was any provision for MLA to be there in the general constitution of the HDS.

1.159 The Principal Secretary explained that public representatives were there in the HDS previously and there was no expenditure at that time. Current Government Orders were issued after due consideration. The Principal Secretary also submitted that MLA should be at a higher level than these bodies and should be able to review their functioning and if the MLA was part of the body, there would be nobody to review.

1.160 The Principal Secretary further explained that in terms of the National Health Mission (NHM), it was Rogi Kalyan Samithi (RKS)

and it consists of the people having some knowledge in the particular area. The Principal Secretary further explained that the constitution had now been made non-political and the District Collector only was to pick up the members.

1.161 The Committee, however, observed that the officers mentioned in the HDS would not be in touch with the public and the people's problems would not be known if all the members were Government Officials.

1.162 The Chairman stated that although an MLA or MP or the Municipal Chairman or mayor could review, they would not be in a position to make a recommendation to the HDS without being part of it.

1.163 The Chairman also opined that as the District Collector would be busy with various activities it might be difficult for him to supervise this and suggested that the Joint Collector or any other might be the Chairman.

1.164 The Committee observed that it should be stipulated that the Committee meetings should be conducted once in 30 or 90 days and review. The Committee also enquired as to what action would be taken if the meetings were not conducted within the stipulated time. The Committee opined that District Headquarters MLA should preside over the HDS meetings and that HDS meetings should be conducted regularly as was the case of Mandal level meetings.

1.165 The Deputy Secretary to the State Legislature informed that HDS meetings should be conducted once in every month depending on the urgency and convenience of the majority of the members; a minimum seven days of notice should be given.

1.166 The Chairman enquired about the action to be taken if the meetings were not conducted in time and stated that Government should give instructions making it mandatory to convene the meetings in time.

1.167 The Committee opined that the Convener of the HDS should be held responsible for conduct of meetings.

1.168 The Director, Medical & Health submitted a copy of the GO No 145 to the Committee.

1.169 The Committee decided to recommend that the HDS meetings should be conducted mandatorily once in a month; steps should be taken to convene the meetings within the stipulated time.

1.170 In connection with the HDS funds amounting to Rs. 48.87 lakh lying unutilized, in fixed deposits / savings bank accounts, the Principal Secretary stated that the problems would be sorted out once the HDS meetings were conducted regularly.

1.171 The Director, Medical & Health stated that audit of HDSs had been completed up to 2015.

1.172 The Committee asked specifically as to what happened to the unspent balance of Rs. 48.87 lakh.

1.173 In reply, the principal Secretary stated that during 2009-14, funds had been released to the HDSs, but review meetings were not conducted properly. Funds were not expended due to various reasons such as disputes at some places and out of fear at some other places. The Principal Sectary assured to verify all the Audit Reports, ascertain the balances available with the HDS and would take necessary action.

1.174 The Chairman advised to ascertain specific details of the amount of Rs.48.87 lakh.

1.175 The Commissioner, APVVP stated that an amount of Rs. 9 lakh was there in Chittoor district due to non-conduct of the meetings (The balance amount pertains to the hospitals in Telangana in post bifurcation scenario) out of which Rs.5 lakh pertains to HDS and the balance Rs.4 lakh relates to the hospital stoppages. The Commissioner also added that the HDS amount of Rs.5 lakh had now been spent.

1.176 The Principal Accountant General explained that as per norms, the PHCs conducting less than 20 deliveries per month should be provided with one Medical Officer and three Staff Nurses; the PHCs conducting 20 or more deliveries should be provided with two Medical Officers and four Staff Nurses. Although there was no shortfall of Medical Officers in the test checked PHCs, there was 67 *percent* shortfall in the cadre of Staff Nurses. Shortfall of Staff Nurses was 63 *percent* in Visakhapatnam, 46 *percent* in East Godavari district. Shortage of pharmacists was 31 *percent* in Chittoor district. Further, 7 *percent* of the 25044 ANMs and 62 *percent* of the 12522 MPHAs required for the 12522 Sub Centres in the State were vacant.

1.177 The Committee asked for the latest status of manpower in various cadres, posts sanctioned, posts filled and the measures taken by the Government to fill the vacancies. The Committee expressed dissatisfaction over the intermittent reply given by the Government in the Explanatory Note stating that necessary steps would be taken to fill the vacancies.

1.178 The Principal Secretary explained that out of 2325 posts of nurses in the State, 1866 were filled and 459 posts were vacant. In respect of Pharmacists posts, 810 posts were filled. The Department had submitted proposals to the Government for filling up the vacancies.

1.179 The Committee pointed out that although the issue of recruitment of nursing staff in King George Hospital, Visakhapatnam was brought to the notice of the Government several times, there was no response from Government. Though there was requirement of 1000 staff nurses in KGH itself, those posts were sanctioned and posted in all Hospitals in the entire State. The Committee further felt that the staff sanctioned way back was only being continued now and extending their health services with great difficulty.

1.180 The Principal Secretary while agreeing with the Committee's observation stated that shortage of staff was not only in KGH but also prevailed in the entire State and PHCs in particular as pointed by Audit. Government recently reviewed the vacancy situation in APVVP and filled the vacancies of 1000 medical staff posts in all categories.

1.181 The Committee questioned the Principal Secretary that when requisition was made for requirement of 1000 posts

exclusively to Visakhapatnam district, how was it justifiable to recruit only 176 posts.

1.182 The Principal Secretary agreed that the recruitment of 1000 posts were not sufficient and stated that this recruitment was taken up after a long gap of eight years which was certainly a commendable achievement on the part of Government. Though it was not sufficient, proposals for one more 1000 posts of nurses was sent to Government.

1.183 The Committee questioned as to why the department had sent proposals for only 1000 posts as against the actual requirement of 3000.

1.184 The Principal Secretary, in reply to the Committee, stated that a requisition for 3000 nursing posts was sent to Government and posts were being sanctioned in a phased manner.

1.185 When the Chairman questioned whether all the vacancies were sanctioned posts, the Principal Secretary replied that those were both vacancy as well as sanctioned posts. Principal Secretary further stated that Government also permitted to recruit 200 Specialist Doctors; but only 63 Specialist Doctors responded to the notification and of them, only 3 doctors reported to duty.

1.186 On knowing that nursing staff had been engaged on contract basis for monthly salary of Rs.15000, the Committee opined that it was not a big financial issue to Government to recruit 1000 nurses by expending Rs.1.50 crore per month.

1.187 The Chairman observed that there was a shortage of 7 per cent ANM posts and 62 per cent MPHA posts in 12,522 sub-centres in the State.

1.188 The Chairman enquired whether all the MPHAs were working on contract basis and their nature of duties.

1.189 The Director, Medical & Health stated that out of 4360 sanctioned posts of MPHAs at present, 213 were on regular basis; 2453 working on contract basis and the remaining posts were vacant. The Director further added that MPHAs primarily work at field level. Male MPHAs look after the issues on malaria activities whereas the female MPHAs are on the activities of water sources and sanitation at village level.

