E. C. No. 106

ESTIMATES COMMITTEE
(1958-59)

THIRTY-SIXTH REPORT
(SECOND LOK SABHA)

MINISTRY OF HEALTH

MEDICAL SERVICES

PART I

LOK SABHA SECRETARIAT
NEW DELHI
December, 1958

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C O R R I G E N D A
T O

THIRTY-SIXTH REPORT OF THE ESTIMATES COMMITTEE ON THE MINISTRY OF HEALTH ON THE SUBJECT "MEDICAL SERVICES PART I"

Page 1, para 2, line 6, read "In the words" for "In words"
Page 3, para 6, in the table against 1958-59, read "(budget)" for " ..d.et)"
Page 4, para 7, line 12, read "satisfactory" for "satisfactorily"
Page 8, para 12, line 13, read "1958" for "1957"
Page 25, para 53, line 9, read "acute" for "acuate"
Page 29, line 9, read "for" for "far"
Page 36, para 74, lines 2-3, read "Dr. A.Lakshmanaswamy Mudaliar" for "Dr. Lakshmanaswamy Mudaliar
Page 39, para 77, lines 6-7 from bottom, read "Medical Stores Depots" for "Medical Stores"
Page 74, S.No. 20, lines 2-3, read "feasibility" for ".easibility"
Page 78, S.No.43, line 7, read "non-official" for "non-officia."
Page 79, S.No.47, line 3, read "the" for ".he"
Page 80, S.No.49(iv), line 4, read "supplying" for "supply"
Page 84, S.No.64, line 6, read "drugs" for "drug"
Page 86, S.No.76, line 3, read "indicate" for "indica.e"

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27. Shrimati Renu Chakravartty
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*Elected w.e.f. 28-8-1958 *vice* Shri Mahavir Tyagi resigned.

**Elected w.e.f. 17-9-1958 *vice* Shri J. Rameshwar Rao resigned.

@Elected w.e.f. 23-9-1958 *vice* Shrimati Renuka Ray resigned.

†Elected w.e.f. 23-9-1958 *vice* Shri Nemi Chandra Kasliwal resigned.

‡Elected w.e.f. 17-12-1958 *vice* Shri Vijayram Raju resigned.

29. Shri Jhulan Sinha
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SECRETARIAT

Shri S. L. Shakdher—*Joint Secretary.*

Shri H. N. Trivedi—*Deputy Secretary.*

Shri R. P. Kaushik—*Under Secretary.*

INTRODUCTION

I, the Chairman, Estimates Committee, having been authorised by the Committee to submit the Report on their behalf, present this Thirty-sixth Report on the Ministry of Health on Medical Services—Part I.

2. The Committee wish to express their thanks to the Secretary and other officers of the Ministry of Health for placing before them the material and information that they wanted in connection with the examination of the estimates. They also wish to thank the representatives of the Indian Medical Association for giving evidence and making valuable suggestions to the Committee.

NEW DELHI;
The 19th December, 1958.

BALVANTRAY G. MEHTA,
Chairman,
Estimates Committee.

I

INTRODUCTORY

The Constitution of India has laid down the following Directive Principles of State Policy:—

Article 41.—"The State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want".

Article 42.—"The State shall make provision for securing just and humane conditions of work and for maternity relief"

Article 47.—"The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of Public Health as among its primary duties.....".

In consonance with these principles, the health of the people has, no doubt, received increasing attention by the State. After Independence, the total expenditure of the Central Government on Medical and Public Health Services has gone up from Rs. 1·40 crores in 1948-49 to Rs. 3·82 crores in 1955-56. During the last three years, the development of these services has received further impetus as seen from the figures stated below:—

	Expenditure (in crores).		
Year	Medical	Public Health	Total
	Rs.	Rs.	Rs.
1956-57	2·87	3·35	6·22
1957-58 (Revised)	4·58	5·84	10·42
1958-59 (Budget)	6·15	9·88	16·03

2. The problem of Public Health in India is varied and complex. In the words of the National Planning Committee on National Health (1948): "The root cause of disease, debility, low vitality and short span of life is to be found in poverty, almost destitution, of the people which prevents them from having sufficient nutrition, clothing and shelter." Poverty and health do not go together. In words of Shri Jawaharlal Nehru, "a war on disease and ill-health is, therefore, essentially a war on poverty and all its evil brood."

3. The following table gives the figures of expenditure on Medical and Public Health as against the total amount of expenditure on social

services during the First Five Year Plan in respect of both the Centre and the States:—

Year	*Actual Expenditure on* Medical and Public Health (Rs. in crores)	Social Services including Medical and Public Health (Rs. in crores)
1951-52 . . .	11·72	64·58
1952-53 . . .	13·25	63·97
1953-54 . . .	16·50	68·33
1954-55 . . .	22·87	91·13
1955-56 (Revised estimates) . .	36·62	134·86
TOTAL .	100·96	422·87

During the Second Five Year Plan, the total Plan provision for Medical and Public Health is Rs. 273·82 crores as against Rs. 944·45 crores on Social Services, inclusive of Medical and Public Health. Thus, the ratio of expenditure on Medical and Public Health to the total outlay on Social Services has increased from nearly 23·8% in the First Five Year Plan to 28·9% in the Second Five Year Plan.

4. In the First Five Year Plan, Rs. 137·79 crores were allocated for "Health" out of the revised plan provision of Rs. 2377·67 crores or 5:7% of the provision. In the Second Five Year Plan, Rs. 273·82 crores have been allocated for Health out of the total Plan provision of Rs. 4,800 crores or 5·7% of the Plan Provision.

5. The following table gives the amounts provided for Medical and Public Health in the Central Budget during the years 1948-49 to 1958-59:—

Year	*Central Budget* (Rs. in crores) Expenditure on Medical and Public Health	Total Expenditure	Percentage of (2) to (3)
1	2	3	4
1948-49	1·40	308·08	0·45
1949-50	1·66	299·79	0·55
1950-51	2·00	334·24	0·59

1	2	3	4
1951-52	2·31	366·41	0·63
1952-53	1·41	358·52	0·39
1953-54	1·61	371·43	0·43
1954-55	2·74	386·69	0·70
1955-56	3·82	425·39	0·90
1956-57	6·22	457·49	1·35
1957-58 (Budget)	10·79	619·05	1·74
1957-58 (Revised)	10·42	648·77	1·60
1958-59 (Budget)	16·03	693·01	2·31

It is heartening to note that the percentage has increased from 0·45 in 1948-49 to 2·31 in 1958-59. It is, however, obvious that *the present medical and public health facilities are totally-insufficient to meet the requirements of a Welfare State.* The Committee understand that in the Soviet Union, approximately, one fifth of the total budget is earmarked for Health and Medical Services. *The Committee are, therefore, clearly of the view that the existing provision in the Plan for this subject is inadequate, and that in the Third Plan much larger percentage of expenditure in the Central and State budgets will have to be earmarked for Medical and Public Health Services. Another disconcerting feature noticed by the Committee, is that inspite of the very limited provision made in the Second Plan, several schemes for which funds have been provided, have not progressed according to the schedule. This clearly points to the urgent necessity of tuning up the administrative machinery both at the Central and State levels.*

Importance of Public Health

6. Health Services for a long time in the past had been planned and administered more or less as agencies for medical care as could be seen from the figures of expenditure stated below:—

Year	*Expenditure* (Rs. in crores) Public Health	Medical Services
1948-49	0·56	0·84
1949-50	0·72	0·94
1950-51	0·68	1·32
1951-52	0·80	1·51
1952-53	0·69	0·72
1953-54	0·87	0·74
1954-55	1·51	1·23
1955-56	2·36	1·46
1956-57	3·35	2·87
1957-58 (Revised)	5·84	4·58
1958-59 (Budget)	9·88	6·15

Thus, the shift in expenditure towards Public Health is markedly evidenced after 1952-53. The distribution of the total provision of Rs. 274 crores under Medical and Public Health in the Second Five Year Plan is roughly as under:—

	Amount, (Rs. in crores)
(*i*) Control of Communicable Diseases	57
(*ii*) Water Supply and Sanitation	91
(*iii*) Medical Education and Research	40
(*iv*) Hospitals and Dispensaries	66
(*v*) Indigenous Systems of Medicine	6
(*vi*) Other schemes	14
TOTAL	274

Medical Services

(a) *Hospital Services*

7. As stated in the Second Five Year Plan, the aspects to be kept in view in respect of the provision of hospital facilities are quantity, distribution, integration and quality. Referring to the pattern of Hospital Services in the country, the Second Five Year Plan states:—

> "An effective regional system of hospitals would include four distinct elements, namely, the teaching hospital, the district hospital, the tehsil hospital and the rural medical centre associated with a health unit. Each element in such a system would be linked administratively with the others. A co-ordinated hospital system with its free flow of medical services and patients should help to provide satisfactorily medical care both in urban and rural areas."
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> "The creation of more hospital facilities is needed but, in view of the high cost of these services, it is equally important to develop existing Hospital Services and to make them both efficient and economic."

According to Entry 6 of the List II of the Seventh Schedule, the subjects of Hospitals and Dispensaries come under the State List. The Committee have, therefore, confined their examination, primarily, to the Hospital Services under the management of the Ministry of Health, but many of their observations and suggestions will be applicable to all the Hospital Services in the country. The question of overcrowding in hospitals, the necessity of strengthening the out-patient departments, proper integration of available facilities, securing co-operation of the

persons to be served through the Advisory Committees, necessity of giving proper training to Class IV staff attached to hospitals, preparation of suitable informative brochures indicating the hospital facilities available for the benefit of the public, proper scrutiny of every case of death during hospitalization by an expert committee, relieving the Medical Superintendents of the burden of routine administrative work—these are some of the general suggestions applicable to all hospitals and dispensaries. *The Committee have no doubt, that such suggestions of general applicability will be placed before the Central Council of Health.*

(b) *Medical Training*

8. As rightly observed by the Bhore Committee, the number of properly qualified doctors in the country has been very inadequate in comparison with the total population. The training of medical personnel had, therefore, necessarily to be given a high priority in the programme for development of health services during the First Five Year Plan. The number of Medical Colleges increased from 30 to 42 and the number of admissions from about 2,500 to more than 3,500. By the end of 1960-61, the number of doctors required at the rate of 1 doctor per 5,000 of the population, will be 90,000. At present, there are 70,000 qualified doctors and about 12,500 doctors will qualify during the Second Plan. *It would, therefore, be seen that the training facilities will have to be suitably augmented, if the target laid down in the Second Plan is to be achieved.*

9. Medical Colleges in India are, at present, staffed by teachers who are permitted private practice. This concession is, perhaps, one of the important reasons for low standards of teaching and for the small amount of attention which medical research has received. To remedy this situation, it is necessary to strengthen the Medical Colleges by the appointment of whole time staff.

(c) *Indigenous Systems of Medicine*

10. In the field of Indigenous Systems of Medicine, the Committee are glad to learn that research is being actively assisted by the Central Government by a system of grants-in-aid to approved research schemes. There is, however, scope for intensifying the work and the Committee propose to deal with the subject at some length in one of the subsequent chapters. Central subsidy is also envisaged to be given for teaching institutions that may be set up or upgraded in the States on the same basis as for Medical Colleges. A Committee was appointed during 1955 to study and report on the question of establishment of uniform standards in respect of the education and regulation of professional practice by Vaids, Hakims, and Homoeopaths. The recommendations of this Committee, along with the views of the State Governments thereon, were placed before the Central Council of Health in

its meeting held in January, 1958. The following resolution was passed by the Council:—

> "The Central Council of Health having considered the views expressed on the recommendations of the Dave Committee are of the opinion that under existing conditions it is not possible to lay down a uniform policy for all State Governments and recommends to State Governments to take such steps as they consider practicable and desirable for the development of Ayurveda and other Indigenous Systems of Medicine. The Council further recommends that the Union Government should actively encourage research in Ayurveda, Unani and Homoeopathy and other Indigenous Systems."

Regarding the existing controversy about the place of Ayurvedic and Unani systems, the Committee cannot do better than to quote the following views of Shri Jawaharlal Nehru as contained in his Foreword to a recent official publication of the Ministry of Health:—

> "There is much controversy often about the place of the Ayurvedic and Unani systems. There can be no doubt that both these ancient systems of India have an honourable history and that they had a great reputation. Most people know also that even now they have some very effective remedies. It would be wrong and absurd for us to ignore this accumulation of past knowledge and experience. We should profit by them and not consider them as something outside the scope of modern knowledge. They are parts of modern knowledge. But, in many directions, modern science, as applied to both medicine and surgery, has made wonderful discoveries and, because of this, health standards in advanced countries have improved tremendously. We cannot expect to improve our standards unless we take full advantage of science and modern scientific methods. There is no reason why we should not bring about an alliance of old experience and knowledge, as exemplified in the Ayurvedic and Unani systems, with the new knowledge that modern science has given us. It is necessary, however, that every approach to this problem should be made on the basis of the scientific method, and persons who are Ayurvedic and Unani physicians should have also a full knowledge of modern methods. This means that there should be a basic training in scientific methods for all, including those who wish to practise Ayurvedic or Unani systems. Having got that basic training, a person may practise either of these systems or Homoeopathy.

> "The question is thus not of a conflict between various systems but of sound education in knowledge as it is today and then the freedom to apply it according to any system. It is the scientific approach that is important."

It is hoped that serious efforts will be made to develop the ancient knowledge on scientific lines and the doctors of the future be encouraged to learn from the different systems of medicine.

11. The Committee also propose to deal, in this report, with the subject of Mental Health, Drug Control, Medical Stores Depots and the Contributory Health Service Scheme in Delhi and New Delhi.

II

HOSPITAL SERVICES

A. Introduction

12. The Ministry of Health is directly responsible for the administration of the Willingdon Hospital and Nursing Home, and the Safdarjang Hospital, New Delhi. The former was taken over from the New Delhi Municipal Committee on 1-1-1954, with a view to improving its efficiency and providing better medical facilities, while the latter was taken over from the erstwhile Delhi State on 1-3-1954, in connection with the establishment of the All India Medical Institute. The bed strength of these hospitals, when taken over by the Ministry of Health, was 50 and 179 respectively. During 1958, it was 237 and 424 respectively. Both these hospitals cater to the needs of the public as well as the Contributory Health Service Scheme. The following table gives the figures of development of these two hospitals, relating to the years 1954 to 1957:

	Year				
	1954	1955	1956	1957	1958
The Willingdon Hospital and Nursing Home					
No. of beds	50	60	69	136	237
No. of doctors (Sanctioned strength of Class I and II posts)	6	17	21	31	44
No. of patients treated					
Indoor	1,513	1,538	1,955	2,491	5,012
Outdoor	2,09,236	2,42,170	2,45,562	2,64,381	2,40,871
Actual recurring expenditure in rupees*	5,15,036	5,14,000	8,3a,855	12,73,643	..
(Figures in brackets indicate expenditure on pay and allowances)	..	(2,78,241)	(3,60,333)	(4,83,643)	..
The Safdarjang Hospital					
No. of beds	179	204	326	338	424
No. of doctors (Sanctioned strength of Class I and II posts)	15	23	30	36	46
No. of patients treated					
Indoor	3,950	7,975	9,171	11,706	14,932
Outdoor	1,32,184	1,95,151	2,35,862	2,13,210	2,80,881
Actual recurring expenditure in rupees*	6,42,803	14,98,270	23,37,657	23,76,577	..
(Figures in brackets indicate expenditure on pay and allowances)	(3,43,598)	(5,02,843)	(8,72,003)	(10,68,438)	..

*Figures correspond to the respective financial year.

The Committee observe that the rise in expenditure during 1954 *to* 1957 *in respect of these hospitals is disproportionate to the increase in the number of indoor and outdoor patients. This needs investigation.*

B. Advisory Committees

13. The Committee were informed that the Safdarjang and Willingdon Hospitals did not have any Advisory Committees. The Committee are of opinion that a properly constituted Advisory Committee for every hospital would be of assistance to the Medical Superintendent in the discharge of his functions and responsibilities, and would also act as a liaison between the hospital authorities and the patients. *The Committee, therefore, recommend that the hospitals, directly administered by the Ministry of Health, should have properly constituted non-official Advisory Committees with adequate scope of work to enable them to function in an effective manner. Suitable rules should be framed regarding the procedure of work of these Advisory Committees, including the number of meetings to be held, recording of the minutes of meetings etc. The Committee also suggest that, after these Advisory Committees gather some experience, the question of converting them into Hospital Management Committees may be examined.*

C. Medical Administration

14. The Study Group of the Committee that visited some of the government hospitals in New Delhi were informed that the proportion of work discharged by Medical Superintendents in respect of administrative matters varied from 30% to 100% of the total working time in hospitals. In view of the shortage of qualified medical specialists in the country, at present, the Committee are of opinion that it is waste of talent of medical personnel to utilise their services for routine administrative work. *The Committee, therefore, recommend that the Medical Superintendents in-charge of government hospitals should be assisted by non-medical administrative officers, under their supervision, to deal with routine administrative work in order to enable the former to devote more time to professional work.*

D. Administrative and Financial Powers of Medical Superintendents

15. The Medical Superintendents of the Safdarjang Hospital and Willingdon Hospital and Nursing Home, New Delhi, have been declared as "Heads of Offices" for purposes of the Fundamental and Supplementary Rules, General Financial Rules and other Services Rules etc. framed by the Government of India. In regard to appointments, they are empowered to make appointments to Class III and IV posts. The schedule of financial powers delegated to the Medical Superintendents is given in Appendix I. The Committee were informed that these powers were delegated in 1955 when these hospitals were in the initial stage of development. The Study Group of the Committee

that visited these hospitals in September, 1958 were informed that the existing powers enjoyed by the Medical Superintendents were inadequate in view of the vast expansion of the Hospitals which had taken place during the past three years. *The Committee, therefore, recommend that the existing powers delegated to the Medical Superintendents in-charge of the Willingdon and Safdarjang Hospitals, and similar other institutions under the overall charge of the Ministry of Health, should be reviewed suitably, with a view to delegate more powers for the efficient running of these institutions.*

E. Specialised Medical Facilities

16. In view of the high cost of specialised equipment, the increasing number of patients and the existing shortage of medical specialists, it is becoming more and more imperative to make the best possible use of the available specialised facilities in different Hospitals in Delhi and New Delhi, to the maximum advantage of the patients requiring such facilities. It will be pertinent to quote the views of the Delhi State Medical and Health Reorganisation Enquiry Committee (1955) in this regard:—

> "At present, there is not adequate co-ordination between hospitals and dispensaries in the matter of X-ray and laboratory investigation as well as specialist advice and guidance. For obvious reasons, it is not possible to equip every hospital and dispensary with up-to-date scientific apparatus. The Committee is of the view that there should be close relationship between large hospitals and smaller institutions located in their areas irrespective of the fact whether such hospitals or institutions are maintained by Government, local bodies, missionary or charitable organisations. The smaller institutions should be offered full facilities for investigation of cases referred by them to the large hospitals in their zones. The patients after investigation should be referred back to the medical officer concerned. It is also felt that specialists from the zonal hospitals should visit the smaller institutions and offer such guidance as may be necessary. In planning future hospitals and health centres, note should be taken of the existing facilities in a particular area and provision for additional requirements made accordingly."
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> "A system should be devised and introduced in all the major institutions whereby qualified general medical practitioners could be given facilities for investigation and advice of specialists for their areas."

The Committee suggest that the feasibility of devising some system, whereby it may be possible to pool such specialised facilities under a

Central Co-ordinating Organisation for guiding the patients to proper medical specialists in different hospitals on a regional basis, may be explored.

