Twenty Fourth Report

PUBLIC ACCOUNTS COMMITTEE
(2010-11)

FIFTEENTH LOK SABHA

PROCUREMENT OF MEDICINES AND MEDICAL EQUIPMENT

MINISTRY OF HEALTH AND FAMILY WELFARE

Presented to Lok Sabha on 24.2.2011
Laid in Rajya Sabha on 24.2.2011

LOK SABHA SECRETARIAT
NEW DELHI
February 2011/*Phalguna* 1932 (*Saka*)

PAC No. 1931

Price: Rs. 56.00

Published under Rule 382 of the Rules of Procedure and Conduct of Business of Lok Sabha (Fourteenth Edition) and Printed by the General Manager, Government of India Press, Minto Road, New Delhi-110 002.

CONTENTS

COMPOSITION OF THE PUBLIC ACCOUNTS COMMITTEE

(2010-11)

Dr. Murli Manohar Joshi — *Chairman*

MEMBERS

Lok Sabha

2. Shri Anandrao Vithoba Adsul
3. Dr. Baliram
4. Shri Ramen Deka
5. Shri Naveen Jindal
6. Shri Satpal Maharaj
7. Shri Bhartruhari Mahtab
8. Dr. K. Sambasiva Rao
9. Shri Yashwant Sinha
10. Shri Jitendra Singh (Alwar)
11. Kunwar Rewati Raman Singh
12. Shri K. Sudhakaran
13. Dr. M. Thambidurai
14. Shri D. Venugopal
15. Shri Aruna Kumar Vundavalli

Rajya Sabha

*16. Vacant
17. Shri N. Balaganga
18. Shri Prasanta Chatterjee
19. Shri Kalraj Mishra
20. Shri N.K. Singh
21. Shri Tiruchi Siva
22. Prof. Saif-ud-Din Soz

SECRETARIAT

1. Shri Devender Singh — *Joint Secretary*
2. Shri D.R. Mohanty — *Deputy Secretary*

---

*Vacancy occurred *vice* Shri Ashwani Kumar has been appointed as Minister of State *w.e.f.* 19th January, 2011.

COMPOSITION OF THE PUBLIC ACCOUNTS COMMITTEE
(2009-10)

*Shri Gopinath Munde — *Chairman*

MEMBERS

Lok Sabha

2. Shri Anandrao Vithoba Adsul
3. Dr. Baliram
4. Shri Khagen Das
5. Shri Naveen Jindal
6. Shri Satpal Maharaj
7. Shri Bhartruhari Mahtab
8. Dr. K. Sambasiva Rao
9. Shri Jashwant Singh
10. Shri Jitendra Singh (Alwar)
11. Kunwar Rewati Raman Singh
12. Shri Yashwant Sinha
13. Shri K. Sudhakaran
14. Dr. M. Thambidurai
15. Shri Aruna Kumar Vundavalli

Rajya Sabha

16. Shri Prasanta Chatterjee
17. Shri Sharad Anantrao Joshi
#18. Vacant
19. Shri Shanta Kumar
20. Dr. K. Malaisamy
21. Shri N.K. Singh
22. Prof. Saif-ud-Din Soz

---

*Appointed as the Chairman of the Committee *w.e.f.* 6th January, 2010 *vice* Shri Jaswant Singh resigned from the Chairmanship of the Committee.
#*Vice* the expiry of the term of Shri Ashwani Kumar *w.e.f.* 9th April, 2010.

COMPOSITION OF THE PUBLIC ACCOUNTS COMMITTEE
(2008-09)

**Shri Santosh Gangwar — *Chairman*

MEMBERS

Lok Sabha

2. Shri Furkan Ansari
3. Shri Vijay Bahuguna
4. Shri Khagen Das
5. Shri Sandeep Dikshit
6. Shri P.S. Gadhavi
7. Shri Shailendra Kumar
8. Shri Bhartruhari Mahtab

***9. Vacant

10. Prof. M. Ramadass

*11. Shri K.S. Rao

12. Shri Sita Ram Singh
13. Shri Kharabela Swain
14. Shri Tarit Baran Topdar
15. Shri Arun Yadav

Rajya Sabha

16. Shri Raashid Alvi
17. Shri Prasanta Chatterjee
18. Shri B.K. Hariprasad
19. Shri Shanta Kumar
20. Prof. P.J. Kurien
21. Dr. K. Malaisamy
22. Sardar Tarlochan Singh

---

* Elected *w.e.f.* 17th December, 2008 *vice* Shri Rajiv Ranjan 'Lalan' Singh resigned his seat in Lok Sabha on 11th November, 2008.

** Elected *w.e.f.* 17th December, 2008 *vice* Shri Brajesh Pathak ceased to be a Member of Committee consequent upon his election to Rajya Sabha.

*** Prof. Vijay Kumar Malhotra resigned his seat in Lok Sabha *w.e.f.* 18th December, 2008.

INTRODUCTION

I, the Chairman, Public Accounts Committee (2010-11), having been authorised by the Committee, do present this Twenty-fourth Report (Fifteenth Lok Sabha) on **'Procurement of Medicines and Medical Equipment'** based on the C&AG Report No. 20 of 2007 (Performance Audit), Union Government (Civil) for the year ended March, 2007 relating to the Ministry of Health and Family Welfare.

2. The Report of the Comptroller and Auditor General of India for the year ended March, 2007 was laid on the Table of the House on 27th November, 2007.

3. The Public Accounts Committee (2008-09) selected the subject for examination and report. The Committee took evidence of the representatives of the Ministry of Health and Family Welfare on the subject at their sitting held on 14th August, 2008. As the examination of the subject could not be completed due to paucity of time, the Public Accounts Committee (2009-10) re-selected the subject for examination. Further evidence of the representatives of the Ministry of Health and Family Welfare was taken on 28th January, 2010. However, due to paucity of time they also could not finalize the Report on the subject. The Public Accounts Committee (2010-11) decided to continue the examination of the subject and present a Report thereon based on the earlier evidences taken by their predecessor Committees. Accordingly, a Draft Report was prepared and placed before the Committee for their consideration. The Committee considered and adopted the Report at their sitting held on 3rd February, 2011. Minutes of the sittings form Appendices to the Report.

4. For facility of reference and convenience, the Observations and Recommendations of the Committee have been printed in thick type in the body of the Report.

5. The Committee thank their predecessor Committees for taking oral evidence and obtaining information on the subject.

6. The Committee would also like to express their thanks to the representatives of the Ministry of Health and Family Welfare for tendering evidence before them and furnishing the requisite information to the Committee in connection with the examination of the subject.

7. The Committee place on record their appreciation of the assistance rendered to them in the matter by the office of the Comptroller and Auditor General of India.

NEW DELHI;
21 *February*, 2011
2 *Phalguna,* 1932 *(Saka)*

DR. MURLI MANOHAR JOSHI,
Chairman,
Public Accounts Committee.

REPORT

PART—I

I. Introductory

Adequate procurement and prudent supply of medicines and medical equipment play a vital role in improving the quality of health services in the country. The Ministry of Health and Family Welfare remain responsible for purchasing and procuring medicines and medical equipment by making substantial investments for the implementation of various Disease Control Programmes, Central Government Health Scheme (CGHS) and for providing essential health care facilities to the people in Central Government Hospitals, Research Bodies and Institutes. In the procurement procedure, an attached office of the Department of Health and Family Welfare, known as Director General of Health Services (DGHS) is responsible for implementing Central Government Health Scheme through a network of 331 dispensaries (246 Allopathic; 32 Ayurvedic and 53 others), 19 Polyclinics, 65 Laboratories and 17 Dental Units to provide comprehensive medical care to the Central Government Employees, pensioners and members of their families and other beneficiaries.

2. For the procurement of machinery and medical equipment valued at Rs. 50 lakh and above there is a Procurement Cell, which was constituted in 1993 under DGHS. Machinery and equipment costing less than Rs. 50 lakh is procured by the respective hospitals and other sub-ordinate offices after necessary financial assistance is accorded by the competent authority. Apart from this, the Ministry of Health and Family Welfare have also constituted a number of Purchase Committees/Purchase Advisory Committee(s) and Review Committees. The Purchase Committees are constituted for handling purchase of (a) drugs and medicines (b) equipment and stores (c) insecticides and larvaecides and (d) vaccines and contraceptives. The State Governments have not been delegated powers of procurement in any of the schemes of the Central Government including the Centrally Sponsored Schemes. All cases of purchase upto the value of Rs. 10 crore are decided by the respective Purchase Committees and cases in which the value of purchases exceeds Rs. 10 crore, the recommendations of the Purchase Committee are considered by the Secretary (Health and Family Welfare) upto Rs. 20 crore and by MoS/Minister in cases above Rs. 20 crore.

3. In addition to this, there is an attached office of the Department of Health and Family Welfare, called Medical Stores Organisation (MSO) which is entrusted with the task of procurement of drugs and medicines required for health care and research in various Central Government Hospitals and Dispensaries as well as implementation of various Disease Control Programmes. The MSO operates through seven Medical Store Depots (MSDs) located at Mumbai, Kolkata, Chennai, Hyderabad, Guwahati, Karnal and New Delhi. Besides the Procurement Cell of the Department and the MSO, the Central Government Hospitals have been assigned with the powers by the Ministry to procure drugs/medicines upto Rs. 50 lakh after a No Objection Certificate (NOC) is

obtained from the Medical Store Organisation, which is not required if the cost of drugs/medicines to be procured is up to Rs. 5 lakh. Autonomous bodies functioning under the Ministry *viz.* All India Institute of Medical Sciences (AIIMS), Post-Graduate Institute of Medical Education and Research (PGIMER), National Institute of Mental Health and Neuro Sciences (NIMHANS) etc. make purchase of medicines, drugs and medical equipment under a decentralized system. The responsibility for procurement of drugs/medicines for CGHS dispensaries in Delhi and under various Disease Control Programmes was outsourced to various PSUs *i.e.,* Hospital Services Consultancy Corporation Ltd. (HSCC), Bharat Immunologicals and Biological Corporation Ltd. (BIBC), Rail India Technical Economic Services Ltd. (RITES) etc.

4. Inadequate management of the pharmaceutical procurement procedures and operational principles for acquisition of medical equipment result not only in financial losses but also adversely affect the objective of providing diagnostic and therapeutic services to the public. The Audit carried out a performance audit of the procedure of procurement of medicines and medical equipment and gave their comments in Report No. 20 of 2007 for the year ended March, 2007. Some of the important observations made by Audit were as under:—

(i) During the years 2002-07, the expenditure on purchase of medicines and medical equipment constituted 13 to 16 per cent of the total expenditure of the Ministry. The total expenditure on supply of material was Rs. 6148.85 crore and on purchase of medicines and medical equipment it was Rs. 1388.46 crore during 2002-07, out of which the cost of medicines, materials and equipment procured through the MSO and DGHS (Procurement Cell) was 171.05 crore and Rs. 75 crore respectively during the corresponding period, which represented only 3 and 5 per cent of the total expenditure.

(ii) The basic objective of making procurement in large quantities *i.e.,* to achieve economies of scale, both under centralized and decentralized systems, was by and large not achieved. Various studies including a study made by the internal audit of the Ministry had brought out serious irregularities in the scheme of purchase of medicines from local chemists under CGHS.

(iii) The quality assurance procedures were not reliable as pre and post qualification procedures for eliminating sub-standard suppliers and performing targeted quality control testing had not been established. The practice of purchasing pretested medicines had become inoperative owing to bulk local purchases.

(iv) Standard good pharmaceutical practices were not established and entire procurement procedure was characterized by *ad-hoc* and arbitrary decisions.

(v) The basic requirement of developing formal written procedures using explicit criteria or key performance indicators for making procurement decisions was not met.

(vi) Management Information System (MIS) for tracking demand and supply of medicines and medical equipment has not been set-up either in manual or computerized environment for planning and managing procurement.

(vii) Instead of having a common essential drug list or a local formulary list for Director General of Health Services (DGHS) and Central Government Hospitals, separate formulary lists had been prepared by DGHS, All India Institute of Medical Sciences (AIIMS), Lady Harding Medical College (LHMC) Hospital and Jawaharlal Institute of Post Graduate Medical Education and Research (JIPMER), Ram Manohar Lohia (RML) and Safdarjung Hospitals did not have any formulary list at all.

(viii) Large scale purchases of medicines which were not included in the approved lists had been made by most of the organizations making the essential drug list unreliable.

(ix) Wide variations in the medicines actually included under various groups in the essential drug lists, across different institutions were observed.

(x) Techniques adopted for making accurate qualification of procurement requirements were not reliable.

(xi) The procedure adopted for acquisition of medical equipment suffered from improper planning, non-evaluation of full life-time costs before the acquisition of equipment, non-standardization of medical equipment, excessive provision or under provision of medical equipment across hospitals and absence of medical equipment libraries.

(xii) There were excessive delays ranging from 2 to 23 months in installation of medical equipment in the Central Government Hospitals after they were received.

5. Against this backdrop, the Committee took up the subject for detailed examination and report. In the process, the Committee had a briefing by the Comptroller and Auditor General of India and other Audit Officers. The Committee also obtained Background Note and Advance Replies from the Ministry of Health and Family Welfare. The representatives of the Ministry appeared before the Committee for tendering evidence on 14th August, 2008 and 28th January, 2010. Subsequently, the Post Evidence Replies were also obtained from the Ministry. Based on all these written and oral information, the Committee examined the subject in detail and identified certain critical issues, as enumerated below, in the entire procedure for procurement of medicines and medical equipment for the Central Government Health Scheme as well as Central Government Hospitals and Dispensaries.

II. Procurement procedure and codification of purchase manual

6. The pharmaceutical procurement procedures which were followed by the Ministry have been assessed and audited against the good pharmaceutical practices. The adequacy of procedures were also audited against criteria laid down in Rule 137 of the General Financial Rules of the Government of India which stipulate that each

authority exercising financial powers in respect of procurement would be responsible and accountable for efficiency, economy and transparency in matters relating to public procurement and for fair and equitable treatment of suppliers and promotion of competition in public procurement. Audit observed that none of the major Hospitals/ Institutes or other purchasing agencies in the Department had documented written procedures and practices on procurement. According to Audit, a Procurement Manual with detailed guidelines and standardized purchase procedures was not there in the Ministry. The MSO Manual which was prepared in 1979 had become outdated and was under revision. As there was no uniform and comprehensive Procurement Policy, guidelines and Purchase Manual, the system of procurement was quite often *ad-hoc* and there was no uniformity in the procedures followed by various subordinate offices.