1.190 When the Chairman sought to know the plan for recruitment of staff, Director, Medical & Health replied that the process of recruitment of staff was under consideration of Government.

1.191 Regarding the observation on Secondary health care, the Committee noted that there was shortage of staff in all cadres from the level of civil surgeon to MNO. Against the requirement of 20,006 posts in all cadres as per IPHS norms, only 9,472 posts were filled up out of 12,907 sanctioned posts in 207 hospitals thereby the shortage was 53 *per cent* against the IPHS norms.

1.192 The Commissioner, APVVP stated that the requirement of posts pointed out in the Audit Report are as per IPHS norms but the Department had no such sanctioned posts. Although, Government had tried to fill the vacancies against the sanctioned posts, most of the specialists had not showed willingness to come into Government service; hence the posts were vacant. In response to Government notification for 200 posts with enhanced salaries, 59 posts were filled and out of them, only two specialists joined

the duties; and finally one specialist left the service. In this scenario, proposals for further enhancement of salaries to specialists were submitted to Government and further recruitment would be taken up after approval.

1.193 When the Chairman questioned whether the entire recruitment was on contract basis, Commissioner, APVVP replied that regular recruitment was also simultaneously going on and the vacancy list was furnished to APPSC for regular recruitment in APVVP. Pending completion of the recruitment process for regular posts, some posts have been taken up to fill on contract basis.

1.194 The Committee noted that vacancies for the posts of Theatre Assistants was higher in Visakhapatnam (95 *per cent*) followed by East Godavari district (88 *per cent*).

1.195 The Chairman expressed dissatisfaction over not filling even the lower level staff like Staff nurse, Pharmacists, Radiographer, Lab technician, Theatre Assistants etc., The Chairman pointed out specifically the issue of vacancies with regard to FNO and Theatre assistant.

1.196 When the Chairman enquired as to why even the sanctioned posts were not being filled, the Principal Secretary stated the process of recruitment of staff was at various levels in a phased manner. Principal Secretary further added that the process of recruitment of all the sanctioned posts should be routed through Finance department.

1.197 The Committee further mentioned that bogus physiotherapists subsisted in the market and requested Principal Secretary to establish Physiotherapists Council to regulate bogus physiotherapists.

1.198 When the Chairman sought to know that IPHS norms were practically possible to implement, the Principal Secretary stated that IPHS norms were standard norms for the entire country and it was an ideal health care model.

1.199 The Committee expressed deep concern over huge vacancies and over non-filling up of vacancies at all the levels and recommended that all the posts should be filled immediately in both medical and para medical staff, especially personnel skilled in specialist branches of medicine at primary, secondary and tertiary health care centres to cater the medical needs of the people. Government should also sanction the posts in accordance with the IPHS and MCI norms at secondary and tertiary levels.

1.200 Regarding the observation on delayed receipt of drugs / surgicals from the suppliers, the Committee was informed that as per agreement conditions, every firm had to supply the agreed quantity of drugs within 60 days. For the delays up to 10 days, a penalty of 0.5 *per cent* of the value of items not delivered within 60 days is to be levied. In case items are not delivered even after 70 days, the purchase order is deemed to have been cancelled. However, there was delayed supply of drugs / surgical in 44 *per cent* of total supplies.

1.201 The Managing Director (MD), APMSIDC while agreeing with the audit observations, stated that certain delays like transporters strike etc., to be excused and penalties were being levied for the delay in supply of drugs. MD further added that if the purchase order was cancelled for not supplying the quantities within the stipulated period, then a new purchase order should be placed with L2 firm for supplies and need to wait 60 more days. If L2 firm also fails to supply within the stipulated period, the process will

go on continuing. In order to keep the hospital facilities and considering of logistical problems of supplier, the supply period had been extended.

1.202 When the Chairman enquired whether the APMSIDC goes for procurement of drugs from open market as a short term measure, the MD stated that they maintain L2 to L7 suppliers and when the L1 firm had not supplied the stocks within time, all the remaining suppliers would be preferred for participation in the bid to supply the stock at the rate agreed by L1 supplier. If, all the L2 to L7 suppliers were not willing to supply at the rate prescribed, quantities would be procured from the open market and difference of the amount would be charged to L1 supplier.

1.203 The Principal Secretary, however, intervening the discussion, disagreed with the explanation of the MD and stated that the procedure what could have been followed in order to get the supplies on time had not been followed by APMSIDC. The Principal Secretary further added that supply of 44 *per cent* of drugs with a delay of more than 60 days during 2009-14 indicated that the procurement system was not effective in the State. Principal Secretary also opined that strict conditions should be followed and implemented in respect suppliers for delay supplies.

1.204 When the Committee expressed doubt whether the drug suppliers come under the purview of the Department for taking action on the suppliers for non-supply of drugs or supply of substandard drugs, the Principal Secretary replied that it was very much under the purview of Department. Principal Secretary further stated that some of the drug companies had been black listed for supply of substandard drugs and intimated the fact to

the State Governments across the Country as well as the Central Drug Suppliers. Principal Secretary opined that Drug suppliers who had cheated the Government as well as public should be punished.

1.205 The Committee while noting that the system of procurement was marked by delay in supply of medicines/ drugs / surgicals resulted in APMSIDC purchased these items at higher rates from the market/ defaulting firms, recommended that stringent action should be taken on the suppliers for delayed supplies. The agreement conditions entered into with suppliers for supply of drugs should strictly be adhered to. The suppliers who frequently supply the drugs with the delay of more than the stipulated period should also be identified and be discouraged to participate in future biddings.

1.206 The Committee observed that though Central Medicine Stores (CMS) should maintain three months stock of medicines in Essential Medicines List (EML) and Additional Medicines List (AML), those medicines were not available in the CMS test checked by Audit. Further, several number of drugs and surgicals figured in the lists of EML and AML were required to be maintained at all levels of health care units were also not included in the rate contract.

1.207 In reply, the Managing Director (MD), APMSIDC stated that there was no response from the bidders for some particular drugs; hence these drugs could not be procured. The MD further added that the Hospitals were at liberty to purchase the medicines in EML/AML with the 20 *per cent* budget allotted to each Hospital under local purchase category. The non-availability of medicines in EML/AML was mainly due to lack of response from the bidders.

1.208 The Committee suggested to list out the drugs for which the bidders did not come forward to supply for the last 4 to 5 years and its manufacturers to find out whether any cartel formation of the manufacturers was there for not bidding the particular drug.