17. *The Committee also suggest that besides giving facilities to qualified general medical practitioners for investigation and advice of specialists, Government may suitably encourage by providing suitable grants, the establishment of pathological laboratories by competent private agencies, who may come forward to render such services at reasonable standard rates.*

F. Efficient utilisation of available beds

18. The Study Group of the Committee that visited the Willingdon Hospital in September 1958 observed that 24 beds were lying vacant in the newly constructed ward for nearly 5 months, from 11-4-1958 to 8-9-1958, due to the shortage of nursing staff. At the same time, they observed that there was overcrowding in other hospitals and in other wards of the same hospital resulting in placing of patients on the floor. *The Committee consider this to be an unfortunate state of affairs. They recommend that the Ministry of Health should explore the feasibility of entrusting the task of co-ordination and mobilisation of all the available hospital beds in Delhi and New Delhi to the Central Co-ordinating Organisation suggested in paragarph 16 above. It should be the job of this Organisation to see to it that proper planning is done so that staff and equipment are made available immediately on the completion of a building and that hospital beds are not allowed to remain unoccupied for more than a week or so after completion.*

G. Blood Bank

19. The Committee understand that separate Blood Banks are being maintained in the Safdarjang and Irwin Hospitals apart from some private Blood Banks run with government aid, where blood is deposited and transfused according to requirements. Other Blood Banks are to be started in the near future. The following table shows the quantity of blood deposited and consumed in the Irwin and Safdarjang Hospitals' banks since their inception:

	Blood Bank in the Irwin Hospital*	Blood Bank in the Safdarjang Hospital**
Total number of donors of blood .	20,151	1,310
Total quantity of blood deposited .	60,45,300 c.c.	9,01,500 c.c.†
Total quantity of blood consumed for transfusion . . .	55,77,300 c.c.	6,39,900 c.c.

*Established in 1949.

**Established in July, 1957.

†Upto the end of 1958.

The representative of the Directorate General of Health Services stated that for the successful functioning of a Blood Bank, there should be a large number of donors regularly coming forward to donate blood which could then be stored and utilised as and when required. He did not consider it practicable to have such a Bank till the time the public became more conscious of the importance of blood donation. *The Committee recommend that the Ministry should launch a special drive to attract a large number of blood donors (a) by adopting appropriate means of publicity to emphasise the humanitarian aspect of blood donation, (b) by evolving a suitable scheme for Blood Bank Insurance on the lines of similar schemes in some foreign countries, which will guarantee free supply of blood for the donor and his family, if necessity arises.*

20. The Committee understand that the principle of having centralised Blood Banks is already accepted by some of the advanced countries of the world. In the U.K. blood is kept in the Regional Blood Bank, or issued to Area Blood Banks which are maintained at general hospitals in each country. Each of the principal hospitals holds a supply of blood sufficient not only for its own needs but also for the smaller hospitals, nursing homes and general practitioners in its district. The Committee also understand that the Medical Superintendents of the Safdarjang and Irwin Hospitals had reacted favourably to the idea of having a centralised Blood Bank in Delhi and offering suitable incentives. The representative of the Ministry also accepted the principle underlying the suggestion. *The Committee, therefore, recommend that the idea of having a centralised Blood Bank for the various hospitals in Delhi area may be developed and given a concrete shape. This may be treated as a pilot project, and if it proves successful, the State Governments may be requested to establish similar centralised Blood Banks in their respective States. Such a centralised Blood Bank would make it possible to use the surplus blood for the production of blood plasma and prevent its wastage.*

H. Supply of Spectacles and Dentures

21. At present, the services of dentists and eye-specialists are available in many of the Government Hospitals, but patients have to go to the private agencies for getting dentures and spectacles. They are, sometimes, required to pay exorbitant prices for obtaining the same. *The Committee, therefore, recommend that Government Hospitals should either supply dentures and spectacles at no-profit no-loss basis or maintain an approved panel of Dentists and Opticians, who may agree, to serve the patients directed by Government Hospitals with such aids at reasonable standard rates which should be made known to all. They also suggest that such a scheme should be made applicable to all patients served by Government Hospitals, irrespective of the fact whether they are Contributory Health Service Scheme patients or the general public.*

22. *The Committee also suggest that Government may give suitable grants-in-aid, if necessary, to competent public institutions which may come forward to render such services* (viz., *supply of dentures and spectacles*) *at reasonable rates to be fixed by Government.*

I. Deaths during hospitalization

23. The following table gives the figures of deaths recorded in the Safdarjang and Willingdon Hospitals during each of the last three years:—

	1955	1956	1957
The Safdarjang Hospital			
Total number of indoor patients	7,975	9,171	11,706
No. of Deaths	329	575	718
Percentage of deaths to the total number of indoor patients .	4·1	6·2	6·1
The Willingdon Hospital			
Total number of indoor patients .	1,538	1,955	2,491
No. of Deaths . .	51	56	91
Percentage of deaths to the total number of indoor patients .	3·3	2·8	3·6

The Study Group or the Committee were informed that the facts about the cases of deaths were scrutinised, personally, by the respective Medical Superintendent in-charge of the hospital. In respect of the Willingdon Hospital, the Study Group were informed that the cases of deaths were also discussed in staff meetings of which regular proceedings were maintained. *The Committee suggest that the procedure of reviewing of the cases of deaths occurring in Government Hospitals may be examined and a standard procedure evolved, which may include* inter alia *a detailed investigation of the causes of every death by a small committee consisting of the Medical experts, proper recording of the proceedings of the meetings of the Investigation Committee and remedial measures for future guidance.*

J. Training of Class IV Staff

24. In view of the fact that a majority of Class IV staff employed in hospitals are required to maintain proper hygienic conditions in the hospital and that they also have to come into contact with patients in the discharge of their functions, *the Committee consider it necessary to impress upon them the importance of their functions and responsibilities which may not only enhance their efficiency and utility but also assure better service to the patients. The Committee, therefore, suggest that Class IV staff, immediately on their appointment in big hospitals, should receive a short course of training in hygiene, specially, in respect of the technique of sweeping the floor, cleaning the bed pans*

etc., keeping the bed-sheets and other linen clean, cleansing the furniture and other articles and observing proper bedside manners. Importance of prompt and willing attention to the calls of patients should also be stressed during this training.

K. Complaint Books

25. The Study Group of the Committee, during their visits to these Hospitals observed that complaint books were not maintained in these hospitals, excepting in the Nursing Home attached to the Willingdon Hospital. *The Committee recommend that complaint books should be maintained in all Wards and Out-patient departments in hospitals, administered by the Ministry of Health. Such complaints should be reviewed, periodically, by the Medical Superintendent incharge of the hospital with the assistance of the Hospital Advisory Committee, and the nature of action taken over each of the complaints should, briefly, be indicated under his signature.*

L. Relieving over-crowding in Hospitals and Dispensaries

26. The Study Group of the Committee observed that there was considerable over-crowding in the out-patient departments of these hospitals. The following table gives the figures of the average daily attendance of patients in the out-patient departments during the last three years:

	Average daily attendance of out-patients		
	1955	1956	1957
The Willingdon Hospital and Nursing Home, New Delhi. .	663	672	724
The Safdarjang Hospital, New Delhi.	534	646	584

The Committee understand that the question of providing more out-door facilities in Delhi has been, generally, considered by the Delhi State Medical and Health Reorganisation Enquiry Committee (1955). They have recommended *inter alia* the establishment of more Health Centres, appropriately linked with big hospitals, to afford some relief. *In view of the sustained over-crowding in dispensaries and out-patient departments of Government Hospitals in New Delhi, and looking to the high cost of establishing new hospitals or expanding the existing ones, the Committee suggest that the feasibility of working double shifts in out-patient departments of Government Hospitals in New Delhi may be examined.*

27. *Besides organising the out-door facilities on the lines suggested above, the Committee also suggest that the feasibility of suitably organising the Ayurvedic and other dispensaries on an experimental basis to serve the out-patients, may also be examined.*

M. Waiting Facilities

28. The Study Group of the Committee observed, during the course of their visits, that the waiting facilities for patients in the Safdarjang and Willingdon Hospitals are far from satisfactory. Patients do not have even adequate sitting space during the peak hours. *The Committee, therefore, recommend that these facilities should be improved.*

N. Recovery of charges from private patients

29. The Committee understand that all persons, other than those specified below, are required to be charged fees at the prescribed rates in the Safdarjang and Willingdon Hospitals:—

(i) in-patients in the general wards;

(ii) indigent patients attending the out-patients departments;

(iii) C. H. S. S. patients referred to the hospital on written requisition of the authorised medical attendant; and

(iv) Central Government servants and members of their families not coming within the scope of the C. H. S. S. who are referred to the hospital by an authorised medical attendant.

The Medical Superintendent, Safdarjang Hospital, informed the Study Group of the Committee that due to some practical difficulties encountered in determining the true income of patients treated in the Hospital, it was not possible to enforce the schedule of charges. *The Committee suggest that the procedure of the levy and recovery of charges from patients may be reviewed so as to plug all loopholes which enable the private patients to conceal their true income and thus avoid payment of legitimate dues to the hospital.*

30. The Committee understand that at present there are no means of acquainting the general public with the nature of various facilities available in Government Hospitals. *The Committee, therefore, recommend that small brochures containing information about the nature of facilities available in each hospital, the procedure to be followed to avail of them and the approximate cost involved, should be published and made available to members of the public.*

O. Costing Statistics

31. The Committee note with interest the following suggestion of the Medical Superintendent, Safdarjang Hospital, contained in his administrative report submitted to the Director General of Health Services for the year 1957:

> "In India, at least in Government Hospitals, there is no method by which the actual cost per patient per day both In-patient and Out-patient is worked out. The information will be very valuable in planning and estimating

the budget. Even in U.K. cost accounts for hospitals have only recently been taken up. I feel that the Safdarjang and Willingdon will be ideal hospitals where fairly accurate cost accounting can be carried out, under reasonably controlled conditions. I would strongly recommend the Ministry of Finance to detail a team to take up this work. The information gained will be valuable."

The Committee feel that the chief criteria of financial efficiency of a hospital can be judged only if costing statistics are standarised and compiled on a scientific basis and published from time to time. This alone would make it possible to make valid comparisons between the costs prevailing in different hospitals. They, therefore, recommend that costing statistics should be standardised and introduced in Government Hospitals.

P. Statistical Information

32. *With a view to have some reliable tests of efficiency which may provide valuable evidence of the work load and the index of efficiency or inefficiency of a hospital, the Committee recommend that factors such as bed occupancy, bed interval, length of stay of patients, etc. may be standardised and compiled in a scientific manner in Government Hospitals. They also recommend that these statistics should be included in the Annual Reports of the Ministry in so far as the hospitals under the Central Ministry are concerned.*

Q. Administrative Reports

33. The Committee were informed that Administrative Reports of the hospitals, under the control of the Ministry of Health, were not published. *The Committee recommend that copies of the Annual Administrative Reports should, at least, be made available to the public on request. Some copies should also be kept in the waiting halls of patients for their study.*

R. Plan Lay-out

34. The Committee understand that in regard to the development schemes of the Willingdon Hospital and Nursing Home, out of the total plan provision of Rs. 46·50 lakhs, an amount of Rs. 7·79 lakhs has been spent during the first two years of the Plan and an amount of Rs. 59,000 has been provided in the budget during the current year. Thus, a balance of Rs. 38·12 lakhs will have to be spent during the last two years of the Plan, provided, the entire amount is made available by the Planning Commission. This indicates that the progress of the development scheme, during the first three years of the Plan, is very slow. *The Committee suggest that the position about the balance of Rs. 38·12 lakhs in the Plan provision for the development of the Willingdon Hospital, may be reviewed in consultation with the Planning Commission to ascertain whether the whole of this earmarked*

amount is really necessary and can be usefully spent for the expansion of the hospital or whether a part of it can be diverted to the setting up of another hospital in some other part of Delhi.

35. In regard to the development scheme of the Safdarjang Hospital, the Committee understand that out of the total plan provision of Rs. 66·00 lakhs, an amount of Rs. 11·15 lakhs has been spent during the first two years of the Plan and an amount of Rs. 5·40 lakhs has been provided in the budget during the current year. This would leave a balance of Rs. 49·45 lakhs. *The Committee consider it undesirable to concentrate medical facilities in one corner of Delhi. They would have preferred it if the original idea of using the Safdarjang Hospital for the All India Institute of Medical Sciences was adhered to. But, in view of the fact that the Health Ministry are anxious to keep it for the sake of the Contributory Health Service Scheme, and the authorities of the Institute are anxious to have a separate hospital, the least that can be done is to stop the further expansion of the Safdarjang Hospital.* The Committee understand that the expansion of the Safdarjang Hospital which was taken over from the Delhi Administration to serve as the nucleus for the All India Institute of Medical Sciences was provided for in the first place in order to make it serve as the teaching hospital for the All India Institute of Medical Sciences. Later, it was decided to have a separate hospital for the All India Institute of Medical Sciences, but the expansion of the Safdarjang Hospital still continued. In the memorandum supplied by the Health Ministry, it was proposed to expand it to about 1100 beds. The Committee understand that the Ministry has already commitments for 652 beds. *The Committee recommend that it be stabilised at that and the bed strength of the new hospital for the Institute be also kept at the minimum necessary, so that the surplus resources could be utilised for providing hospital facilities to other parts of Delhi.*

III

MENTAL HEALTH SERVICES

A. Introduction

(a) *Statutory Responsibility*

36. As stated by the Health Survey and Development Committee, conditions of mental ill-health may be divided into two broad groups (i) mental disorder and (ii) mental deficiency. A large proportion of mentally sick patients is amenable to modern methods of treatment. Mental deficiency is ascribed, on the other hand, to a hereditary or congenital taint or to some accident or illness occurring during pregnancy, at birth or during infancy. Although, the condition is generally regarded as incurable, by proper eare and supervision, the majority of defectives can be made to lead useful lives and be prevented from becoming a burden on society or turning into criminals. Read with Article 246(2) of the Constitution of India, the following function in regard to the provision of mental health services in the country has been laid down in Entry 16 of the List III (Concurrent List) of the Seventh Schedule:

> "lunacy and mental deficiency, including places for the reception or treatment of lunatics and mental deficients."

Thus, the statutory responsibility for the provision of the service as required under Article 246 in respect of the above function rests with both the Central and the State Governments. The Committee were informed by the representative of the Ministry of Health that the function of the Central Government was limited to legislation and co-ordination. So far as the co-ordination of policy is concerned, the Central Government renders advice to the State Governments which is, generally, accepted by them. Besides these functions, the Central Government is mainly confining its activities to research and training. For this purpose, it is running model institutions, *viz.* the Hospital for Mental Diseases, Ranchi and the All India Institute of Mental Health, Bangalore, directly under the control of the Ministry of Health.

(b) *Legislative Functions*

37. Referring to the legislative aspect of the work, the Committee were informed that lunacy was governed by the Indian Lunacy Act, 1912 which had become outmoded due to the passage of time. The Government of India, had, therefore, appointed a Special Officer and a Special Committee to revise the Act. ***The Committee suggest that the work of the revision of the existing Act may be expedited and a comprehensive Bill be brought before Parliament at an early date.***

(c) *Incidence of Mental Diseases*

38. The Committee were informed that no reliable statistics regarding the incidence of mental morbidity in India were available. To give a rough idea about the incidence of the disease, the Committee would like to quote the following extract from an article written by the Director, All India Institute of Mental Health, Bangalore:—

> "In India, correct statistics as to the incidence of mental disorder are not available. Roughly, we may take about 2 per thousand of our population as likely to be afflicted with a disorder which requires hospitalisation at some stage or other; and the total number runs into several millions. We have also to take into account the mental defectives who average at least 8 to 10 per thousand of our population and epileptics who perhaps number 0·5 per cent of the population. Further, we must include in this category various types of physical illnesses like high blood pressure, skin disorders of various types, cardio-vascular conditions and others in which chronic emotional stresses do contribute a major share. Added to this formidable list, we have problems of social pathology. In our country, about one million and 7,50,000 crimes are committed every year; between 15,000 and 17,000 people commit suicide in a year; and, at the lowest estimate, about 15 to 20 per cent of our teenagers are juvenile delinquents. Correct statistics of alcoholics in India are not available but it seems to form a tremendous figure."

The above statement, if correct, would indicate that the problem of mental illness is alarmingly serious and needs to be tackled immediately and efficiently. Its accuracy needs to be determined. Unless accurate statistics are available and the magnitude of the problem is accurately known, Government cannot properly plan the provision of mental health services in the country. *The Committee, therefore, recommend that with a view to have a correct estimation of the incidence of mental diseases in the country and its connected problems, Government should sponsor a systematic survey under the aegis of a competent organisation, independent of the author of the above statement.*

39. *The Committee also suggest that annual returns of mental sickness from general hospitals and dispensaries may also be compiled and to that end proper record forms be introduced.*

B. Hospital for Mental Diseases, Ranchi

(a) *Utilisation of Beds*

40. The Study Group of the Committee that visited the Hospital for Mental Diseases, Ranchi were informed that prior to 1956, the Medical Superintendent was allowed to admit patients coming from various contributing States, if they were able to provide *bona fide* proof of their belonging to a particular State. After admission of cases, a routine report was sent to various States showing them the number of cases occupying their quota. Since 1956, the procedure has been revised and the Medical Superintendent is not allowed to admit cases on the quota of any of the contributing States. This has resulted in the increase in the number of chronic patients. Out of the first 100 admissions to the Hospital from April, 1957, 62 have had their symptoms for more than 3 years. Out of this number, 12 patients have such symptoms for more than 6 years, while only 20 have been ill for 2 years and 18 for one year or less. The following statement shows the position on 1-8-1958 about the length of stay of patients in the Hospital:—

Duration	*No. of patients*
Upto three years	168
Between three and five years	47
Between five and ten years	66
More then ten years	115
TOTAL	396

These figures show that a large number of chronic patients who are incurable have permanently occupied some beds, due to which patients with acute disease capable of being helped are often denied admission. *The Committee suggest that the situation may be carefully investigated by the Ministry in consultation with the State Governments concerned and suitable remedial measures be taken to ensure, as far as possible, full utilisation of all available facilities in this Hospital and other mental hospitals, primarily, for patients suffering from acute and curable diseases.* In this connection, attention is invited to the subsequent para under the heading "Separate Home for chronic and incurable patients.

(b) *Reservation of Beds by State Governments*

41. As regards the reservation of beds by State Governments, the Committee were informed that when the Hospital was started in 1918, only "European" and "American" patients, including persons of mixed blood from certain specified areas, were eligible for admission to the Hospital. In subsequent years, reservations were made on the basis of accommodation enjoyed by participating States from year to year. These States agreed to pay for beds reserved for them. As against the present bed strength of 420 beds in the Hospital, allotted to differ-

ent States, the Committee understand that only 394 beds were actually occupied on 4th August, 1958, as per the table given below:—

Name of the State	No. of allotted beds	No. of occupied beds as on 4-8-1958	No of vacant beds as on 4-8-1958
1. West Bengal . . .	255	247	—8
2. Bihar	60	40	—20
3. Uttar Pradesh . . .	35	35	..
4. Madhya Pradesh . . .	10	10	..
5. Delhi	10	9	—1
6. Assam	6	6	..
7. Orissa	6	7	+1
8. Other areas* . . .	8	3	—5
9. Independent . . .	30	37	+7
TOTAL . .	420	394	—26

*Tripura, Rajasthan, Bhopal, N.E.F.A. and PEPSU.