7. Responding to the above observation of Audit, the Ministry clarified that consequent upon the above Audit observations, they had started following written procedures for all their procurement activities and as a result, the MSO Manual was in the final stages of revision. The preparation of its own Manual of purchase procedure had also been taken up by the Ministry.

8. Expressing their surprise over the functioning of MSO without any uniform and comprehensive procurement policy, the Committee desired to know the reasons for the delay in updating the MSO Manual of 1979 and the time by which the revision of the MSO manual would be completed. In reply, the Ministry stated that while it was a fact that the Manual of 1979 had become out dated in many respects and was in need of updating, it still contained very useful and appropriate guidelines for procurement of Medical Stores. The Ministry further submitted that a Committee had been constituted for the revision of MSO Manual. The said Committee was reported to be actively engaged in the exercise of completing draft updated manual. In the meanwhile, computerized system for inventory management of MSO linking with its indenters', quality control laboratories and suppliers was already in place using a website. The indenters had also placed online indents using the system. The compilations of the demands and supply orders for the same had also been placed online to the respective suppliers. The Ministry further stated that MSO was in the process of receiving supplies at Government Medical Store Depots (GMSDs) and verifying the receipts using bar code system in the GMSDs. The system included testing of samples at quality control laboratories, up loading reports, supply to the indenters and finally payment to be done online. Besides, MSO was largely catering to the requirements of procurement of medicines for Government Hospitals. In suitable cases, however, the MSO Manual was applicable to procurement of medicines in other institutions as well.

9. So far as procurement of equipment was concerned, the Ministry stated that the provisions of General Financial Rules (GFR) and the Manual of Purchase Policies and Procedures issued by the Ministry of Finance were sufficient. A separate Manual of Financial Management for All India Institute of Medical Sciences (AIIMS) was also under preparation. The Ministry also apprised the Committee that an information system to make the entire process of procurement of medicines by the MSO more reliable, accountable and free from corruption was likely to be completed in December, 2009.

10. In the evidence held in January, 2010, the Committee desired to know whether the codification of the Purchase Manual had been completed. In reply the Director DGHS submitted:—

> "The Revised Draft of the codified Purchase Manual has been completed. It is not yet bound and circulated as computerized input was to be added in it. I hope that this work will be completed in two-three months."

11. Regarding the finalization of the Manual of Financial Management on AIIMs, the Additional Secretary, Ministry of Health and Family Welfare submitted during evidence:—

> "As far as that manual is concerned, I am afraid it is stuck up because in the meantime it was realized that the computer based information system in AIIMS is unfortunately woefully inadequate. It was felt that if a manual is put in place, which only codifies the conventional drugs and which does not take into account the IT based solutions, it will be for all practical purposes a redundant manual. What is happening currently is that a computer aided and computer based system is being developed. So I am afraid the Manual on Financial Management which has been promised to this Committee may see the light of the day not before the end of this year (2010)."

12. In a post evidence reply, the Ministry stated that as an interim measure, the Institute Authorities has been requested to hire an expert to review the draft manual and to make such minimum amendments to enable the Institute to carry out its financial business onlines that might later facilitate a shift to an IT enabled system of financial management.

13. In response to a query of the Committee regarding the specific measures taken by the Ministry to make the entire exercise of procurement, distribution, storage etc. of medicines and medical equipment transparent, the Ministry replied that the following steps were taken in that direction:—

(i) Publication of Tender Notices, even those falling in the 'limited category' on the web site of the Ministry/the organization concerned.

(ii) On-line acceptance of indents in case of the Medical Store Organisation (MSO) with each indentor given user id and password for this accessibility to the web-based application *www.msotransparent.nic.in*

(iii) Gradual introduction of 'e-procurement'.

(iv) Efforts to make technical specifications of equipments as 'generic' or indicative as possible so as to make competition wider and transparent.

(v) Bar-coding of all drug supplies to the MSO which helps in uploading of data by Suppliers to website and online marking of medicines by MSO.

(vi) For procurement of medical equipments, Ministry of Health has prepared detailed compendium of technical specifications of 700 commonly used equipments and placed on website so that is available on public domain.

14. Asked to state categorically whether the Ministry were satisfied with the existing procurement procedure, the Secretary, Ministry of Health and Family Welfare submitted in evidence:—

> "While much has been done to streamline the procurement mechanism, we are conscious that there still exists ample scope for further improvement.....".

III. Local Purchase/Purchase of Medicines and Medical Equipment Outside Formulary List

15. Audit had pointed out that there was procurement of smaller number of medicines from the formulary list which indicated the non-comprehensiveness of the essential list of medicines as either all the medicines were not indented by the indenting department or these medicines were procured through local purchases.

According to Audit, CGHS dispensaries made extensive purchase of medicines from local chemists ignoring the quality and cost-effectiveness of these purchases Audit had further highlighted that under the centralized procurement system through MSO and consultants, the major suppliers were generally the well established large pharmaceutical companies who were provided discounts up to 40 per cent on MRP against which the local purchases were made whereas for medicines procured from small manufacturers and local chemists, discounts generally up to 3 per cent and in isolated cases up to 8 per cent only were allowed. In CGHS (Delhi) alone, based on the variation of 11.25 per cent in discount rates between the minimum discount rate of 20 per cent offered by the suppliers under the centralised purchases and maximum discount of 8.75 per cent offered by local chemists (20-8.75), the Department incurred extra avoidable expenditure of Rs. 41.21 crore (at the rate of 11.25 per cent of total payment of Rs. 366.33 crore made to ALCs during 2002—06) on account of the local purchases of medicines. Moreover, in the absence of a system of quality checks on the supply of medicines by ALCs, the quality of the locally purchased medicines were also not ensured by the Ministry.

16. Regarding local purchases of medicines prescribed by the Doctors, Audit observed that out of the total expenditure of Rs. 459. 21 crore on purchase of medicines for CGHS dispensaries at Delhi during the period 2002—06, the value of medicines purchased through local chemists was Rs. 366.33 crore which constituted 80 per cent of the total purchases. Similarly, the percentage of local purchase of medicines to total purchases in CGHS Hyderabad, Bangalore, Allahabad, Patna, Kolkata, Mumbai, Pune and Guwahati during the years 2002—07 ranged between 74 to 91 per cent respectively. Audit also pointed out that during 2002—07, local purchases constituted as large as 77 to 97 per cent of the total purchases in Smt. Sucheta Kriplani and RML Hospitals.

17. In the above context, the Committee desired to be apprised of the reasons for the unjustifiable high rate of local purchases of medicines as well as the purchases made outside the formulary list. In response, the Ministry clarified that due to seasonal variation of diseases and changes in prescription pattern, CGHS had to procure medicines outside the formularly. The Ministry further stated that loss worked out by audit was notional in view of need based medicines purchased for the patients in distress as per the specialist Doctor's prescription.

18. Not satisfied, when the Committee desired to know the rationale for adopting the local purchase system, a representative of the Ministry of Health and Family Welfare submitted in evidence:

> "Local purchase system was introduced to enable CGHS dispensaries to supply medicines to the beneficiaries, those medicines that were not in stock. Over the years, the system degenerated when CGHS was actually procuring 70 to 80 per cent of its medicines that were being given to the beneficiaries through local purchase and only 20 to 30 per cent from the centralized procurement. There were three reasons for this.
>
> Firstly, though we had a formulary howsoever old it may be, most of the medicines that were on the formulary did not have a rate contract.....and so, There was no procurement. If a doctor prescribed that medicine, the dispensary had to supply that.
>
> The second point was about the degeneration that crept in. We had no data base and we had no system to monitor what are the medicines that we were getting actually through local procurement because each dispensary was doing its own local procurement.
>
> Thirdly,.....large stocks were lying which were procured centrally in the dispensary stores but not being disbursed and getting expired. So what we analysed is the lack of data regarding procurement, distribution and inventory management of drugs. That is the root cause of out inefficiency in the system which was being exploited by certain vested interests apart from the fact that we pay more for medicines that are procured locally.....".

19. Asked to state the measures taken to remove the shortcomings and bring in efficiency, the representative of the Ministry stated:—

> ".....We started with the small pilot project in Delhi by computerizing Delhi CGHS dispensaries and today, all the dispensaries in Delhi with the lone exception of the one in Ghaziabad have been computerized and networked. Each doctor prescribes through the computer, we capture the data and so, we are building a data base. Pharmacists get online advice that this medicine has been prescribed for this patient. So, by the time you go there, it is available. Earlier, Pharmacists used to get a manually written indent which used to go to him after the dispensary is shut down. He would get the indent around four to five in the evening. He would conveniently tell us that we gave the indent late and that he was unable to source the medicines and that he would give them the third day. Now, the condition is that the chemist of that dispensary has also to be a part of the network. The moment the doctor in the dispensary clicks indent of a particular medicine, the chemist gets the intimation. At 1.30 p.m. when the dispensary shuts down, the chemist has the entire indent ready with him and he has to supply medicines by 7.30 or 8 in the morning. Otherwise, the system automatically generates a penalty on him. That has brought in a lot of discipline so far as timely supply of locally prescribed medicines is concerned."

20. The representative of the Ministry further stated that they started analyzing what were the medicines that they were buying so much from the local chemists and

why they could not procure them centrally. They did an analysis, identified about 88 dispensaries in Delhi and found that there were more than 500 drugs that were being commonly prescribed and were being largely procured through local purchase. They called out a list of about 262 medicines that were not in the formulary of the Medical Stores Organization but were being prescribed by the doctors and procured locally. They entered into a rate contract for all those medicines with the companies that manufactured them and authorized the dispensaries to place the indent directly with the companies after estimating the requirement every month through computerized projection. Payment was made centrally but supply and demand was local.

21. The Committee then desired to know the prescription pattern by doctors which reportedly led to excessive local purchases and the remedial measures taken by the the Ministry to refrain the doctors in prescribing drugs outside the formulary. In reply, the then Secretary, Ministry of Health and Family Welfare, submitted in evidence:

> ".....Basically, there are two types of drugs, namely proprietary drugs that are patented and are manufactured either by the patent holder or licensees of the patent holder, and there are generics that are off patented drugs. Generics are further divided into branded and non-branded categories.....Generics are usually much cheaper than proprietary drugs, and the non-branded drugs are usually cheaper than the branded drugs. We try to see that maximum purchases are made from generics and non-branded medicines, but there is a resistance from both the doctors as well as the patients as both have greater confidence in the efficacy of branded medicines.
>
> I receive a lot of complaints that the dispensary has supplied medicines that are not of the same name as the ones prescribed by the doctors to them. This is a very common complaint. In the USA, I am told that, the doctors have to prescribe drugs from amongst the lists given by the insurance companies and if they do not prescribe those drugs, then they are not covered by insurance. We are unable to impose such a discipline on our doctors."

22. Asked to indicate the impediments faced by the Ministry in imposing discipline on the doctors and measures taken to ensure proper prescription of medicines, the Secretary Ministry of Health and Family Welfare responded:—

> ".....All dispensaries in Delhi are now fully computerized and we can see what drug each doctor is prescribing and which drugs are being most frequently prescribed. We are now, therefore, moving towards basing out formularies on computer generated drug list. We are also now able to pull up doctors who are frequently prescribing expensive medicines."

23. In the same context, the Additional Secretary, Ministry of Health and Family Welfare submitted in another evidence:

> ".....Computerisation helps to monitor doctors who are prescribing various types of medicines.....Regarding certain doctors who were not willing to listen to us, I personally hold meetings with the specialists every quarter, share

with them the data that is available so that they can see what they are prescribing is available for scrutiny. Two of our doctors had to be produced before the Director-General of Health Services as we observed that their prescribing patterns were at variance with what normally is expected and corrective measures have to be taken.....".

24. In the same context, the Ministry in a written note submitted that meetings had been taken by the Director General Health Services with specialists to advise them to confine their prescription to the formulary. Circulars had also been issued in this regard by the Director, CGHS and also by the Ministry.

25. The Committee then asked whether the system of local purchase should be altogether dispensed with. In reply the Secretary, Ministry of Health and Family Welfare stated:—

"My response to it is 'No.' A 70-30 mix is a healthy ratio, that is 70 per cent bulk procured (and 30 per cent local purchase) and we need to provide the dispensaries some flexibility. If some odd medicines are not available, they should not tell the beneficiaries that they will not give the medicines if they have been prescribed. We would strive for a healthy ratio for 70-30 with minor fluctuations".

26. In another evidence, the Secretary, Ministry of Health and Family Welfare in response to a specific query of the Committee regarding the feasibility of making all the purchases in a centralized way, submitted:—

".....Yes, ideally if we can forecast the demand, give the list of medicines which are frequently prescribed, then we can make up all purchases by a centralized way."

27. When the Committee desired to know about the latest position on the percentage of local purchase, the Secretary, Ministry of Health and Family Welfare deposed during the course of evidence:

".....in the local purchases which was the main concern in the previous meeting, now constitute only 21 per cent of the CGHS procurement which was originally many years ago, 70 per cent..... ."

IV. Updation of formulary

28. Audit had pointed out that DGHS had adopted in March 1996 a list of 317 essential proprietary medicines, valid for two years for procurement of proprietary medicines by Medical Stores Organization. This list was extended from time to time up to 2004-05. Audit also observed that the formularies of drugs and medicines adopted by various institutions did not serve the intended purpose of economical and efficient procurement of medicines as they failed to include pharmaceuticals that were routinely required by medical practitioners.

29. Asked to state the process adopted for periodical updation of the medicine selections, the Ministry replied that there was no defined process adopted by them to update the medicine selections which could reflect new therapeutic options and needs. However, with the computerization of CGHS Delhi and maintenance of computer data

base for procurement of medicine through local chemists in the last one year, the process of identification of slow and fast moving medicine had become simplified in order to update the medicine selection. Medical Store Depots had already started using this data for the process of revising formularly for CGHS, Delhi.

30. When the Committee desired to know the last revision of the formulary lists, the Ministry replied that the formulary list was last revised on 21st August, 2007. In view of the fact that the formulary list was last revised in August, 2007, the Committee asked whether any definite time frame had been fixed to regularly revise the formulary list. In reply, the Ministry stated that while revision of formulary was regularly undertaken, no fixed periodicity was prescribed in the matter. The Ministry further stated that the draft of the revised CGHS formulary had been finalized and was under submission.