1.209 The Committee expressed displeasure over the system of maintenance of medicines in EML/AML and opined that all the Central Medicine Stores should invariably maintain three months stock of medicines in EML/AML. The medicines under emergency list should be procured through the 80 *per cent of* budget allocated to APMSIDC only. The 20 *per cent* of the budget funds allocated to the Hospitals should be kept with the Superintendents only to make emergency purchases of drugs depending upon the need of the hour.

1.210 The Committee noted that though there was a Drug Control Laboratory (DCL) in Vijayawada, the equipment in DCL were non-functional and outdated. Although the equipment required for analysis of drug samples were not working since May 2011 – September 2012, the department had not initiated any corrective action.

1.211 The DG, DCA replied that high end medical equipment was not available in Vijayawada laboratory and it was running with the available equipment only.

1.212 The Committee also noted that a minimum of five samples of drug/ cosmetic are to be analysed by a Junior Scientific Officer and Junior Analyst has to be analyse not less than 20 samples per month. However, there was a shortfall of 45 *per cent* (7,343 analysed as against a total of 13,275) in analysing of the samples received.

1.213 The DG, DCA stated that there was shortage of human resources as well as infrastructure in the department. The Director further added that a proposal was sent to Government for sanction of required posts and budget for infrastructure facilities.

1.214 On knowing that there were no technical staff like Junior Scientific Officer and Junior Analyst and even supporting staff like Typists and attender, the Committee felt bad with the pathetic condition of the department and stated that the department had not been provided even logistic support to inspect the local medical shops.

1.215 The DG, DCA stated that proposal for setting up of a new laboratory at Vijayawada was approved by GoI with 60:40 ratio. Although State Government released its component, GoI had not released the fund.

1.216 The Committee expressed displeasure with the action of the Government and decided to recommend to set up a new Laboratory in the State duly providing high end laboratory equipment and necessary human resources. Logistic support should also be provided to the drug inspectors to conduct inspections.

1.217 The Committee with regard to issue / renew of licenses to Blood Banks observed that there was pendency in grant of licences in 11 cases and renewal in 51 cases as of March 2014 due to non-conducting of joint inspections with Central Drug Control Standard Organisation and non-pursuance with Central Licensing Approving Authority.

1.218 The DG, DCA in reply stated that 100 licences / renewals out of 140 had been granted. Of the remaining, 11 were pending for want of joint inspection and assured the committee for early action.

1.219 On knowing that there was slow progress in grant renewal of license to blood banks, the Committee decided to recommend that the process of grant of license/ renewal should be completed without any delay.

1.220 The Committee on elaborate discussion on the performance review felt that the primary objective of health reforms improving accessibility to health care facilities to rural and tribal areas remained unachieved and **made the following recommendations**:

Andhra Pradesh Health Sector Reform

1.221 Government should take initiation to set up Sub-centres, Primary Health Centres and Community Health Centres in rural area, and tribal areas in specific, based on the population as per NHM norms to fill the gap between the requirement and existing health care institutions.

1.222 The Committee recommended that at least two per cent of the budget of the department should be allotted for maintenance of buildings of PHCs, CHCs and hospitals and at least one per cent to meet the energy charges. A Standard Protocol should be defined for effective maintenance of the buildings for better longevity of the structure and to ensure functional availability of amenities provided to the institution duly fixing up the accountability on the Engineering department concerned.

1.223 The Committee noted that the Medical colleges and attached teaching hospitals in the State are functioning with deficient medical equipment and faculty. The Committee recommended that the Government should provide necessary equipment and faculty in all the medical colleges and attached teaching Hospitals in a time bound manner to match the norms prescribed by the Medical Council of India. Immediate action should be taken for recruitment of the faculty required.

1.224 The Committee while mentioning the good practices being followed by CMC, Vellore regarding stress on community health as a preventive measure and minimizing the stay of patients in tertiary hospitals, recommended that Government should lay emphasis on community health for prevention of diseases by providing a separate wing for it. The Committee also recommended to enhance bed strength in PHCs and CHCs to take post-operative care and minimize the stay of patients in tertiary hospitals, thereby reducing load on them.

1.225 Referring the case of VIMS, Visakhapatnam visited by the Committee, the Committee recommended that such super specialities should recruit their own medical staff instead of taking staff on deputation as such deputation system would reduce availability of staff, and shortage of facilities in other hospitals.

1.226 The Chairman, while quoting the issue of breakdown of the ambulances during emergency situation due to bad condition of tyres and battery, recommended that specific

condition to change the tyres after running of every 50000 km should invariably be added while entering into agreement with the service provider.

1.227 The Chairman recommended that a specific penal clause should be incorporated in the MoU with the service provider in cases of failure in keeping the minimum number of vehicles on road at any time, required as per the MoU. There should be an SOP fixing the responsibility and accountability on the District Medical & Health Officer concerned who should verify and certify the number of vehicles actually on road; and ensure affecting the penal clause.

1.228 The Committee recommended that there should be effective monitoring mechanism to ensure availability of infrastructure facilities in the empanelled hospitals as committed by them at the time of empanelment. Periodical inspections of the empanelled hospitals should be conducted by the medical team of Trust comprising of various specialists to ensure continuous availability of the infrastructure and qualitative services by the empanelled hospitals. The empanelment team needs to be strengthened and updated with the advanced technology. Stringent action should be taken on the empanelled hospitals which failed in adhering to the stipulated criteria in terms of infrastructure, manpower and equipment.

1.229 The Committee, observing that it is essential to involve public representatives in the Hospital Development Societies to focus on the problems faced by the public, recommended that local MLA should be made the Chairman; with the District Collector as Member Secretary of the HDS of the District Hospital. In respect of the Hospitals located in other places, the elected head of the local body concerned and administrative heads of those bodies should be made as Chairman and Member Secretaries respectively. The Committee further recommended that the HDS meetings should be conducted mandatorily within the stipulated period.

1.230 The Committee recommended that both medical and para medical staff including ANM, Staff Nurse, MPHAs and Pharmacists should be sanctioned as per norms applicable, and action should be taken to fill all the vacancies of sanctioned post in all the Sub Centres, PHCs and CHCs, and other hospitals.

1.231 The Committee recommended that Government should get administrative sanction for ASHA posts from the GoI required as per norms, based on the relevant population and also to fill the unfilled vacancies of the sanctioned posts.

1.232 The Committee recommend that Village Health and Sanitation Committee (VHSC) funds should be allocated to Grama Panchayat concerned placing the main responsibility of utilization of such funds with the Panchayat Secretary and the village level health worker jointly.

1.233 The Committee while noting that the system of procurement and supply of medicines/ surgicals was marked by delay as a result of which the APMSIDC purchased these items at higher rates from the market/ defaulting firms and recommended that stringent action should be taken on the suppliers for delayed supplies. The agreement conditions entered into with suppliers for supply of drugs should strictly be adhered. The suppliers who frequently supply the drugs with the delay of more than the stipulated period should also be identified and be discouraged to participate in future biddings.