Giving reasons for the existence of a large number of vacant beds in the Hospital, the representative of the Ministry stated that the State Governments to whom the beds were allotted were unwilling to surrender any of them and that there was no extra demand from other States. *The Committee are surprised to note the statement made by the representative of the Ministry in view of the fact that a large number of applicants are being denied admission to the Hospital every year as seen from the following table:—*

	Year		
	1955-56	1956-57	1957-58
Total no. of applicantions received for admission . . .	486	540	443
Total no. actually admitted .	212	188	179

In view of the facts stated above, *the Committee recommend that the policy of having a fixed quota for different States decided upon the basis of white population, years ago, should be reviewed suitably under the existing changed conditions, as some States have no quota. Suitable criteria may be evolved in consultation with the State Governments at the time of effecting the revision.*

(c) *Cost of Treatment*

42. The Committee were informed that charges are realised from patients of various categories at the rates shown in the following table:

Class	Independent bed	Government bed	Remarks
	Rs.	Rs.	
I . .	400 p. m.	350 p. m.	Inclusive of wages of two attendants at Rs. 75 p.m. and diet at Rs. 4 per diem.
II . .	320 p. m.	200 p. m.	Inclusive of the wage of one attendant at Rs. 75 p. m. and diet at Rs. 4 per diem.
Intermediate .	..	100 p. m.	Inclusive of diet at Rs. 1/12 per diem (no attendant).
III . .	200 p. m.	50 p.m.	Inclusive of diet at Rs. 1/10 per diem (no attendant).

The Committee understand that a large number of patients approach the Hospital for admission every year. They are found suitable for treatment, but due to their inability to pay the charges for an indefinite period without any certainty of obtaining a Government quota bed, they prefer to go away without treatment. *The Committee feel that the matter needs careful consideration by Government. They recommend that the feasibility of increasing the existing number of beds in the Hospital and also rationalising and reducing the charges levied per patient, ensuring thereby full utilisation of the expanded capacity of the Hospital, may be examined.*

(d) *Mental Cases from other Hospitals*

43. As regards the treatment of special and difficult cases from other mental hospitals in India, the Committee were informed that it could be arranged if the Government of India and the State Governments concerned, both agreed to the proposal. *The Committee recommend that Government should evolve a scheme in consultation with the State Governments concerned and admit such patients either in the Government quota or in the independent category; but such cases should not be refused.*

(e) *Equipment*

44. The Study Group of the Committee that visited the Hospital were informed that the work in the Hospital was suffering due to the want of the following items of equipment:—

(i) Magnetic Tape Recorder.

(ii) Electroencephalograph Machine.

(iii) Material for psychological tests.

In this connection, the Committee were informed that a sanction for the purchase of a new tape recorder had been issued. Attempts were being made by the Ministry to obtain a new 8-channel "Grass" Electro-encephalograph, along with some other equipment under the Colombo Plan. Regarding the material for psychological tests, they are not available in the country, but it is considered feasible to manufacture some of them indigenously, if grants are made available for the construction and standardisation of the same. *The Committee suggest thdt the question of indigenous manufacture of the mateial for psychological tests may be pursued in consultation with experts and the Ministry of Commerce and Industry.*

(f) *Development Expenditure*

45. As against a budget provision of Rs. 2,50,000 for the development of the Hospital, during the first two years of the Plan, the Committee were informed that an amount of Rs. 1,18,218 was, actually spent. The shortfall in expenditure is stated to be due to the non-finalisation of the details of additional buildings and equipment. *The Committee consider this rather unfortunate and recommend that special measures should be taken to ensure full utilisation of the amount provided in the Second Five Year Plan for the development of the Hospital.*

(g) *Co-ordination with the Indian Mental Hospital, Ranchi*

46. *In view of the fact that the Hospital for Mental Diseases, Ranchi and the Indian Mental Hospital, Ranchi (under the Government of Bihar) are situated adjacent to each other, the Committee are of opinion that there should be greater co-ordination in the matter of utilising specialised facilities and equipment available in one hospital for the other. For this purpose, they suggest that the feasibility of having either a Joint Advisory Committee or a Co-ordination Committee for these Hospitals may be examined.*

C. **Miscellaneous**

(a) *Inadequate facilities in Union Territories*

47. From the statement given in Appendix II, showing the situation of different mental hospitals in India, it would be seen that such facilities are conspicuously absent in the Union Territories, resulting in a large number of mentally sick patients being locked up in jails and in various other places like the Women's Rescue Homes. *The Committee recommend that Government should devise a scheme whereby it may be possible to provide some healthier accommodation and more appropriate care for the mentally sick persons, misplaced in Rescue Homes and in Jails in the Union Territories, where such facilities are practically non-existent.*

(b) *Personnel*

48. With a view to develop and improve the existing mental health services in India, it is necessary to have properly qualified psychiatrists, psychologists and other types of workers in adequate numbers. The

Committee were informed that one of the reasons for the existing shortage of mental health specialists in the country was due to the reluctance of medical men and women to specialise in this line because of the want of suitable opportunities for employment and promotion. Among the steps taken by Government to increase the number of qualified personnel in the country, the Committee were informed that the Ministry had evolved a scheme for the establishment of Child Guidance Clinics and Psychiatric Departments in teaching hospitals, whereby it was contemplated to establish 13 units at a total cost of Rs. 20 lakhs in the Second Five Year Plan. At the same time, the Ministry had impressed upon the State Governments, to send the maximum number of students to the All India Institute of Mental Health, Bangalore for training. Apart from training the additional number of personnel, the question of ensuring the maximum utilisation of the existing number of qualified personnel is equally important. The Committee understand in this connection that the matter of forming an All India Health Service has been considered in the past and that the Central Council of Health did not consider it necessary to form such a service. *The Committee suggest that the question may be examined again for constituting an All-India Mental Health Service at least.*

49. *The Committee also suggest that pending the formation of an All-India Mental Health Service, Government may pursue the idea of having a Central pool of all the existing medical and non-medical mental health specialists who can move from one institution to another and learn and exchange their experiences in different medical institutions for the care of the mentally sick in the country; the difference in emoluments as a result of such postings should be made up by the Government of India.*

(c) *Assistance from International Organisations*

50. The Committee understand that during the year 1958, five international experts have been provided by the World Health Organisation to work in the All India Institute of Mental Health, Bangalore. *In view of the existing shortage of qualified specialists in the country, the Committee recommend that fullest possible advantage of the technical assistance provided by the International Organisations should be taken in the matter of improving and developing mental health services in the country.*

(d) *Separate Home for Chronic and Incurable Patients*

51. As regards the chronic and incurable patients, the Committee were informed that at one stage, the Ministry had contemplated establishing a separate Home for such patients at Ranchi but the scheme had to be postponed on grounds of economy. *The Committee are of the view that it would be advisable to establish a separate Home for the custodial care of the chronic and incurable patients and recommend that the position in this regard should be reviewed. Such a Home will prove much less costly because specialists for treatment may not be needed.*

52. The Committee were informed by the representative of the Ministry that there was the problem of finding suitable accommodation for incurable mental patients and that the State Governments were not prepared to take up any such schemes without Central assistance. *As ultimately, it would serve the problem of improving the existing mental health services in the country, the Committee recommend that Government should evolve a scheme whereby it may be possible to give assistance to the State Governments and to some non-official organisations in the country for meeting a substantial proportion of their non-recurring and recurring expenditure on schemes designed to fulfil this objective.*

(e) *Work Settlements for Chronic Mental patients*

53. Regarding the necessity of having a plan for the establishment of Work Settlements of chronic mental patients in association with philanthropic social institutions, the Committee were informed that the matter had not been considered by Government. *The Committee suggest that such a scheme may be prepared and taken up for execution by Government and given a fair trial. Apart from the humanitarian aspect, implementation of such a scheme will have the further advantage of replenishing the inadequate bed-capacity in the existing Mental Hospitals for patients suffering from acuate and curable mental diseases.*

IV

CONTRIBUTORY HEALTH SERVICE SCHEME

A. Introduction

54. The Contributory Health Service Scheme for Union Government servants stationed in Delhi and New Delhi, except the Armed Forces personnel and those employed in the Railway Services, was inroduced with effect from the 1st July, 1954. While introducing the Scheme, the Ministry of Health had stated:—

> "The working of the Scheme shall be reviewed after a period of two years from the date of implementation. The Scheme is in the nature of a pilot scheme and on its success will depend the inauguration of a National Health Insurance Scheme. The Government of India, therefore, trust that the beneficiaries of the Scheme will extend their full co-operation in making it a success."

Prior to the introduction of the Scheme, the Central Government Servants had initially to incur the expenditure on their medical treatment under the advice of the authorised medical attendants and get reimbursement of such expenses later on from the Government to the extent admissible under the rules. In the opinion of the Ministry, "the system of reimbursement was a great handicap, especially, for low paid Government employees, who could ill afford to incur the initial expenditure in availing of the facilities provided by Government and getting medical aid at the right time. Besides, it involved considerable clerical labour in the Ministries and Departments of the Government of India. It also resulted in delays in the settlement of claims preferred by Government servants. Class IV Government servants could not get domiciliary service and treatment even in cases of serious illness and their families as well as those of other classes of Government servants were also not entitled to such service and treatment. Moreover, the system of allowing the authorised medical attendants, who were mostly working on a part time basis only, to charge fees, was unsatisfactory and led to a number of malpractices. It raised the amount of reimbursement claims without giving any real benefit to the Government servants." A copy of the Ministry of Health Notification announcing the Contributory Health Service Scheme Rules, 1954 and the facilities available thereunder, is given in Appendix III. The following table gives the figures about the working of this scheme during the years 1954-55 to 1957-58:—

	Year			
	1954	1955	1956	1957
1. Number of Government servants registered under the scheme	53,000	70,600	80,000	88,023

	Year			
	1954	1955	1956	1957
2. Number of beneficiaries . .	2,23,000	2,73,000	3,20,123	4,04,800
3. Number of C. H. S. S. Dispensaries:				
Static . .	16	18	19	21
Mobile . .	..	3	3	3
4. Number of family planning clinics . .	..	6	6	8
5. Number of doctors working under the Scheme:				
Specialists .	11	20	20	20
Assistant Surgeons . .	29	69	69	96
6. Total number of new cases registered in the dispensaries .	2,30,898	7,01,978	9,03,395	10,37,180
7. Total number of new and old cases registered in the dispensaries .	7,37,572	22,95,678	29,62,265	32,50,930
8. Daily average .	4,504	8,092	10,332	10,676
9. Total receipts and expenditure on the Scheme in rupees:				
Receipts . .	7,51,472	16,55,601	20,90,119	22,13,000*
Expenditure .	15,91,368	27,91,174	35,44,967	39,74,400*
(Figures in the brackets indicate expenditure on pay and allowances) .	(7,24,374)	(9,28,140)	(13,40,729)	(13,68,209)

*Based on Budget estimates

B. Financial Results

55. In the absence of the figures of the total cost of reimbursement on medical treatment of the Central Government servants, prior to the introduction of the Contributory Health Service Scheme, the Committee are not in a position to compare the financial advantages or disadvantages of the present Scheme. The following extract, quoted from the brochure on the Contributory Health Service Scheme, published by the Central Health Education Bureau of the Directorate General of Health Services, however, gives a rough idea about the magnitude of the expenditure, previously borne by the Government of India on the

cost of reimbursement of medical treatment of the Central Government servants:—

> "Since reimbursement was effected through various offices, no definite figures regarding its extent are available, but a rough computation put this figure at between Rs. 60 and 75 lakhs per year."

As compared to the amount of Rs. 60 lakhs and Rs. 70 lakhs spent by the Central Government prior to the introduction of the Scheme, the figures of subsidising the cost of the Scheme during each of the last four years are as follows:—

Year	*Amount* Rs.
1954	8,39,896
1955	11,35,573
1956	14,54,848
1957	17,61,400

The following table gives the figures *per capita* of the participants' contribution and the total expenditure on the Scheme from 1954 to 1957:

	Year			
	1954	1955	1956	1957
	Rs.	Rs.	Rs.	Rs.
1. Participants' Contribution *per capita*	14·1	23·4	26·1	25·5*
2. Total Expnditure *per capita*	30·2	39·5	44·3	45·1*
3. Total number of participants	53,000	70,600	80,000	88,023
4. Total number of beneficiaries	2,23,000	2,73,000	3,20,123	4,04,800

*Based on estimates

Taking into account the figures of 1954 and 1956, the Committee observe that with an increase of 50% in the total number of participants and 43% in the total number of beneficiaries, the corresponding amount of contribution has increased by nearly 178%. At the same time, the percentage increase in the total expenditure and the corresponding amount of subsidy met by Government on the Scheme, are 127% and 73% respectively.

C. Doctor-patient Relationship

56. In their Memorandum submitted to the Committee, the Indian Medical Association have stated as follows:—

> "One main objection to the Scheme is that the patients (employees and their families) have no choice of doctors. Whether they like him or not, though they are making their contributions, they have to seek the services of

the doctor allotted to their respective areas. This is against the principle accepted by the World Medical Association and most national Governments of the free countries of the world and the reason is obvious; in order to get the maximum beneficial results, there must be mutual confidence between the doctors and the patients, more so as the doctor-patient relationship is a very intimate and confidential personal relationship. This is particularly so far general practitioner service which is described as family doctor service, where opportunities are given of free choice on the part of both the doctor and the patient and for change, if for any reason one is dissatisfied with the other."

* * * *

"We are strongly of the opinion that the detailed working of the Scheme should be radically altered and free choice of family physicians and consulting specialists should be introduced in the interest of efficiency and perhaps economy."

Referring to this criticism, the Director, C.H.S.S., explained that there were certain limitations under the set up of the Scheme which prevented an unlimited choice of doctors. He enumerated them as follows:—

(a) restricted choice of doctors out of those attached to a particular dispensary, serving a particular area;

(b) restricted choice of selecting a medical officer, out of those attached to a particular dispensary with a view to ensure an equitable distribution of workload among them.

He added that a patient wanting to exercise his choice was not prevented from doing so, but it had often resulted in the formation of long queues for consultation of selected few medical officers, while for others there was not enough work. *The Committee recommend that patients under the C.H.S. Scheme should invariably have their free choice of doctors working within a dispensary in a particular area and that one of the important factors in the assessment of the work of medical officers for the purpose of confirmation, promotion, transfer etc. should be the extent of their popularity earned during the period of their service in a particular area.*

D. Distribution of work-load on doctors

57. The Study Group of the Committee that visited some of the C.H.S. Scheme Dispensaries were informed that the work-load on doctors was more on Saturdays and Mondays and on days preceding and following holidays. The Committee feel that by keeping open the dispensaries on Sundays and holidays, it may not only facilitate the beneficiaries to have ordinary consultations on those days but may also prevent to some extent late attendance in Governments Offices on working days. *The Committee, therefore, recommend that the C.H.S. Dispensaries should be kept open on all days. Till suitable arrangements are made for keeping the C.H.S. dispensaries open on all days,*

it would be useful to keep them open on Sundays and close them on one of the week days. This will give greater facility to the government servants to take advantage of the facilities on Sundays when they have ample spare time at their disposal.

E. Waiting Period

58. The Committee were informed that the waiting period for a patient in a C.H.S. Dispensary was from one to one and a half hour, ordinarily. In order to improve the position and to reduce the waiting time, it has since been decided to open five more dispensaries during 1958-59, bringing the total number of dispensaries to 30 and to appoint additional medical officers as and when necessary. The following additional medical officers have also been sanctioned for the scheme:—

Two Staff Surgeons

Eight Junior Staff Surgeons

Thirty-seven Assistant Surgeons Grade-I.

The Committee note with satisfaction the steps taken by Government to reduce the overcrowding and congestion in the C.H.S. Dispensaries. *They, however, recommend that there should be a constant review of the needs of the different areas served by the C.H.S. Dispensaries in respect of the volume of work and that the average waiting period of a patient should not normally exceed* 30 *to* 45 *minutes.*

F. Facilities for Out-patients

59. The Study Group of the Committee that visited the C.H.S. Dispensary in the main Vinay Nagar observed that the Dispensary was housed in a couple of 'G' Type residential quarters and its rooms were overcrowded with patients, who did not have even adequate sitting space. *The Committee recommend that adequate waiting facilities and sitting arrangements should be provided in all the C.H.S. Dispensaries.*

60. *The Committee emphasise the need to ensure that watermen and sweepers remain constantly on duty at a place assigned to them in the patients' waiting shed and that they regularly perform their duties. They suggest that a small notice board may be displayed in the dispensary at a prominent place to inform the patients about the availability of these free services. The waterpot and utensils should also be kept in a hygienic place and kept scrupulously clean. They also suggest that it will be preferable and more economic in the long run to instal automatic cool water fountains instead of employing watermen and supplying utensils for serving water.*

G. Specialised Facilities

61. The Committee understand that specialist staff consisting of surgical and medical consultants, obstetricians and gynaecologists, and specialists in diseases of the eye, ear, nose and throat and dentists are stationed at the Willingdon and Safdarjang Hospitals for the benefit

of the members of the Scheme. The specialists are of the rank of Staff Surgeons. All Government Servants and their families, irrespective of their pay or status, are entitled to consult the Assistant Surgeons Grade I in the first instance, either at the dispensaries or at their residences. If the Assistant Surgeons Grade I, on first examination, consider that examination by a higher medical officer, *viz.*, a Junior Staff Surgeon or a Staff Surgeon is necessary, they send the patient to them with full particulars of the case. Officers drawing a pay of Rs. 800 per month and above, if they so desire, are entitled to avail of the services of the Staff Surgeons even for first consultation and subsequent treatment. In regard to the availablity of treatment of specialists to the different categories of government servants, it was pointed out to the representative of the Ministry that complaints were sometimes made that the specialists were ordinarily attending on high dignitaries only and that they were often indifferent to the government servants of lower categories. The Committee were informed by the representative of the Mmistry that it was not so. *The Committee would, however, like to emphasise that in the matter of rendering medical treatment by the medical staff, especially, by the specialists working in government hospitals, care should be taken to see that priority is given to the urgent and emergent cases and that there is no discrimination whatsoever in the selection of patients of different economic categories or social status. Criticism is sometimes made that the doctors and the nursing staff employed under the Scheme as whole-time paid government servants, are often unsympathetic towards the patients and do not care too much about pleasing them and treating them with courtesy and consideration. The Committee recommend that Government should take appropriate steps to discourage such an attitude on the part of public servants.*

H. Local Advisory Committees

62. The Committee were informed that there were no local Advisory Committees to the C. H. S. Dispensaries, situated in different areas. In the opinion of the representative of the Ministry, the General Advisory Committee, consisting of the representatives of the Ministries and subordinate offices, and the Service Associations, was functioning satisfactorily. *The Committee feel that a small local committee for every C. H. S. Dispensary may assist the Medical Officer in charge of the dispensary to improve the facilities and to cater to the needs of the beneficiaries of the respective area in a better co-ordinated manner. The Committee, therefore, recommend that local Advisory Committees should be constituted for C. H. S. Dispensaries.*

I. Option of C.H.S.S.

63. Referring to the feasibility of giving an option to government servants for joining the C. H. S. Scheme, the Committee were informed that it was not possible to have two sets of systems which may require the government to entertain applications for frequent changes of option. Another difficulty, conceived from the administrative point of view, was that the Government may be required to provide facilities

also under the Civil Servants Medical Attendance Rules to those Government servants, who may prefer to opt out. The representative of the Ministry stated that the government was saving some money by the introduction of the C. H. S. Scheme, which he considered was not possible in the old system. Asked to state whether the C. H. S. Scheme could be made optional for those Government servants who may agree to forego their claim of reimbursement of the cost of medical treatment, the representative of the Ministry stated that such cases could favourably be considered. *The Committee recommend that a decision on the above lines should be taken and communicated to all the Central Government servants.*