V. Absence of formulary list in Ram Manohar Lohia and Safdarjung Hospitals

31. According to Audit observation, Dr. Ram Manohar Lohia Hospital (RML) and Safdarjang Hospital (SJH) did not have any essential list of drugs and these hospitals indented for or purchased medicines directly on the basis of drug lists compiled every year on the basis of requisitions made by the Departmental heads.

32. On being asked about the failure on the part of Dr. Ram Manohar Lohia Hospital (RML) and Safdarjang Hospital (SJH) to maintain a formulary list, the Ministry stated that the Central Government Hospitals had a formulary of generic medicines for essential and non-essential drugs divided into Group A to H. The formulary was updated periodically in consultation with Head of the Departments and approved by the Medical Superintendent.

33. Not satisfied, when the Committee desired to hear the views of the Secretary, Ministry of Health and Family Welfare on the issue, she submitted in evidence:—

> "Much efficiency has been brought about in the functioning of the Medical Stores Depot and hospital level formularies of both RML and SJH. In this case, both the formularies have been updated and as advised by the Committee, they now have a formulary that they follow to procure their drugs."

VI. Role of Medical Stores Organisation

34. The main objective of establishing Medical Stores Organisation (MSO) was to meet the needs of various indentors including other Ministries in respect of medicines, surgical equipment and other medical supplies and manufacture drugs/medicines, as far as possible, in the manufacturing units under MSO. However, Audit pointed out that against the total expenditure of Rs. 6148.85 crore by the Ministry on supply of materials during 2002-07, the contribution of MSO in these purchases was only Rs. 171.05 crore which constituted about three per cent of the total expenditure. This indicated under utilisation of the manpower and physical resources provided to the MSO which has, by and large, failed to meet the abovesaid objectives as its role over the years was limited to procurement of small quantities of drugs/medicines indented by CGHS dispensaries outside Delhi, Central Government Hospitals and for para military forces (*viz*. CRPF, BSF, ITBP, etc.). Audit further pointed out that a significant reason

for poor performance by MSO in the procurement of drugs and medicines was the absence of a documented system for placing indents, consolidation of indents, issue of supply orders, procurement and supply etc.

35. Responding to the above observations of Audit, the Ministry clarified that the issue of computerization of procurement activities in all GMSDs and MSO had been taken up with the National Informatics Centre for inventory management, better linkage and transparency.

36. The Committee enquired about the measures taken for optimal utilization of manpower and resources by MSO. The Ministry replied that the functioning of MSO got reviewed by Expert Committees like Tata Consultancy, Ahluwalia Committee and Vaidyanathan Committee to streamline the functioning of the organization. Many of the recommendations of these committees concerning transparency of operations through IT based Management Information System (MIS) and procurement processes had been accepted by the Ministry and were under implementation by MSO.

37. Asked to elaborate the role of MSO in the procurement of medicines, the then, Secretary, Ministry of Health and Family Welfare submitted in evidence:—

> "Even in the 1940s and 1950s, ...the Medical Stores Organisation (MSO) was not only the exclusive agency for procurement of medicines and adjuncts like syringes and bandages for the Central Government Institutions, but it also catered to the bulk requirements of the States. Gradually, the State Governments acquired their own medicine procurement capabilities, but this did not relieve the MSO of much of its load as from the Second Plan onwards, the institution of centrally sponsored scheme was initiated with most of such schemes having a significant share of medicines as their components. The lead role of MSO, however, showed signs of dwindling from the late 1970 onwards..... ."

38. When the Committee desired to be apprised of the reasons for the decline in the role of MSO in the procurement procedure, the then Secretary, Ministry of Health and Family Welfare replied that many factors could be held responsible for the decline. Chief among them were the development of capabilities at the level of States so that even bulk of the requirements of the centrally-sponsored schemes could be met locally; a more widespread market of pharmaceuticals obviating the need for much centralized procurement; increasing outreach of CGHS beyond Delhi; emergence of tertiary healthcare system with its specialized needs which were best met at Hospital level; and wider acceptability of the rate contract system.

39. The Committee then enquired whether lack of efficient functioning of the MSO itself also contributed, apart from the above cited factors, towards its decline. In response the Secretary, Ministry of Health and Family Welfare submitted:—

> "..... To be very frank with you all, ... there was both system and human failure. Human failure was in terms of the integrity of the officers who were managing MSO as they failed to live up to the expectation that were given. There was a time when all the senior officers were under suspension or in jail or on court cases and MSO lost that leadership and those valuable years when it

was required to have changed its entire working position and today we have out of the 1100 people working in the MSO, there are hardly 13 to17 officers of the A&B grade. So, with this kind of very limited technical leadership and manned largely by Class IV and Class III (employees) you cannot expect very good organization structure..... ."

40. Expressing concern at such state-of-affairs in the MSO, the Committee querried about its utility and steps taken by the Ministry to revamp the organization. In reply, the Secretary, Ministry of Health and Family Welfare stated that a Central Procurement Agency, in the line of Tamil Nadu, was proposed to be set-up as an Autonomous Body headed by an Additional Secretary level officer. The proposal had gone for EFC and later it would go to the Cabinet and hopefully the Ministry would be able to establish their own professionalized comprehensive procurement agency.

41. The Secretary, Ministry of Health and Family Welfare continued:—

"The MSO will then definitely have to undergo a change. Their strength lies in the fact that they have in almost eight to ten places good storage facilities, they have land in their area; they have experienced people who can do inventory management..... We still need our own storage and inventory processing capability within the Ministry and therefore MSO is going to be trained to take on the responsibility of ensuring that whatever we procure in the Ministry actually reaches the last PHC (Public Health Centre) in the country. That is where the challenge is. Even by procuring it, whether we keep in Mumbai or in Chennai or deliver it to the district headquarters, we are not very sure whether it is still reaching the last outpost, the sub-centres and the PHCs and that is a task we would like to give to MSO. So, in the future months, you will see this change where procurement will be done through professionalized agencies contracted and set up by us in the entire inventory control management for vaccines, drugs and other equipment to be supplied to the States in kind..... will be taken up by the MSO besides keeping the stocks for any emergencies that we might need..... ."

VII. Monitoring of drug quality

42. Audit pointed out that there was no formal system of pre and post-qualification of the prospective suppliers to ensure procurement of medicines from suppliers of quality products. Since about 80 per cent of the medicines were bought from local chemists/suppliers in CGHS dispensaries and Central Government Hospitals, the standing instructions, from the Ministry that only pre-tested medicines were to be accepted from MSO/HSCC (Hospital Services Consultancy Corporation), had become redundant as local purchases did not allow the scope of drawing of samples of drugs for testing and their subsequent follow up.

43. Audit also pointed out that during the years from 2001-02 to 2006-07 in CGHS—Delhi, Pune and Kolkata and GMSD (Kolkata), 35 items of medicines were sent for laboratory testing on the basis of complaints received from the Chief Medical Officers and individuals. The laboratory testing reports had confirmed that these

drugs were of sub-standard quality. In two cases, the test report was submitted after a lapse of one year by which date the drugs/medicines had already been prescribed and administered to the 'beneficiaries'. Similarly, in 20 other cases, more than 70 per cent of the medicines had been administered to the beneficiaries before test results could be received. Besides, the Central Government Hospital and AIIMS had not drawn any samples for testing by Central Indian Pharmocopial Laboratory (CIPL), Ghaziabad which further violated the instructions of the Ministry.

44. In the above context, the Committee desired to know the measures taken by the Ministry to ensure proper quality assurance of drugs procured both centrally and locally. In reply, the Ministry stated that in respect of medicines procured in bulk, either through the MSO or the procurement support agent for (CGHS Delhi), there was prior inspection of the supplier. In case of local purchases on prescriptions of the specialists, such pre-procurement inspection was not possible. In such cases, however, the bonafides of the supplier were checked with reference to their past records as per the records maintained by the State Drug Controller. The Ministry further stated that in case of any complaints a sample was immediately sent for examination.

45. The Committee then asked whether the Ministry had put in place any formal system for checking the pre and post qualification of prospective suppliers to ensure procurement of quality medicines. In reply, it was stated that the Double Bid (Technical and Price) system being used provided adequate safeguards for ascertaining the eligibility and suitability of the bidders and the quality of supplies effected in the execution of the contracts. Using the formulary as the basis of initiating the bidding process not only ensured adequate technical qualifications but also served to check the quality of bulk supplies against these specifications.

46. In the same context, a representative of the Ministry stated in evidence:—

> ".....ever since we introduced the rate contract system in Delhi about one and a half years ago, we have tested more than 1650 samples based on a very planned and random sampling methodology and none of them have failed so far. We have today been able to improve the quality of medicines supplied from the CGHS dispensaries and we have been able to improve the situation. I will not say that we have achieved 100 per cent efficiency but we have been able to improve the timeliness in supply of medicines and that is the most important index of patient satisfaction from a CGHS dispensary."

47. The Secretary, Ministry of Health and Family Welfare supplemented:

> ".....there was a lot of concern about how we monitor the drug quality and supply of quality drugs throughout the country. It is a fact that has been engaging our attention also. For that reason, we had come up with a law under which we would be centralizing. The Drug Controller at Delhi would have the power of licensing drug companies and ensuring the quality product. This was supported by the Parliamentary Standing Committee. But the State Governments, almost everyone of them, have opposed the centralization of powers with the DCGI. So, unlike in America, we do not have a centralized FDA, we have not been able to

centralize the power. Every State Government has very inadequate number of inspectors, and the functioning of the Drug Controller in the State Governments is not as optimal as it could be."

48. In response to a specific query regarding measures taken/proposed to extend the system of testing medicines by the government laboratories to other States/Union Territories, as was being done in the National Capital Territory, the Ministry replied that under the Drugs and Cosmetics Act, a State Government could avail the spare facility in a government testing laboratory of another State by declaring a person from that laboratory as Government analyst for his State with the concurrence of the Government under which he was serving.

49. When the Committee desired to know whether the Government laboratories were well equipped to test all categories of drugs, the Ministry replied that Central Government Drug Testing Laboratories at Kolkata, Mumbai, Chennai, Guwahati and Kasauli were adequately equipped to test the drug samples sent to them. Two new adequately equipped laboratories were also being established at Chandigarh and Hyderabad.

50. Asked to state the position about the State Level Testing Laboratories, the Ministry informed that only 17 States had drug testing laboratories and even among these laboratories, onlyseven laboratories had the capacity to test all classes of drugs.

51. The Committee then asked about the measures taken by the Central Government to persuade/support the State Governments in upgrading/establishing drug testing laboratories. In reply, the Ministry stated that under a Capacity Building Project through World Bank, assistance was provided to the States to upgrade the testing facilities and establish New Drug Testing Laboratories in 23 States and UnionTerritories.

52. Regarding the prescription of any fixed timeline for the laboratories to furnish the test reports, the Ministry stated that in view of the large number of samples received by the Government Laboratories and the variations in time taken in testing of different categories of drugs, no time limit had been prescribed for furnishing Test Reports by the Government Laboratories.

VIII. Excess Procurement of Medicines and loss due to Expiry of Drugs

53. Audit review revealed that the orders for procurement of indents of five medicines purchased during 2003-04 were placed by CGHS (Delhi) with HSCC far in excess of actual requirements. This subsequently resulted in huge stockpiling of medicines worth Rs. 51.69 lakh with short shelf life at the close of the year 2003-04. In order to liquidate the huge stock of medicines with short shelf life, circulars were issued from time to time to all the dispensaries directing them to lift the stocks by placing indents. Bulks of these medicines were dispatched to various dispensaries between April 2004 to July 2004 by CGHS (Delhi). Scrutiny of the records of 17 dispensaries to which the excess quantity of medicines was unilaterally supplied revealed that quantity of the medicines supplied during that period exceeded the previous year stocks and consumption of these medicines, manifold.

54. Further, in seven Medical Store Depots and two CGHS stores, failure of the Department to periodically asses procurement requirements reasonably and accurately resulted in unwanted medicines worth Rs. 5.87 crore becoming time expired at the end of January 2007.

55. On being asked whether any responsibility was fixed for purchase of medicines far in excess of the requirement and also issue of medicines to dispensaries without indents, the Ministry replied that based on a complaint received about excess purchase of medicine by the then Joint Director,CGHS, Pune, the Ministry of Health and Family Welfare got the matter inquired into by a Committee of Senior Officers. The Central Vigilance Commission (CVC) was also consulted. The Commission recommended no action in view of the retirement of the Officer concerned on 30.6.2000 and the expiry of the four years' time limit under Central Civil Services (Pension) Rules, 1972. The case was referred back to CVC for reconsideration of their advice; the CVC, however, reiterated their earlier stand. The Department, however, disagreed with the CVC's decision and initiated disciplinary proceedings against the then Joint Director, CGHS, Pune. The case was subsequently re-examined in the Ministry and it was decided with the approval of the disciplinary authority to accept the advice of the CVC to drop the proceedings.

56. Asked to state the remedial measures adopted by the Ministry to ensure that medicines in excess of requirement were not purchased in order to avoid their expiry, a representative of the Ministry submitted in evidence:—

> "When we procure medicines, there are two conditions. Number one, the company will not supply us any medicine that does not have a shelf life of three-fourth of valid shelf life. The second condition which we have successfully negotiated is that, in case the drug expires, the company will take it back from us and replace it with fresh batch."

57. The Committee desired to know the steps initiated by the Ministry, besides the above cited conditions imposed upon the companies, to realistically assess the requirement of medicines. The representative of the Ministry replied in evidence:—

> ".....(Earlier) The procurement was done on an annual basis, but supplies were made on the basis of a quarterly indent which was subsequently generated by each dispensary. So, there was sometimes a total mismatch between what was annually indented and what was being actually asked for every quarter. In that situation ..... Drugs could lie in the store and not get distributed at all. That we have done away with. The indenting is now on-line both for CGHS as well as for Medical Stores Organisation..... ."

58. On the expiry issue, the representative of the Ministry further stated:—

> "..... Our supplies are tracked through bar-code system. If you would ask me as to what are the medicines that are nearing expiry, we can share with you the information at any given time on a real-time basis.....Expiry of medicines in our computerized system would be a thing of the past and if it would have to be occurred, it would not be an account of system failure, but it would be a deliberate human failure. I would stand by that."