1.234 The Committee expressed displeasure over the system of maintenance of medicines in EML/AML and opined that all the Central Medicine Stores should invariably maintain three months stock of medicines in EML/AML duly procuring stock from origin point. The medicines under emergency list should be procured through the 80 per cent of budget allocated to APMSIDC only. The 20 per cent of the budget funds allocated to the Hospitals should be kept with the Superintendents only to make emergency purchases of drugs depending on the need of the hour.

1.235 The Committee recommended to set up a new Drug Testing Laboratory with high end laboratory equipment and necessary human resources, in the State. Logistic support should also be provided to the drug inspectors to conduct inspections.

1.236 *The Committee recommended that action should be taken to complete the joint inspection of blood banks for renewal of the license / issue of new license immediately and ensure that no blood bank continues to function without a valid licence and without complying with the requisite norms endangering the lives of donors/ recipients.*

2. Para 5.5 Page 122 of Audit Report 2013-14

Implementation of Food Safety and Standards Act

Government of India (GoI) enacted Food Safety and Standards Act (FSSA) 2006 (Act) to ensure wholesome food, regulate manufacture, storage, distribution or sale of any article of food and prohibit misbranding of food stuff. Although the Act was passed in August 2006, Food Safety and Standards Rules came into force only with effect from August 2011. Director, Institute of Preventive Medicine (IPM) - a division of Commissioner, Health and Family Welfare is responsible for implementation of the Act in the State.

Audit scrutinised the records of Directorate, State Food Laboratory and Gazetted Food Inspectors offices in six districts[13] during April – May 2013 and in February and July 2014 covering the period 2009-14 with the objective of assessing whether the Act was implemented effectively and provisions relating to survey, licensing system, lifting of samples, inspection of food business establishments, etc. were complied with.

[13] **Chittoor,** Hyderabad, **Kurnool, Prakasam, Visakhapatnam** and Warangal

Para 5.5.1 Survey of food establishments

(a) *As per Section 30 of the Act, the Department shall carry out a survey of industrial units engaged in the manufacture or processing of food in the State to find out compliance by such units of the standards notified by the Food Authority for various articles of food.*

(b) *As per Food Safety and Standards Rules[14], Food Safety Officer (FSO) shall maintain database of all food businesses within the areas assigned to him.*

Audit scrutiny revealed that survey of units engaged in manufacture or processing of food in the State was not conducted by the department. Further, FSOs did not maintain any database of food businesses. Thus, a majority of food establishments in the State have been functioning without any surveillance. Considering this situation, the possibility of existence of unauthorised food manufacturing/processing units cannot be ruled out. This eventuality would seriously compromise the health of citizens.

Government in its reply (November 2014) accepted that the implementation of the Act was still at initial stages and attributed the slow progress in the survey of manufacturing/ food processing units to lack of sufficient number of FSOs in the districts and lack of mobility of these officers to visit remote places for conducting the survey, and assured corrective action in this regard.

[14] Rule 2.1.3 (4) (iii) - (f)

In Explanatory Notes, Government attributed non-conducting the survey to lack of sufficient staff. It further stated that recruitment of personnel was under process and assured to conduct survey after the required posts were filled.

Para 5.5.2 Licensing System

(a) As per Section 31[15](1) of the Act, no person shall commence or carry on any food business except under a licence.

(b) As per Section 31 (2) of the Act, petty manufacturer who himself manufactures or sells any article of food or a petty retailer, hawker, itinerant vendor or a temporary stall holder or small scale or cottage or such other industries relating to food business or tiny food business operator shall register themselves with such authority and in such manner as may be specified by regulations.

As per Food Safety and Standards (Licensing and Registration of Food Businesses) Regulations, petty food manufacturers come under the purview of registration and all other food business operators are under the purview of licensing. It was estimated by National Institute for Smart Government (NISG)[16] that there were 1.10 lakh food establishments, of which 65,000 food establishments fell under the purview of licensing and 45,000 establishments under the purview of registrations.

[15] This section is enforceable from July 2010. Food Safety Standards Authority of India, Ministry of Health and Family Welfare, GoI, extended timeline up to 4 August 2014 for Food Business Operators (FBOs) seeking conversion/ renewal of their existing licences and also for FBOs who have not obtained licences/ registrations under the new Act

[16] a-for-profit company incorporated in 2002 by the Government of India

Audit scrutiny revealed that as of February 2014, only 15,466 (24 *per cent*) food establishment units were licenced and 24,357 (54 *per cent*) units were registered. Although licences were issued for one to five years as requested for by food business operators, these were to be renewed wherever required. There was **no system of monitoring of renewals** and necessary follow-up in the Directorate. Thus, 76 *per cent* unlicensed units and 46 *per cent* unregistered units were operating in food sector.

Government accepted the slow progress in issuing licences and stated that corrective measures would be initiated immediately.

In Explanatory Notes, Government stated that due to insufficient staff, mobility and monitoring systems, the targets could not be achieved.

Para 5.5.3 Inspection of Food Business Establishments

As per Food Safety and Standards Rules 2011[17] FSO should carry out food safety surveillance to identify and address the safety hazards and to inspect all food establishments within the area assigned to him.

Audit scrutiny revealed that out of estimated 1.10 lakh food establishments in the State, only a meagre 1,241 food establishments[18] (1 *per cent*) were inspected during 2012 and 2013 by FSOs. In reply, Commissioner attributed (September 2014) the poor performance of the inspections of the food

[17] Rule 2.1.3 (4)(iii)-(1) and (a)

[18] in 2012 : 473; in 2013 : 768

establishments to lack of sufficient number of FSOs and lack of mobility in respect of the existing FSOs.

In Explanatory Notes, Government stated that due to insufficient staff, inspection could not be conducted.

Para 5.5.4 Lifting of samples

Under Section 38 of the Act, FSO may take a sample of any food, or any substance, which appears to him to be intended for sale, or to have been sold for human consumption; or, of any article of food or substance which is found by him on or in any such premises.

Audit scrutiny revealed that **no criteria were fixed** by the department for lifting of samples for analysis of various categories of food items. **No priority was given** to items of mass consumption. From analysis reports of State Food laboratory, it was observed that, when compared to 2011, the percentage of adulteration of mass consumption items like packaged mineral water, tea, coffee, cocoa, chicory, edible oils, fats and vanaspati, cereal products, fruit products, milk and milk products categories was high in the year 2012. Among these, the percentage of adulteration was high in packaged mineral water as shown alongside. The increasing trend in adulteration was evident during 2013 also, except in case of cereals and cereal products and packaged drinking water.

In Explanatory Notes, Government attributed the reasons for not lifting the samples to lack of required personnel and further stated that action is being initiated to fill up sanctioned posts.