J. Need for Evaluation

64. As stated earlier, the C. H. S. Scheme is in the nature of a pilot scheme for the inauguration of a National Health Insurance Scheme. The Committee were informed that the government intended to expand it gradually with the availability of adequate funds and that the provision was there in the Employees State Insurance Act, whereby the Scheme could be extended to any class or section of the people simply by issuance of a notification. The Committee feel that time has come to give serious consideration to the experience gained by the working of the C. H. S. Scheme during all these years, so that its benefits can be extended to other classes or sections of the people. *The Committee, therefore, recommend that a proper evaluation of the working of the C. H. S. Scheme by an independent agency like the Programme Evaluation Organisation of the Planning Commission may be undertaken to see* (i) *whether the results achieved so far are commensurate with the expenditure incurred,* (ii) *the quality of service rendered, and* (iii) *the satisfaction derived by the beneficiaries. The Committee hope that such an evaluation will not only help the Government in having an objective assessment of the results achieved so far by the C.H.S. Scheme but also help in laying down a solid foundation for a much desired National Health Insurance Scheme for the country.* Prima facie, *the mere facts that the number of beneficiaries, the new cases registered and the daily average attendance have been steadily increasing every year, indicate that the Scheme despite some of its drawbacks, has achieved a measure of success and has met a long felt need of Government servants, specially, in lower categories. In view of this, the Committee suggest that after the above evaluation is completed, the scope of the Scheme may be extended to bring more and more families within its fold. Any such expansion should, however, be preceded by forward thinking, careful planning and adequate preparation. Prompt and adequate medical facilities are a* sine-qua-non *for lasting popularity of the Scheme; and these should not be sacrificed, merely to give increased coverage.*

V

DRUG CONTROL ORGANISATION

A. Introduction

65. As observed by the Health Survey and Development Committee (1945), this country has suffered much in the past from the lack of organised control and supervision over therapeutic substances and medical appliances. The unscrupulous have reaped a rich harvest at the cost of a long suffering public. The need for supervision and control has, however, grown more insistent with the ever widening range of medical substances and appliances that the march of science is, from time to time, bringing into existence and general use. In 1930, the Government of India appointed the Drugs Enquiry Committee under Sir Ram Nath Chopra to investigate the drug position in India. In 1940, the Drugs Act was passed by the Central Legislature giving statutory sanction to the recommendations of that Committee regarding drug control. This Act provides for the control of drugs imported into India as well as of their manufacture, sale and distribution in the country. The Central Government is responsible for the control of import, including 'New Drugs', while the State Governments are authorised to regulate the manufacture, sale and distribution of drugs inside their respective territories. The Central Drug Standard Control Organisation functions under the Drugs Controller (India), who is the authority for granting licences under the Drugs Act for import of biological and other special products coming within the purview of Schedules C and C(1) to the Drugs Rules. The Drugs Controller (India), also exercises control over the import of new drugs into the country. He keeps a close liaison with the State Drug Standard Control Authorities in order to secure uniformity in the administration of the Drugs Act. The Drugs Controller (India) is assisted by a Deputy Drugs Controller (India) and two Assistant Drugs Controllers (India), at the headquarters and one Assistant Drugs Controller at each of the ports of Bombay, Calcutta and Madras and a Technical Officer at the port of Cochin. Besides these offices, the Central Drugs Laboratory, Calcutta, is a statutory institution set up under the Drugs Act to act as the official referee in matters of dispute regarding the composition of drugs when these are referred to the Laboratory by Law Courts and Customs Collectors. The main functions of the Central Drugs Laboratory, Calcutta and the Assistant Drugs Controllers (India), at the ports of Bombay, Calcutta and Madras, and the Technical Officer at the port of Cochin, are given in Appendix IV. *The Committee suggest that the feasibility of permitting import of foreign drugs also at Vishakhapatnam and Kandla may be examined.*

B. Indian Pharmacopoeia

66. The Committee were informed that there were no established methods of assaying Ayurvedic, Unani or Homoeopathic drugs and

that no standards were laid down and maintained. So far as the Ayurvedic and Unani medicines are concerned, they are exempted from the purview of the Drugs Act. The Government of India, however, constituted in November, 1948 a permanent Indian Pharmacopoeia Committee to prepare an Indian Pharmacopoeia and to keep it up-to-date. The Committee prepared a text and the Government published the first edition of the Indian Pharmacopoeia in 1955, which includes many preparations and drugs used both in Ayurveda and in the modern system of medicine. The Pharmacopoeia Committee is reviewing new drugs and getting them standardised. Looking to the large number of indigenous drugs, the representative of the Ministry considered it difficult to fix a particular programme of work which would ensure its completion within some measurable distance of time. However, he added that the Indian Council of Medical Research had a regular plan for the development of indigenous drugs and that every effort was being made to add to the number of drugs which could be included in the Indian Pharmacopoeia from time to time. *While appreciating the difficulties involved in the process, the Committee feel that the work needs greater impetus. They, therefore, recommend that the work of standardisation of indigenous drugs and their inclusion in the Indian Pharmacopoeia should be taken up in a planned manner so as to ensure a continuity of the programme from year to year to be completed within a specified period according to a time schedule. Once the work of standardising the commonly used indigenous drugs and including them in the Indian Pharmacopoeia is completed, periodical revision of that document would be a much simpler task.*

67. *For achieving the above purpose, the Committee recommend that all the available facilities in the country, irrespective of the fact whether they are in the public or the private sector, should be utilised for the purpose of standardising the indigenous drugs which may expedite proper compilation of the Indian Pharmacopoeia. The Committee suggest that Government may take up the work in consultation with the local governments, Universities and similar institutions in the country.*

C. Standardisation of methods of preparation of indigenous drugs

68. The Committee understand that there is no plan for standardising the methods of preparation of Ayurvedic and other indigenous preparations. *In view of the existing diversity in the methods of the preparation of Ayurvedic drugs, the Committee suggest that the feasibility of standardising the methods of preparation of Ayurvedic and other indigenous drugs, may be examined. It may also be worthwhile examining whether some methods could be evolved to ascertain and standardise the proportions of the different constituents of important and famous indigenous medical preparations like the "च्यवनप्राशावलेह" (Chyavanprashavaleh), "मकरध्वज" (Makaradhwaja) etc.*

69. *The Committee consider it to be an unfortunate state of affairs to note that there is no control over the Ayurvedic, Unani and*

Homoeopathic drugs manufactured in India. Lack of any check on the new preparations of drugs put in the market may not only result in the people being cheated by false claims, but may also result in undermining the health of the users and bring discredit to the systems of medicine concerned. *The Committee, therefore, suggest that the feasibility of suitably extending the provisions contained in the Drugs Act and Rules to the Ayurvedic, Unani and Homoeopathic drugs, manufactured in India, or alternatively, bringing a separate legislation for this purpose, may be examined, in consultation with the experts in these systems of medicine.*

D. Replacement of Imported Drugs by Indigenous Drugs

70. The import policy in regard to drugs and medicines is formulated by the Ministry of Commerce and Industry, as in the case of other items. The Development Wing of the Ministry of Commerce and Industry which is responsible for the development of the drug industry in the country, maintains a close liaison with the Drugs Controller (India), and the import policy to be adopted for drugs and medicines is discussed by the two departments with reference to the following aspects:

(i) essentiality of a drug;

(ii) indigenous production capacity;

(iii) availability in the country; and

(iv) price factor.

The representative of the Ministry stated that in order to stimulate the increased indigenous production during the Five Year Plans, only basic raw materials which were absolutely essential for the manufacture of formulations in the country, were allowed to be imported. He added that the National Formulary Committee appointed by the Government of India had also suggested a number of essential formulae and substances for inclusion in the National Formulary which would also help in reducing the import bill to a considerable extent. *The Committee feel that besides increasing the indigenous production of standard drugs, there may be scope for identifying certain drugs manufactured under Ayurvedic, Unani or Homoeopathic formulae which could be substituted for imported drugs. All these methods could help substantially to reduce the import bill of the country. The Committee, therefore, suggest that a special drive may be initiated for replacing the imported drugs by the indigenous drugs, as rapidly as possible. To do so, it is not enough to process imported drugs but a concerted effort must be made to replace imported raw materials by indigenous products. To that end, more emphasis on growing of medicinal plants is necessary.*

E. Drug Inspectorates in States

71. Under the provisions of the Drugs Act, 1940 the responsibility for the control over the quality of drugs manufactured and sold in the country rests with the State Governments. Referring to the

existence of spurious and adulterated drugs, the representative of the Ministry, while acknowledging the fact that a good deal of spurious drugs were to be found in the market, stated that the drug inspection in the various States was grossly inadequate. He informed the Committee that a proposal was made by the Ministry of Health to subsidise the State Governments for strengthening their Drug Inspectorates which may enable them to exercise sufficient check over the sale of spurious drugs, but it was turned down by the Ministry of Finance on the ground that money was not available, unless an excise duty was levied on pharmaceuticals to finance the scheme. *The Committee view with great concern the continued existence of spurious and adulterated drugs in the market due to the ineffective operation of the Drugs Act and Rules in the country and recommend that all remedial measures, including the strengthening of the State Drug Inspectorates, should be taken by Government to check this evil effectively and expeditiously. Even a recourse to levying suitable excise duty on pharmaceuticals may be adopted, if considered inevitable, for achieving this objective, although, it would be undesirable to do so. However, it will be a lesser evil than the prevalence of spurious drugs.*

F. Sub-Standard Drugs

72. Referring to the confiscation of sub-standard drugs, the Drugs Controller (India) stated before the Committee that according to the provisions of the Drugs Act, only those sub-standard drugs could be confiscated and destroyed in respect of which the offender had been convicted in a court of law. He admitted that there was a lacuna in the Drugs Act. *The Committee recommend that the procedure of confiscation of drugs detected to be sub-standard, prior to the institution of the legal proceedings may be suitably examined and tightened up. It should also be ensured that the confiscated drugs are sealed and adequate* care taken against their being used surreptitiously.

G. Punishment for violation of the Drugs Act

73. The Committee understand that under Section 27 of the Drugs Act, 1940 as amended in 1955, the penalty prescribed for the manufacture, sale etc. of drugs in contravention of the various provisions of the Act is a maximum of three years' imprisonment, with or without fine, or both. The Committee understand that often a lenient view is taken for such offences and light punishments are awarded to 'educate' the offenders. *The Committee feel that adequate provision should be made to enable Government to take drastic measures against those responsible for manufacture and sale of sub-standard drugs. The Committee, therefore, recommend that minimum deterrent punishment should he prescribed for the infringement of the Drugs Act and Rules.*

H. Drug Manufacturing Standards

74. In this connection, the Committee quote below the relevant extract from the memorandum received by them from Dr. Lakshmanaswamy Mudaliar:

"Many a piece of legislation is passed in rapid succession which is more or less ineffective in its actual working. One such law pertains to drug control. Spurious drugs, adulterated drugs and various forms of drugs exist all over the country. Now and again, a sensational disclosure is made but this will not to any extent solve the problem, unless the root of the evil is controlled. Drug control must extend to the manufacture of the drugs; the plant must be inspected, the capacity of the persons concerned to exercise reasonably scientific control over these plants must be investigated; the qualifications of the staff must be determined and the establishment must not be treated as a business enterprise of a rich magnate who has more money than brains to start such an enterprise. It is unfortunate that the promotion of the manufacture of drugs would appear to have fallen into the hands of speculators and hence the evil. Drug Control Organisation is woefully deficient in the whole country and it is my experience that unless strong steps are taken, unless proper care is exercised in regard to issue of licence, imposition of penalty, periodic inspection and maintenance of minimum standards, conditions in this country will rapidly deteriorate. I cannot imagine the manufacture of biological products without the exercise of tests, standardisation and proper packing in approved conditions. A visit to some of the great Swiss centres in Basle will reveal the extraordinary care that is being taken by the great organisations that have been set up for the manufacture of drugs. In this country, it almost appears as if somebody can open a drug store and manufacture drugs in the backyard, so to say, of certain premises."

The representative of the Ministry stated that the standards laid down were sufficiently stringent but he admitted that in the administration of the standards there might be some relaxation. *The Committee would like to emphasise that the provisions in respect of the manufacturing standards should be rigidly enforced and that there should not be any relaxation of those minimum standards.* One of the reasons for overlooking some relaxation in the administration of the standards is stated to be the desire not to cause hardship to small manufacturers. The *Committee are definitely of the view that the imperative need of maintaining the quality and standards of drugs should not be compromised in order to encourage the small manufacturers. To help them, the feasibility of their forming themselves into larger and more viable units, such as co-operatives so that they can afford adequate apparatus, staff and premises for proper manufacture of drugs, may be examined.*

I. Centralisation of Drug Control

75. In view of the criticisms made against the Drugs Act, the representative of the Ministry was asked to state whether it

would be desirable to centralise the control over the manufacture of drugs which at present vests in the State Governments under the provisions of the Drugs Act, as recommended by the Pharmaceutical Enquiry Committee. He stated that the matter of the central operation of the Drugs Act had been considered by the Government of India and it was decided not to interfere with the powers of the State Governments. He, however, added that the Ministry was again reconsidering the matter. In this connection, the Committee understand that the Central Council of Health, in their third meeting held at Trivandrum on 25-1-1955, have passed the following resolution to bring the production of drugs and pharmaceuticals under the control of the Central Government:—

> "The Central Council of Health accepts the proposal to bring the production of drugs and pharmaceuticals under the control of the Central Government and recommends that the Drugs Act may be amended accordingly. The Council further recommends that the Government of India shall take immediate steps to pass the amended Drugs Act in the Lok Sabha".

In view of the recommendation of the Central Council of Health, the Committee suggest that the centralisation of drug control machinery, in so far as it concerns the production of drugs and pharmaceuticals, may be expedited.

J. Review of the Drug Control Machinery

76. *With a view to make the drug control really effective in the interest of general health of the people, the Committee feel that the existing machinery for drug control needs an overhaul. The Committee suggest that it may be desirable to appoint a Reviewing Committee to examine the operation of the existing Act and suggest modifications, wherever necessary.*

VI

MEDICAL STORES ORGANISATION

A. Introduction

77. The Medical Stores Organisation of the Government of India was created towards the end of the last century, entirely for the purpose of ensuring the supply of drugs, instruments, appliances, etc. of uniform standard and quality for the Military Medical Units and Veterinary Hospitals. Four Medical Stores Depots were established for this purpose in Bombay, Madras, Calcutta and Lahore respectively. At first these Depots were placed under the control of the respective Surgeons General but in 1894, they were taken over by the Government of India in the Army Department and their administrative control was vested in the Director General of Indian Medical Service. Though originally established to meet the needs of the Military, subsequently, these Depots also started catering to the needs of the civil medical institutions. During the first World War, in view of the difficulties of procurement of medical stores, more and more civil organisations, *e.g.* railways, the then Indian States and numerous municipal and local bodies approached the Government for help and were permitted to get themselves enlisted as regular indentors on the Government Medical Store Depots. Even schools, colleges, laboratories and other scientific institutions which previously used to obtain supplies direct through the Director General, India Stores Department, London, were allowed to obtain their requirements from these depots. To meet these increased demands some of the depots also started the manufacture of tinctures, extracts etc., and two factories, one at Madras and the other at Bombay were established for this purpose. As a result of the recommendation of the Drugs Enquiry Committee (1930-31) the Depots were placed on a new footing, more or less, as commercial organisations on a 'no profit, no loss' basis. During the Second World War, a separate Military Medical Stores Organisation was set up in 1941, and therefore the Medical Store Depots at Bombay, Madras, Calcutta and Lahore became purely civil formations and their administrative control was transferred from the Defence Department to the erstwhile Education, Health and Lands Department of the Government of India. Each of the Medical Stores is placed under the charge of a Deputy Assistant Director General. The policy of the Medical Stores Organisation, as enunciated by the Ministry of Health before the Central Council of Health is 'not only to ensure standard quality but also to supply medical stores and equipment at prices which would compare favourably with those prevailing in the market'. The following table gives in brief the working

results of these depots during the last three years:—

	1955-56	1956-57	1957-58
No. of indentors on the roll .	8,124	9,001	9,573*
Total number of indents served .	6,401	6,098	6,221
Total number of supplementary indents	7,272	8,494	6,718
Total requirements of the indentors in respect of different items stored by Medical Stores Depots	6,26,779	6,56,412	6,33,433
Total number of items supplied to indentors against their indents .	4,46,280	3,94,651	6,14,842
Total value in rupees of the store supplied	1,58,18,202	1,55,30,320	1,79,28,972
Total expenditure incurred . .	1,40,03,717	1,53,73,312	1,68,11,500**
(Figures in brackets represent the expenditure on pay and allowances and land, works, plant and machinery.)	(20,37,359)	(22,65,476)	(26,34,300)

*As on 31-12-57.
**Revised estimates.

B. Correlation of Prices

78. The prices charged for the stores by the Depots depend upon the rates at which they are procured by the Director General of Supplies and Disposals in respect of indigenous items and the Director General, India Stores Department, London, in respect of imported articles. In the case of imported stores, the prices charged by the depots include the cost of freight, packing, landing, wharfage, port charges etc. calculated at the rate of 12½ per cent, plus customs duty, plus 20 per cent as departmental charges; and in the case of indigenous stores, 5 per cent on account of inland freight plus 20 per cent as departmental charges, resulting in a surcharge of 25 per cent. In addition, all transit and packing charges from the depots to the destination of the indentors have to be paid by the indentors. In respect of the manufactured stores, the price is calculated taking into account the cost of the item manufactured in the factory, including the cost of raw material and 5% thereof for inland freight plus 20 per cent as departmental charges. The formula for the calculation of Price Vocabulary (P.V.) rates for the medical stores issued by the depots is given in Appendix V. The Study Group of the Committee that visited the Medical Stores Depot at Madras were informed that the formula did not stipulate any particular period for the calculation of the P.V. rate which was fixed up every time a new consignment was received. *The Committee suggest that there should be close correlation between the prevailing market rates and the rates charged by the Medical Stores Depots and that they should be reviewed periodically.*

79. *The Committee feel that* 20 *per cent departmental charges excluding the freight and customs duty charges appear to be excessive and suggest that the question of suitably reducing this charge may be examined.*

C. Handling Stages

80. The Committee understand that the medical stores procured through the Director General of Supplies and Disposals and the Director General, India Stores Department, London are first received by the respective Medical Stores Depots and then supplied to the indentors. This involves double handling of medical stores. The Committee feel that in some cases of bulk supply of medical stores it may be possible to select certain groups of indentors, major hospitals, etc. for whom arrangements could be made for direct supply of Medical Stores. It may lead to some economy and efficiency in the working of the existing procedure. *With a view to eliminate the work involved in the double handling of stores and to relieve pressure on the Medical Stores Depots as well as to reduce the cost on transportation, the Committee suggest that the feasibility of making arrangements for the direct supply of some of the medical stores to certain indentors and big hospitals at rate contracts, may be explored.*

D. Delays in supply of medical stores

81. *From the table furnished by the Ministry and reproduced below, it will be seen that in comparison with other Medical Stores Depots, which, on an average, take* 30 *to* 45 *days for the compliance of indents, the Medical Stores Depot at Calcutta takes nearly two months*:

Year	Average time taken for compliance of indents	Total No. of stores indents demanded	Total No. of items supplied in the first instance	Percentage of original supply	Total No. of items marked hereafter	Total No. of items supplied on H. A. Voucher	% of H.A. supply	Remarks
			Medical Stores Depot, Karnal					
1955-56	One month	137909	67855	49·2	70054	8268	11·8	
1956-57	Do.	133748	61039	45·7	72649	5131	7·1	
1957-58	Do.	138152	62420	45·2	75732	11428	15·1	
			Medical Stores Depot, Calcutta					
1955-56	45 days	112433	66851	59	45582	6687	14	All outstandings are cleared within 2 months. Whatever is left over is cancelled. Indentors can put in fresh demand if they require those items.
1956-57	34 days	134978	39917	30	95061	1796	1·8	
1957-58	59 days	997586	82892	44	54694	2571	4·7	
			Medical Stores Depot, Bombay					
1955-56	One month	172637	133219	77·1	13557	6507	48	
1956-57	Do.	167186	116908	69·9	18223	5649	31	
1957-58	Do.	166295	122131	69·2	16497	6103	37	
			Medical Stores Depot, Madras					
1955-56	45 days			65%			30	Out of this 15% to 20% are supplied within 2 to 2½ months from the original date of indent.
1956-57	Do.			70%			to	
1957-58	Do.						35	

It is sometimes complained by State Governments that the supply of medical stores is often delayed by several months at the end of which only 30 *per cent or so of the supplies are received and the rest of the quantity is marked 'hereafter'. Since the figures given in the table are average figures, it is obvious that considerable delays must be occurring in individual cases, and there is justification for these complaints.* From the figures given in the table it is also seen that the percentage of the original supply during the last two years has not exceeded 70 per cent of the indented requirements in the case of Medical Stores Depots at Bombay and Madras, and 46 per cent in the case of Medical Stores Depots at Calcutta and Karnal. Even in respect of the total number of items supplied on 'hereafter' voucher, the figures are not at all assuring. *The Committee consider this an unsatisfactory state of affairs and recommend that the question of guaranteeing expeditious full supply of medical stores to the indentors should be carefully examined and the position improved.*

E. Means of Transport

82. With a view to eliminate delays in the consignment of stores to the indentors by rail it may be possible to explore the feasibility of utilising some other transport services available locally, provided they are not costlier. The Committee were informed that it was not safe to entrust Government cargo to transport agents, who might utilise the Road Transport Goods Services in the hands of private bodies, unless the indentors themselves specifically desired to have their supply despatched through such agencies. *The Committee suggest that the feasibility of utilising the State Transport Services in the transit of medical stores to indentors for comparatively shorter distances, may be examined.*

F. Outstanding dues

83. The Study Group of the Committee that visited the Medical Stores Depot at Madras were informed that in respect of non-Government institutions, the adjustment of cost is done under the prepayment system, whereby the parties estimate the cost of the stores required by them at the latest Price Vocabulary of Medical Stores rate and add 30 per cent thereof to cover the probable cost of containers, packing, freight etc. The indent with the treasury chalan is received at the depot and complied with. After the actual issue of stores, the vouchers are priced, got checked and credit balances, if any, are adjusted against the cost of the subsequent indents or refunded if claimed by the indentors. From the figures given in the following table, the Committee observe that large amounts are outstanding for more than one year both from Government and non-Government institutions:

Medical Stores Depots	*Amounts outstanding in Rs.*	
	Govt. Institutions	*Non-Govt. Institutions*
Madras	16,122	42,544
Bombay	27,241	8,818

Calcutta	3,31,617	10,337
Karnal	3,01,984	1,41,640

The Committee observe with regret that an amount of Rs. 1,41,640 *has remained outstanding in the Medical Stores Depot, Karnal in respect of the value of the stores supplied to non-Government institutions. The Committee suggest that the procedure of the recovery of dues, more specially, from non-Government institutions may be reviewed so as to avoid large accumulation of dues.*

G. Losses due to short-life items

84. The value of stores written off by each of the Medical Stores Depots due to deterioration during the last three years is given below:—

(*Amount in Rupees*)

Medical Stores Depots	*Year*		
	1955-56	1956-57	1957-58
Madras	34	915	..
Bombay	1,46,943	569	5,70,471
Calcutta	2,345	1,063	2,130
Karnal	312	1,719	1,910

The figures of losses of the Depot at Bombay are disturbing. The Committee were informed that the main reasons for the surplus stores which became time-barred and had to be written off, were as follows:—

(i) the fluctuating demands of short-life items from the indentors, and

(ii) the sudden reduction in the life of certain subject items (such as P.V. 01884—Tablet Multivitamin, the life of which was reduced from 4 to 2 years).

The Committee suggest that adequate steps may be taken to avoid such losses in future by carefully assessing the fluctuating demands on 'short-life items'. They feel that an arrangement for making the supplies directly to the indentors on the basis of rate contracts may help avoiding this wastage.

H. Supplies by rate contracts

85. The Committee understand that in the U.K., in respect of certain categories of stores, hospitals are permitted to order and obtain such supplies direct from the contractors for which a number of schemes of joint contracting have been developed. *The Committee suggest that Government may examine the feasibility of adopting the method of accepting rate contracts from reliable drug houses in the country for the supply of selected categories of medical stores so as to avoid the need of storage and double handling as far as possible.*

I. Factories

86. The Sub-Committee of the Committee that visited the Medical Stores Depot at Bombay were informed that the Factory attached to the Depot was producing some common articles which could be obtained elsewhere in the market. The volume of production was not such as to have any impact on the market prices for such articles. In this connection, the Committee would like to draw attention to the following recommendation of the Pharmaceutical Enquiry Committee (1954):—

> "Since Government have participated in the manufacture of pharmaceuticals, which is a key industry, through these depots, the Committee do not consider it advisable to scrap them straight-away. The manufacturing activities should be reorganised and the method of management changed to conform to commercial practices. The antiquated equipment should be replaced by modern equipment and in addition to the existing manufacturing activities, production of essential items like fine chemicals, glandular products and vitamins which are not being made adequately by the private sector should be taken up. For example, the Government Stores Depot at Bombay can take up the manufacture of glandular products including the hormones as they are more favourably situated close to a very big slaughter house which could supply the required glands, tissues etc. Similarly the Madras Depot could probably take up the manufacture of vitamins and other related products. The choice, however, of the new products should mainly depend upon the feasibility of such development and availability of raw materials, power, market etc."

The Committee feel that the Factories attached to the Medical Stores Depots could make a useful contribution by manufacturing some of the items of the stores which, though patented, may not ordinarily be available in the market or those which are not taken up for manufacture by the private manufacturers. The production programme of these factories may have to be geared in such a manner as to create an impact on the market and ensure their supply at reasonable rates.

87. *While on the subject of production of medical stores, the Committee recommend that Government should comprehensively examine the question of limiting imports of foreign medical stores and replacing* them by indigenous products according to a phased programme.

J. Losses due to deterioration of stores etc.

88. During the course of their examination, the Committee came across certain instances of losses incurred by the Medical Stores Depots due to the deterioration of stores etc. These are indicated below:—

(a) *Deterioration of Quinine Compounds*

The total stock of quinine items is 1,73,298 lbs., comprising 1,27,207 lbs. of quinine salts and 46,721 lbs. of quinine items other than quinine salts. The total value of all quinine items is Rs. 64,20,450. The total quantity of deteriorated stock in terms of pounds is 14,068 lbs. and its value is Rs. 7,66,012. The deterioration is stated to be due to negligible off-take, and long storage over a period of more than 12 years.

(b) *Oxygen Cylinders*

14,095 oxygen cylinders were acquired in 1949 from the surplus stocks of the Central Provisioning Office (Eastern Group) under the War Office, London, lying at Medical Stores Depot, Raipur at a cost of Rs. 38,000 approximately. An additional cost of Rs. 78,000 was incurred on these cylinders for refitting valves etc. Of these 14,095 cylinders, 8,523 cylinders were declared to the Director General of Supplies and Disposals. The balance was kept for the issues on civil indents. Karnal and Calcutta stocks have been disposed of by the Director General of Supplies and Disposals. It is stated that the balance of the stock lying in Madras and Bombay will be disposed of shortly. Cylinders which are retained by the Depots are being issued on civil indents.

(c) *"M & B 693" Tablets*

The total quantity of "M & B 693" tablets which required reconditioning at all the Medical Stores Depots was 33,50,460 tablets of the total value of Rs. 3,04,892. The quantity so far reconditioned is 18,35,235 tablets. The balance of 15,15,225 tablets requiring reconditioning is lying at the Medical Stores Depot, Calcutta. Reconditioning was undertaken during 1957-58. Out of this reconditioned quantity, nearly 12 lakhs tablets have been issued out. It is stated that further quantity will be reconditioned in instalments as and when demands are received. This reconditioning is being done by the Medical Stores Depot Factory at Bombay.

(d) *Multivitamin Tablets*

The total quantity and value of the Multivitamin tablets written off by the Medical Stores Depot Bombay during the last three years are as follows:—

Item	*Quantity*	*Value*
(i) Multivitamin tablets.	76,98,725	Rs. 1,46,276
(ii) Vitamin Compound tablets.	3,92,85,405	Rs. 5,69,638
	TOTAL	Rs. 7,15,914

The reason for the loss suffered in item (i) above is due to issuing at concessional rate to the Government of Madras *viz.* at half the P.V. rate less 1/6th due to the reduction in the contents of vitamins C and B1. The loss of item (ii) above is due to the vitamin contents of the stock, having become sub-standard. The stocks were issued free of charge as gift to the State Governments for relief work.

(e) *V D R L Antigen*

The losses of V D R L Antigen which have occurred during the last three years are detailed below:—

Cardiolipin Antigen 0·5 cc. amp., boxes of 100

Medical Stores Depot	Boxes	Amps.	Value in Rs.
Madras	30	20	8,758
Karnal	79	51	23,058
Calcutta	886 (boxes of 10 amps)		28,352
		TOTAL	60,168

The loss at Madras and Karnal Depots is due to certain batches of the stocks at these Depots, having been declared over sensitive by the Serologist to the Government of India, Calcutta, before their life expiry. The loss at Calcutta is due to the poor off take and subsequent life expiry.

Referring to the deterioration in respect of the quinine compounds, the representative of the Ministry stated that it had taken place five to six years earlier. He acknowledged that there was considerable slackness in the Directorate. In his opinion some deterioration could have been avoided. Government had, however, taken suitable action against the officers responsible for the deterioration. One officer was severely censured. He had been ultimately removed from the Directorate. Action was also taken against some other officers. He added that the procedure had been revised and the Ministry was receiving quarterly statements for scrutiny. *The above instances indicate that there is an urgent need to improve the working of the Medical Stores Depots, if such losses are to be prevented in future.*

K. Reviewing Committee

89. *The Committee feel that the Medical Stores Depots have not been successful in the objective of ensuring medical supplies adequately, cheaply or promptly.* They quote below the resolution of the Central Council of Health, passed at its sixth meeting held in January, 1958:—

> "The Central Council of Health having considered the views of the Central and the State Governments on the present system of the working of the Central Medical Stores Organisation recommends that the matter be

further examined in the light of the difficulties experienced by the indentors in securing their requirements from the Medical Stores Depots. The Council recommends to the Union Ministry of Health the appointment of a Committee under the Chairmanship of the Secretary of the Health Ministry with the Administrative Medical Officers of the participating States as members, to examine the entire question and to submit its report."

The Committee were informed that a meeting of the Administrative Medical Officers of the States concerned and the Deputy Assistant Directors General of Medical Stores Depots was held in Bombay on the 8th March, 1958, where certain unanimous decisions regarding better working of the Medical Stores Depots had been taken. One of these decisions was to appoint an Advisory Committee for each Depot. These Advisory Committees would hold quarterly meetings by personal discussion. In the opinion of the Government, such a measure would considerably improve the working of the Depots and ensure a regular stream of supply to the indentors. *The Committee are not satisfied with the adequacy of the step taken by Government to meet the requirements. This Organisation is suffering from a number of defects, some of which are indicated below:—*

(a) The machinery engaged in the factories attached to the Medical Stores Depots at Bombay and Madras is obsolete.

(b) The Depots are unable to meet the demands of the indentors fully and promptly. There appears to be a case for enhancing the powers of local purchase of D.A.D.G.

(c) The overhead charges of 20 percent levied by the Depots for the supplies of stores are excessive. Due to this, in some cases the prices charged by the Depots are even higher than the market prices.

(d) The supplies through the D.G. S. & D. are often delayed and the delivery dates are extended liberally.

(e) The position regarding the recovery of dues from the indentors for the supplies made, is unsatisfactory in some cases. The procedure requires to be reviewed and revised. One of the reasons for the delay in the payment of dues is stated to be caused by the delay in the sending of price vouchers by the Medical Stores Depots. It might, therefore, be laid down that the price vouchers should invariably accompany the supplies in all cases.

(f) It is understood that the contracts for the supply of instruments are entered into without the samples being approved. The check over the quality of instruments is exercised only at the post contract stage. This needs looking into.

(g) Storage capacity of some Depots is inadequate. Bombay Depot, for instance, has hired two godowns for which the monthly rent of Rs. 12,200 is being paid. The rent appears to be excessive.

90. *In view of this situation, the Committee recommend that an Expert Reviewing Committee with the association of non-officials should be appointed by Government to review in detail the existing practice and procedure for procurement, stocking, pricing and distribution of stores, and to assess the utility of the Depots and also to suggest measures for assuring a regular supply of foreign and patent medicines to indentors at controlled rates. The Reviewing Committee should also examine,* inter alia, *the necessity of continuing the Medical Stores Depots. If they are to be continued in some form, the Reviewing Committee may also consider whether it would be useful to set up an autonomous corporation to manage all the Medical Stores Depots which would not only store and supply drugs and equipment but might also undertake production on a substantial scale.*

NEW DELHI;
The 19th December, 1958.

BALVANTRAY G. MEHTA.
Chairman,
Estimates Committee.

APPENDIX I

(*Vide* para 15)

Schedule of financial powers delegated to the Medical Superintendents of the Willingdon and Safdarjang Hospitals, New Delhi.

Sl. No.	Nature of Powers	Extent of Powers
1.	Power to incur contingent expenditure.	*Recurring*—Not exceeding Rs. 15 p.m. in each case. *Non-recurring*—Not exceeding Rs. 200 in each case subject to the necessary funds being available.
2.	Power to purchase for the use of his office, books, newspapers or periodicals.	Full power as per item 31 of Appendix 8 to the General Financial Rules, Vol. II, subject to the existence of funds.
3.	Power to incur expenditure on maintenance, purchase and repair of furniture.	Not exceeding Rs. 1,000 per annum provided funds are available.
4.	Power to incur expenditure on repair and maintenance of ambulance car(s).	Not exceeding Rs. 100 at a time subject to a limit of Rs. 1,000/- per annum, provided funds are available and the rules regarding the invitation of tenders are observed.
5.	Power to make petty purchases of stationery and rubber stamps locally.	Upto Rs. 10/- at a time subject to a limit of Rs. 200/- per annum provided funds are available.
6.	Power to write off losses . .	Power to write off losses of irrecoverable value of stores or irrecoverable dues of the institution or public money due to fraud, theft, or negligence of individual or other such causes to the extent of Rs. 100/- in each case, provided that (*i*) the loss does not disclose a defect in the system the amendment of which requires the orders of higher authority and (*ii*) there has not been any serious negligence on the part of some individual officer or officers which might call for disciplinary action requiring the orders of higher authority.

APPENDIX II

(*Vide* para 47)

List of Mental Hospitals in India

Sl. No.	Name of State	Name of Mental Hospital	Number of beds
1.	Andhra. . .	(1) Government Mental Hospital, Waltair . . .	210
		(2) Hospital for Mental Diseases, Jatara . .	600 average strength 750.
2.	Assam . . .	Mental Hospital, Tezpur .	740
3.	Bihar . . .	(1) Hospital for Mental Diseases, Ranchi . .	420
		(2) Indian Mental Hospital, Kanke, Ranchi . .	1380
4.	Bombay . .	(1) Central Mental Hospital, Yervada	1297
		(2) Mental Hospital, Thana .	440
		(3) Mental Hospital, Ahmedabad	317
		(4) Mental Hospital, Baroda	155
		(5) Mental Hospital, Dharwar	249
		(6) Mental Hospital, Ratnagiri	226
		(7) Mental Hospital, Bhavnagar	18
5.	Jammu & Kashmir	Mental Hospital, Srinagar .	24 taken over from Jail Deptt in 1941 (14 beds).
6.	Kerala . . .	(1) Mental Hospital, Colampara, Trivandrum . .	201
		(2) Mental Hospital, Trichur	189
		(3) Govt. Mental Hospital, Kozhikode . . .	364
7	Madhya Pradesh .	(1) Mental Hospital, Nagpur	600
		(2) Mental Hospital, Gwalior	120
		(3) Mental Hospital, Indore	50

Sl. No.	Name of State	Name of Mental Hospital	Number of beds
8	Madras. . .	Govt. Mental Hospital, Madras	888
9	Mysore. . .	Govt. New Mental Hospital, Bangalore . . .	500
10.	Orissa . . .	Nil	75 beds reserved in Mental Hospital, Ranchi for Orissa patients.
11.	Punjab . .	Mental Hospital, Amritsar .	500—another with 30 beds proposed under 2nd plan in the erstwhile PEPSU Region.
12.	Rajasthan . .	(1) Mental Hospital, Jaipur .	120
		(2) Mental Hospital, Jodhpur	60
		(3) Mental Hospital, Udaipur	24
13.	Uttar Pradesh .	(1) Mental Hospital, Agra .	622
		(2) Mental Hospital, Bareilly	412
		(3) Mental Hospital, Benaras	331
14.	West Bengal .	(1) Bangiya Unmad Asram, Dum Dum . . .	85
		(2) Lumbini Park, Mental Hospital, Tiljala 24, Parganas	80
		(3) Mankund Mental Hospital, Calcutta . . .	60
		(4) Mental Observation Ward, Bhawanipur, Calcutta .	30

APPENDIX III

(*Vide* para 54)

Copy of Ministry of Health Notification No. F. 6(I)-30/54-HOSP., June 1954, from the Government of India, Ministry of Health, New Delhi to all the Ministries of the Government of India etc.

S.R.O. 2128.—In exercise of the powers conferred by the proviso to article 309, and in relation to persons serving in the Indian Audit and Accounts Department, also by clause (5) of article 148, of the Constitution, the President, after consultation with the Comptroller and Auditor General as regards, the persons referred to above, hereby makes the following rules, namely:—

1(1) These rules may be called the Contributory Health Service Scheme Rules, 1954.

(2) They shall apply to all persons serving in connection with the affairs of the Union and having their headquarters in Delhi or New Delhi except the following:—

(a) all personnel other than Civilian Government Servants, paid from the Defence Services Estimates;

(b) persons employed in the Railway Services;

(c) persons engaged on contract;

(d) persons not in the whole-time service of Government; and

(e) persons paid out of contingencies.

(3) They shall come into force on the 1st July, 1954.

2. Notwithstanding anything contained in the Secretary of States' Services (Medical Attendance) Rules, 1938, or the Central Services (Medical Attendance) Rules, 1944, the persons referred to in sub-rule (2) of rule 1 shall be governed, in respect of matters relating to medical attendance and treatment by the provisions of the Memorandum of the Government of India in the Ministry of Health No. F. 6(I)-1/54-Hosp., dated the 1st May, 1954 as amended from time to time.

Copy of Ministry of Health Notification No. F.6(1)-30/54-HOSP., dated the 22nd September, 1954.

S.R.O. 3137.—In exercise of the powers conferred by the proviso to article 309 and clause (5) of article 148 of the Constitution the President, after consultation with the Comptroller and Auditor General in relation to persons serving in the Indian Audit and Accounts Depart-

ment, hereby makes the following amendment in the Contributory Health Service Scheme Rules, 1954, published with the notification of the Government of India in the Ministry of Health, S.R.O. No. 2128 dated the 23rd June, 1954, namely:—

In sub-rule (2) of rule 1 of the said Rules, clause (c) shall be omitted, and clauses (d) and (e) shall be relettered as clauses (c) and (d) respectively.