IX. Appointment of consultants/contractors for procurement of medicines

59. Audit observed that the Department of Health and Family Welfare had engaged consultants from time to time for procurement of drugs and medicines required for CGHS dispensaries in Delhi and for other National Disease Control Programmes including externally aided projects. Even though these agencies were termed consultants, they were in fact contracted to carry out procurements. These agencies were appointed despite the existence of MSO, which had been allocated the function of procuring, stocking and supplying pharmaceutical supplies by the Ministry of Health and Family Welfare. Audit also observed that the task of procurement of medicines for CGHS Units in Delhi was assigned to M/s. Hospital Services Consultancy Corporation (HSCC) India,Noida for the year 2002-03 and onwards. Eventually, the Department entered into an agreement with M/s HSCC from November 2002 appointing it as consultant for procurement of drugs/medicines on consultancy fee of 4.5 per cent of the value of drugs procured and the term of contract was extended up to November, 2008. The reasonableness of consultancy fee of 4.5 per cent paid seemed to be doubtful as the Purchase Advisory Committee (PAC) of the Ministry had in their meeting held on July, 2005 observed that commission claimed by M/s HSCC was on a very high side and should have been 1 to 2 per cent in view of the job done by the procurement agency. The Joint Secretary, Vigilance Commission (VC) had also instructed Director CGHS in November 2005 to take up the matter for reducing the consultancy fee to 2 per cent at the time of the renewal of contract from December 2005. However, the fee was never reviewed or revised.

60. On being asked about the reasons for no reduction in the rate of consultation fee despite the observation of Purchase Advisory Committee and instructions of the Joint Secretary (VC) to Director, DGHS in this regard, the Ministry stated that it had been decided that the consultation fee shall be capped at 2.5 per cent+Service Tax and the same had been conveyed to M/s Hospital Services Consultancy Corporation (HSCC). Further, a Purchase Committee had been constituted in MSO to supervise the procurement of drugs and to explore the possibility of procuring the formulary drugs whose rates were approved by MSO, directly from the manufacturer.

61. The Committee desired to be apprised of the specific reasons for appointment of consultants/contractors for procurement of medicines. In reply, the then Secretary, Ministry of Health and Family Welfare, deposed in evidence:—

> ".....For procurement of medicines under some of the more important disease control programmes like TB, Malaria and Kala Azhar there are specialized arrangements involving consultants as procurement support agents mostly from the Public Sector Undertakings, like HSCC..... under the control of the Ministry of Health. These consultants fill the skill gaps within the programme execution organizations. There are certain issues concerning this category like the quantum of fees and the role these sources can play to build capacity within the client organizations. An empowered procurement wing has also been set up within the Ministry to coordinate procurement under externally aided projects and purchase of vaccines under the Universal Immunization Programme..... I would like to point out that some States like Tamil Nadu have made rapid strides

in building capacity and procurement of medicines through IT enabled state-of-the-art methodology. TNMSC, Tamil Nadu Medical Supplies Corporation, has made a particular name for itself in the field. We are currently examining whether a similar agency could be created at the central level also. We are trying to encourage States to set up similar procurement agencies like TNMSC. Several States are already in the process of doing so. It is all the more important because under the National Rural Health Mission, our mandate is to send money to the States and let the States do their own procurement. If these efforts succeed, it is possible that the role and relevance of the MSO will have to be revisited in future."

62. In the same context, the Secretary, Ministry of Health and Family Welfare deposed in another evidence:—

"..... Over the years, because the MSO could not live up to the expectation given and with the funding support coming from the external bodies,such as the World Bank, increasing the reliance on taking Public Sector Units, of course selected based on tender as our procurement agents, came in.....Now the position in the Ministry is that in the last two to three years, we have been trying to develop and professionalise our procurement system within our Ministry..... ."

X. Spurious drugs

63. On the basis of the irregularities and excess payments detected in the review of indents, bills and records of the chemists, Audit had *inter alia* pointed out that there was a possibility of spurious drugs being supplied in CGHS in addition to the leakage in the distribution system in CGHS and delay in processing the bills of local chemists.

64. Responding to the above observation, the Ministry of Health and Family Welfare appointed A.F. Ferguson and Company, a consulting company for carrying out a review of the CGHS. In their interim report in December, 2006, the Consultant had *inter alia* pointed out suspected formation of cartels of the local chemists, absence of a mechanism to track drugs procured from them but not issued to beneficiaries and delays of about six months in settlement of individual claims of the chemists.

65. On being asked about the action taken on the above mentioned issues, the Ministry stated possibility of supply of spurious drugs was checked through random samples of locally purchased medicines taken from the dispensaries for testing by Government approved laboratory to ensure that the beneficiaries were not being supplied spurious drugs. Leakage in distribution system was avoided/reduced by sealing the van loaded with medicines for distribution to dispensary from MSD and the same was opened only at the dispensary. In addition to this, surprise stock verification and periodical annual stock verifications were also carried out by Vigilance Division.

66. As regards the number of cases of involvement of firms/persons in manufacturing/selling spurious drugs that had come to the Notice of the Minstry

during the years 2005-06 to 2007-08, the following information was furnished to the Committee:—

Sl. No.	Year	No. of drug samples tested	No. of drug samples declared not of standard quality	No. of drug samples declared spurious/ adulterated	No. of prosecution launched for manufacturing, sale and distribution of spurious/ adulterated drugs	No. of cases (as mentioned in the earlier column) decided	No. of persons arrested
1.	2005-06	43138	2934	152	316	94	35
2.	2006-07	34738	2024	58	115	89	12
3.	2007-08	39117	2429	46	115	54	85

67. Asked to state the action taken against the firms/individuals found to have been involved in cases of spurious drugs, the Ministry replied that 8 products of different firms had been debarred for supply to MSO. Specific identified products of 3 items, which were found to be sub-standard, had been debarred for procurement by MSO; and products of 15 firms which were found to be sub-standard repeatedly, had been permanently debarred to supply their products to MSO.

68. When the Committee desired to know about the specific measures taken by the Ministry to curb the spread of spurious drugs, the Secretary, Ministry of Health and Family Welfare stated in evidence:—

> ".....now we have a full-fledged Federal Drug Authority set-up. We are recruiting 400 inspectors. We have brought in whistle blower policy to tell us about the spurious drugs. We also conducted a survey of 40,000 samples recently and tested in 24 laboratories. If I recall the data for spurious drugs it was 0.03 per cent or 0.10 per cent. So, it is not as prevalent and as rampant as it is being made out to be. It is a little sensitive topic for us because we are a major exporter of generic drugs. Internationally, there is also a movement to try and condemn all our generic drugs as spurious and counterfeit..... ."

69. As regards the mechanism put in place by the Ministry to keep vigilance and monitor the menace of spurious drugs, the Committee were informed that under the provision of the Drugs and Cosmetics Act, 1940, the State Governments were the licensing Authorities for manufacture and sale of drugs and were responsible for monitoring the quality of drugs moving in the market.

70. Categorically asked to state the measures taken by the Central Government to fight the menace of spurious drugs, it was replied that the following measures were taken in that direction:—

(i) The Drugs and Cosmetics Act, 1940 has been amended under Drugs and Cosmetics (Amendment) Act, 2008 and it has come in to force since 10th August, 2009. Under this Act stringent penalties for manufacture of spurious and adulterated drugs have been provided. Certain offences have been made cognizable and non-bailable.

(ii) Whistle Blower Policy has been announced by Government of India to encourage vigilant public participation in the detection of movement of spurious drugs in the country. Under this policy, the informers would be suitably rewarded for providing concrete information in respect of movement of spurious drugs to the regulatory authorities. The details of policy are available at the website of CDSCO (www.cdsco.nic.in).

(iii) Guidelines for taking action on samples of drugs declared spurious or not of standard quality in the light of enhanced penalties under the Drugs and Cosmetics (Amendment) Act, 2008 were forwarded to the State Drugs Controllers for implementation. The guidelines are available on the website of CDSCO (cdsco.nic.in).

(iv) In a survey conducted by CDSCO, under which 24,136 samples of 61 fast moving brands of 9 therapeutic categories were collected from sale outlets of different stratum *i.e.* metro cities, big cities, district H.Q., towns and villages, the extent of spurious drugs has been found to be 0.046% only.

71. As regards sale of CGHS drugs in the open market, the Secretary apprised the Committee in evidence:—

> ".....Except those supplied by the local chemists, every other medicine that is supplied from a dispensary is actually stamped that it is 'CGHS supply, not for sale'. However, we observed that there were cases where these stamps were obliterated. There were solutions brought in by employees and suppliers, where they were erasing the stamp on the medicine and then giving it out. That is the reason we have .....bar coding..... Currently, on the primary level, it is through a sticker, which is non-removable, we believe. But by April, 2010, it will be printed on the strip itself. A two-dimensional bar code sticker will be there, which will capture all the details. If it is in the market, one can very easily pick it up..... ."

72. Regarding precautionary measures taken to curb misuse of CGHS medicines, the representative of the Ministry stated:

> "Medicines were distributed through CGHS with marking in indelible ink. It is now proposed to introduce bar-coding for greater security. Further, a Standing Committee periodically visited Dispensaries to examine indents issued, their reasonsableness and their pattern of issue to beneficiaries. This exercise *inter alia* ensured early detection of pilferage and misuse of medicines."

XI. Strikes by chemists on delayed payment of bills

73. Audit scrutiny revealed that in the process of purchasing the medicines locally through Authorised Local Chemists (ALCs), there was delay in processing the bills of local chemists. The Ministry agreed that there were delays in settlement of claims of ALCs and accepted the fact that due to delay in payment of bills there were 3 instances of strikes by local chemists in the years 2005, 2006 and 2007.

74. When the Committee desired to know the reasons for delay in the payment of bills, the Ministry clarified that it occurred due to the non-availability of funds during

earlier years but the position had been improved as availability of funds became better with the result that the local chemists' bills were cleared within 4 to 6 weeks.

75. Asked to state additional measures taken to bring down the pendency period of bills, it was stated that with the computerization of CGHS dispensaries in Delhi and online connectivity with ALCs, the pendency of bills had come down. It was further stated that there had been no strike by ALCs in CGHS Delhi.

76. Commenting in the above context, the Joint Secretary, Ministry of Health and Family Welfare, deposed in evidence:—

> "Strikes by chemists in the CGHS are now history. The last strike that we had was in 2005. When payments were not made, the chemists went on strike because they were not getting payments and so, the supplies were held. We have, with the intervention of the Committee of Secretaries, been able to ensure timely allocation of funds to the CGHS. There has been no major strike, and therefore, no chemist has held back supplies on this ground that payments have not been made. We have a very formal system. Billing is generally done by the chemist one month after the supply of medicines. So, there is a time of about one month to one and a half month within which payment is made. But it is made in time. There is no complaint on that at all."

XII. Unauthorised expenditure on purchase of inadmissible items

77. Audit observed that MSO and CGHS Delhi made irregular and unauthorised purchase of cosmetics and toiletry items such as creams, lotions, mouth washes etc. amounting to Rs. 0.90 crore during 2003-04 to 2005-06 and issued these to CGHS beneficiaries. Further, an expenditure of Rs. 6.38 crore and Rs. 7.20 crore was made by MSO and CGHS, Delhi respectively during the same period on purchase of inadmissible tonics, vitamins and minerals in violation of the provisions of Civil Services (Medical Attendance) Rules, 1944. This resulted in irregular expenditure of Rs. 14.48 crore.

78. The Ministry, responding to the above observation by Audit, stated that Medical Attendance Rules were not applicable to CGHS beneficiaries. Not satisfied, the Committee desired to be apprised of the specific reasons and action taken to prevent unauthorized expenditure incurred on the above mentioned toiletry and cosmetic items. In reply, the Ministry stated that supply of lotions etc. was permissible under the CGHS, if these items were included in the formularies for branded and generic medicines of MSO. This was applicable to the CGHS also. It was further stated that there were two formularies (branded and generic) approved by the Competent Authority which were combined for MSO and CGHS. Any item figuring in this formulary, whether it was tonic, lotion or cream, was to be procured, if prescribed for the patients.

79. Further clarifying the position, a representative of the Ministry submitted in evidence:

> ".....we have removed them from the formulary now..... we have taken them out of the formulary, issued detailed instructions that in case they are prescribed— there will be certain reasons where a cream is prescribed because there is a

sunburn or there will be certain reasons where a mouthwash is prescribed—the specialist will prescribe it and the HoD will countersign it. Only then, it will be given. These instructions have been issued to take care of the concerns of the CAG as well as the PAC."

80. In a post evidence reply, the Ministry stated that such items were prescribed only in specific cases like oral cancer, skin burns and in such other rare cases where the treatment necessitated its prescription. In these circumstances, there was no room for any specific action against the Doctors or Hospitals concerned.

XIII. Inventory management and control

81. As mentioned earlier Audit pointed out that there was no roadmap for various stages of activities of a procurement process of medicines and medical equipment. Audit also pointed out that a uniform and comprehensive procurement policy, guidelines and Purchase Manual were not there and the systematic and orderly procedure for procurement and stocking of material that the setting up of the MSO was intended to achieve, was not realized. The poor performance of MSO in the procurement of drugs and medicines was due to the absence of a documented system for placing indents, consolidation of indents, issue of supply orders, procurement and supply etc.

82. In response to the Audit observation, the Ministry stated that the issue of computerization of procurement activities in all GMSDs and MSO had been taken up for inventory management, better linkage and transparency.

83. In this context, the Committee desired to be apprised of the measures taken by the Ministry to strengthen internal control and monitoring system. In reply, the Ministry of Health and Family Welfare stated that computerization of the CGHS, Delhi had been completed, except in four dispensaries, for internal control and online monitoring thereby exercising inventory control. The Ministry also stated that computerization of CGHS dispensaries outside Delhi had been commenced.

84. In the above context, the Secretary, Ministry of Health and Family Welfare deposed during the evidence:—

".....We are also able to do better in our inventory management. Since all of our dispensaries in Delhi are computer-enabled, the MSD (Medical Store Depot) of CGHS is able to get stock of medicines with each dispensary on time and is able to take advance action to replenish medicines which may be running out of stock so that a situation does not occur when mediciens are available from the formularies and bulk purchase but stock out in individual dispensary... ."

85. In the same context, another representative of the Ministry stated:—

".....The centralized procurement agency will get functional from April or May (2010). This whole system of computerizing the inventory control and supplies will be done, as is being done today in Tamil Nadu by the TNMIC Corporation. That has been in principle, agreed to by the Ministry. We just have to go through the motions of an EFC and a Cabinet Note. Once that comes in, we would be able to get the kind of information that the hon. MPs have been asking us, *viz.,* what kind of monitoring quality is there. We would get real data in real time."