Para 5.5.4.1 Shortage of FSOs

As per norms laid down by Central Council of Health and Family Welfare in 1995, there should be one whole time Food Inspector (now called Food Safety Officer - FSO) per 50,000 population for urban areas and one Food Inspector per one lakh population for rural areas. Thus, there was a requirement of 1,127 Food Inspectors in Urban (564) and Rural (563) areas as per 2011 Census.

The analysis revealed that against the sanctioned strength of 106 FSOs in the State, 43 (41 *per cent*) posts were vacant. Only five full time FSOs were deployed per one crore population in the State. In the sampled districts only one FSO each was available in Visakhapatnam, Prakasam and Chittoor districts and two FSOs each in Kurnool and Warangal districts. In Hyderabad district, against the 30 sanctioned, only four FSOs were positioned.

It is pertinent to note that after 1984, no additional posts were sanctioned by State Government (except one post of Joint Food Controller and Deputy Food Controller each) despite the increase in population of the State and number of Food Business Establishments as well. Commissioner stated (September 2014) that, proposals for sanctioning eight FSOs per district were pending with the Government.

It was further observed that no funds were provided by the Government under NRHM[19] for food safety programme

19 National Rural Health Mission

although proposals were submitted (August 2012) by Director, IPM for release of Rs. 5.57 crore[20] from NRHM funds in terms of directions of Chairperson, Food Safety and Standards Authority (GoI), towards various strengthening activities like procurement of additional hardware, sanction of manpower in district offices, training to food regulators, awareness programmes to street food vendors, etc. Due to non-allocation of funds, gaps in terms of lack of mobility to field staff for enforcement of the Act, establishment of e-food laboratory, civil works, equipment for laboratories, etc. continue to exist.

Government in its reply (November 2014) stated that criteria for fixing targets for lifting of samples would be given due consideration. With regard to funding under NRHM, Government replied that funding would depend upon the approval of the programme by GoI and its inclusion in the Record of Proceedings. Audit verification however, revealed that the proposals were not included in the NRHM programme implementation plan of 2013-14.

In Explanatory Notes, Government stated that 61 FSO posts sanctioned for effective implementation of the Act.

Para 5.5.4.2 Non-compliance with GoI directions

As per directions (March 1999) of Director General, Health Services, GoI, Food Inspectors should collect uniformly 12 samples per month.

20 for establishment of Food Safety and Standards Enforcement Wing L `2.37 crore; for strengthening of State Food Laboratory, Hyderabad : `1.48; crore; and for strengthening of Water Quality Monitoring, Surveillance and Laboratories : `1.72 crore

Analysis of year-wise and month-wise details of samples lifted revealed that, against uniform monthly target of 12 samples to be lifted per FSO per month, on an average **about five samples only** were lifted per month. During the five year period 2009-13[21], against 84,072[22] samples, only 35,949 samples were lifted. Further, it was observed that the number of samples lifted has been declining year on year (except in 2013).

In the sampled districts, against 16,972 samples required to be lifted, only 8,238 samples were lifted leaving shortfall of about 51 per *cent*. The performance was very low in Hyderabad (shortfall being 71 *per cent*) followed by Prakasam (65 *per cent*) and Visakhapatnam (53 *per cent*) districts. In Hyderabad, no samples were lifted during the years 2011 and 2012. Thus, there was no effective surveillance of risk of adulterated food being supplied to consumers.

Government in its reply (November 2014) stated that apart from inadequacy of regular manpower in critical positions, the function is interdependent and involves close coordination with other departments like Panchayats, Municipalities, etc. and that the matter would be addressed to attain the targets in a phased manner.

In Explanatory Notes, Government stated that due to shortage of required staff, target of lifting the samples could not be achieved.

21 report were being maintained on calendar year basis
22 worked out based on number of FSOs in a year X 12 samples X 12 months

Para 5.5.4.3 Lifting of samples from Food Corporation of India and Civil Supplies Corporation godowns

The Act empowers FSOs to conduct inspection of and lift samples for analysis from any establishment engaged in 'food business'[23] which inter alia include godowns of Food Corporation of India (FCI), Civil Supplies Corporation (CSC) and Fair Price Shops (FPSs).

Scrutiny however, revealed that no samples were lifted from FPSs and godowns of CSC for analysis. In respect of FCI although 150 godowns existed in the State, only a meagre 20 and 22 samples were received during the years 2012 and 2013 respectively in the State Food Laboratory for analysis (inspection reports were not made available by the department though specifically called for in Audit).

Thus, there was **no assurance** about quality of ration and provisions being supplied to consumers by CSC through FPSs.

Government attributed the shortfall in lifting of samples to shortage of manpower, and stated that this area would be focused for improvement.

Para 5.5.8 Supply of equipment to State Food Laboratory

As per Section 21 of the Act, no article of food shall contain insecticides or pesticides residues, veterinary drugs residues, antibiotic residues, solvent residues, pharmacological active substances and micro-biological counts in excess of such tolerance limits as may be specified by regulations.

[23] As defined under 3(1) (n) of Food Safety and Standards Act, 2006

State Food laboratory, Hyderabad is the lone statutory laboratory in the State to analyse samples received from FSOs. This laboratory has received accreditation of National Accreditation Board for Laboratories (NABL) for chemical testing in April 2012.

Audit scrutiny revealed that State Food Laboratory was not equipped with NIST[24] traceable standards for analysis of insecticides, pesticides, veterinary drugs residues, antibiotic residues, solvent residues, pharmacological active substances, etc. in food samples lifted by FSOs.

Further, to expand scope of accreditation by NABL, Chief Public Analyst, State Food Laboratory submitted proposals (July 2012) to Director for supply of equipment required[25]. It was however, observed that the **equipment was not supplied** as of April 2014 to the laboratory.

Thus, there was no assurance of quality of food being supplied to consumers as envisaged in the Act. It was also observed that there were vacancies in key posts of Junior Scientific Officer (six against 11 sanctioned), Technical Assistant (two against three sanctioned) and Laboratory Technician (five against 11 sanctioned) in the laboratory.

Government replied (November 2014) that out of 15 items required, three were procured and the remaining would be procured soon. Government however, did not offer specific remarks with regard to the vacancies in key posts.

[24] National Institute of Standards and Technology

[25] Digital Hot Air Oven : Decimal Digital Balance ; 2; Thermostatically controlled Water Bath : 5; Thermostatically controlled Hot Plate : 1; Cold Water Circulating Cooler : 2; Binocular Microscopes : 5; Refrigerator 320 litres : 2; UC Chamber : 1; Thermometers (0°C to 50°C): 4; Thermometers 0°C to 350°C) : 21 Multimeter with clamp meter : 1

In Explanatory Notes, Government stated that the present laboratory was under Administrative control of Government of Telangana.