2. This amendment shall take effect from the 1st October, 1954.

Copy of Ministry of Health Memorandum No. F. 6(1)-1|54-HOSP., dated the 1st May 1954 regarding Contributory Health Service Scheme for Central Government Employees in Delhi and New Delhi.

1. The undersigned is directed to say that at present Central Government Servants stationed in Delhi (as in other places) receive medical attendance and treatment to the extent laid down in the Secretary of State's Services (Medical Attendance) Rules, 1938, or the Central Services (Medical Attendance) Rules, 1944, as the case may be. The families of Central Government servants are entitled to receive free medical attendance and treatment to the extent laid down in the orders issued by the Ministry of Finance from time to time. It is felt that the present system as outlined below (Section I), while it is quite expensive to Government, does not provide satisfactory service to the Government servants concerned. The system of reimbursement of medical expenses incurred by Government servants and their families involves not only considerable clerical labour in the Ministries|Departments etc., but also delays in the settlement of claims preferred by Government Servants. With a view to remedying this state of affairs and also to providing a more satisfactory service, the President has decided to introduce a Scheme of Contributory Health Service for Central Government Servants and their families in Delhi and New Delhi. The details of the Scheme are given below:—

SECTION I—PRESENT SYSTEM OF MEDICAL CONCESSIONS

2. (a) *For Government servants other than Class IV servants*:

(i) Free medical attendance by the authorised medical attendant, both in hospital and at the residence of the patients, the latter being restricted to illness requiring confinement to their homes;

(ii) Free medical treatment in hospitals including free service with respect to the diagnostic, medical and surgical facilities available in the institution as well as provision, without payment, of accommodation suited to the status of the Government servant concerned;

(iii) Free medical treatment at the patient's residence if the authorised medical attendant is satisfied that this is

necessary "owing to the remoteness of a suitable hospital or to the severity of illness";

(iv) Supply of such special medicines at the cost of Government as are considered necessary by the medical attendant for the proper treatment of the patient;

(b) *For families of Government servants (other than class IV).*

(i) Free medical attendance at the hospital or at the consulting room of their respective authorised medical attendants

(ii) Free medical treatment in hospitals including supply of special medicines, at the cost of Government, on the same scale and conditions as are allowed to Government servants themselves;

(c) *For Class IV Government servants*:

Free medical attendance and treatment at a hospital including free service with respect to the diagnostic, medical and surgical facilities available in the institution as well as accommodation in free wards and the supply of such special medicines, at the cost of Government, as are considered necessary by the medical attendant for the proper treatment of the patient.

3. Under the present arrangements, Class IV Government servants are not entitled to the services of the authorised medical attendant at their residence, however serious the nature of the illness may be. The families of all Government servants are not entitled to receive medical attendance and treatment at their residence even when they are considered necessary by the authorised medical attendant.

4. Government servants are not required to pay hospital charges for medical treatment in a Government hospital in so far as such treatment is covered by the rules. If, however, they are required by the medical attendants to purchase special medicines not stocked in the hospitals, the charges incurred by them thereon are reimbursed to them by Government on submission of claims. Members of Government servants' families are charged fees by the authorised medical attendant at the prescribed rates; such medical attendance may be at the hospital or at the consulting room of the medical officer concerned. Families are required to pay, in the first instance, the requisite charges for medical service, such charges being recovered later from Government by the Government servant to the extent admissible under the medical attendance rules and orders.

SECTION II—SCOPE AND EXTENT OF APPLICATION OF THE CONTRIBUTORY HEALTH SERVICE SCHEME.

5. The Contributory Health Service Scheme will, for the present, be confined to the Delhi Urban area including New Delhi. The limits

of the locality within which the scheme will be applicable, are those of the New Delhi Municipal Committee, the Delhi Municipal Committee, the Notified Area Committees, Civil Station, Southern New Delhi and Fort, Delhi Cantonment and such other areas as may be notified by the Government of India from time to time.

6. The concessions admissible under the Scheme shall be applicable to:—

(a) All Central Government servants paid from Civil Estimates [illegible] Railway Services and those employed under the Delhi State Government) and having their headquarters in Delhi or New Delhi, and their families;

(b) Civilian Government servants paid from the Defence Services Estimates and having their headquarters in Delhi or New Delhi, and their families;

(c) Ministers of the Central Government, Deputy Ministers, Parliamentary Secretaries while on duty in Delhi, and their families;

(d) Central Government servants whose headquarters are elsewhere than in Delhi and New Delhi and who visit the latter stations on tour or on leave and members of their families but no contribution shall be recovered from them for the services rendered under the Scheme;

(e) Central Government servants and members of their families actually receiving treatment under the Scheme at the time of Government servants' retirement upto a period of one month from the date of actual retirement;

(f) Families of Central Government servants who are on temporary transfer outside Delhi or New Delhi, for a period of less than six months' duration, if they wish to continue the contributions.

7. If a Central Government servant or a member of his family falls ill at a place other than Delhi and New Delhi, treatment shall be admissible under the Secretary of States' Services (Medical Attendance) Rules, 1938, or the Central Services (Medical Attendance) Rules, 1944, as the case may be.

8. The term "family" for the purpose of the Scheme shall consist of—the wife or husband, as the case may be, children or step children and parents who are mainly dependent on and residing with the Government Servant concerned.

SECTION III—DETAILS OF THE SCHEME

9. *Medical Attendance and Treatment*

(a) There shall be three classes of medical officers to provide medical attendance and treatment for Central Government servants and their families, *viz.*, Staff Surgeons, Junior Staff Surgeons and Assistant Surgeons, Grade I. The Staff Surgeons will be attached to the Willingdon Hospital and Nursing Home and the Safdarjang Hospital, New Delhi, while one or more of the other two classes of medical officers will be attached to each of the dispensaries which will be established by the Central Government for the purpose. All Government servants and their families, irrespective of their pay or status, shall when they fall ill, consult the Assistant Surgeons, Grade I, in the first instance, either at the dispensaries or at the medical officers' consulting rooms or if necessary, at their own residences. If the Assistant Surgeons, Grade I, on first examination, consider that examination by a higher medical officer—*viz.*, Junior Staff Surgeon or Staff Surgeon—is necessary, they shall send the patient to them with full particulars of the case. Officers drawing a pay of Rs. 800 p.m. and above, may however, if they so desire, avail of the services of the Staff Surgeons even for first consultation and subsequent treatment. There shall also be Lady Staff Surgeons and Lady Assistant Surgeons, Grade I, for medical attendance and/or treatment of (i) lady members of the families of the Government servants, and (ii) lady Government servants.

(b) All Government servants and their families shall be entitled to free medical attendance and treatment at their residence or at the consulting rooms of the medical officers. As the medical officers will not be in a position to visit the patients at their residence in all cases of illness, medical attendance at the residence of the patients shall be resorted to only in cases requring such attention *i.e.*, when, on account of severity of illness, the patient is unable to consult the medical officer at his consulting room in the hospital or at his residence, or when, on account of protracted illness, it is not possible to provide accommodation in hospitals. In all other cases, medical attendance shall be obtained only at the consulting rooms of the medical officers.

(c) The details regarding the demarcation of various zones, the names and addresses of the medical officers will be intimated later. Every effort will be made to provide the medical officers with accommodation in or near the zone allotted to each of them and with telephones.

(d) *Hospitalisation*: (i) The Government of India have now under their direct control and management two hospitals in New Delhi *viz.*, the Willingdon Hospital and Nursing Home, New Delhi, and the Safdarjang Hospital, New Delhi. Cases requiring hospitalisation shall be admitted to any of these institutions or to such other institutions as may be recognised by the Central Government for this purpose on the advice of the authorised medical attendant, and all facilities for the

proper treatment shall be provided free of charge. The type of accommodation provided will depend upon the status of the Government servant concerned. Except in the case of Government servants whose pay is less than Rs. 100 per month and their families, diet charges, if any, shall be borne by the patient himself.

(ii) A lady member of a Government servant's family or a lady Government servant shall also be entitled to medical treatment at the Lady Hardinge Medical College Hospital, the St. Stephen's Mission Hospital, Tis Hazari or Mrs. Girdhari Lal Maternity Hospital, and in such other hospitals as may be recognised by the Central Government for the purpose, only as an in-patient on the advice of the authorised medical attendant. Payment to these hospitals on account of the treatment of lady Government servants or lady members of Governments servants' families, shall be made direct by the Directorate-General of Health Services, New Delhi, on presentation of bills by the institutions concerned, as and when treatment is given.

10. *Pathological, X-Ray, etc. Examination for Diagnosis*

These examinations shall be conducted on the advice of the authorised medical attendant, free of charge at the Willingdon Hospital and Nursing Home, New Delhi, at the Safdarjang Hospital, New Delhi, or in any other institution recognised by the Central Government for the purpose, in respect of both the Government servants and their families.

11. *Specialist consultation and treatment*

Specialists for the diseases of the eye, ear, nose and throat and also dental surgeons shall be employed. Consultation with these specialists and subsequent treatment shall be obtained on the advice of the authorised medical attendants. Treatment of eye diseases, testing of eye-sight for glasses and all kinds of dental treatment shall be provided free. Provision of spectacles, artificial dentures, and hearing aids, free of cost, do not come within the purview of the Scheme.

12. *Concessions for treatment of special diseases*

(1) Central Government servants and/or members of their families suffering from special diseases like Tuberculosis, Cancer and Poliomyelitis, shall receive ordinary treatment from their respective authorised medical attendants. If the authorised medical attendant considers that the patient requires treatment at the hands of a specialist in Tuberculosis, Cancer, Poliomyelitis, or treatment in a specialised institution for such diseases, the following procedure shall be observed:—

(a) *Tuberculosis*

The authorised medical attendant shall send the patient, with full particulars of the case to the specialists in the New Delhi Tuberculosis Centre, New Delhi, for expert opinion. If the Tuberculosis

Specialist thus consulted recommends ambulatory treatment, such treatment will be given by the authorised medical attendant on the periodic advice and direction given by the specialist at the Centre. If, however, the specialist recommends sanatorium treatment as an in-patient, the Directorate-General of Health Services, should be approached in writing by the patient or by the Government servant concerned for a free bed either at the Lady Linlithgow Sanatorium, Kasauli, King Edward Sanatorium, Dharampore, Lala Ram Sarup T.B. Cottage Hospital, Mehrauli, Madar Union Sanatorium, Madar, Ajmer, or at such other institutions as may be recognised by the Government of India from time to time. The hospital charges incurred at these institutions (except diet charges) and the fees charged by the Tuberculosis specialists for consultation, X-ray, etc., shall be paid direct by the Directorate-General of Health Services, New Delhi, on presentation of bills by the institutions/specialists concerned. In the case of the Government servants whose pay is less than Rs. 100 p.m. diet charges shall also be borne by Government.

(b) *Cancer*

Special facilities for treatment for cancer exist in the following hospitals :—

(1) Irwin Hospital, New Delhi.

(2) Lady Hardinge Medical College Hospital, New Delhi. The authorised medical attendant shall, under intimation to the Directorate-General of Health Services send the patient to these hospitals for treatment. If the specialist in the institution to whom the patient is sent for treatment recommends that special treatment at the Tata Memorial Hospital, Bombay, is necessary, the patient will be referred to that institution by the authorised medical attendant in consultation with and with the approval of the Directorate-General of Health Services, New Delhi. All the charges incurred for the treatment, except diet charges, shall be paid direct by the Directorate-General of Health Services, New Delhi, on presentation of bills by the institutions concerned. In the case of Government servants whose pay is less than Rs. 100 p.m. and their families, the diet charges shall also be borne by the Government.

(c) *Poliomyelitis*

The following hospitals in Delhi have special facilities for treatment for poliomyelitis :—

(1) Irwin Hospital, New Delhi.

(2) Safdarjang Hospital, New Delhi.

(3) Lady Hardinge Medical College Hospital, New Delhi. The authorised medical attendant shall, under intimation to the Directorate-General of Health Services, send the patient to any of these hospitals for treatment. If the specialist in the institution to whom the patient is sent for treatment recommends that treatment in the Children's Orthopaedic Hospital, Bombay, is necessary, the patient will be referred to that institution in consultation with and with the approval of the Directorate-General of Health Services, New Delhi. All the charges incurred for the treatment, except diet charges, shall be paid direct by the Directorate-General of Health Services, New Delhi, on presentation of bills by the institution concerned. In the case of Government servants whose pay is less than Rs. 100 p.m. and their families the diet charges shall also be borne by Government.

(2) In all cases requiring special treatment at an institution outside Delhi, the Government servants or members of their families may have to incur expenditure on travelling. A Government servant in such circumstances, shall be entitled to travelling allowance for the outward and return journey, *i.e.*, 1½ rail fare of the class of accommodation to which he is entitled or of any lower class by which he may travel, but no halting allowance shall be paid. If the travelling allowance is claimed in respect of a member of a Government servant's family suffering from any one of the special diseases mentioned in this paragraph actual single railway fare of the class of accommodation to which the Government servant is entitled or of any lower class by which the patient actually travels, shall be admissible to and from the place of treatment. If the authorised medical attendant certifies in writing that it is unsafe for the patient to travel unattended and that an attendant is necessary to accompany him to the place of treatment, the attendant accompanying the patient shall be granted actual single railway fare, both ways of the appropriate class in which the patient travels or of a lower class by which the attendant actually travels.

NOTE.—The outward journey will be deemed to have commenced from the headquarters of the Government servant or from the place from which the patient actually travels, whichever is nearer to the hospital. Likewise the return journey will be deemed to have ended at the headquarters or at the place to which the patient actually travels, whichever is nearer.

13. *Maternity Cases.*—Apart from the hospitals mentioned in paragraph 9(d)(ii), the following Maternity and Child Welfare Centres in Delhi have arrangements for in-patients in cases of confinement:—

(a) Maternity and Child Welfare Centre, Lodi Road.
(b) Maternity and Child Welfare Centre, Rajendar Nagar.
(c) Maternity and Child Welfare Centre, Kingsway Camp.
(d) Maternity and Child Welfare Centre, Daryaganj.

Charges leviable for treatment at these centres or through these centres at the Government servants' residence shall be paid direct by the Directorate-General of Health Services, New Delhi, on presentation of bills by the centres concerned.

14. *Arrangements for the storage and issue of Medicines, etc.*

There shall be a Central Medical Store Depot in Delhi in charge of an Assistant Superintendent. This depot shall build up and replenish its stock of medicines by indenting on the Medical Stores Organisation under the control of the Directorate-General of Health Services, and, whenever necessary, by purchase from the open market. The Medical Officers in charge of the hospitals and dispensaries set up under the Scheme shall obtain their requirements from the depot referred to above once a month or oftener, whenever necessary, in emergent cases, through proper receipts and issue vouchers. The actual issues of medicines to Government servants and their families shall be made by these hospitals and dispensaries on the authority of the prescriptions from the authorised medical attendants. Each hospital and dispensary shall maintain an account of the receipt and issue of special medicines together with the name, number and disease of the patient for whom they are prescribed. This account shall be checked by the medical officer in charge of the dispensary and occasionally also by the Staff Surgeon who will be in supervisory charge of the hospital or dispensary concerned. The system of work in the medical store depot under the Scheme in Delhi shall be maintained after the pattern of the Central Medical Store Depot, Karnal.

All important drugs shall be maintained in stock. A Committee of Experts shall from time to time review the list of special medicines stocked.

15. *Contributions recoverable under the Scheme*

(a) For the improved medical service provided under the Scheme, a compulsory monthly contribution on a graded scale shall be levied on Ministers, Deputy Ministers, Parliamentary Secretaries and all classes of Government servants as indicated below:—

Gradation according to pay	*Rate of monthly contribution*
1. Rs. 2,000 and above	Rs. 12/-
2. From Rs. 1,500 to Rs. 1,999	Rs. 9/-
3. From Rs. 1,000 to Rs. 1,499	Rs. 6/-
4. From Rs. 750 to Rs. 999	Rs. 5/-
5. From Rs. 500 to Rs. 749	Rs. 4/-
6. From Rs. 250 to Rs. 499	Rs. 2/8/-
7. From Rs. 151 to Rs. 249	Rs. 1/8/-
8. From Rs. 76 to Rs. 150	Re. -/12/-
9. Upto Rs. 75	Re. -/8/-

(b) "Pay" for the purpose of the recovery of contributions shall be:—

(1) Pay as defined in F. R. 9 (21) (a):
(2) Dearness Pay.

(c) The contributions shall be recovered on the basis of rate of pay of the Government servant on the first day of each month and in the case of persons newly appointed or transferred to Delhi after the first day of the month, on the basis of the rate of pay for the day of the first appointment or assumption of duty in Delhi.

(d) In the case of Government servant on leave, the contributions shall be recovered on the basis of the pay last drawn by him immediately before proceeding on leave.

(e) The contributions shall be recovered from Government servants during periods of duty as well as leave of all kinds not exceeding four months other than extraordinary leave, irrespective of the place where it is spent. But they will not be recovered if the controlling authority certifies that the Government servant concerned is likely to be posted elsewhere on the expiry of his leave and that neither he nor any member of his family entitled to the benefits of the Scheme will stay during any part of his leave in Delhi. If the facts go contrary to the certificate granted and the officer is actually reposted to Delhi, contributions shall be recovered for the entire period of leave in such instalments as may be decided by the head of the office.

(f) In case of leave exceeding four months, the Government servants shall be treated as though on temporary transfer outside Delhi and New Delhi and shall be given the same option as is given to Government servants under sub-paragraph (i) below.

(g) In the case of extra-ordinary leave without pay, the Government servant shall be given the option to contribute and obtain the benefits of the Scheme or to discontinue the contributions. The contributions in such cases shall be recovered in cash in advance.

(h) In the case of a Government servant under suspension and in receipt of a subsistence grant, the contribution shall be recovered on the basis of the amount of the subsistence grant, provided that if such Government servant is subsequently allowed to draw pay for the period of suspension the difference between the contribution recovered on the basis of the subsistence grant and the contribution due on the basis of the pay ultimately drawn shall be recovered from him.

(i) The contributions shall continue to be recovered from the Government servant who is on a temporary transfer outside New Delhi or Delhi for a period of less than six months' duration but whose family continues to reside there, provided that the Government servant himself expresses the wish to continue the contribution in which case the members of his family shall continue to receive the benefits of the Scheme while the Government servant is away on temporary transfer. if, however, he does not wish to contribute during the period in question, the members of his family shall not be entitled to the concessions under the Scheme. This fact will be communicated to the medical officer in charge of the dispensary which serves the area in which the Government servant's family resides. The contributions in such cases shall be recovered in cash by the head of the office and deposited in the Treasury in the usual manner.

(j) If the appointment of a Government servant in or on transfer to Delhi takes place within the first fifteen days of a month, the recovery of contributions shall be made for the full month, otherwise it shall be waived altogether for that month. The same principle shall apply to Government servants transferred from Delhi *i.e.*, in the case of Government servants transferred after the 15th of a month, the recovery for the full month shall be made while in the case of those transferred from an earlier date of a month the recovery for that month shall be waived.

(k) If a Government servant retires in the course of a month, contributions shall be recovered for the full month if the actual date of retirement is after the 15th of the month. If, however, the actual date of retirement takes place before the 15th of the month, the recovery of contributions for that month shall be waived.

If the Government servant who retires from service wishes to continue to avail of the concessions under the Scheme up to a period of one month from the actual date of retirement for himself or any member of his family who is actually receiving treatment, on the date of retirement, from the medical officers employed under the Scheme, contributions shall be recovered in full from him. In such cases contributions shall be recovered in cash in advance and deposited in the Treasury in the usual manner.