86. So far as inventory management of local purchase is concerned, the representative of the Ministry submitted:—

> ".....In so far as the local purchase is concerned, the presumption has been that there would be no inventory of that because it comes one day and is handed over to the patient. So, there is no holding of the local purchase medicine theoretically. However, people do take time sometimes to come to the dispensary. The system has been so developed whereby there can be an inventory of medicines that have been procured locally for about eight to ten drugs and not beyond that.....Our drug movement has been computerized. Any day we can monitor which drug in which dispensary has gone below a threshold level..... ."

87. He further stated:—

> ".....this indenting is now on-line both for CGHS as well as for Medical Stores Organisation. We have acheived another success for purposes of inventory management. We have bar-coded all our supplies..... ."

XIV. Acqusition procedure for and shortage of medical equipment

88. Audit had pointed out that there was no long-term and well documented plan for procurement of medical equipment that had been prepared either centrally by the Ministry or at the level of individual hospitals. The hospitals had no documented system for assessing the need to acquire and replace medical equipment by analysing demand and usage information from medical equipment inventories and other sources of information including estimates of the volume of clinical demand. All acquisition cases, irrespective of value, contained very few details and were not made on a formal basis. There was no evidence to demonstrate that purchase decisions were taken after assessing the needs of the patients and were economically sound and affordable. Audit also observed that there was no system in place for compiling and consolidation of information on commonly used items of machinery and equipment in each hospital for their collective purchasing under one contract for obtaining economy from bulk purchase. Audit also revealved that the procedure adopted for acquisition of medical equipment suffered from improper planning, non-evaluation of full lifetime costs before the acquisiton of equipment, non-standardization of medical equipment, excessive provision or under provision of medical equipment across hospitals. There were underutilization of equipment and lack of skilled manpower.

89. The Ministry in their reply stated that the issue of identifying common items in Government hospitals, under a system of Joint Purchase Committee had been initiated and would be in place soon. The Ministry also stated that underutilization of equipment was due to non-availability of sufficient number of cardiologists and technical staff.

90. As regards action taken by the Ministry to formulate a long-term procurement plan at the Central level so as to consolidate and co-ordinate procurement needs of medical equipment of various hospitals and autonomous bodies, the Ministry responded that for a six AIIMS type institutions, which were under establishment, a common list of major equipments had already been drawn up. The Ministry also informed that it had

been decided to undertake common procurement of machinery and equipment having value above Rs. 10 lakh and below 1 crore by the 3 hospitals *viz*. Ram Manohar Lohia Hospital, Safdarjung Hospital and Lady Harding Medical College from the financial year 2010-11 so as to obtain economy in bulk buying and to avoid duplication of work. The distribution of work among the hospitals had been made discipline-wise. The Hospitals had been instructed to follow the spcifications as contained in the "compendium of specification" as far as possible so that there was standardization in procurement.

91. The Secretary, Ministry of Heatlh and Family Welfare, apprised the Committee during the course of evidence that the Centralized Procurement Agency would get functional from April or May (2010) for computerizing the inventory control for streamlining the procedure of procurement of medicines and medical equipment.

92. The Secretary, Ministry of Health and Family Welfare, further stated:—

> "In so far as the shortage of equipment is concerned, I did say that there is a very major shortage. As I said, again this is linked with the non-availability of the expertise that we need. Therefore, we are constrained in this..... ."

93. Asked to state the measures taken to employ adequate experts so that there was no shortage of equipment, the Secretary, Ministry of Health and Family Welfare replied:

> ".....Under this Five Year Plan, we are now strengthening it and also to see that all medical colleges have the required equipment so that they are also able to employ the experts. That is how we will have to increase the number of availability of these experts."

XV. Delay in installation of medical equipment

94. Audit scrutiny revealed that 39 items of equipment costing Rs. 31.94 crore received during 2004-05 to 2006-07 were installed after delays ranging from 2 to 23 months. In NIMHANS, Bangalore and National Tuberculosis Institute (NTI), Bangalore, equipment was installed after delays ranging from 10 to 54 months. Similarly, in March, 2005, Post Graduate Institute of Medical Education and Research (PGIMER), Chandigarh procured attachment of Haematology Analyzer at a cost of Rs. 18.37 lakh without procuring custom slides which were essential for operationalising the equipment as a result the equipment installed in August, 2005 had laid idle as of May, 2007.

95. Audit further pointed out that the test check of the records of PGIMER, Chandigarh revealed that the hospital had to incur extra avoidable expenditure due to delay in initiating procurement process, uncoordinated approach and indecisiveness on the procurement of equipment which resulted in the acquisition of the same meterial subsequently at higher rates.

96. Asked to state whether a definite time-limit had been prescribed for supply and installation of equipment, the Ministry stated that in the Procurement Cell of DGHS, the contracts placed with the suppliers had a fixed time-limit by which the

equipment were to be supplied and thereafter installed satisfactorily. This time-limit varied from case to case. The time required for installation also varied depending on the type of the Medical Equipment involved *i.e.,* whether it was low end/high end equipment. Contracts for supply and installation laid down time-limits and had stipulations for levy of penalty in the form of liquidated damages for delays and late performance.

97. As regards the monitoring mechanism evolved to ensure installation of equipment in a time bound manner, the Ministry stated that the instructions had already been circulated in 2007 to the Hospitals/Institutions to complete the process of obtaining administrative approval, financial sanction and technical evaluation in a time bound manner as per the time-limit laid down.

XVI. Overall Health Care System in the Country

98. The Committee were informed that as far as Central Government Hospitals were concerned, there was always room for improvement. The problem in these institutions was over-crowding and consequent pressure on infrastructure. The Committee were also informed that initiatives like introduction of the National Urban Health Mission, wider coverage of Medical Insurance and piloting Public-Private Partnership together with much higher budgetary allocations for the Health Sector should be the right steps to contemplate.

99. The Committee asked in evidence whether the Ministry was trying to give an impression that until the budgetary allocation or Public-Private Partnership were ensured, the situation would continue as it was. In response, the Secretary, Ministry of Health and Family Welfare stated:—

> "Sir, under the NRHM, we have received adquate funding, not adequate and that would be a wrong word to use, I would say, some definite scale of funding under the NRHM. So far as the primary health care centres and the district hospitals in the rural areas are concerned, today we are in much better position in terms of saying that drugs are available.
>
> Secondly, at every level of the primary health structure, whether it is the PHC or the Community Health Centres or the District Hospitals, we have constituted Committee and we have given flexible funding. For example, a sum of rupees one lakh is given for every Primary Health Centre where whatever shortage they have and if they feel that a particular drug is required, they can procure locally with that money. Our report shows that drug availability has improved. But..... in many of the backward States, our main problem is that we do not have doctors and adequate number of nurses and that continues to be a problem..... ."

100. Asked to quantify the shortage of doctors/specialists all over the country, the Secretary, Ministry of Health and Family Welfare deposed in evidence:—

> ".....The shortage is huge. In the Western countries, there is doctor-patient ratio of 1:280, but in India it is something like 1:2000. So, the demand for human resources is very large, even though we have 300 medical colleges; we have got 33,000 graduates coming out of these colleges every year. Still there is a shortage because the base is very large."

101. When the Committee desired to know the specific reasons for such huge shortage of doctors and the measures taken by the Ministry to get adequate number of doctors, a representative of the Ministry submitted in evidence that upto the year 2005, there was a ban on direct requirement. In the year 2005-06 the ban was lifted and the Ministry of Health was given permission to directly recruit doctors. The representative of the Ministry further stated:—

> ".....For bringing in additional manpower, the Ministry has prepared comprehensive plans. For the Lady Hardinge Medical College, more than 800 posts were sanctioned last year. These are in the process of filling up because the physical infrastructure of the Medical College and Hospital is being re-developed. Similarly, for the RML Hospital, a Post- Graduate institute has been set up. Thereagain, additional posts have been created. In the Safdarjung Hospital also, additional posts have been created. It is not that we have made one effort only. We are trying to take a holistic approach to retain manpower and to make the Central Health Services more attractive than what it has been in the past."

102. Asked to state the measures taken for ensuring availability of adequate doctors throughout the country, the Secretary, Ministry of Health and Family Welfare submitted:—

> "..... a sum of Rs. 1300 crore has been approved ..... We are going to give this money to the Government Medical Colleges. We have permitted them and sanctioned about 5,000 additional post-graduate seats. But so far, we have received requests for only 2,000 medical seats. We are reminding the State Governments ..... we are pushing the State Governments to avail this offer..... We have relaxed every conceivable rule under the MCI for a Government Medical College to create the PG seats..... ."

103. The Committee then enquired about the special attention paid by the Ministry towards rural, remote and backward areas where there was reluctance on the part of the doctors to be posted to. In reply, the Secretary, Ministry of Health and Family Welfare submitted in evidence:—

> " Sir, the remote areas have always been our concern, and it is largely because the medical doctors do not want to go to the rural and remote areas. It is a fact. That is a very major problem that we have. So, there are one or two issues that are being addressed. We have been able to convince the MCI. The Central Committee for Health and Family Welfare, for several years, has been recommending that the system of education of doctors is not relevant to the people's needs in the rural areas and there has to be some other form of education given where the doctors are incentivized to go to the remote and rural areas. Now, finally, the Medical Council of India has come around. They have developed a three-year short-term course for doctors to be appointed in sub-centres and in Primary Health Care Centres only. They will not be qualified to work beyond that but they will be able to address the primary needs of the rural people ..... I do hope that once that course gets recognized we will be really able to expand a

good quality primary health care to the people living in the remote and rural areas....."

104. As regards the shortage of specialists/experts and steps taken by the Ministry to bridge the gap, the Secretary, Ministry of Health and Family Welfare , apprised:—

"..... We do have a programme for scaling up services for hypertension, diabetics, cardiovascular diseases and cancers, which are really growing ..... But the reason why we are not able to scale up is because we do not have these experts. We need diabetologists, we need radiologists, we need radio therapists. There is a huge shortage..... So, for this reason, we are now working on a human resource policy where we are trying to convince the MCI and work with the NBE and others. To build certain flexibilities, we are working with IGNOU to try and see how they can train our own in-service MBBS doctors by certificate courses so that they can work in the community health centres for coping with these non-communicable diseases on the one hand and also increase the number of seats for Professor and Assistant Professor, to create the MDs in transfusion medicine, in radiotherapy and in these kinds of scarce disciplines....."

105. The Committee, then, desired to know whether it was not a fact that several hospitals in the country are in an appalling condition and the overall health care system in the country was suffering from several inadequacies. The Secretary, Ministry of Health and Family Welfare , replied in evidence:—

"..... We are more than aware that the health care system in our country has several inadequacies, and all I can say is that we are trying our best. We have been sincere to our task in trying to address those issues..... I agree with you, Sir, that that there are several hospitals which are in an appalling condition. All I can say is that you compare to the previous data of say a few years ago to now, which I will be happy to provide to you. Even in a State like Bihar or U.P. we do find that the uptake of public health facilities has remarkably improved under NRHM....."

106. She further stated:—

" ..... I would also like to say that to put the blame of disfunctionalism of the health system at the doors of the Central Ministry itself is not very fair because as you know, Sir, health is a State subject and the State Governments also have more than their share of responsibility for making the systems work...."

107. The Committee asked about the role of the Central Government in motivating the State Governments to improve the overall health care system. In reply, the Secretary, Ministry of Health and Family Welfare submitted:—

" ..... All that the Central Government can do and does is to provide them financial assistance and technical assistance ..... we give them all the help that they need....."

108. The Committee, expressing their surprise over the appalling condition of the overall health care system despite all the help from the Central Government, desire to

be apprised of the further move on the part of the Ministry to improve the situation. In response, the Secretary, Ministry of Health and Family Welfare submitted:—

> " ..... I fully agree with you, Sir, that there is a lot to be done but some improvements have taken place and we are working in partnership with the State Governments. I will show you the change. You do kindly trust us that in a few years we will be able to show you the change that we are trying to bring about....."

PART II

OBSERVATIONS AND RECOMMENDATIONS

1. Procurement of medicines and medical equipment is carried out by the Ministry of Health and Family Welfare for the implementation of various Disease Control Programmes, Central Government Health Scheme (CGHS) and for providing essential health care facilities to the people in Central Government Hospitals, Research Bodies and Institutes. There is a network of 331 dispensaries (246 Allopathic; 32 Ayurvedic and 53 others), 19 Polyclinics, 65 Laboratories and 17 Dental Units through which the Directorate General of Health Services (DGHS), an attached office of the Department of Health and Family Welfare, is responsible for implementing the Central Government Health Scheme that provides comprehensive medical care to the Central Government employees, pensioners and members of their families and other beneficiaries. A Procurement Cell under the DGHS is responsible for procuring machinery and equipment valued at Rs. 50 lakh and above. The machinery and equipment costing less than Rs. 50 lakh is procured by the respective hospitals and other subordinate offices after necessary financial assistance is accorded by the competent authority. The Ministry have also constituted a number of Purchase Committees/ Purchase Advisory Committee (s) and Review Committees. Among these the Purchase Committees are responsible for purchasing drugs and medicines, equipments and stores, insecticides and larvaecides and vaccines and contraceptives. The cases of purchase upto the value of Rs. 10 crore are decided by the respective Purchase Committees and cases where the value of purchases exceeds Rs. 10 crore, the recommendations of the Purchase Committee are considered by the Secretary (Department of Health and Family Welfare) upto Rs. 20 crore and by the Minister of State (MoS)/ Minister in cases above Rs. 20 crore. Apart from this, there is an attached office of the Department of Health and Family Welfare called the Medical Stores Organisation (MSO) which is entrusted with the task of procurement of drugs and medicines required for health care and research in various Central Government Hospitals and Dispensaries and Implementation of various Disease Control Programmes, whereas the autonomous bodies functioning under the Ministry *viz*. AIIMS , PGI, NIMHANS etc. make purchase of medicines, drugs and medical equipment under a decentralized system. The responsibility for procurement of drugs/ medicines for CGHS dispensaries in Delhi and under various Disease Control Programme has also been outsourced to various PSUs. The Committee's examination of the subject has revealed certain disquieting aspects including deficient procurement procedure and inadequate inventory control management as highlighted in the succeeding paragraphs.