Para 5.5.11 Establishment of referral/cluster laboratories

(a) *As per Section 43(1) of the Act, Food Authority may notify food laboratories and research institutions accredited by National Accreditation Board for Testing and Calibration Laboratories or any other accreditation agency for the purposes of carrying out analysis of samples by the Food Analysts under the Act.*

(b) *As per Section 43 (2) of the Act, the Food Authority shall establish or recognise by notification, one or more referral food laboratory or laboratories to carry out the functions entrusted to the referral food laboratory by the Act or any rules and regulations made thereunder.*

Audit scrutiny revealed that although proposals were submitted in April 2012 by Chief Public Analyst for establishment of six cluster laboratories[26] in the State and for up-gradation of State Food Laboratory, Hyderabad as a referral laboratory, sanction for establishment as well as upgradation of State Food Laboratory was not yet received as of April 2014.

[26] **Visakhapatnam** (for Srikakulam, Vizianagaram and Visakhapatnam districts), **Eluru**(for East Godavari, West Godavari and Krishna districts); **Krishnapatnam** (for Guntur, Prakasam and SPS Nellore and Chittoor districts); **Kurnool** (forYSR Kadapa,Kurnool and Anantapuram districts); Karimnagar (forWarangal,Karimnagar, Khammam, Adilabad and Nizamabad districts); Hyderabad (for Ranga Reddy, Mahabubnagar, Nalgonda, Medak and Hyderabad districts)

Government replied (November 2014) that the matter would be considered *denovo* to establish laboratories based on the need and scientific study.

In Explanatory Notes, Government replied that the proposals for establishment of referral cluster laboratories are with them.

2.2 Initiating the discussion, the Committee noted that although the Food Safety and Standards Act was passed in August 2006 and the Rules made there under came on to effect in August 2011, the survey of units engaged in manufacture and processing of food was not conducted by the department. The Food Safety Officers had not maintained any data base of units engaged in the food business. The Chairman, PAC sought explanation from the Director, Food Safety, Health Medical and Family Welfare Department (Director), for not implementing the Act effectively though Rules came into effect in 2011.

2.3 The Commissioner for Food Safety submitted that the strength of the staff at present was not sufficient to carry out the survey. He also submitted that there were only 20 Food Safety Officers (FSOs) in the State.

2.4 The Chairman asked about the details of the other associated staff and the plan of action for listing out all the food manufacturing and processing units in the State.

2.5 The Committee also sought to know as to whether any plan of action was prepared by the Department with regard to requirement of FSOs in rural and urban areas in the State.

2.6 Principal Secretary, Health Medical and Family Welfare (Principal Secretary) informed the Committee that there were 83 sanctioned posts of FSOs in the combined State. After division of the State, there were only 28 sanctioned posts (out of which 8 posts were vacant) to cover all 13 districts against the requirement of 640 FSOs based on the population of the State.

2.7 The Principal Secretary further stated that, as per the Act, every food business unit should compulsorily be got registered and of which the unit with turnover of above ·12 lakh should obtain license from the Department. Principal Secretary expressed difficulty to implement the Act with the 20 FSOs in the State and stated that the department had addressed the Government seeking permission to fill the vacancies of FSO posts. However, Government had not accorded permission.

2.8 The Principal Secretary also explained that the department had submitted a report to the Government duly submitting the difficulties faced due to shortage of staff in the State and also the information collected from other States. She also informed that there were about 500 FSOs in Maharashtra, 400 in Karnataka and 300 in Tamilnadu.

2.9 The Committee directed the Legislature Secretariat to obtain the information on the staff pattern, structure of the

department with regard to Food safety measures and the system of Food Safety and Standards Act being implemented in the neighbouring States i.e., Karnataka, Tamilnadu and Maharashtra.

2.10 On an enquiry by the Committee about requisition submitted by the department for sanction of posts, the Special Secretary to Finance Department replied that the health department was asked to send proposals based on work load; conduct survey and assess the requirement of posts based on the total number of food establishments and not on the basis of the population. However, no proposal for requirement of staff was received from the Department so far.

2.11 The Principal Secretary stated that Finance Department had not denied to sanction posts; Finance department had asked to recruit the 28 posts first and then approach them with fresh proposals. The recruitment process was entrusted to the AP Public Service Commission and more people would be available after completion of the recruitment process.

2.12 When the Committee questioned with regard to engaging staff from other Departments, Principal Secretary stated that Act does not permit it as the FSO should be a qualified one.

2.13 While observing that the survey of food establishments was not conducted by the Department, the Chairman opined that the data available with other departments i.e., Civil supplies, Revenue, Industries could have been utilized and

complete the survey. Quoting the Government policy of giving permissions for new Industries within 21 days under single window system, the Committee suggested that the department could have utilised database of industries maintained by the Industries department for survey purpose.

2.14 The Director, Health & Family Welfare informed the Committee that, in compliance with the suggestions and instruction of the Chairman in the earlier meetings, database on food and non-food based establishments was collected from the Departments of Industries, Civil Supplies, Labour and Municipal Administration and sorting out of data was under process. The Director further informed the Committee that all the efforts had been made to get the licenses for all the establishments as a result of which 67000 food establishments had been registered so far, and out of them, licenses had been issued to 40000 food establishments.

2.15 The Commissioner, Food Safety also informed the Committee that a proforma was designed and the Government was requested to extend the services of other Departments to conduct the survey of food establishments. The Commissioner for Food Safety further assured the Committee that survey would be completed within three months and after completion of the survey, Government would be requested to appoint additional staff to streamline the entire system. Commissioner further firmly stated that every type of food establishment including roadside hawkers should also be compulsorily

registered under this Act and in this regard, campaigns had also been conducted for creating awareness among public.

2.16 The Committee pointed out that the food adulteration is at an alarming stage in the State and mentioned the incidents of mixing of edible oil with animal fat and chilli powder with some sort of colours. The Committee expressed serious concern over the pathetic situation of usage of rotten vegetables in Hotels and ripening of fruits with carbide, adulteration of milk, food poisoning problems with the sea foods, sanitation problems near meat shops, use of rotten eggs in bakeries etc.

2.17 The Committee suggested that the bank loans should be linked to the license and the bankers should be directed that the loans would be issued to the Food business operators only if they were registered / had a license from the department. The Act could be enforced by stipulating that loan would be sanctioned only on production of registration/ license and PAN card.

2.18 The Chairman also endorsed that it should be linked either to the bank loan or to the power connection.

2.19 The Committee also observed that the licensing system should be strengthened and action should be taken against those who did not obey the Law. It should be ensured that any food product would not be consumed after the date of expiry and should be disposed of in a proper way. The Committee suggested that the good practices followed in other States of

the country should be studied and implement the best practices in the State.

2.20 The Chairman suggested the department for utilisation of services of Sanitary Inspectors available in Gram Panchayats and Municipalities as a temporary measure till the department gets additional resources. They could persuade the food establishments to get them registered.