(l) When both the husband and the wife are Central Government servants employed in Delhi, the contribution shall be recovered from only one of them whose pay is higher. In such cases, the Government servant, whose pay is higher, shall give a certificate every month in writing to the head of his/her office that his wife/her husband is not in receipt of pay exceeding his/her pay, if he/she is non-gazetted. In the case of gazetted Government servants, such certificate should be endorsed every month on the salary bills which are drawn directly on the Treasury.

(m) In the case of Parliamentary Secretaries, the contribution shall be recovered during the periods Parliament is in session at Rs. 6/- p.m. and during non-session periods, when they are on duty in Delhi, at Rs. 4/- p.m.

(n) In the case of Gazetted Officers, the accounts officers concerned will effect the recoveries at the rate of contribution prescribed, while in the case of non-gazetted employees, the head of the office shall be responsible for the recoveries at the prescribed rates of contribution.

(o) The contributions shall be recovered through the monthly pay bills of Government servants. The contributions recovered from all Government servants, other than those who are paid from the Defence Services Estimates and those employed in the Posts and Telegraphs Department, shall be credited to a new minor head of account

"Receipts under the Contributory Health Service Scheme for Government servants" under the major head XXVII-Medical. The contributions recovered from the Government servants paid from the Defence Services Estimates shall be credited to their revenues and those recovered from the employees of the Posts and Telegraphs Department shall be credited to the Posts and Telegraphs Revenues.

(p) The contributions shall be leviable from the date of implementation of the Scheme.

SECTION IV—ADMINISTRATION AND DATE OF IMPLEMENTATION OF THE SCHEME

16. The Scheme shall be administered by the Government of India, Ministry of Health, through the Director-General of Health Services, New Delhi, who shall be the "Head of the Department" for the purpose. The date of implementation of the Scheme will be notified later. The existing provisions in the Secretary of State's Services (Medical Attendance) Rules, 1938, and the Central Services (Medical Attendance) Rules, 1944 and the orders issued by the Ministry of Finance from time to time shall stand modified, with effect from the date of implementation of the Scheme, to the extent indicated above. Necessary amendments to the Medical Attendance Rules will be issued in due course.

Functions of the Head of Office under the Scheme

17. (a) The Head of the office shall be responsible for the recovery of contribution at the prescribed rates from the non-gazetted Government servants employed under him. He will also, in addition be responsible for the contributions recoverable in cash from Government servants, both gazetted and non-gazetted, on extra-ordinary leave, temporary transfer outside New Delhi and Delhi, or on retirement upto a period of one month from the date of such retirement and for the deposit of the contributions, thus collected in the Treasury in the usual manner.

(b) In the event of stoppage of contributions by Government servants on account of leave exceeding four months, extra-ordinary leave without pay, transfer, termination of service, retirement, etc., the head of office shall intimate the fact immediately to the accounts officers concerned and to the Directorate-General of Health Services. He shall also be responsible for the surrender of identity cards, family cards, etc., by such Government servants.

SECTION V—EXPENDITURE ON THE SCHEME

18. The total expenditure on the Scheme shall be debitable to the head of account "38-Medical-Health Services for Government employees in Delhi". One seventh of the total expenditure involved in the Scheme plus a sum of Rs. 40,000/- shall provisionally be recovered from the Defence Services Estimates. An amount to be determined

shortly shall be recovered from the revenues of the Posts and Telegraphs Department. The proportion of the expenditure to be borne by the Defence Ministry and the P. & T. Department will be periodically reviewed.

SECTION VI.—APPLICATION OF THESE ORDERS TO OFFICERS AND STAFF OF THE INDIAN AUDIT AND ACCOUNTS DEPARTMENT

19. In so far as persons serving in the Indian Audit and Accounts Department and having their headquarters in Delhi and New Delhi are concerned, these orders are issued with the concurrence of the Comptroller and Auditor-General of India.

SECTION VII—CONCLUSIONS

20. The working of the Scheme shall be reviewed after a period of two years from the date of implementation. The Scheme is in the nature of a pilot Scheme and on its success will depend the inauguration of a National Health Insurance Scheme. The Government of India, therefore, trust that the beneficiaries of the Scheme will extend their full co-operation in making it a success.

APPENDIX IV

(*Vide* Para 65)

Main functions of the Central Drugs Laboratory, Calcutta, and the Assistant Drugs Controllers (India) at the ports of Bombay, Calcutta and Madras and the Technical Officer at the port of Cochin.

Central Drugs Laboratory, Calcutta

(i) To analyse or test such samples of drugs as may be sent to it under sub-section (2) of Section II, or under sub-section (4) of section 25, of the Drugs Act.

(ii) To carry out such other duties as may be entrusted to it by the Central Government or, with permission of the Central Government by a State Government after consultation with Drugs Technical Board.

(iii) To act as the official referee in matters of dispute regarding the composition of drugs when these are referred to the laboratory by law courts and Customs Collectors, and also as an analytical laboratory under the Drugs Act for certain States which have no such facilities of their own.

(iv) To train candidates sponsored by State Governments as well as representatives from the trade in analytical work.

Offices of the Assistant Drugs Controller (India) at Ports viz. *Bombay Calcutta and Madras and the Technical Officer, Cochin*

(i) Scrutiny of bills of entry relating to import of drugs with a view to ensuring that they comply with the provisions of the Drugs Act and the Rules made thereunder.

(ii) To take samples of imported drugs with a view to ensuring that all imported drugs conform to the standard prescribed in the Drugs Act and the Rules thereunder.

(iii) To ensure that the drugs imported, which come within the purview of Schedules C and D (1) to the Drugs Rules are duly covered by an Import Licence under the Drugs Act.

(iv) To ensure that no new drug is imported into the country unless its import is permitted by the Drug Licensing Authority under Rule 30-A of the Drugs Rules.

(v) To ensure that small quantities of the drugs imported for clinical trials in the country or for personal use are duly covered by an import licence in form No. 11 and 12 B under the Drugs Act.

(vi) Examination of samples of drugs with a view to ascertaining that they conform to the labelling and other requirements of the Drugs Act, 1940 and the Drugs Rules 1945 and the drugs imported are of standard quality.

(vii) Maintenance of statistics regarding imports of essential drugs.

(viii) Liaison with the Collector of Customs on matters connected with the administration of the Drugs Act and Rules.

(ix) Liaison with State Drugs Control Authorities.

(x) Advising the members of the trade with regard to the provisions and requirements of the Drugs Act and the Drugs Rules.

(xi) Exercising of a running check over the quality of biological products by taking samples under Rule 26 of the Drugs Rules, with a view to ensuring that their potency does not deteriorate during storage period in the godowns of the importers.

APPENDIX V

(*Vide* para 78)

Formula for the fixation of P.V. rates charged by Medical Stores Depots

No. F. 24-44|55-D

Government of India

Ministry of Health

New Delhi-2, the 7th July, 1956.

From

Shri T. V. Anantanarayanan, M.A.

Under Secretary to the Government of India.

To

The Director General of Health Services,

New Delhi.

Subject: Medical Store Depots—Fixation of P.V. rates—Formula.

Sir,

In supersession of all previous orders on the subject the President has been pleased to decide that the P.V. rates for Medical Stores issued by the Medical Stores Depots shall be calculated according to the following formula:—

I. *Indigenous Stores*

(a) Actual cost of stores (including sales tax when applicable) plus 5% thereof for inland freight charges.

(b) Add 20% of (a) for departmental charges.

(c) Add value of stock balance at the time of fresh receipts at the existing P.V. rate.

(d) Divide the total of (a), (b) and (c) by the total quantity of stock *i.e.* existing stocks plus fresh receipts to arrive at the P.V. rate.

II. *Imported Stores*

(a) Invoice price.

(b) Add 12½% for freight, packing, landing, wharfage, haulage and other port charges.

(c) Add customs duty as per percentages notified by the Ministry of Finance (Defence) from time to time.

(d) Add 20% of the total of (a), (b) and (c) for departmental charges.

(e) Add value of stock balance at the time of fresh receipt at the existing P.V. rate.

(f) Divide the total of (a), (b), (c), (d) and (e) by the total quantity of stock, *i.e.* existing stocks plus fresh receipts to arrive at the P.V. rate.

III. *Manufactured Stores*

(a) Cost of the item manufactured in the Medical Stores Depot including the cost of raw material and 5% thereof for inland freight.

(b) Add 20% of (a) for departmental charges.

(c) Add value of stock balance at the time of fresh receipt.

(d) Divide the total of (a), (b) and (c) by the total quantity of stock *i.e.* existing stocks plus the fresh receipts to arrive at the P.V. rate.

2. I am to add that it has also been decided that P.V. rates should not be altered where the fluctuation as a result of the calculation on the basis aforesaid is 4% or less.

I am also to convey the sanction of the President to the delegation of powers to the Deputy Assistant Directors General (Medical Stores), Medical Stores Depots, Madras, Bombay, Calcutta and Karnal to fix P.V. rates in accordance with formulae laid down in para 1 above.

Yours faithfully,
Under Secretary.

Copy of letter, from the Accountant General, Madras, No. LA. MSD/ 427 dated 31-7-56, to the Secretary to the Government of India (Ministry of Health) New Delhi.

Subject: Medical Store Depots—Fixation of P.V. rates—Formulae.

Reference: Letter No. F. 24-44|55-D dated 7-7-56 from the Government of India, Ministry of Health, New Delhi to the Director General of Health Services, New Delhi, copy received with Government of India (Finance Department) Endorsement No. 5759-EG. V|56 dated 12-7-56.

With reference to the orders of the Government of India referred to above, it is presumed that the intention of Government is to give effect to the revised formula in costing from the date of the orders (*viz.*) 7-7-56 which, in effect, will be that the formulae will have to be applied for the receipts from July, 1956 onwards, the rates so calculated being applicable to the Issue vouchers from August, 1956 onwards. The above presumption may please be confirmed.

It may also be clarified whether the 5% addition for inland freight for manufactured items referred to in para 1 (III) (a) is on the cost of the raw materials alone or on the total cost of manufacture inclusive of the cost of the raw materials.

Copy of letter No. F. 18-20|57-*D dated* 4-10-57 *from the Government of India, Ministry of Health, New Delhi to the Accountant General, Madras.*

With reference to the correspondence ending with your letter No. LA.MSD|412 dated the 27th September, 1957 on the subject mentioned above, I am directed to confirm presumption made in para 1 of your letter No. LA.MSD|427 dated the 30th July, 1956. As regards para 2 I am to state that the 5% charges for inland freight for manufactured items referred to in para 1(III) (a) in the formula indicated in this Ministry's letter No. F. 24-44|55-D dated the 7th July, 1956 is based on the cost of Raw Materials alone.

APPENDIX VI

Statement showing the summary of conclusions/recommendations of the Estimates Committee contained in the Report

Sl. No.	Reference to paragraph No in the Report	Summary of conclusions/recommendations
1	2	3
1	5	(*i*) The present Medical and Public Health facilities are totally insufficient to meet the requirements of a Welfare State. (*ii*) The Committee are of the view that the existing provision in the Plan for Medical and Public Health is inadequate, and that in the Third Plan much larger percentage of expenditure in the Central and State Budgets will have to be earmarked for these services.
2	5	Another disconcerting feature noticed by the Committee, is that in spite of the very limited provision made in the Second Plan, several schemes for which funds have been provided, have not progressed according to the schedule. This clearly points to the urgent necessity of tuning up the administrative machinery both at the Central and State levels.
3	7	In regard to the subject of Hospitals and Dispensaries, many of the observations and suggestions of the Committee, contained in Chapter II of the Report will be applicable to all Hospitals and Dispensaries in the country. The Committee have no doubt that such suggestions of general applicability will be placed before the Central Council of Health.
4	8	The training facilities of medical personnel will have to be suitably augmented, if the target laid down in the Second Five Year Plan is to be achieved.
5	12	The Committee observe that the rise in expenditure during 1954 to 1957 in respect of the Safdarjang and Willingdon Hospitals is disproportionate to the increase in the number of indoor and out-door patients. This needs investigation.

1	2	3
6	13	(*i*) The Committee recommend that the hospitals directly administered by the Ministry of Health, should have properly constituted non-official Advisory Committees with adequate scope of work to enable them to function in an effective manner. (*ii*) Suitable rules should be framed regarding the procedure of work of these Advisory Committees, including the number of meetings to be held, recording of the minutes of meetins etc. (*iii*) The Committee suggest that after these Advisory Committees gather some experience, the question of converting them into Hospital Management Committees may be examined.
7	14	The Committee recommend that the Medical Superintendents in-charge of Government hospitals should be assisted by non-medical administrative officers, under their supervision, to deal with routine administrative work in order to enable the former to devote more time to professional work.
8	15	The Committee recommend that the existing powers delegated to the Medical Superintendents in-charge of the Willingdon and Safdarjang Hospitals, and similar other institutions under the overall charge of the Ministry of Health should be reviewed with a view to delegate more powers for the efficient running of these institutions.
9	16	The Committee suggest that the feasibility of devising some system, whereby it may be possible to pool specialised facilities under a Central Co-ordinating Organisation for guiding the patients to proper medical specialists in different hospitals on a regional basis may be explored.
10	17	The Committee suggest that besides giving facilities to qualified general medical practitioners for investigation and advice of specialists, Government may suitably encourage by providing suitable grants the establishment of pathological laboratories by competent private agencies, who may come forward to render such services at reasonable standard rates.
11	18	(*i*) The Committee consider it to be an unfortunate state of affairs to note that 24 beds in the Willingdon Hospital, New Delhi should have remained vacant for nearly 5 months from 11-4-1958 to 8-9-1958. At the same time, they observed that there was overcrowding in other hospitals and in other wards of the same hospital resulting in placing of patients on the floor.

1	2	3
		(*ii*) The Committee recommend that the Ministry of Health should explore the feasibility of entrusting the task of co-ordination and mobilisation of all the available hospital beds in Delhi and New Delhi to the Central Co-ordinating Organisation suggested in paragraph 16 of the Report. It should be the job of this Organisation to see to it that proper planning is done so that staff and equipment are made available immediately on the completion of a building and that hospital beds are not allowed to remain unoccupied for more than a week or so after completion.
12	19	The Committee recommend that the Ministry should launch a special drive to attract a large number of blood donors: (*a*) by adopting appropriate means of publicity to emphasise the humanitarian aspect of blood donation, (*b*) by evolving suitable schemes for Blood Bank Insurance on the lines of similar schemes in some foreign countries, which will guarantee free supply of blood for the donor and his family, if necessity arises.
13	20	The Committee recommend that the idea of having a centralised blood bank for the various hospitals in Delhi area may be developed and given a concrete shape. This may be treated as a pilot project, and if it proves successful, the State Governments may be requested to establish similar centralised blood banks in their respective States. Such a centralised blood bank would make it possible to use the surplus blood for the production of blood plasma and prevent its wastage.
14	21	(*i*) The Committee recommend that Government hospitals should either supply dentures and spectacles at no-profit no-loss basis or maintain an approved panel of dentists and opticians, who may agree to serve the patients directed by Government hospitals with such aids at reasonable standard rates, which should be made known to all. (*ii*) They also suggest that such a Scheme should be made applicable to all patients served by Government hospitals irrespective of the fact whether they are Contributory Health Service Scheme patients or the general public.
15	22	The Committee suggest that Government may give suitable grants-in-aid, if necessary, to competent public institutions which may come forward to render such services (*viz.*, supply of dentures and spectacles) at comparatively lower rates to be fixed by Government.

1	2	3
16	23	The Committee suggest that the procedure of reviewing of the cases of deaths occurring in Government hospitals may be examined and a standard procedure evolved, which may include *inter alia* a detailed investigation of the causes of every death by a small committee consisting of the medical experts, proper recording of the proceedings of the meetings of the Investigation Committee, and remedial measures for future guidance.
17	24	(*i*) The Committee consider it necessary to impress upon Class IV staff, employed in hospitals, the importance of their functions and responsibilities which may not only enhance their efficiency and utility but also assure better service to the patients. (*ii*) The Committee suggest that Class IV staff, immediately on their appointment in big hospitals, should receive a short course of training in hygiene, specially, in respect of the technique of sweeping the floor, cleaning the bed pans etc., keeping the bed sheets and other linen clean, cleansing the furniture and other atricles and observing proper bedside manners. Importance of prompt and willing attention to the calls of patients should also be stressed during this training.
18	25	The Committee recommend that complaint books should be maintained in all the wards and out-patient departments in hospitals, administered by the Ministry of Health. Such complaints should be reviewed periodically by the Medical Superintendent in-charge of the hospital with the assistance of the Hospital Advisory Committee, and the nature of action taken over each of the complaints should be briefly indicated under his signature.
19	26	In view of the sustained overcrowding in dispensaries and out-patient departments of Government hospitals in New Delhi, and looking to the high cost of establishing new hospitals or expanding the existing ones, the Committee suggest that the feasibility of working double shifts in out-patient departments of government hospitals in New Delhi may be examined.
20	27	Besides organising the outdoor facilities on the lines suggested above, the Committee suggest that the easibility of suitably organising the Ayurvedic and other dispensaries on an experimental basis to serve the out-patients, may also be examined.

1	2	3
21	28	The Committee recommend that the waiting facilities for patients in the Safdarjang and Willingdon Hospitals should be improved.
22	29	The Committee suggest that the procedure of the levy and recovery of charges from patients may be reviewed so as to plug all loopholes which enable the private patients to conceal their true income and thus avoid payment of legitimate dues to the hospital.
23	30	The Committee recommend that small brochures, containing information about the nature of facilities available in each hospital, the procedure to be followed to avail of them and the approximate cost involved, should be published and made available to members of the public.
24	31	(*i*) The Committee feel that the chief criteria of financial efficiency of a hospital can be judged only if costing statistics are standardised and compiled on a scientific basis and published from time to time. This alone would make it possible to make valid comparisons between the costs prevailing in different hospitals.
		(*ii*) The Committee recommend that costing statistics should be standardised and introduced in Government hospitals.
25	32	(*i*) With a view to have some reliable tests of efficiency which may provide valuable evidence of the work load and the index of efficiency or inefficiency of a hospital, the Committee recommend that factors such as bed occupancy, bed interval, length of stay of patients etc. may be standardised and compiled in a scientific manner in Government hospitals.
		(*ii*) The Committee also recommend that the above statistics should be included in the Annual Report of the Ministry of Health in so far as the hospitals under its control are concerned.
26	33	The Committee recommend that copies of the annual administrative reports should at least be made available to the public on request. Some copies should also be kept in the waiting halls of patients for their study.