2. The Committee are surprised to note that prior to the Audit review of the system adopted by the Ministry of Health and Family Welfare for procurement of medicines and medical equipment , there were no uniform and comprehensive Procurement Policy Guidelines and Purchase Manuals. It is quite unbelievable that the Ministry responsible and accountable for efficiency, economy and transparency in the procurement of medicines and medical equipment including life saving drugs and high end machinery, did not follow any standardized purchase procedure for years together. It was not even thought prudent to timely revise the MSO Manual of

1979 which has become outdated. The Ministry's submission that a Committee has been constituted for the revision of the MSO Manual does not satisfy the Committee in view of the fact that such a move by the Ministry should have been initiated much earlier and certainly not after almost three decades of the existence of the MSO Manual. What is a matter of more concern is the callous attitude of the Ministry in finalizing the codification of the Revised Purchase manual. Despite an assurance given to the Committee that the codification process of the Revised Manual would be completed by December, 2009, the Ministry have not yet been able to do so on the plea that although the Revised Draft of the codified Purchase Manual has been completed, it has not yet been bound and circulated as some computerized input has to be added in it. This is something totally unacceptable to the Committee as it depicts an indifferent attitude on the part of the Ministry towards such an important issue. Although the Ministry are reportedly taking a number of measures like publication of Tender Notices on the website, on-line acceptance of indents and gradual introduction of e-procurement, yet there still exists ample scope for further improvement in the procurement system, as admitted by the Secretary, Ministry of Health and Family Welfare. The Committee feel that the first and foremost step towards improving the procurement process is to follow a standardized purchase procedure. And that can be done only when there is a codified Purchase Manual. They, therefore, impress upon the Ministry to urgently bring in the codified Purchase Manual so as to ensure that the entire procurement process becomes more reliable, accountable and transparent.

3. The Committee are concerned to note that the Manual on Financial Management of All India Institute of Medical Sciences is stuck up as the computer based information system is woefully inadequate in AIIMS. As an interim measure, the Institute authorities have been asked to hire an expert to review the draft manual and make such minimum amendments so as to enable the Institute to carry out its financial business on line that might later facilitate a shift to an IT enabled system of financial management. It is really a sorry state of affairs that at this age of advanced information technology evolution, that has penetrated almost every walk of life, a computer aided information management system is inexplicably deficient in a super speciality hospital like the AIIMS. It will be indeed, for all practical purposes, a redundant Manual if it only codifies the conventional drugs and does not take into account the IT based solutions as submitted by a representative of the Ministry during evidence. The Committee, therefore, recommend that urgent measures be taken by the Ministry to develop a computer aided and computer based system in AIIMS so that the premiere Institute is able to take into account the IT based solutions besides codifying the conventional drugs, thus appropriately shifting to an IT enable system of effective financial management.

4. The Committee find that during the period 2002-06, out of the total expenditure of Rs. 459.21 crore on purchase of medicines for CGHS dispensaries at Delhi, the value of medicines purchased through local chemists was Rs. 366.33 crore which constituted 80 per cent of the total purchases. Similarly, the percentage of local purchase of medicines to total purchases in CGHS Hyderabad, Bangalore, Allahabad, Patna, Kolkata, Mumbai, Pune and Guwahati ranged between 74 to 91 per cent during the year 2002-07. Further, during the same period local purchases in Smt. Sucheta

Kriplani and Ram Manohar Lohia Hospitals constituted as large as 77 to 97 per cent of the overall purchase of medicines. The Committee are given to understand that the local purchase system was introduced to enable the CGHS dispensaries to supply to the beneficiaries those medicines which were not in stock. But over a period of time the system degenerated as would be gauged from the fact that CGHS was actually procuring on an average at least 70 to 80 per cent of its medicines through local purchase and only 20 to 30 per cent through centralized procurement. The Committee's examination of the subject has revealed that such degeneration crept in as there was no data base regarding procurement distribution and inventory management of drugs, for which no effective monitoring could be put in place to ascertain the reasons of large scale procurement through local purchases. Another shortcoming was that most of the medicines that were on the formulary, did not have a rate contract. All these factors led to inefficiency in the procurement system, as also candidly admitted by the senior officers of the Ministry during evidence. However, post Audit review and after this Committee took up the subject for detailed examination, the Ministry sprung to action and resorted to a number of measures to cut down the local purchases as well as to bring in efficiency in the procurement system. Such measures, *inter-alia,* include computerization of all the dispensaries in Delhi; culling out a list of about 262 medicines that were not in the formulary of the Medical Stores Organisation (MSO) but were frequently prescribed by the doctors and procured locally; entering into a rate contract for all these medicines with the companies that manufacture them; and authorizing the dispensaries to place the indent directly with the companies after estimating the requirement every month through computerized projection. The Committee are informed that as a result of the above cited measures initiated by the Ministry, the local purchase of medicines has come down to 21 per cent. But the moot point is that such measures should have been initiated much earlier. However, now that the Ministry have been able to identify the grey areas and are taking corrective measures, the Committee stress that the measures initiated should continue unabated and be extended to the CGHS dispensaries in other cities also to check large scale procurement of medicines through local purchases. An effective monitoring mechanism should be firmly put in place for regular oversight of the appropriate implementation of the measures initiated. Further, as there is scope for making all the purchases by a centralized way if the demand is forecast and the frequently prescribed medicines is kept track of, as admitted by the Secretary, Ministry of Health and Family Welfare, the Committee recommend that steps be taken by the Ministry accordingly to explore the feasibility of doing away with the local purchases altogether so that exploitation of the system by certain vested interests is prevented and higher payment towards locally procured medicines is checked. Results of the measures taken in this regard be intimated to the Committee from time to time.

5. The Committee are concerned to note that the prescription pattern by doctors has reportedly led to excessive local purchases of medicines. In this context, the Committee find that there are two types of drugs *viz*. proprietary drugs and generic drugs. Proprietary drugs are patented and are manufactured either by the patent holder or the licensees of the patent holder whereas generic drugs, both branded and non-branded, are off patented drugs and much cheaper than the proprietary drugs. Although the Ministry reportedly make efforts to see that maximum purchases are made from generic and non-branded medicines, doctors quite often prescribe expensive medicines which lead to large scale purchase of medicines outside the formulary. In this context, the Committee are informed that two of the CGHS doctors were produced before the Director General of Health Services (DGHS) after it was observed that their prescription pattern was regularly at variance with what is normally expected. Further, meetings have been taken by the DGHS with the doctors/specialists advising them to confine their prescription of medicines to the formulary. Moreover, circulars have been issued in this regard by the Director, CGHS and also by the Ministry. The Committee feel that these measures are in right direction to keep tabs on the unusual variances in the prescription pattern of the doctors concerned which lead to unnecessary local purchase of medicines. The Committee desire that the Ministry should earnestly continue with the measures already initiated besides exploring introduction of other innovative measures to check the prescription pattern of the doctors. The Committee also recommend that the monitoring mechanism be strengthened and exemplary action taken against the errant doctors, who take advantage of the helplessness of the patients and frequently prescribe expensive medicines outside the formularly, so that superfluous local purchase of medicines is avoided.

6. The Committee are dissatisfied that no defined process that has been adopted by the Ministry to update the medicine selections which could reflect the new therapeutic options and needs. The Ministry's statement, that the process of identification of slow and fast moving medicines has become simplified with the computerization of CGHS Delhi and maintenance of computer data, does not anyway convince the Committee as the formularies of drugs and medicines have failed to include pharmaceuticals that are routinely required by the medical practitioners. What further concerns the Committee is the fact that the formulary for essential and life saving drugs was last revised in August, 2007 and the Ministry's callous response that while revision of formulary is regularly undertaken, no fixed periodicity has been prescribed in the matter. The Committee wonder what restrains the Ministry in prescribing a defined process and a definite time frame for revision of the formulary and updation of the medicine selection. In view of the imperatives involved, the Committee urge upon the Ministry to codify and adopt a defined process for annual updation of the medicine selection and periodical revision of the CGHS formularies so as to ensure that the intended purpose of economical and efficient procurement of medicines is well served and the emerging therapeutic options and needs are appropriately catered to.

7. Absence of formularies entailing the essential list of drugs in Hospitals of repute like Dr. Ram Manohar Lohia and Safdarjung Hospitals is another grey area that came to the notice of the Committee in the process of the examination of the subject. Audit scrutiny revealed that these two hospitals did not have any essential list of drugs and they indented for or purchased medicines directly on the basis of drug lists compiled every year on the basis of requisition made by the Departmental Heads. The Secretary, Ministry of Health and Family Welfare apprised the Committee in evidence that both the Hospitals have started maintaining/updating the formularies which they follow to procure their drugs. It is surprising that such major Hospitals used to procure drugs without adhering to any formulary for years together and only after Audit pointed out the shortcomings and the PAC took notice of the matter, that the Ministry impressed upon the Hospitals to stem the rot. It implies lack of self discipline on the part of the Ministry as well as the Hospitals, to say the least. However, now that Dr. Ram Manohar Lohia and Safdarjung Hospitals have started following formularies for procurement of medicines, the Committee desire that there should not be any further aberrations in this regard. The Committee also impress upon the Ministry to carry out periodical inspections to ensure that all the CGHS hospitals/ dispensaries maintain their respective formularies and update them at regular intervals for purchasing/indenting essential drugs.

8. The Medical Stores Organisation (MSO) whose origin dates back to the 1940s was established with the main objective of meeting the needs of various indentors including other Ministries of the Government of India, in respect of medicines, surgical equipments and other medical supplies and manufacture drugs/medicines, as far as possible, in the manufacturing units under MSO. But the Committee are deeply concerned to note that MSO has failed to meet the above said objectives as its role over the years has been limited to procurement of small quantities of drugs/medicines intended by CGHS dispensaries outside Delhi, Central Government Hospitals and for para-military forces *viz*. CRPF, BSF, ITBP etc. The under utilization of the manpower and resources provided to MSO is quite visible from the fact that against the total expenditure of Rs. 6148.85 crore by the Ministry on the supply of materials/medicines during the years 2002 to 2007, the contribution of MSO in these purchases was only Rs. 171.05 crore which constituted a meagre three per cent of the total expenditure. The Committee are informed that the lead role of MSO in catering to the needs of various indentors showed signs of dwindling from the late 1970s onwards due to a number of factors which *inter-alia* include the development of capabilities of the States to locally meet the bulk of the requirements of the centrally-sponsored schemes; a more widespread market of pharmaceuticals obviating the need for much centralized procurement; increasing outreach of CGHS beyond Delhi; emergence of tertiary health care system with its specialized needs best met at the hospital level; and wider acceptability of the rate contract system. More than anything else, what contributed towards the rapid decline of the MSO, was both system and human failure, as candidly admitted by the Secretary, Ministry of Health and Family Welfare. The Committee are perturbed to note that at one point of time all the senior officers of MSO were under suspension or in jail or on court cases for which MSO lost the leadership and the valuable years when it was required to change its entire working strategy. Moreover, the organization is manned largely by Group III and IV employees as there

are hardly 13 to 17 officers of Group A and B grade working in MSO out of a total workforce of 1100 people. It would be an understatement to say that the state of affairs in MSO is in a complete mess and the organization needs an urgent revamp. Such restructuring of MSO seems more imperative in view of the imminent establishment of a professionalized comprehensive Central Procurement Agency by the Ministry which would further diminish the primary role of MSO *i.e.* to cater to the needs of various indentors for procurement of medicines and medical equipment. In view of the apparent relegation of MSO to the background so far as procurement aspect is concerned, the Ministry is reportedly planning to train the organization to take on the responsibility of the entire inventory control management. The Committee are of the opinion that the onus lies squarely with the Ministry to take effective measures in order to make the MSO corruption free as well as adequately staffed so that the organization is able to gradually shift its focus from procurement to management aspect of medicines and medical equipment, ensuring in the process its own gainful utilization.

9. The Committee observe that during the years 2001-02 to 2006-07, 35 items of medicines in CGHS—Delhi, Pune and Kolkata and Government Medical Store Depot (GMSD) (Kolkata) were sent for laboratory testing on the basis of complaints received from the Chief Medical Officers and individuals. The laboratory testing reports had confirmed the sub-standard quality of the drugs. In this context, the Committee are given to understand that the problem lies with the drugs that are procured locally where pre-procurement inspection is not possible. In other words, in respect of medicines procured in bulk in a centralized way, there is prior inspection of the supplier whereas local purchases do not allow the scope of drawing of samples of drugs for testing and their subsequent follow up. In such cases, only the bonafides of the suppliers are checked with reference to their past records available with the State Drug Controller. It is really shocking that such stopgap arrangement has been made to confirm the quality of drugs procured locally. The seriousness of the problem could be well gauged from those years when local purchases of medicines constituted about 70 to 80 per cent of the total purchases and the large number of CGHS patients who might have been administered sub-standard drugs during that period. However, when better sense prevailed upon the Ministry and they introduced the rate contract system in Delhi to cut down the local purchases, they have tested more than 1650 samples of drugs procured centrally on a very planned and random sampling methodology and none of them has reportedly failed the quality test so far. This is precisely why the Committee are keen to see that local purchases of medicines are altogether done away with or confined to the barest minimum as life saving drugs without quality assurance, emergency of the situation notwithstanding may prove to be counter productive. The Committee also desire that after restricting local purchases to absolute emergencies, till such time they are completely stopped, the Ministry should innovate some alternate effective measures, instead of just checking the bonafides of the suppliers from the past records, to test the quality of the medicines procured locally so that any possibility of administering sub-standard drugs to the patients in distress is eliminated.

10. The Committee are informed that the Central Government Drug Testing Laboratories at Kolkata, Mumbai, Chennai, Guwahati and Kasauli are adequately equipped to test the drug samples sent to them. Two new similar kind of laboratories are reportedly being established at Chandigarh and Hyderabad. The Committee, however, find that the position in this regard in various States is deplorable. For example, only 17 States have Drug Testing Laboratories and even among them, only seven laboratories have the capacity to test all types of drugs. Not only that, every State Government has grossly inadequate inspectors and the functioning of the Drug Controllers in various States is not as optimal as it should be. The Ministry on their part is providing assistance, under a Capacity Building Project through World Bank, to the States to upgrade the testing facilities and establish new Drug Testing Laboratories in 23 States and Union Territories. But the Ministry's move to centralize the monitoring mechanism to ensure the quality of drugs and their supply throughout the Country has not found favour with the State Governments and almost all of them have opposed the centralization of powers with the Drug Controller General of India. The Committee are well aware that Health is a State Subject. But when the State Governments have not been able to establish adequately equipped Drug Testing Laboratories and ensure optimal functioning of their respective Drug Controllers, despite getting financial assistance, they should not have any reservations over the centralization of drug testing mechanism, as contemplated by the Government of India. After all, it involves larger public interest. The Committee, therefore, recommend that the Ministry, besides providing assistance to the State Governments through the World Bank, should persuade them to establish adequately equipped Drug Testing Laboratories and concur on an effective centralized mechanism to monitor the drug quality so that both the Center and States are able to perform in unison towards a common cause of providing quality drugs throughout the Country.