2.21 The Principal Secretary agreed that they could be given some sort of training and at least feed the information.

2.22 The Committee expressed serious concern over lack of perspective planning and the way the Act was being implemented. The Committee asked whether the department had any perspective plan for registration of all the food establishments and issue of licenses as per the Act. The Committee also observed that there should be one FSO for every 50,000 population in rural areas and one FSO for every lakh of population in urban areas and sought to know about the perspective plan of the department for implementation of the Act.

2.23 The Director, IPM stated that after collection and segregation of data pertaining to the food business operators, the department could see how many of them were licensed. If the business operator had applied for license, it was to be inspected, notices were to be issued to all the unregistered Food business operators that if they were not registered before a stipulated date, they would be penalised.

2.24 The Chairman stated that the opinion of the Committee was that the department should prepare proper plan of action; and all those who were entrusted with the work of collection of data should be directed to act according to the plan of action so as to obtain a definite result.

2.25 The Committee observed that only 1241 out of estimated 1.10 lakh food establishments were inspected during 2012 and 2013 by FSOs and sought the explanation.

2.26 The Director attributed the poor performance of the inspections of the food establishments to lack of sufficient number of FSOs and lack of mobility for the existing FSOs. The Director further stated that 4038 food establishments had been inspected during 2013-14 and assured this would definitely be increased in the coming years.

2.27 On knowing that mobility support was not provided to the field staff in the Department, the Committee opined that the Department should have the required vehicles and supporting system to conduct inspection of food establishments.

2.28 The Chairman pointed out that even the road side establishments are using the reheated cooking oil more number of times causing health hazards to the public and opined that these road side establishments should also be inspected.

2.29 The Chairman observed that the laboratories were also in need of strengthening and also to be more in number.

2.30 The Principal Secretary submitted that there were three laboratories in Guntur, Visakhapatnam and Kurnool. The Principal Secretary also submitted that the laboratories at Guntur and Visakhapatnam were functioning; the laboratory at Kurnool was not functioning due to shortage of staff and equipment.

2.31 The Committee enquired as to how the food samples were being tested without having proper laboratory facilities in the State.

2.32 The Director replied that, at present, samples were being sent to the Laboratory situated in Nacharam, Ranga Reddy district, Telangana State which was covered under X schedule of State Re-organisation Act. The Director assured the Committee to strengthen the regional labs in Kurnool and Visakhapatnam by providing required staff.

2.33 The Committee noted that against the uniform monthly target of 12 samples to be lifted by each FSO per month, on an average about five samples only were lifted per month. During the five year period 2009-13, only 35949 samples were lifted against 84072 samples to be lifted. The Committee sought to know the reasons for non-compliance with GoI directions in lifting the prescribed samples.

2.34 Responding to the Committee's observation, the Director admitted the fact of non-achieving of the target in lifting of the samples and attributed the failure to shortage of staff.

2.35 The Committee observed that no samples were lifted from FPSs and godowns of the Civil Supplies Corporation for analysis. The Committee further noted that though 150 godowns existed in the State, only a meagre 20 and 22 samples were received during the years 2012 and 2013 respectively.

2.36 The Director, in response to observation of Committee, replied that samples were usually being lifted whenever there was a complaint.

2.37 The Committee while expressing its dissatisfaction over Department's reply and failure to adhere to provisions of the Act recommended to lift the samples regularly once in a month.

2.38 The Committee while expressing its displeasure with the failure of the department in implementation of Food Safety and Standards Act opined that ineffective implementation of key provisions of the Act endangers the quality of food and poses serious health hazard to the general public. The Committee noticed that failure of implementation of Act was mainly due to shortage of manpower, logistical support and collaboration with other departments etc., and **the following recommendations were made:**

2.39 The Committee, expressed anguish over the lack of serious concern *ab-initio* on the part of the officers in implementation of the Food Safety and Standards Act. The Committee noted that there was no database of food establishments in State with the Department and

recommended that the database of all the food establishments the State should be collected in co-ordination with other Government departments like Industries and Commerce, Labour, Civil Supplies and Municipal Administration & Urban Development departments and synchronize it.

2.40 The Committee observed that a meagre 28 sanctioned posts of FSO in the State against the requirement of 640 as per population norms. Observing that shortage of staff is the main reason for failure in implementation of the Act effectively, recommended that the required staff should be sanctioned and all the vacant posts should be filled immediately for effective implementation of Act.

2.41 Logistical support should be provided to the Food Safety Officers to carry out food safety surveillance to identify and address the safety hazards and to inspect all food establishments.

2.42 The Committee also recommended that the good practices followed in other States of the country should be studied by the department and the best practices followed in implementation of Food Safety Standards should be adopted to improve the system in the State.

2.43 The Committee expressed serious concern over the callousness in lifting of samples and recommended that the samples should be lifted from FCI, Civil Supplies

Corporation godowns and Fair Price Shops at least once in a month for analysis.

2.44 The Committee recommended that a State Food Laboratory should be set up in the State of Andhra Pradesh with the State of the Art equipment. The Committee further recommended strengthening the laboratories at Guntur, Kurnool and Visakhapatnam by providing required staff and equipment and set up more number of laboratories to suit the requirement.

2.45 Government should focus on skill development to ensure availability of qualified technicians for effective implementation of the Act.

2.46 Government should prepare a perspective plan and a time bound action plan for registration / issue of licenses to all the food business operators in the State, as per the criteria fixed in the Act. The Committee suggested considering the linkage of bank loans / power connection to the food business operators with the registration / license to be obtained from the department. The Committee also recommended to give wide publicity to the provisions of the Act and also to encourage vigil blowers to prevent / arrest adulteration of food products which is at an alarming stage causing health hazards to the public.

Summary of observations and recommendations:

1. Chapter 2 Page 11 of Audit Report 2013-14

Andhra Pradesh Health Sector Reform Programme

1.220 The Committee on elaborate discussion on the performance review felt that the primary objective of health reforms improving accessibility to health care facilities to rural and tribal areas remained unachieved and **made the following recommendations**: (para 1.220)

1.221 ***Government should take initiation to set up Sub-centres, Primary Health Centres and Community Health Centres in rural area, and tribal areas in specific, based on the population as per NHM norms to fill the gap between the requirement and existing health care institutions.*** (para 1.221)

1.222 ***The Committee recommended that at least two per cent of the budget of the department should be allotted for maintenance of buildings of PHCs, CHCs and hospitals and at least one per cent to meet the energy charges. A Standard Protocol should be defined for effective maintenance of the buildings for better longevity of the structure and to ensure functional availability of amenities provided to the institution duly fixing up the accountability on the Engineering department concerned.*** (para 1.222)

1.223 ***The Committee noted that the Medical colleges and attached teaching hospitals in the State are functioning***

with deficient medical equipment and faculty. The Committee recommended that the Government should provide necessary equipment and faculty in all the medical colleges and attached teaching Hospitals in a time bound manner to match the norms prescribed by the Medical Council of India. Immediate action should be taken for recruitment of the faculty required. (para 1.223)