1	2	3
27	34	The Committee suggest that the position about the balance of Rs. 38·12 lakhs in the plan provision for the development of the Willingdon Hospital may be reviewed in consultation with the Planning Commission to ascertain if the whole of this earmarked amount is really necessary and can be usefully spent for the expansion of the hospital or whether a part of it can be diverted to the setting up of another hospital in some other part of Delhi.
28	35	The Committee consider it undesirable to concentrate Medical facilities in one corner of Delhi. They would have preferred it if the original idea of using the Safdarjang Hospital for the All India Institute of Medical Sciences was adhered to. But in view of the fact that the Health Ministry are anxious to keep it for the sake of the Contributory Health Service Scheme and the authorities of the Institute are anxious to have a separate hospital, the least that can be done is to stop the further expansion of the Safdarjang Hospital. The Committee recommend that the total bed strength of the Safdarjang Hospital be stabilised at 652 and the bed strength of the new Hospital for the All India Institute of Medical Sciences be also kept at the minimum necessary, so that the surplus resources, could be utilised for providing Hospital facilities to other parts of Delhi.
29	37	The Committee suggest that the work of the revision of the existing Indian Lunacy Act, 1912 may be expedited and a comprehensive Bill be brought before Parliament at an early date.
30	38	The accuracy of the statement quoted in para 38 needs to be determined. The Committee recommend that with a view to have a correct estimation of the incidence of mental diseases in the country and its connected problems, Government should sponsor a systematic survey under the aegis of a competent organisation independent of the author of the statement quoted in para 38.
31	39	The Committee suggest that annual returns of mental sickness from general hospitals and dispensaries may also be compiled and to that end proper record forms be introduced.
32	40	The Committee suggest that the situation resulting in the admission of a large number of chronic and incurable patients, permanently occupying some beds

1	2	3
		in the Hospital for Mental Diseases, Ranchi, may be carefully investigated by the Ministry in consultation with the State Governments concerned and suitable remedial measures be taken to ensure, as far as possible, full utilisation of all available facilities in this hospital and other mental hospitals, primarily, for patients suffering from acute and curable diseases. In this connection, attention is invited to para number 51 of the Report.
33	41	The Committee recommend that the policy of having a fixed quota for different States in the Hospital for Mental Diseases, Ranchi, decided upon the basis of white population, years ago, should be reviewed suitably under the existing changed conditions, as some States have no quota. Suitable criteria may be evolved in consultation with State Governments at the time of effecting the revision.
34	42	The Committee recommend that the feasibility of increasing the existing number of beds in the Hospital for Mental Diseases, Ranchi and also rationalising and reducing the charges levied per patient, ensuring thereby full utilisation of the expanded capacity of the hospital, may be examined.
35	43	The Committee recommend that Government should evolve a scheme, in consultation with the State Governments concerned and admit special and difficult cases from other Mental Hospitals in India in the Hospital for Mental Diseases, Ranchi either in the Government quota or in the independent category; but such cases should not be refused.
36	44	The Committee suggest that the question of indigenous manufacture of the material for psychological tests, may be pursued in consultation with experts and the Ministry of Commerce and Industry.
37	45	The Committee consider it rather unfortunate to note that there was considerable shortfall in the budgeted amounts during the first two years of the Second Five Year Plan, and recommend that special measures should be taken to ensure full utilisation of the amount provided in the Second Five Year Plan for the development of the Hospital for Mental Diseases, Ranchi.
38	46	(i) In view of the fact that the Hospital for Mental Diseases, Ranchi and the Indian Mental Hospital, Ranchi (under the Government of Bihar) are situated

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		adjacent to each other, the Committee are of the opinion that there should be greater co-ordination in the matter of utilising specialised facilities and equipment available in one hospital for the other. (*ii*) For the above purpose, they suggest that the feasibility of having either a Joint Advisory Committee or a Coordination Committee for these hospitals may be examined.
39	47	The Committee recommend that Government should devise a scheme whereby it may be possible to provide some healthier accommodation and more appropriate care for mentally sick persons misplaced in Rescue Homes and in Jails in the Union Territories, where such facilities are practically non-existent.
40	48 & 49	The Committee suggest that Government may re-examine the question of constituting, at least, an All India Mental Health Service and pending the formation of an all India Mental Health Service, pursue the idea of having a Central pool of all the existing medical and non-medical mental health specialists who can move from one institute to another, learn and exchange their experiences in different medical institutions in the country; the difference in emoluments as a result of such postings should be made up by the Government of India.
41	50	In view of the existing shortage of qualified specialists in the country, the Committee recommend that fullest possible advantage of the technical assistance provided by the International Organisations should be taken in the matter of improving and developing mental health services in the country.
42	51	The Committee are of the view that it would be advisable to establish a separate Home for the custodial care of chronic and incurable patients at the Hospital for Mental Diseases, Ranchi, and recommend that the position in this regard should be reviewed. Such a Home will prove much less costly because specialists for treatment may not be needed.
43	52	As ultimately, it would serve the problem of improving the existing mental health services in the country by finding suitable accommodation for incurable mental patients, the Committee recommend that Government should evolve a scheme whereby it may be possible to give assistance to the State Governments and to some non-officia

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		organisations in the country for meeting a substantial proportion of their non-recurring and recurring expenditure on schemes designed to fulfil this objective.
44	53	The Committee suggest that a scheme for the establishment of work settlements of chronic mental patients in association with philanthropic social institutions may be prepared and taken up for execution by Government and given a fair trial. Apart from the humanitarian aspect, implementation of such a scheme will have the further advantage of replenishing the inadequate bed-capacity in the existing Mental Hospitals for patients suffering from acute and curable mental diseases.
45	56	The Committee recommend that patients under the C. H. S. Scheme should invariably have their free choice of doctors working with a dispensary in a particular area and that one of the important factors in the assessment of the work of medical officers for the purpose of confirmation, promotion, transfer etc. should be the extent of their popularity earned during the period of their service in a particular area.
46	57	The Committee recommend that the C. H. S. Dispensaries should be kept open on all days. Till suitable arrangements are made for keeping the C.H.S. Dispensaries open on all days, it would be useful to keep them open on Sundays and close them on one of the week days. This will give greater facility to the Government servants to take advantage of the facilities on Sundays when they have ample spare time at their disposal.
47	58	The Committee recommend that there should be a constant review of the needs of the different areas served by the C.H.S. Dispensaries in respect of the volume of work and that the average waiting period of a patient should not normally exceed 30 to 45 minutes.
48	59	The Committee recommend that adequate waiting facilities and sitting arrangements should be provided in all the C. H. S. Dispensaries.
49	60	(*i*) The Committee emphasise the need to ensure that watermen and sweepers engaged by the C. H. S. Dispensaries remain constantly on duty at a place assigned to them in the patients' waiting shed and that they regularly perform their duties.

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		(*ii*) The Committee suggest that a small Notice Board may be displayed in the dispensary at a prominent place to inform the patients about the availability of the free services of watermen and sweepers which could be utilised in the dispensary.
		(*iii*) The waterpot and utensils for serving water to patients in the C. H. S. Dispensaries should be kept in a hygienic place and scrupulously clean.
		(*iv*) The Committee suggest that it will be preferable and more economical in the long run to instal automatic cool water fountains instead of, employing watermen and supply utensils for serving water.
50	61	(*i*) The Committee would like to emphasise that in the matter of rendering medical treatment by the medical staff, especially by the specialists working in government hospitals care should be taken to see that priority is given to the urgent and emergent cases and that there is no discrimination whatsoever in the selection of patients of different economic categories or social status.
		(*ii*) Criticism is sometimes made that the doctors and the nursing staff employed under the Scheme, as whole time Government servants, are often unsympathetic towards the patients and do not care too much about pleasing them and treating them with courtesy and consideration. The Committee recommend that Government should take appropriate steps to discourage such an attitude on the part of public servants.
51	62	The Committee recommend that local Advisory Committees should be constituted for the C. H. S. Dispensaries.
52	63	The Committee recommend that a decision making the C. H. S. Scheme optional for those Government servants who may agree to forego their claim of reimbursement of the cost of medical treatment should be taken and communicated to all the Central Government servants.
53	64	(*i*) The Committee recommend that a proper evaluation of the working of the C. H. S. Scheme by an independent agency like the Programme

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		Evaluation Organisation of the Planning Commission may be undertaken to see (*i*) whether the results achieved so far are commensurate with the expenditure incurred, (*ii*) the quality of service rendered, and (*iii*) the satisfaction derived by the beneficiaries.
		(*ii*) The Committee hope that such an evaluation will not only help the Government in having an objective assessment of the results achieved so far by the C. H. S. Scheme but also help in laying down a solid foundation for a much desired Health Insurance Scheme for the country.
		(*iii*) The Committee suggest that after the evaluation of the C. H. S. Scheme is completed, the scope of the Scheme may be extended to bring more and more families within its fold.
		v) Any such expansion of the C. H. S. Scheme should be preceded by forward thinking, careful planning and adequate preparation. Prompt and adequate medical facilities are a *sine-qua-non* for lasting popularity of the scheme and these should not be sacrificed merely to give increased coverage.
54	65	The Committee suggest that the feasibility of permitting import of foreign drugs also at Visakhapatnam and Kandla may be examined.
55	66	(*i*) While appreciating the difficulties involved in the process of the preparation of the Indian Pharmacopoeia, the Committee feel that the work needs greater impetus.
		(*ii*) The Committee recommend that the work of standardisation of indigenous drugs and their inclusion in the Indian Pharmacopoeia should be taken up in a planned manner so as to ensure a continuity of the programme from year to year to be completed within a specified period according to a time schedule. Once the work of standardising the commonly used indigenous drugs and including them in the Indian Pharmacopoeia is completed, periodical revision of that document would be a much simpler task.

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56	67	(i) The Committee recommend that all the available facilities in the country, irrespective of the fact whether they are in the public or in the private sector, should be utilised for the purpose of standardising the indigenous drugs which may expedite the compilation of the Indian Pharmacopoeia.
		(ii) The Committee suggest that Government may take up the above work in consultation with the local governments, universities and similar institutions in the country.
57	68	(i) In view of the existing diversity in the methods of the preparation of Ayurvedic drugs, the Committee suggest that the feasibility of standardising the methods of preparation of Ayurvedic and other indigenous drugs, may be examined.
		(ii) It may also be worth while examining whether some methods could be evolved to ascertain and standardise the proportions of the different constituents of important and famous indigenous medical preparations like the च्यवनप्राशावलेह (Chyavanprashavaleh), मकरध्वज (Makaradhwaja) etc.
58	69	(i) The Committee consider it to be an unfortunate state of affairs to note that there is no control over the Ayurvedic, Unani and Homoeopathic drugs manufactured in India.
		(ii) The Committee suggest that the feasibility of suitably extending the provisions contained in the Drugs Act and Rules to the Ayurvedic, Unani and Homoeopathic drugs, manufactured in India or alternatively bringing a separate legislation for this purpose may be examined, in consultation with the experts in these systems of medicine.
59	70	The Committee feel that besides increasing the indigenous production of standard drugs, there may be scope for identifying certain drugs manufactured under Ayurvedic, Unani or Homoeopathic formulae which could be substituted for imported drugs. All these methods could help substantially to reduce the import bill of the country. The Committee, therefore, suggest that a special drive may be initiated for

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		replacing the imported drugs by the indigenous drugs as rapidly as possible. To do so, it is not enough to process imported drugs but a concerted effort must be made to replace imported raw materials by indigenous products. To that end, more emphasis on growing of medicinal plants is necessary.
60	71	(*i*) The Committee view with grave concern the continued existence of spurious and adulterated drugs in the market due to the ineffective operation of the Drugs Act and Rules in the country and recommend that all remedial measures, including the strengthening of the State Drug Inspectorates, should be taken by Government to check this evil effectively and expeditiously.
		(*ii*) For achieving the above objective, even a recourse to levying suitable excise duty on pharmaceuticals may be adopted, if considered inevitable, although, it would be undesirable to do so. However, it will be a lesser evil than the prevalence of spurious drugs.
61	72	(*i*) The Committee recommend that the procedure of confiscating drugs detected to be substandard, prior to the institution of legal proceedings, may be suitably examined and tightened up.
		(*ii*) It should also be ensured that the confiscated drugs are sealed and adequate care taken against their being used surreptitiously.
62	73	The Committee recommend that minimum deterrent punishment should be prescribed for the infringement of the Drugs Act and Rules.
63	74	(*i*) The Committee would like to emphasise that the provisions in respect of the manufacturing standards of drugs should be rigidly enforced and that there should not be any relaxation of those minimum standards. The Committee are definitely of the view that the imperative need of maintaining the quality and standard of drugs should not be compromised in order to encourage the small manufacturers.
		(*ii* The feasibility of small manufacturers of drugs forming themselves into larger and more viable units such as co-operatives, so

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		that they can afford adequate apparatus, staff and premises for proper manufacture of drugs, may be examined.
64	75	In view of the recommendation of the Central Council of Health to bring the control over the production of drugs and pharmaceuticals under the Central Government, the Committee suggest that the centralisation of drug control machinery in so far as it concerns the production of drug and pharmaceuticals may be expedited.
65	76	With a view to make the Drug Control really effective in the interest of general health of the people the Committee feel that the existing machinery for Drug Control needs an overhaul. The Committee suggest that it may be desirable to appoint a Reviewing Committee to examine the operation of the existing Act and suggest modifications wherever necessary.
66	78	The Committee suggest that there should be close correlation between the prevailing market rates and the rates charged by the Medical Stores Depots and that they should be reviewed periodically.
67	79	The Committee feel that 20% departmental charges, excluding the freight and customs duty charges, being levied by the Medical Stores Depots appear to be excessive and suggest that the question of suitably reducing this charge, may be examined.
68	80	With a view to eliminate the work involved in the double handling of stores and to relieve pressure on the cost of transportation, the Committee suggest that the feasibility of making arrangements for the direct supply of some of the medical stores to certain indentors and big hospitals at rate contracts, may be explored.
69	81	(*i*) From the table furnished by the Ministry of Health and reproduced in para 81 of this report, it is seen that in comparison with other Medical Stores Depots, which take on an average about 30 to 45 days for the compliance of indents, the Medical Stores Depot at Calcutta takes nearly two months.
		(*ii*) It is sometimes complained by State Governments that the supply of medical stores is often delayed by several months at the end of which only 30 per cent or so of the supplies are received and the rest of the quantity is marked

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		'hereafter'. Since the figures given in the table in para 81 of this report are average figures, it is obvious that considerable delays must be occurring in individual cases, and there is justification for these complaints.
		(iii) The Committee consider the position regarding delayed and incomplete compliance of indents by the Medical Stores Depots as unsatisfactory and recommend that the question of guaranteeing expeditious and full supply of medical stores to the indentors should be examined carefully and the position improved.
70	82	The Committee suggest that the feasibility of utilising the State Transport Services in the transit of Medical Stores supplied by the Medical Stores Depots to indentors for comparatively shorter distances may be examined.
71	83	(i) From the figures given in the table in para 83 the Committee observe with regret that large amounts are outstanding for more than one year both from Government and non-Government institutions.
		(ii) The Committee observe that an amount of Rs. 1,41,640 has remained outstanding in the Medical Stores Depot, Karnal in respect of the value of stores supplied to non-Government institutions. The Committee sugges that the procedure of the recovery of dues, more especially, from non-Government institution may be reviewed so as to avoid large accumulation of dues.
72	84	(i) From the table given in para 84, he Committee observe that the figures of losses of the Depot at Bombay are disturbing. The Committee suggest that adequate steps may be taken to avoid losses due to deterioration of short-life items stocked by the Medical Stores Depots, in future, by carefully assessing the fluctuating demands of 'short-life items'.
		(ii) The Committee feel that an arrangement for making the supplies directly to the indentors on the basis of rate contracts may help avoiding the wastage due to deterioration of short-life items stocked by the Depots.
73	85	The Committee suggest that Government may examine the feasibility of adopting the method of accepting rate contracts from reliable drug houses, in the

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		country for the supply of selected categories of medical stores so as to avoid the need of storage and double handling by the Medical Stores Depots as far as possible.
74	86	The Committee feel that the factories attached to the Medical Stores Depots could make a useful contribution by manufacturing some of the items of the stores which, though patented, may not ordinarily be available in the market or those which are not taken up for manufacture by the private manufacturers. The production programme of these factories may have to be geared in such a manner as to create an impact on the market and ensure their supply at reasonable rates.
75	87	While on the subject of production of medical stores the Committee recommend that Government should, comprehensively examine the question of limiting imports of foreign medical stores and replacing them by indigenous products according to a phased programme.
76	88	The instances of large losses due to deterioration of stores etc. quoted by the Committee in para 88 indica e that here is an urgent need to improve the working of the Medical Stores Depots, if such losses are to be prevented in future.
77	89	(i) The Committee feel that the Medical Stores Depots have not been successful in the objective of ensuring medical supplies adequately, cheaply or promptly. (ii) The Committee are not satisfied with the adequacy of the steps taken by Government to meet the various requirements of the indentors in respect of the medical stores. The Medical Stores Organisation is suffering from a number of defects, some of which are indicated in para 89.
78	90	(i) The Committee recommend that an Expert Reviewing Committee with the association of non-officials should be appointed by Government to review in detail the existing practice and procedure for procurement, stocking, pricing and distribution of stores, and to assess the utility of the Depots and also to suggest measures for assuring a regular supply of foreign and patent medicines to indentors at controlled rates.

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		(ii) The Reviewing Committee should also examine *inter-alia* the necessity of continuing the Medical Stores Depots. If they are to be continued in some form, the Reviewing Committee may also consider whether it would be useful to set up an autonomous Corporation to manage all the Medical Stores Depots, which would not only store and supply drugs and equipment, but might also undertake production on a substantial scale.

APPENDIX VII

Analysis of recommendations contained in the Report

I. *Classification of recommendations* :

A. Recommendations for improving the organisation and working :

S. Nos.	*Total*
2, 3, 4, 6, 7, 8, 9, 11, 12, 16, 17, 18, 20, 22, 24, 25, 26, 27, 29, 30, 31, 32, 33, 36, 37, 38, 40, 41, 42, 43, 45, 47, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 68, 69, 70, 71, 73, 74, 75, 76, 77, 78	60

B. Recommendations for improving and/or extending the welfare activities in the country :

S. Nos.	*Total*
1, 10, 14, 15, 21, 23, 34, 35, 39, 44, 46, 48	12

C. Recommendations for effecting economy :

S. Nos.	*Total*
5, 13, 19, 28, 67, 72	6

II. *Analysis of the more important recommendations directed towards economy*:

S. No.	No. as per summary of recommendations	Particulars
(1)	(2)	(3)
1	5	The rise in expenditure during 1954 to 1957 in respect of the Safdarjang and Willingdon Hospitals is disproportionate to the increase in the number of indoor and out-door patients and needs investigation.
2	13	A centralised Blood Bank would make it possible to use the surplus blood for production of blood plasma and prevent its wastage.
3	19	The feasibility of working double shifts in out-patient departments of Government Hospitals in New Delhi may be examined looking to the high cost of establishing new hospitals or expanding the existing ones.

(1)	(2)	(3)
4	28	The Ministry of Health are anxious to develop the Safdarjang Hospital, New Delhi, for the Contributory Health Service Scheme. The All India Institute of Medical Sciences, New Delhi, is anxious to have a separate hospital of its own for teaching purposes. It would be undesirable to concentrate medical facilities in one corner of Delhi and therefore the total bed strength of the Safdarjang Hospital should be stabilised at 652. The bed strength of the new hospital for the All India Institute of Medical Sciences, New Delhi, should also be kept at the minimum necessary requirements.
5	67	20 per cent departmental charges, excluding the freight and Customs Duty charges levied by the Medical Stores Depots, appear to be excessive and the question of reducing the charges requires examination.
6	72	(i) Adequate steps should be taken to avoid losses due to deterioration of short-life items by carefully assessing the fluctuating demands. (ii) An arrangement of supplies directly to indentors on the basis of rate contracts may avoid wastage due to deterioration.

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(1)	(2)	(3)
4	28	The Ministry of Health are anxious to develop the Safdarjang Hospital, New Delhi, for the Contributory Health Service Scheme. The All India Institute of Medical Sciences, New Delhi, is anxious to have a separate hospital of its own for teaching purposes. It would be undesirable to concentrate medical facilities in one corner of Delhi and therefore the total bed strength of the Safdarjang Hospital should be stabilised at 652. The bed strength of the new hospital for the All India Institute of Medical Sciences, New Delhi, should also be kept at the minimum necessary requirements.
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67.	Bookland, 663, Madar Gate, Ajmer (Rajasthan).
68.	Oxford Book & Stationery Co., Sciendia House, Connaught Place, New Delhi.
69.	Makkala Pustaka Press, Balamandira, Gandhinagar, Bangalore-9.
70.	Gandhi Samriti Trust, Bhavnaga

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