11. The Committee are surprised to note that no time limit has been prescribed for the Government Laboratories to furnish the drug test reports on the plea of large number of samples received by these laboratories and the variations in the time taken in testing of different categories of drugs. The Committee are not inclined to buy the reason advanced by the Ministry for not prescribing any time limit for test reports as inordinate delay in furnishing such reports may invariably result in the administering of the contentious drugs to the patients before establishing their quality. The Committee's apprehension are well founded in the Audit observation that in two cases the test reports were submitted after a lapse of one year by which time the drugs had already been prescribed and administered to the patients. Further, in 20 other cases, more than 70 per cent of the medicines had been administered to the beneficiaries before obtaining the test results. As administering contentious drugs to the patients before assuring their quality defies the very purpose of test checks, the Committee exhort the Ministry to prescribe a definite time frame for the Government Laboratories to furnish the test reports so that slightest possibility of administering sub-standard drugs to the beneficiaries is altogether eliminated.

12. The Committee note that in seven Medical Store Depots and two CGHS stores, failure on the part of the Ministries/Departments concerned to periodically and realistically asses the procurement requirements resulted in unwanted medicines

worth Rs. 5.87 crore becoming time expired. The Committee further note that indents for procurement of some specific medicines was placed by CGHS, Delhi far in excess of actual requirements which resulted in huge stockpiling of medicines worth Rs. 51.69 lakh with short shelf life. In this context, the Committee find that earlier procurement was done annually whereas supplies were made on the basis of quarterly indents generated by each dispensary. In such a situation, there was sometimes a total mismatch between what was annually indented and what was actually asked for every quarter. However, now that the indenting has been made online for both CGHS and the MSO, the Committee desire that infructuous indenting/procurement of medicines is avoided and the gap between the projection and the actual utilization in bridged. The Committee also desire that the conditions imposed on the companies *viz*. to supply medicines which should have a shelf life of three-fourth of the valid shelf life and to replace the medicines on expiry with a fresh batch, should be continued unabted alongwith judicious projections for procurement with a view to preventing stockpiling of medicines and the consequent loss therefrom.

13. The Committee take note of the assurance given by the Ministry that the sale of medicines whose life has expired would be a thing of the past and if there would be such cases, then it would not be on account of system failure, but due to deliberate human failure. In such an eventuality, the Committee urge upon the Ministry to fix responsibility and take stringent action against the errant/delinquent officials so that it acts as a deterrent for deliberate callous or malafide attitude towards the assigned responsibility.

14. The Committee note that as the MSO could not live up to the expectation in discharging its allocated function of procuring, stocking and supplying pharmaceuticals and with the funding support coming from external bodies like the World Bank, the Ministry has been engaging consultants, mainly from Public Sector Undertakings, from time to time for procurement of drugs/medicines required for CGHS dispensaries in Delhi and for other National Disease Control Programmes including externally aided projects. Even though these agencies are termed 'consultants', they are in fact contracted to carry out the procurements. In this context, the Committee find that the task of procurement of medicines for CGHS units in Delhi has been assigned to Hospital Services Consultancy Corporation (HSCC) with effect from November 2002 for a period of six years on a consultancy fee of 4.5 per cent of the value of drugs procured. The Committee are informed that the reasonableness of the consultancy fee paid to HSCC appeared doubtful in view of the Purchase Advisory Committee's observation in its meeting held in July, 2005 that the commission paid to the company was on a higher side and it should have been 1 to 2 per cent, taking into consideration the job done by them. The Joint Secretary, Vigilance Commission had also instructed the Director, CGHS in November, 2005 to take up the matter for reducing the fee to 2 per cent at the time of renewal of the contract during December, 2005. The Committee are surprised to find that despite the Purchase Advisory Committee's observation and the Joint Secretary, VC's instructions in 2005 to downwardly revise the consultancy fee of HSCC, no action was taken till 2007. Only after Audit pointed out the shortcomings and the Committee took up the subject for examination that the Ministry informed that the consultation

fee shall be capped at 2.5 per cent plus Service Tax and the same has been conveyed to HSCC. In this context, the Committee would like to be apprised of the specific reasons for allowing higher consultancy fee to the extent of at least 5 per cent than what was suggested by the Purchase Advisory Committee and the Joint Secretary, VC. The Committee would further like the Ministry to inform them whether the consultancy fee was reduced at the time of renewal of the contract from December, 2005 as instructed by the JS (VC) and in case of deviation, if any, the action taken by the Ministry to fix responsibility. In view of the fact that the Ministry are making efforts to develop and professionalise their procurement system within the Ministry itself, to oversee and coordinate the entire procurement process under the externally aided projects and purchase of vaccines under the Universal Immunisation Programme, the Committee would like to impress upon the Ministry to revisit their decision to appoint consultants/contractors on commission basis for the purpose.

15. The Committee are happy to note that some States like Tamil Nadu have made rapid strides in capacity building and procurement of medicines through IT enabled State-of-the-art methodology and made a distinct name for themselves in the field. The Ministry, on their part, besides considering the creation of an agency on the line of Tamil Nadu Medical Supplies Corporation (TNMSC) at the Central Level, are also encouraging the States to set up similar procurement agencies. The Committee are informed that under the National Rural Health Mission, the Ministry's mandate is to provide financial assistance to the States and let the States do their own procurement. In such a scenario, encouraging the States to create IT enabled and professionalized procurement agencies by emulating TNMSC is a move in the right direction. But the responsibility of the Ministry does not just end there. The Committee desire that the Ministry should undertake periodical comparative studies of the progress made by different States in the establishment of State-of-the-art procurement agencies and based on the findings of the studies, the laggard States should be constantly cajoled to do the needful for their own benefit.

16. The Committee also recommend that the Ministry should expidite setting up of an IT enabled State-of-the-art procurement agency at the Central Level, taking the cue from the TNMSC, so that the procurement procedure is streamlined and the whole system of inventory management and control strengthened.

17. The Committee note that during the years 2005-06 to 2007-08, out of 1,16,993 drug samples tested, 7,387 samples were declared not of standard quality and 256 samples were found to be spurious/adulterated. As regards action taken against the firms/individuals found involved in the manufacture and supply of substandard and spurious drugs, the Committee are informed that 8 adulterated products of different firms and specific identified sub-standard products of 3 firms have been debarred for supply to MSO. Similarly, products of 15 firms which were repeatedly found to be sub-standard have been permanently debarred to supply their products to MSO. Further, prosecution has been launched against 546 firms for manufacturing, sale and distribution of spurious/adulterated drugs and 132 persons have been arrested. In view of the above facts and figures, the Secretary, Ministry of Health and Family Welfare's deposition, that the menace of spurious/adulterated drugs is not as prevalent and as rampant as it is being made out to be, does not hold

good. Similarly, his statement on an international movement to condemn all the Indian generic drugs as spurious and counterfeit does not convince the Committee as evidence of adulterated/spurious drugs being sold in the sales outlets of metro cities, towns, district headquarters and villages have been established in a survey conducted by the Central Drugs Standard Control Organisation (CDSCO). That the extent of spurious drugs has been found to be 0.46 per cent only on the basis of the aforesaid survey as reported by the Ministry, is a matter of little consolation. The Committee are of the firm opinion that the element of adulteration in drugs should be absolutely non-existent and there should be zero tolerance on the part of the Government towards spurious drugs. In other words, it is only after the firms/persons involved in the manufacture, supply and distribution of spurious/adulterated drugs, are dealt with iron hand to wipe out the menace of such drugs, can the Government defend themselves on the international fora. The Committee, therefore, urge upon the Ministry to intensify the measures initiated which *inter-alia* include recruitment of 400 inspectors, amendment of the Drugs and Cosmetics Act and introduction of the Whistle Blower Policy and ensure their effective implementation so that stringent penalties are imposed for manufacture and supply of spurious and adulterated drugs.

18. As regards the pilferage and misuse of CGHS medicines, the Committee are concerned to find that there have been cases where some employees of CGHS in connivance with the suppliers tampered with the stamps on CGHS medicines for their sale in the open market and misuse. In order to counter that, the Ministry are reportedly contemplating introduction of a two-dimensional bar code sticker on the medicines. Besides, a Standing Committee has been entrusted with the responsibility of making periodical visits to the CGHS dispensaries to examine the pattern and reasonableness of issue of indents to the beneficiaries in order to ensure early detection of pilferage and misuse of CGHS medicines. As pilferage of CGHS medicines is a serious issue which deprives the genuine beneficiaries of the much needed drugs, the Committee impress upon the Ministry to resort to all possible foolproof measures to prevent the misuse of CGHS medicines besides taking stringent positive action against the CGHS employees and the suppliers who indulge themselves in such clandestine activities.

19. The Committee note that in the process of purchasing medicines locally through Authorised Local Chemists (ALCs), there was delay in processing the bills and settlement of claims as a result of which there were three instances of strikes by the ALCs in the years 2005, 2006 & 2007. The Committee are informed that the reasons for delay in the settlement of claims of the ALCs was non-availability of adequate funds in the earlier years. However, the position has reportedly been improved considerably in the recent years as the Ministry, with the intervention of the Committee of Secretaries, were able to ensure timely allocation of adequate funds to the CGHS. With the result, there has been no major strike by the ALCs in the recent years. As the delay in settlement in bills/claims leads to strikes and holding back of supplies by the ALCs greatly inconveniencing the bonafide CGHS beneficiaries, the Committee desire that there should not be any further let up in the provision of adequate funds to the CGHS so that bills/claims of the ALCs are timely processed and settled.

20. The Committee note that the MSO and CGHS, Delhi made irregular and unauthorized purchase of inadmissible tonics, vitamins, minerals and cosmetics and toiletry items such as creams, lotions and mouthwashes amounting to Rs. 14.48 crore during 2003-04 to 2005-06 in violation of the provision of Civil Services (Medical Attendance) Rules 1944. The Ministry have contended that the Medical Attendance Rules are not applicable to the CGHS beneficiaries and any items that figures in the formulary, approved by the Competent Authority, whether it is tonic, lotion or cream is to be procured, if prescribed for the patients. The Ministry's contention proved untenable as later on taking care of the concerns expressed by the C & AG and PAC, they have deleted the above mentioned inadmissible items from the formulary and issued instruction to provide such items only after the specialists prescribe them with proper reasons and the Head of the Department countersigns it. Thus, it is apparent that just because the said items have earlier been included in the formulary, these were issued indiscriminately for years together without sufficient reasons, resulting in unauthorized expenditure of crores of rupees. However, now that the toiletry and cosmetic items have been removed from the formulary, the Committee desire that these items be issued with proper justification based on the specialist's prescription and the competent Authority's approval so that there is proper adherence to the prescribed rules and procedures and regularization of expenditure.

21. The Committee regret to note that the procedure adopted for acquisition of medical equipment suffers from improper planning, non-evaluation of full lifetime costs before the acquisition of equipment, non-standardisation of medical equipment and excessive provision or under provision of equipment across hospitals. In short, no long term and well documented plan for procurement and utilization of medical equipment has been prepared either by the Ministry or by the individual hospitals. Consequent upon the above Audit findings, the Committee are informed that the issue of identifying common items in Government Hospitals, under a system of Joint Purchase Committee, has been initiated and would be in place soon. The Ministry have further submitted that it has been decided to undertake common procurement of machinery and equipment having value above Rs. 10 lakh and below Rs. 1 crore by RML and Safdarjung Hospitals and Lady Hardinge Medical College from the financial year 2010-11, so as to have economy in bulk buying and to avoid duplication of work. Moreover, for the six new AIIMS type institutions, which are under establishment, a common list of major equipment has already been drawn up. As regards shortage of medical equipment and non-availability of expertise, the Secretary, Ministry of Health and Family Welfare has admitted before the Committee that there is indeed a major shortage both in terms of equipment and experts and the Ministry are strengthening the system to ensure that all the Medical Colleges have the required equipment and the expertise. The Committee are of the opinion that all the above cited lacunae that have been persisting for years together are a pointer towards the apathetic attitude of the Government and the individual Hospitals towards prudent procurement and effective utilization of medical equipment. In view of the vital role played by the medical equipment and machinery in the provision of an adequate healthcare system, the Committee urge the Ministry to intensify the measures and strengthen their monitoring system so as to ensure that at least from now on a long term procurement

plan to consolidate and coordinate the needs of medical equipment of various Hospitals and Autonomous Bodies is put in place. The optimal utilization of the equipment procured after assessing the needs of the patients and ensuring economy and availability of experts assume greater importance in the provision of a sound health care system.

22. Abnormal delay in the installation of equipment procured by spending crores of rupees is another major issue that seriously engaged the attention of the Committee in the process of examination of the subject. Much to their consternation, the Committee find that there were delays even upto 54 months in installing the equipment. In one case, even after the equipment was installed, it could not be operationalised due to some procedural lapses as a result of which it remained idle for as long as two years. In another case, one hospital of repute had to incur extra avoidable expenditure to procure equipment due to delay in initiating the procurement process, uncoordinated approach and indecisiveness. The Committee are not satisfied with the Ministry's submission that the contracts placed with the suppliers stipulate a fixed time limit, which varies depending upon the type of equipment, for supply and satisfactory installation of equipment. Similarly, the Ministry's instructions to the Hospitals/ Institutes to complete the process of obtaining administrative approval, financial sanction and technical evaluation within a definite time frame have failed to yield the desired result, as is corroborated from the above cited facts. In other words, had the contractual stipulations been properly honoured and the instructions appropriately adhered to, there would not have been delays of more than four years in the installation of the equipment. The Committee, therefore, impress upon the Ministry to make the contractual obligations more stringent and impose exemplary penalties for late supply and unsatisfactory installation of the equipment. Simultaneously, responsibility be fixed upon those Hospitals/Institutes/Autonomous Bodies, which in violation of the instructions of the Ministry, do not complete the procedural formalities within the prescribed time limit. The Committee also desire that the Ministry should strengthen their monitoring mechanism so as to ensure that the purpose of procurement and installation of medical equipment is well served.