1.224 ***The Committee while mentioning the good practices being followed by CMC, Vellore regarding stress on community health as a preventive measure and minimizing the stay of patients in tertiary hospitals, recommended that Government should lay emphasis on community health for prevention of diseases by providing a separate wing for it. The Committee also recommended to enhance bed strength in PHCs and CHCs to take post-operative care and minimize the stay of patients in tertiary hospitals, thereby reducing load on them.*** (para 1.224)

1.225 ***Referring the case of VIMS, Visakhapatnam visited by the Committee, the Committee recommended that such super specialities should recruit their own medical staff instead of taking staff on deputation as such deputation system would reduce availability of staff, and shortage of facilities in other hospitals.*** (para 1.225)

1.226 ***The Chairman, while quoting the issue of breakdown of the ambulances during emergency situation due to bad condition of tyres and battery, recommended that specific***

condition to change the tyres after running of every 50000 km should invariably be added while entering into agreement with the service provider. (para 1.226)

1.227 *The Chairman recommended that a specific penal clause should be incorporated in the MoU with the service provider in cases of failure in keeping the minimum number of vehicles on road at any time, required as per the MoU. There should be an SOP fixing the responsibility and accountability on the District Medical & Health Officer concerned who should verify and certify the number of vehicles actually on road; and ensure affecting the penal clause.* (para 1.227)

1.228 *The Committee recommended that there should be effective monitoring mechanism to ensure availability of infrastructure facilities in the empanelled hospitals as committed by them at the time of empanelment. Periodical inspections of the empanelled hospitals should be conducted by the medical team of Trust comprising of various specialists to ensure continuous availability of the infrastructure and qualitative services by the empanelled hospitals. The empanelment team needs to be strengthened and updated with the advanced technology. Stringent action should be taken on the empanelled hospitals which failed in adhering to the stipulated criteria in terms of infrastructure, manpower and equipment.* (para 1.228)

1.229 *The Committee, observing that it is essential to involve public representatives in the Hospital Development Societies to focus on the problems faced by the public,*

recommended that local MLA should be made the Chairman; with the District Collector as Member Secretary of the HDS of the District Hospital. In respect of the Hospitals located in other places, the elected head of the local body concerned and administrative heads of those bodies should be made as Chairman and Member Secretaries respectively. The Committee further recommended that the HDS meetings should be conducted mandatorily within the stipulated period. (para 1.229)

1.230 *The Committee recommended that both medical and para medical staff including ANM, Staff Nurse, MPHAs and Pharmacists should be sanctioned as per norms applicable, and action should be taken to fill all the vacancies of sanctioned post in all the Sub Centres, PHCs and CHCs, and other hospitals.* (para 1.230)

1.231 *The Committee recommended that Government should get administrative sanction for ASHA posts from the GoI required as per norms, based on the relevant population and also to fill the unfilled vacancies of the sanctioned posts.* (para 1.231)

1.232 *The Committee recommend that Village Health and Sanitation Committee (VHSC) funds should be allocated to Grama Panchayat concerned placing the main responsibility of utilization of such funds with the Panchayat Secretary and the village level health worker jointly.* (para 1.232)

1.233 *The Committee while noting that the system of procurement and supply of medicines/ surgicals was marked by delay as a result of which the APMSIDC purchased these items at higher rates from the market/ defaulting firms and recommended that stringent action should be taken on the suppliers for delayed supplies. The agreement conditions entered into with suppliers for supply of drugs should strictly be adhered. The suppliers who frequently supply the drugs with the delay of more than the stipulated period should also be identified and be discouraged to participate in future biddings.* (para 1.233)

1.234 *The Committee expressed displeasure over the system of maintenance of medicines in EML/AML and opined that all the Central Medicine Stores should invariably maintain three months stock of medicines in EML/AML duly procuring stock from origin point. The medicines under emergency list should be procured through the 80 per cent of budget allocated to APMSIDC only. The 20 per cent of the budget funds allocated to the Hospitals should be kept with the Superintendents only to make emergency purchases of drugs depending on the need of the hour.* (para 1.234)

1.235 *The Committee recommended to set up a new Drug Testing Laboratory with high end laboratory equipment and necessary human resources, in the State. Logistic support should also be provided to the drug inspectors to conduct inspections.* (para 1.235)

1.236 *The Committee recommended that action should be taken to complete the joint inspection of blood banks for renewal of the license / issue of new license immediately and ensure that no blood bank continues to function without a valid licence and without complying with the requisite norms endangering the lives of donors/ recipients* (para 1.236)

2. Para 5.5 Page 122 of Audit Report 2013-14

Implementation of Food Safety and Standards Act

1.237 **The Committee, expressed anguish over the lack of serious concern *ab-initio* on the part of the officers in implementation of the Food Safety and Standards Act. The Committee noted that there was no database of food establishments in State with the Department and recommended that the database of all the food establishments the State should be collected in co-ordination with other Government departments like Industries and Commerce, Labour, Civil Supplies and Municipal Administration & Urban Development departments and synchronize it.** (para 2.2)

1.238 **The Committee observed that a meagre 28 sanctioned posts of FSO in the State against the requirement of 640 as per population norms. Observing that shortage of staff is the main reason for failure in implementation of the Act effectively, recommended that the required staff should be sanctioned and all the vacant posts should be filled**

immediately for effective implementation of Act. (para 2.3)

1.239 **Logistical support should be provided to the Food Safety Officers to carry out food safety surveillance to identify and address the safety hazards and to inspect all food establishments.** (para 2.4)

1.240 **The Committee also recommended that the good practices followed in other States of the country should be studied by the department and the best practices followed in implementation of Food Safety Standards should be adopted to improve the system in the State.** (para 2.5)

1.241 **The Committee expressed serious concern over the callousness in lifting of samples and recommended that the samples should be lifted from FCI, Civil Supplies Corporation godowns and Fair Price Shops at least once in a month for analysis.** (para 2.6)

1.242 **The Committee recommended that a State Food Laboratory should be set up in the State of Andhra Pradesh with the State of the Art equipment. The Committee further recommended strengthening the laboratories at Guntur, Kurnool and Visakhapatnam by providing required staff and equipment and set up more number of laboratories to suit the requirement.** (para 2.7)

1.243 **Government should focus on skill development to ensure availability of qualified technicians for effective implementation of the Act.** (para 2.8)

1.244 **Government should prepare a perspective plan and a time bound action plan for registration / issue of licenses to all the food business operators in the State, as per the criteria fixed in the Act. The Committee suggested considering the linkage of bank loans / power connection to the food business operators with the registration / license to be obtained from the department. The Committee also recommended to give wide publicity to the provisions of the Act and also to encourage vigil blowers to prevent / arrest adulteration of food products which is at an alarming stage causing health hazards to the public.** (para 2.9)

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