23. It is a matter of serious concern for the Committee to take note of the statement of the Secretary, Ministry of Health and Family Welfare that the health care system in the country has several inadequacies and many of the Government Hospitals are still in an appalling condition, although some improvements have taken place in recent years due to reported sincere efforts of the Ministry. In this context, the Committee find that some of the main reasons for the unsatisfactory health care system are over-crowding and consequent pressure on the infrastructure and most importantly huge shortage of doctors. The Committee are informed that in the Western Countries, the doctor-patient ratio is 1:280 whereas in India, it is something like 1:2000. The position in the rural and remote areas is more pathetic due to the unwillingness of the doctors/specialists to be posted there. In order to overcome the problem of huge shortage of doctors, the Ministry are reportedly taking a number of measures which *inter-alia* include creation of additional posts in the Lady Hardinge Medical College and RML and Safdarjung Hospitals; sanctioning Rs. 1300 crore to the Government Medical Colleges in various States for creation of about, 5,000

additional Post-Graduate seats; developing an exclusive three year short-term course, with the initiatives of the erstwhile Medical Council of India, for doctors to be appointed only in sub-centres and Primary Health Care Centres to cater to the needs of the people living in the rural and remote areas; tieing up with other organizations like National Board of Examination (NBE) and Indira Gandhi National Open University (IGNOU) to get experts like Diabetologists, Radiologists and Radio Therapists and train the in-service MBBS doctors to work in Community Health Centres; and working in partnership with the State Governments to improve the overall health care system in the country. The Committee feel that the abovesaid measures initiated by the Ministry are well directed towards meeting the huge shortage of doctors and specialists/experts throughout the country, especially in rural and remote areas. In this context, the Committee appreciate the confidence exuded by the Secretary, Ministry of Health and Family Welfare that in a few years the Ministry would be able to show the improvements by dint of the measures undertaken by them. The Committee trust and hope that the efforts of the Ministry will continue unabated and bear fruit soon in noticeably improving the much maligned health care system in the country.

24. It is pertinent to note that the population of the country has increased manifold during the last two/three decades whereas on the other hand, the Government Hospitals are already overburdened as opening up of new Hospitals has not kept pace with the surge in the population. The Committee would, therefore, like the Ministry to make a comparative study of this situation and based on its findings, urgent suitable measures should be initiated to establish new Government Hospitals especially in those areas where the existing Hospitals are overburdened or facilities of such Hospitals are non-existent. The Committee desire that by taking up the matter at the appropriate level sufficient funds should be made available for the purpose. As mere opening up of new Hospitals will not serve the purpose, the Committee also desire that adequate availability of medicines, State-of-the-art equipment and most importantly docotors/nurses be ensured with a view to catering to the needs of a large number of patients and coming up to their expectation. The Committee be periodically apprised of the specific initiatives taken by the Ministry in this regard.

25. To sum up, the Committee find that there has been no uniform and standardized purchase procedure for procurement of medicines and medical equipment; the objective of the introduction of the local purchase system has been largely abused; no defined process has been adopted to update the medicine selections; major hospitals have not been able to prepare essential list of drugs; the primary role of MSO to cater to the needs of various indentors for procurement of medicines and medical equipment has diminished over the years; no fixed time limit has been prescribed for obtaining the Test reports on contentious drugs; all the States do not have the Drug Testing Laboratories and many of the Laboratories do not have the capacity to test all types of drugs; there has been huge gap between the projection and actual utilization of medicines leading to unnecessary stockpiling of medicines and wastage of money; several samples of drugs have been found to be sub-standard and adulterated/spurious; there have been instances of pilferage and misuse of CGHS medicines and purchase of inadmissible tonics, vitamins, minerals, cosmetics and toiletry items; the procedure adopted for acquisition of medical equipment suffers

from improper planning and disjointed approach; abnormal delay has been noticed in the installation of medical equipment; there is huge shortage of doctors and specialists throughout the country; and the overall health care system is far from satisfactory. The Committee urge the Ministry to plug the loopholes and take timely corrective measures as suggested by the Committee in the preceding paragraphs and constantly endeavour, in unison with the State Governments, to provide an adequate and sound health care system throughout the country, paying special attention towards the rural, remote and backward areas.

NEW DELHI;
21 *February,* 2011
2 *Phalguna,* 1932 (*Saka*)

DR. MURLI MANOHAR JOSHI,
Chairman,
Public Accounts Committee.

APPENDIX-I

MINUTES OF THE FIFTH SITTING OF THE PUBLIC ACCOUNTS COMMITTEE (2008-09) HELD ON 14TH AUGUST, 2008.

The Committee sat from 1100 hrs. to 1315 hrs. on 14th August, 2008 in Committee Room "C", Parliament House Annexe, New Delhi.

PRESENT

Prof. Vijay Kumar Malhotra — *Chairman*

MEMBERS

Lok Sabha

2. Shri Furkan Ansari
3. Shri Vijay Bahuguna
4. Shri Khagen Das
5. Shri Bhartruhari Mahtab
6. Prof. M. Ramadass
7. Shri Rajiv Ranjan 'Lalan' Singh
8. Shri Kharabela Swain

Rajya Sabha

9. Shri Raashid Alvi
10. Shri Prasanta Chatterjee
11. Shri B.K. Hariprasad
12. Prof. P.J. Kurien
13. Dr. K. Malaisamy

SECRETARIAT

1. Shri A. Mukhopadhyay — *Joint Secretary*
2. Shri Gopal Singh — *Director*
3. Shri M.K. Madhusudhan — *Deputy Secretary-II*
4. Shri Ramkumar Suryanarayanan — *Deputy Secretary-II*

Officers of the office of the Comptroller and Auditor General of India

1. Shri A.K. Thakur — DG ACR
2. Shri Nand Kishore — Pr. Director (RC)

Representatives of Ministry of Health and Family Welfare (Department of Health and Family Welfare)

1.	Shri Naresh Dayal	Secretary
2.	Dr. R.K. Srivastava	Director General of Health Services
3.	Shri Naved Masood	Additional Secretary & Financial Adviser
4.	Shri Vineet Chawdhry	Joint Secretary
5.	Smt. Shakuntala Gamlin	Joint Secretary

2. **** **** **** ****

3. Thereafter, the Committee proceeded to take oral evidence of the representatives of Ministry of Health and Family Welfare (Department of Health and Family Welfare) on C&AG's Report No. 20 of 2007 (Civil-Performance Audit) relating to "Procurement of Medicienes and Medical Equipment". The representatives of the Ministry of Health and Family Welfare (Department of Health and Family Welfare) were called in and the Committee commenced oral evidence on the subject. The Secretary, Ministry of Health and Family Welfare (Department of Health and Family Welfare) after introducing his colleagues to the Committee, gave a brief account of the corrective action taken by the Ministry with regard to Audit findings. The Members then sought clarifications on various points arising out of Audit Report and the background note furnished by the Ministry of Health and Family Welfare (Department of Health and Family Welfare). The evidence on the subject remained inconclusive and the Committee decided to hold another sitting on the subject after the receipt of written replies from the Ministry on the points/queries raised by the Members.

4. A copy of the verbatim proceedings of the sitting has been kept on record.

The Committee then adjourned.

*** Matter does not pertain to this Report

APPENDIX-II

MINUTES OF THE EIGHTH SITTING OF THE PUBLIC ACCOUNTS COMMITTEE (2009-10) HELD ON 28TH JANUARY, 2010

The Committee sat on Thursday, the 28th January, 2010 from 1130 hrs. to 1415 hrs. in Committee Room 'C', Parliament House Annexe, New Delhi.

PRESENT

Shri Gopinath Munde — *Chairman*

Lok Sabha

2. Shri Anandrao Vithoba Adsul
3. Dr. Baliram
4. Shri Khagen Das
5. Shri Naveen Jindal
6. Shri Satpal Maharaj
7. Shri Bhartruhari Mahtab
8. Kunwar Rewati Raman Singh
9. Shri Yashwant Sinha
10. Shri K. Sudhakaran
11. Shri Aruna Kumar Vundavalli

Rajya Sabha

12. Shri Prasanta Chatterjee
13. Shri Sharad Anantrao Joshi
14. Dr. K. Malaisamy
15. Prof. Saif-ud-Din Soz

SECRETARIAT

1. Shri Ashok Sarin — *Joint Secretary*
2. Shri Raj Shekhar Sharma — *Director*
3. Shri M.K. Madhusudhan — *Additional Director*

4.	Shri Sanjeev Sharma	—	*Deputy Secretary*
5.	Shri D.R. Mohanty	—	*Under Secretary*

Representatives of the office of the Comptroller and Auditor General of India

1.	Shri Vinod Rai	—	Comptroller & Auditor Genral of India
2.	Ms. Rekha Gupta	—	Dy. C&AG (Report Central)
3.	Shri H. Pradeep Rao	—	Director General of Audit (Central Expenditure)
4.	Shri P.K. Kataria	—	Pr. Director (Report Central)
5.	Shri K.R. Sriram	—	Pr. Director of Audit (Economic & Service Ministries)

Representatives of the Ministry of Health and Family Welfare (Department of Health and Family Welfare)

1.	Ms. K. Sujatha Rao	—	Secretary (Health and Family Welfare)
2.	Shri R.K. Srivastava	—	DGHS
3.	Shri Naved Masood	—	Additional Secretary (Finance)
4.	Shri V. Vekatachalam	—	Additional Secretary
5.	Shri B.K. Prasad	—	Joint Secretary
6.	Shri Vineet Chawdhry	—	Joint Secretary
7.	Ms. Shakuntala Gamlin	—	Joint Secretary
8.	Dr. H.C. Goel	—	Addl. DG. DGHS

2. At the outset, the Chairman, PAC welcomed the members and the Officers of the Office of C&AG of India to the sitting. Then the Audit Officers briefed the Committee on the specified issues arising out of the C&AG's Report No. 20 of 2007, Union Government (Civil—Performance Audit) on "Procurement of Medicines and Medical Equipment".

3. Thereafter, the representatives of the Ministry of Health and Family Welfare (Department of Health and Family Welfare) were called in and the Committee commenced further evidence on the subject. The Secretary and other representatives of the Department of Health and Family Welfare replied to the various queries raised by the Members on the subject. To certain queries on which the witnesses could not give ready replies, the Hon'ble Chairman directed the representatives to furnish the requisite information in writing at the earliest.

4. A copy of the verbatim proceedings of the sitting has been kept on record.

The representatives of the Ministry then withdrew.

5. *** *** ***

6. After some deliberations, the Committee adopted the same with some modifications/changes and authorized the Chairman to finalise these Reports in the light of suggestions made by the members and the consequential changes arising out of factual verification by the Audit and present the same to the Parliament.

7. In addition to the subjects already selected, the Committee decided to select the subject—"Recent Developments in the Telecom Sector including allocation of 2G and 3G spectrums", also for detailed examination.

The Committee then adjourned.

*** Matter does not pertain to this Report

APPENDIX-III

MINUTES OF THE TWENTY FIRST SITTING OF THE PUBLIC ACCOUNTS COMMITTEE (2010-11) HELD ON 3RD FEBRUARY, 2011

The Committee sat on Thursday, the 3rd February, 2011 from 1130 hrs. to 1250 hrs. in Room No. '62', First Floor, Parliament House, New Delhi.

PRESENT

Dr. Murli Manohar Joshi — *Chairman*

Lok Sabha

2. Shri Anandrao Vithoba Adsul
3. Shri Ramen Deka
4. Shri Naveen Jindal
5. Shri Bhartruhari Mahtab
6. Shri Yashwant Sinha
7. Shri Jitendra Singh (Alwar)
8. Kunwar Rewati Raman Singh
9. Shri K. Sudhakaran
10. Dr. M. Thambidurai
11. Shri Aruna Kumar Vundavalli

Rajya Sabha

12. Shri N. Balaganga
13. Shri Prasanta Chatterjee
14. Shri Kalraj Mishra
15. Shri N.K. Singh
16. Prof. Saif-ud-Din Soz

SECRETARIAT

1. Shri Devender Singh — *Joint Secretary*
2. Shri M.K. Madhusudhan — *Additional Director*
3. Shri Sanjeev Sharma — *Deputy Secretary*
4. Shri D.R. Mohanty — *Deputy Secretary*

Representatives of the Office of the Comptroller and Auditor General of India

1. Shri R.S. Mathrani	—	Director General of Audit (Central Expenditure)
2. Shri C.M. Sane	—	Pr. Director of Audit (Air Force & Navy)
3. Ms. Ahladini	—	Director (Central Expenditure)
4. Shri Bhawani Shankar	—	Director (Economic Service & Ministries)

2. At the outset, the Chairman welcomed the Members and the representatives of the Office of the C&AG to the sitting of the Committee. The Chairman, then, apprised that the meeting was convened to consider six Draft Reports of the Committee. Accordingly, the Committee took up the following Draft Reports for consideration:

(i) Draft Report on "Procurement of Medicines and Medical Equipment" (Ministry of Health and Family Welfare) based on C&AG Report No. 20 of 2007:

(ii)	****	****	****	****
(iii)	****	****	****	****
(iv)	****	****	****	****
(v)	****	****	****	****
(vi)	****	****	****	****

3. After some discussions, the Committee adopted the Draft Reports mentioned at Sl. Nos. (i) to (v) with some modifications/amendments. While considering the Draft Reports mentioned at Sl. Nos. (iv) to (v), the Committee desired that the C&AG should conduct thorough audit of the Centrally Sponsored Schemes by devising a suitable mechanism in consultation with the Ministry of Finance so as to assure that the funds released by the Union to the States are spent in the prescribed manner to meet the intended objectives. The Committee also underlined the need for another audit of the Mid Day Meal Scheme in the six defaulting States namely Kerala, Jharkhand, Uttar Pradesh, Andhra Pradesh, Nagaland and Bihar. The Chairman requested the Members to give their respective suggestions to the Audit in this regard.

4. As the Members desired to have some additional inputs on the Draft Report mentioned at Sl. No. (vi), the consideration of that Report was deferred.

5. The Committee authorized the Chairman to finalise the five Reports adopted by them, in light of their suggestions and the factual verifications received from the Audit and present the same to the House on a date convenient to him.

6. The Chairman thanked the Members for their valuable suggestions on the consideration of the Draft Reports.

The Committee then adjourned.

*** Matter does not pertain to this Report

GMGIPMRND—6816LS—21.04.2011.